“IT TOOK MY BRAIN AWAY”: A DEVELOPMENTAL CONTEXTUAL CASE STUDY OF A CHILD WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

by

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The purpose of this study was to investigate the life of one child who has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The definition of ADHD has become very broad and many children are being treated according to the label of ADHD. This study investigated the life of one eight year old boy from conception until present in order to understand the child as an individual. The research was framed in developmental contextualism and developmentally appropriate practice in a case study approach. In depth interviews and observations formed the data for the case. The study case demonstrated the need to focus on the child as an individual, and not just the label of ADHD. Recommendations were made for parenting and teaching, as well as for future research.
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ADHD

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CHAPTER I

INTRODUCTION

Statement of the Problem

Increasing numbers of children are being diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) (Barabasz & Barabasz, 1996; Goodman & Poillion, 1992; Reid, Maag, Vasa, & Wright, 1994; Saunders & Chambers, 1996). Three to five percent of school-age children are estimated as having some form of ADHD (McBurnett, Lahey, & Pfiffner, 1993), and the average United States classroom has two children with some form of ADHD (Barabasz & Barabasz, 1996). There is a concern that students with ADHD may be over-identified (Reid et al., 1994; Sabatino & Vance, 1994).

Traditionally, ADHD has been defined as a completely organic disorder, originating from within the child and not influenced by the environment (Pellegrini & Horvat, 1995). This has brought about the practice of medicating to treat the biological nature of the disorder. It has been noted that the use of psychostimulant medications to treat ADHD may have detrimental side effects (Barabasz & Barabasz, 1996).

Given the rise of prevalence of the disorder, it is important to take environmental factors into consideration (Pellegrini & Horvat, 1995). Although much of the research has focused on etiology, diagnosis, and treatment of ADHD, little attention has been given to why this disorder is becoming more prevalent in children, or to the question of why the use of medication is the treatment of choice in the United States (Barabasz & Barabasz, 1996; Saunders & Chambers, 1996).

With the recent recognition of the potential importance of the child’s environment, it is necessary to investigate the school environment where the child spends many hours of the day (Pellegrini & Horvat, 1995). The current trend toward inclusion points to a need for research focusing on how classroom teachers are meeting the needs of children with ADHD (Reid et al., 1994). The possibility of managing ADHD through the child’s home and school environment as
alternative to medicating the child needs to be explored (Burcham, Carlson, & Milich, 1993; Fiore, Becker, & Nero, 1993; Reid et al., 1994).

Purpose of the Study

I investigated the life of one child who has been diagnosed with ADHD. I used a developmental contextualist approach, which provides a model in which the child is involved in a transactional relationship with his environment (Pellegrini & Horvat, 1995). I investigated the child’s relationships with parents and teachers, with a focus on the influences of both biological and environmental factors. The case study approach used in this investigation allowed me to focus on one child and the contexts in which he participated. I explored the ways different systems in the child’s life influenced the diagnosis and/or treatment of the child. I investigated the systems of one child who is taking medication as the primary form of treatment. This allowed me to describe the decision-making processes as well as sources of support and information for his family and teachers. Given all of the negative effects that medication has on children, it seemed important to explore parent’s and teacher’s perceptions about medication (Barabasz & Barabasz, 1996; & Lerner, Lowenthal, & Lerner, 1995).

Theoretical Frameworks Guiding the Study

This study was framed in developmental contextualism and developmentally appropriate practice (DAP). Developmental contextualism provides a view of development that situates the person in a transactional relationship with the environment (Pellegrini & Horvat, 1995). DAP is a model for decision-making in early childhood settings (Bredekamp & Copple, 1997).

Operational Definitions of Key Terms and Concepts

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, (American Psychiatric Association, 1994), ADHD is defined as “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” (pp.78). Traditionally, ADHD has
been defined as a neurological disorder, coming from the individual’s genetic makeup. However, with the increase in prevalence of the disorder (Barabasz & Barabasz, 1996; Goodman & Poillion, 1992; Reid et al., 1994; Saunders & Chambers, 1996), it is important to explore the alternative definitions for an explanation of why so many children are being diagnosed. The various definitions of ADHD could also be seen as forming a continuum with biological and environmental as the polar factors. Many children with ADHD may have a truly organic problem which inhibits them from being able to learn self-regulation, while other children’s behavior may be reactions to environmental conditions. Some definitions of ADHD found in the literature include:

- a heterogeneous disorder of unknown etiology (Spencer, Biederman, Wilens, Harding, O’Donnell, & Griffin, 1996, pp. 409)
- the child has no marked intellectual deficits, thought disorders, or emotional disturbances that would serve as ready explanations, and neither the family nor the environment has posed great difficulties or been sufficiently provocative to have explanatory power (Henker & Whalen, 1989, pp. 216)
- attentional ‘deficit’ is more accurately described as attentional ‘bias.’ An attentional deficit connotes a lack of attention, whereas an attentional bias more correctly connotes adequate attention, memory, and comprehension, but associated with specific tasks, time period, and conditions (Zentall, 1993, pp. 143)
- a disorder of inhibition, motor control (Barkley, 1997, pp. 271)
- an interactive or transactive model combining the influences of endogenous and exogenous factors may best explain the development of ADHD (Carlson, Jacobvitz, & Sroufe, 1995, pp. 52)
- complex constellations of behaviors, such as those represented in ADHD, are usually the result of the transaction between persons and contexts across developmental time; the frequency of extreme cases of ‘biologically determined’ ADHD is probably low (Pellegrini & Horvat, 1995, pp. 18)
ADHD

The wide range of definitions of ADHD demonstrates the varying opinions in the field and has implications for the types of treatment chosen for each child. If parents and teachers subscribe to the definitions of ADHD as completely organic then there would be no need to alter the environment or teach the child self-regulation. In this case, medication would be the most logical choice for treatment. Parents and teachers may have an easier time accepting the disorder if it comes from within the child, and not by other influences. On the other hand, if parents and teachers believe that ADHD is a result of both the environment and biological factors, then medication may not be the treatment of choice. If environmental influences are thought to be the major cause, a logical way to approach the treatment for a child in this case would be to start by altering the environment and using strategies that would not involve medication. The various definitions and causes suggest a need to see each child as an individual with different etiologies and characteristics of ADHD.

Overview of Proposed Study

I was interested in studying the most appropriate ways, according to DAP, of aiding children’s development who have been diagnosed with ADHD. I wanted to explore with parents the decision-making process that they went through in deciding whether or not to medicate their child who had been diagnosed with ADHD. I was interested in how they acquired their knowledge about ADHD, medication, and alternatives to medication. Another interest was whether there was consistency between the home and school for the child in the areas of parenting and teaching styles, and how this impacted the decision to medicate or not to medicate the child. I wanted to know if either setting offered the child autonomy in terms of activities of interest, as well as limits for discipline. The case study approach allowed me to investigate one child who has ADHD, his family and teachers, and the home and school environments.

Scope and Delimitations of the Study

To limit my study, I only invited children in the age range of six to eight to participate. I chose this age because, according to the DSM-IV (APA, 1994), children should be diagnosed by
ADHD

the age of seven. This is also the age range in which children have begun elementary school. I was interested in talking to the parents about the child’s transition from preschool or kindergarten into elementary school. I also limited my study to one family in a county in southwest Virginia.
I became interested in learning more about children with ADHD during student teaching in my senior year of college at Virginia Tech, 1995-96. I had two different teaching placements, one in first grade and one in third grade. In both placements, I was surprised to see so many children leave the room each day to take their medication. I became very curious and began to ask questions. The teachers with whom I talked explained to me that these children had been diagnosed with ADHD and that they needed to take medication to control their behaviors. Many teachers expressed to me how great medication was because it helped these children to sit still and pay attention. They shared many stories about days that children had forgotten to take their medication and how difficult it had been on them. I began to wonder about how difficult it must be for the child. What child would want to have to sit still and pay attention all day? I observed these children full of energy and life, coming back from lunch and from taking their medication to be almost lifeless, in a trance-like state. I began reading more about ADHD and the medication that these children were taking. I began to discover that the practice of using medication to control behaviors associated with ADHD was becoming more prevalent. I also discovered that the medication had significant side effects, and that it should be combined with other forms of treatment. However, no one that I had talked with about ADHD mentioned anything about other methods of dealing with the child’s behaviors. I began to feel frustration and anger with the practice of medicating growing numbers of children to make them “sit still.” The children that I worked with ranged in age from six to nine. Nowhere in any of my child development classes had I been taught that children in primary grades should be required to sit still in order to learn. In fact, all I had ever learned about had been developmentally appropriate practice in which teachers understand the developmental needs of children, and teach to those needs. In my experiences with children, I had learned that some are very energetic and learn best when they can use their energy to actively learn. I disagree with the practice that children should be expected to sit still all
day long - especially being forced to sit by being medicated. I began to wonder where teachers and parents received their information about ADHD and the medication that helps control some of the behaviors. I even began to wonder if all of these children should have been diagnosed with ADHD. Some of the children that I worked with seemed to me to need more reasonable and age-appropriate limits in their lives rather than medication. I began to wonder about the parenting styles of the parents with children who have ADHD. I also began to wonder what parents and teachers were doing in addition to medicating to help these children. Eventually I came to the decision that I really wanted to explore in depth with a child with ADHD.

Critical Analysis of Research Related to the Theoretical Framework

Drawing from the literature I reviewed on ADHD, I developed a model of developmental contextualism for a child who is diagnosed with ADHD. A drawing of the model is included as shown in Figure 1.
Figure 1
Developmental Contextualist Model of ADHD
I have adapted Urie Bronfenbrenner’s ecological model to be the basis for the child-in-context approach. The five systems in Bronfenbrenner’s model are the microsystem, mesosystem, exosystem, macrosystem, and the chronosystem. I examined both the micro- and mesosystems in this study. The microsystem involves the individual’s immediate setting, which would include the person’s family, school, and peers. The mesosystem involves the interrelations among the person’s microsystems (Bronfenbrenner, 1986). I examined how the specifics of these two systems interacted in the life of one child who has been diagnosed with ADHD. An important aspect of Bronfenbrenner’s view is that the child’s behavior cannot be explained in isolation from other aspect’s in his or her life. It is important to consider the person as an active part of a complex person-environment system. The word active suggests that the person is not a passive recipient of information or experiences, but is involved in multi-directional interactions with other systems. For example, the child’s behaviors may influence the parents’ discipline style or vice versa.

**Child in Context**

Drawing on Bronfenbrenner’s ideas, I proposed that the child who is diagnosed with ADHD could best be seen in a similar model in which he or she is an active part of a complex system of interactions. Instead of seeing the child in isolation from the environment, I included the child in the center of all that is occurring. The placement of the child in the center of the model represents how important it is to focus on the individual child. Characteristics of the child that have been studied in the ADHD literature and which are included in the model are: race, gender, age, socioeconomic status, behaviors, ethnicity, temperament, and comorbidity. Their inclusion represents the importance of taking each of the child’s characteristics into consideration for diagnosis and treatment of ADHD.

The microsystem in my model included three main features: the family, the school, and available services. The dashed lines indicate that the three are interacting systems in the child’s life. I have included important aspects in each area that may be helpful in understanding the child. For example, maybe it is important to consider the parenting styles of both the mother and father. Diana Baumrind (1971) has shown through her research that certain parenting styles affect self-
regulation and impulsivity, which are behaviors associated with ADHD. Also, it is important to examine the classroom environment that the child is in. Pellegrini and Horvat (1995) point to the transition from a low structured pre-school or kindergarten environment into a more formally structured elementary school classroom as the onset of ADHD for many children. Services such as the family doctor also play a role in the child’s diagnosis and treatment. Each aspect of the child’s immediate world needs to be considered to better understand the child’s diagnosis and treatment.

The arrows in the meso-system in my model demonstrate the processes that are occurring in the child’s life. For example, I explored the decision-making processes that the parents of the child with ADHD went through in deciding which treatment is best for their child. I explored the developmental history of the child, the diagnosis, parent-teacher interactions, parent-child interactions, and teacher-child interactions as interacting systems. As shown in Figure 1, each component of my model represents a person, situation or interaction in the individual child’s life that may have an influence on the child’s behaviors or the treatments for the child. I examined how each of these systems in one child’s life influenced the decisions made for the child and the behaviors that the child exhibits. I observed how the child functioned in each of these situations and what was being done to help the child as an individual. The views of each of the people involved, including the child, were investigated in order to be able to discover what is best for the child (Pellegrini & Horvat, 1995).

Age of Onset

The DSM-IV suggests that children should be diagnosed with ADHD by age seven. This is often the age when children are moving from a low-structured preschool or kindergarten into a more formally structured elementary school setting. If many children are being diagnosed by age seven, then it is important to investigate the child’s transition from preschool and kindergarten into elementary school to discover if the child’s change of environment may have brought about the change in behaviors (Pellegrini & Horvat, 1995). Could it be that behaviors associated with ADHD are the result of inappropriate practices or expectations in elementary school?
Developmentally Appropriate Practice

Developmentally appropriate practice is another important aspect of the model. DAP is based on three important components. The first, age appropriateness, is what is known about how children of certain ages learn and develop. The second, individual appropriateness, is what is known about children as individuals; their needs, strengths and interests. The third, cultural appropriateness, ensures that the learning experiences are meaningful based on the social and cultural contexts in which the child lives (Bredekamp & Copple, 1997). All three components must be considered in determining DAP.

I compared the principles of DAP with the environmental needs of children with ADHD. Pellegrini and Horvat (1995) argued that the most appropriate environment for a child with ADHD is one in which a balance of adult-child control is offered. These authors noted that the prevalence of ADHD increases as children move from the preschool to the elementary school setting. In their view, preschools tend to be less structured and more permissive of choices and collaboration, whereas elementary schools begin to require the child to sit and do individual work for extended periods of time. They speculated that behaviors associated with ADHD are not necessarily more prevalent with age but that they are better accommodated in the less structured preschool environment. According to DAP, young children should be provided opportunities to collaborate with others and to actively explore materials to create knowledge. Preschool tends to be more developmentally appropriate than the average elementary school classroom. Preschools often have plenty of opportunities for lots of physical activities and free choice opportunities.

DAP suggests that elementary schools should provide similar environments, but many do not (Pellegrini & Horvat, 1995). DAP also stresses the importance of viewing each child as an individual with individual interests and needs, regardless of whether the child is diagnosed with a disorder or not. A developmentally appropriate classroom will provide a variety of learning experiences to appeal to each individual child. A more appropriate environment will help the child who has self-regulatory problems. Appropriate home and school environments will be
structured in ways that are beneficial, not inhibiting, to the child (Berk & Winsler, 1995; & Pellegrini & Horvat, 1995).

Critical Analysis of the Substantive Literature

Characteristics of ADHD

One of the problems with ADHD research is the diversity and subjectivity of the defining characteristics. In recent years, the definition of ADHD has expanded to include a wide variety of characteristics, many of which have not been supported with empirical evidence. Also, these behaviors are exhibited by “normal” children. This trend coincides with the fact that more and more children are being diagnosed as having ADHD. The broad definition makes it easier for parents and teachers to locate various characteristics in children, and therefore, feel that the children may have ADHD (Fletcher, Morris, & Francis, 1991; Goodman & Poillion, 1992). Behaviors that have been linked to ADHD and supported in the literature include problems with self-regulation, impulsivity, inattention, and hyperactivity (Barabasz & Barabasz, 1996; Berk & Winsler, 1995; Lerner, Lowenthal, & Lerner, 1995; Saunders & Chambers, 1996; Silver, 1990). Aggressive behavior is also frequently displayed in children with ADHD (Hinshaw, Henker, Whalen, Erhardt, & Dunnington, 1989). Impulsivity is characterized by acting without thinking, interrupting others, and not thinking about consequences to behaviors. Inattention is the inability to concentrate on a certain task. Hyperactivity involves constantly moving as well as disruptive behavior (Lerner, Lowenthal, & Lerner, 1995).

There are also many positive characteristics visible in children with ADHD. Tirelessness is one of these characteristics. Children with ADHD often have great enthusiasm and curiosity. They have rich imaginations and can often quickly generate new ideas. These children show great intensity when involved in an activity of interest. Other positive characteristics include spontaneity and zest. The majority of ADHD children go on to lead successful, well-adjusted lives (Henker & Whalen, 1989; Taylor, 1994). As with the negative behaviors, not all of these characteristics are exhibited by every child who has been diagnosed with ADHD.
ADHD

Causes

The possible causes of ADHD are as diverse as the characteristics (Goodman & Poillion, 1992). The definitions of ADHD can be seen as ranging on a continuum between environmental and biological factors. The definition that one chooses to use in diagnosing the child is closely related to the presumed causes (Pellegrini & Horvat, 1995). For example, if a child is diagnosed according to the DSM-IV definition, then it is implied that the child has a neurological disorder in which environment does not play a part. I believe there is a need for each child to be seen as an individual when considering the possible causes of the disorder. The definition I am most comfortable with is Pellegrini and Horvat’s (1995) A “complex constellations of behaviors, such as those represented in ADHD, are usually the result of the transaction between persons and contexts across developmental time; the frequency of extreme cases of ‘biologically determined’ ADHD is probably low” (Pellegrini & Horvat, 1995, pp. 18). Each child has different biological and environmental factors that need to be taken into consideration when determining the causes and discussing treatment options.

Cohen, Ricco, and Gonzalez (1994) investigated how methodological differences in diagnosing ADHD affected the prevalence of the disorder. Children with just ADHD as well as comorbidity with ADHD were chosen for the study. The Conner’s Teacher Rating Scale and the Conner’s Parent Rating Scale-Revised were used to rate the children’s behaviors. The children who had ADHD and a learning disability were rated by just the special education teacher, using the teacher scale. The children with just ADHD were rated by both parents and teachers, using the appropriate scales. There was relatively low parent-teacher agreement on the scales. The prevalence of ADHD varied, depending on whether just the teacher scale was used, or both. The findings revealed that the prevalence of ADHD varied, depending on the diagnostic criteria used. These findings suggest the need to consider both environmental and biological factors when diagnosing and treating the child. There is a need to recognize the same characteristic behaviors of ADHD may have multiple causes and, thus, different treatments.
ADHD

Medication as Treatment

The most prevalent view of ADHD is as a neurobiological disability (Arnett, Fisher, & Newby, 1996; Barabasz & Barabasz, 1996; Lerner et al., 1995). This view has been dominant in research on ADHD. Many studies have investigated the effectiveness of medication as a way of controlling behaviors (Arnett et al., 1996; Hinshaw et al., 1989; Spencer, Biederman, Wilens, Harding, O’Donnell, & Griffin, 1996). Psychostimulant medications have been shown to be effective in treatment of ADHD symptoms and behaviors. The most common psychostimulant medication prescribed for children with ADHD is methylphenidate, which is better known as Ritalin (Evans, Ferre, Ford, & Green, 1995; Henker & Whalen, 1989). Ritalin improves the ability to withhold inappropriate behaviors (Arnett et al., 1996). There are short-term benefits with behaviors associated with ADHD such as reduced impulsivity, inattention, hyperactivity, and aggression (Barabasz & Barabasz, 1996; Lerner et al., 1995). Other benefits include compliance and increased goal-directed behaviors in the classroom setting (Henker & Whalen, 1989). A study of boys with ADHD conducted by Hinshaw, Whalen, Erhardt, and Dunnington (1989) showed the short term benefits of Ritalin. The study observed 25 boys with ADHD and 15 comparison boys, ages 6 to 12. The boys with ADHD were assigned to one of three groups that alternated Ritalin with a placebo. Observations of the boys’ behaviors were made. The findings showed that Ritalin reduced noncompliance and physical and verbal aggression behaviors. There were no significant increases in prosocial behavior, and the effects of the medication were found to be short lived. Limitations of this study include the small sample size as well as the use of boys only.

Ritalin can be beneficial to children with ADHD, but there are also limitations to using medication as treatment (Swanson, McBurnett, Wigal, Pfiffner, Lerner, & Williams, 1993). Medication does not cure ADHD, at best it can only help control some of the behaviors involved (Dykman & Ackerman, 1993). Psychostimulant medication has become the most prevalent, as well as the most controversial, treatment used with children (Henker & Whalen, 1989). Psychostimulant medications, such as Ritalin, have significant side effects. These include insomnia, stunted growth, tics, cardiovascular problems, Tourettes syndrome, and reduction in
ADHD

appetite. These side effects are not present in all children who are taking Ritalin (Barabasz & Barabasz, 1996; Lerner et al., 1995). Recently, Ritalin was found to cause cancer in a controlled study of rats (Barabasz & Barabasz, 1996). No significant improvements in reading, athleticism, social skills, learning, or achievement have been demonstrated in research, and Ritalin may actually make it more difficult for children with ADHD to learn normal adaptive and appropriate behaviors (Barabasz & Barabasz, 1996). Medication cannot ensure that prosocial acts will replace disruptive behavior. (Henker & Whalen, 1989). Ritalin has been found to do nothing to improve the behaviors of 25 to 45% of children diagnosed with ADHD (Swanson et al, 1993).

Little is known about how parents decide whether or not to medicate their child who has been diagnosed with ADHD. In many cases, parents decide to medicate their child based on positive endorsements from friends who have been successful with choosing medication for their children. When parents hear of success stories, the temptation to rely solely on medication to relieve some of the behaviors is great (Henker & Whalen, 1989). A study by Sabatino and Vance (1994) found that parents often turn to friends for advice when it comes to making this decision. Their study involved 75 children diagnosed with ADHD who had been referred to a multidisciplinary clinic because current treatments, involving medicine or educational interventions, had not been effective. This population of children diagnosed with ADHD did not respond to drug therapy or other interventions. Parent and teacher checklists were used to describe children’s behaviors. The authors concluded that many children had been referred because of underachievement or because of emotional problems, and that ADHD is being overdiagnosed. They also found that parents are often devastated when realizing that medication does not cure the disorder, because they feel that ADHD is a biological disorder. This raises the question of how many children are being diagnosed with ADHD when they may have another disorder, such as emotional disturbance or a learning disability. This study also points out the confusion about who should be diagnosing the children and how they should be diagnosed.

Alternative Treatments

There are many other options other than medication to help the child with ADHD behaviors. Since the causes and characteristics of ADHD are so diverse, it is important to focus
ADHD

on the individual child. Several researchers recommend using a multimodal method of treatment which includes combinations of parent training, counseling, behavior management, and medication in preference to medication alone (Evans et al., 1995; Lerner et al., 1995; Silver, 1990). Parent training has been found to be a part of an effective plan in dealing with children with ADHD (Brown & Pachini, 1989; & Fiore et al., 1993). For example, Reid, Maag, Vasa and Wright (1994) conducted a school-based survey of 14,229 first through sixth grade students in a public school district. One hundred thirty-six of these students were diagnosed with ADHD. Of the identified students, 77 had been identified as having some other disability, such as behavior disorders or learning disabilities. This implies that some of the students diagnosed with ADHD have been mislabeled. Ninety percent of the diagnosed students were taking medication as the primary treatment. These results also show that the students who were receiving special services were the ones who were diagnosed with another disorder. This leaves out the students who are only diagnosed with ADHD. This study shows the need for ADHD to be examined in the school setting. There is a need for schools to re-examine their role in treatment programs for these students, with the current emphasis on multimodal treatments.

The people that are closely involved with the child’s life need to have a deep understanding of the child and his or her specific attention problems in order to create the most successful learning atmosphere for the individual child (Burcham et al., 1993; Henker & Whalen, 1989; & Rooney, 1993). A home-school connection that encourages the parents to be actively involved in the education of the child with ADHD has been found to be beneficial (Fiore et al., 1993; Reid et al., 1994). Family counseling has also been found to benefit families of children with ADHD. The families can discuss areas that the child has difficulty in as well as areas in which the child succeeds. This information can help the families decide appropriate activities for the child that can be shared with others who work with the child (Henker & Whalen, 1989; Lerner & Lerner, 1991).

Parenting Styles

Parental influence on child behavior has been of great interest to researchers for decades (Hart, DeWolf, Wozniak, & Burts, 1992). Baumrind (1971) identified three types of parenting
styles in her research affect children’s behavior. The three identified styles are authoritarian, permissive, and authoritative. The authoritarian style of parenting is characterized by using punishment to control a child’s behavior while discouraging independence and individuality. Authoritarian parents tend to exhibit low levels of warmth and high levels of demandingness to their children. They desire an obedient child. On the other hand, a permissive parent uses little punishment and makes few demands of the child. Some permissive parents exhibit high levels of warmth and low levels of demandingness. Others are low on both warmth and demandingness. An authoritative parent sets standard for the child using a fair amount of control, while allowing the child to have some choices. Authoritative parents demonstrate both warmth and adjusted expectations according to the age of the child. Baumrind found that authoritarian parenting was linked to the inability of the child to self-regulate and also to low self-esteem in the child. Children of permissive parents were found to lack impulse control and were unable to take on responsibility. However, the authoritative style of parenting was associated with independent and responsible children who are able to control their own behavior (Baumrind, 1971).

Other research supports Baumrind’s findings that difficulties may arise in a child’s behavior when parents are either too passive or too autocratic. Rogoff (1990) explains that it is possible for parents to exert too much or too little control over their children. Too much control has been shown to cause the child to not learn how to handle life’s challenges. Being too strict may cause the child to need external cues for help with behaviors. On the other hand, being too permissive may cause the child to never learn where the boundaries lie. By giving too little support the child is left on his or her own. Rogoff (1990) suggests that parents and teachers need to be consistent with the child and help the child internalize self-regulation for behaviors. This can be done by communicating guidelines to the child, while allowing for the child to have some say in the decision-making. Autocratic parents tend to be too demanding of children and tend to stifle independent thinking (Lerner et al., 1995). Children become oppositional when they cannot meet the demands of autocratic, or authoritarian parents. Control oriented child-rearing has also been associated with greater child aggression (Stormont-Spurgin & Zentall, 1996). On the other hand, passive or permissive parents tend to have few limits set for the child and too many choices.
When parents are too permissive children cannot learn responsibility or the ability to set limits for themselves (Lerner et al., 1995). The interactions between parents and children involve the parents reacting to the child and changing the style of parenting to fit the child’s need. Parents change their expectations as the child is able to handle more responsibility, thereby increasing the child’s self-regulation (Thompson, 1998). Kuczynski and Kochanska (1995) found that parents adapt to uncooperative children, depending on the children’s behaviors. Parents, specifically mothers, of difficult children showed reduced positive reactions and increased authoritarian parenting with difficult children. This increased demandingness predicted decreased self-regulatory capabilities in children (Kuczynski & Kochanska, 1995). Their findings suggest that parents tend to be more demanding of difficult children and restrict their self-regulatory capabilities.

Grolnick and Ryan (1989) examined three dimensions of parenting style; autonomy support, involvement, and provision of structure in both mothers and fathers of children in grades three through six. This study did not include children who were diagnosed with ADHD, however it did examine children’s self-regulation of behaviors. Children diagnosed with ADHD often have problems with self-regulating behaviors (Barabasz & Barabasz, 1996). One question that this study addressed was whether or not parental autonomy support is related to children’s self-regulatory behaviors. In this study self-regulation was measured by using the academic self-regulation questionnaire which produces one score that is referred to as the Relative Autonomy Index (RAI). Parental autonomous support was measured through individual structured interviews with each parent. The scores from the parent interviews and the RAI were correlated to see if there was any relationship between autonomy support and self-regulation. The results showed that there was significant positive correlation between combined parental autonomy support and the RAI. The parents who scored high on autonomy had children with a high RAI score for self-regulation. Individual parent scores showed a significant positive correlation between mothers’ scores and the RAI but not with fathers’ scores. It is important for parents to provide their children with clear and consistent guidelines for behavior in order for children to use this structure to regulate their own behavior. Parents’ autonomous support is associated with
better adjustment in classroom behavior. Parents can better prepare their children for situations that require self-regulation by fostering autonomy in their children. Children develop self-regulation as their parents respond to their behaviors. Parents can foster autonomy in their children by setting limits, providing clear and consistent guidelines, and encouraging choices for the child to make decisions.

**Teaching Styles**

Teachers can also demonstrate the same three dimensions of teaching styles, authoritarian, permissive, and authoritative. DAP stresses the importance of teachers use of an authoritative style of teaching in which limits are age-appropriate and children can make meaningful decisions. Teachers are responsible for allowing children to contribute to the learning experience by knowing the children’s interests and listening to their ideas. Teachers are responsible for encouraging children’s self-regulation of behaviors (Bredekamp & Copple, 1997). These are both examples of teachers using an authoritative style of teaching, in which children can make appropriate decisions and are learning self-regulation.

The Teacher-Classroom Adjustment Rating Scale measured teacher’s perceptions of children’s self-regulation in school. Results indicated significant negative correlations between maternal and combined parental autonomy support and teacher ratings of acting out and learning problems in the classroom. One limitation to these findings is that the cause cannot be determined, only whether or not there is any relationship can be seen. The important question addressed in this study was whether or not parental autonomy support was related to self-regulation problems in children’s behaviors. This study has shown that, in this sample, higher rating of parental autonomy support is related to increased self-regulation. However, this was only with combined parents’ scores and with mothers’ scores. This study does not investigate many other variables that could be related to self-regulation.

**Critical Analysis of Research Related to Method**

I chose to do in-depth interviews for a number of reasons. I was able to talk to the parents about where they received their information about ADHD and the ways they have found
ADHD

to help their child. I was able to find out about the parent’s and teacher’s perceptions and feelings about the child who has ADHD and the ways that they deal with that child. I talked to the people that are closely involved with the child’s life to try to understand how their perceptions affect the child. In-depth interviews provide a way to have open conversations with the people involved (Bogdan & Biklen, 1992).

Many studies investigating ADHD have been quantitative ones, and mostly correlational studies. These studies have been able to explore a few variables at a time in various samples of children (Arnett et. al, 1996; Evans et al., 1995; Hinshaw et al., 1989; Stormont-Spurgin & Zentall, 1996). It is necessary to study children using qualitative methods in order to be able to gather in-depth information about the lives of a few children. Many studies have also been conducted out of the child’s natural context of home or school (Reid et al., 1994). It is necessary to study children in their typical contexts, where they will be able to feel comfortable and act as usual (Pellegrini & Horvat, 1995). Using qualitative methodology, including in-depth interviewing and observations in a case study approach allowed me to be able to gather in-depth information about a child and his family (Bogdan & Biklen, 1992; Stake, 1994). Longitudinal studies would be able to gather information over the course of childhood in many different areas, but would be too time consuming for my purposes. By using qualitative methodology I was able to investigate the developmental history of one child to be able to explore the many different influences in his life.

A longitudinal study done by Carlson, Jacobvitz, and Sroufe (1995) examined the development of inattentiveness and hyperactivity in childhood from infancy to middle childhood. They pointed out the lack of research of ADHD using a developmental theory. One hundred ninety-one participants were recruited while the mothers were in the third trimester of pregnancy. Different measures of temperament, behaviors, and parenting styles were taken throughout the child’s life. The findings reveal important variables that need to be considered in any study of a child with ADHD. These variables include measures of relationship status at birth, social support for the parents, parental overstimulation, and maternal caregiving style. The findings also suggest the importance of using a developmental view of the causes and characteristics of ADHD. This
study points out the importance of considering multiple routes to the development of ADHD in childhood. The use of a longitudinal study allowed the researchers to examine different variables in the children’s lives before some were diagnosed with ADHD. Limitations of this type of study include the length of time and amount of money necessary to conduct a similar study. However, similar findings could be seen using developmental histories for each child in order to examine patterns across the life span. A more feasible study could accomplish this using case studies and collecting information to formulate a developmental history for each child.

Significance of Proposed Research in Relation to Existing Work

There is a need for studies to examine the development of ADHD behaviors in childhood (Carlson et al., 1995). Research also needs to be done on parents’ decisions about medicating, or not medicating, their child once he or she has been diagnosed with ADHD. Specifically, it would be beneficial for research to be done investigating the relationship between parenting styles and the behaviors of children who are diagnosed with ADHD. Certain parenting styles may have an effect on children’s behavior, especially behavior that displays qualities of ADHD. Research on ADHD also needs to be done in the school setting. With treatments focusing heavily on medication, more research needs to focus on treatments and educational practices that do not require medication for the child with ADHD (Fiore et al., 1993; Goodman & Poillion, 1992). Studies also need to be done taking Developmentally Appropriate Practice into consideration for working with children with ADHD (Lock, 1996).
Overview of the Research Design

I used qualitative methodology with in-depth interviews and observations in order to gather information that provided a description of a child-in-context (Bogdan & Biklen, 1992). I studied the child in the context of his environments and how each influenced the child’s behaviors. I also observed the child as an individual with individual problems and needs (Pellegrini & Horvat, 1995). I realize that the findings of the case study will not be generalizable to all other children with ADHD (Stake, 1994), however, the case study approach was appropriate for this study because I was interested in the process and contexts of the child’s life; parent-teacher-child interactions, cultural influences, support networks, and environmental issues. The case study approach allowed me to focus on one child, his family, and his environments in order to gain a deeper understanding of the multiple factors that influence the life of the child who has been diagnosed with ADHD (Bogdan & Biklen, 1992).

Description of Population and Sample

The participants in this study included a child who has been diagnosed with ADHD, according to the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, and his family and teachers. This child is taking medication as the primary treatment. The age of the selected child is eight. I chose this age because the typical onset of ADHD is by the age of seven (Barabasz & Barabasz, 1996). I also chose this age because it allowed me to explore how the child handled the transition from preschools or kindergarten to more formally structured elementary school. As discussed earlier, Pellegrini and Horvat (1995) stressed the importance of studying this transition because of the contrast in the school contexts. I asked the parents questions that helped to formulate a developmental history of the child’s behaviors.
Sample Selection Procedures

My original intention was to examine two families who each had a child diagnosed with ADHD. I intended to have one of the children with ADHD be using medication as the primary form of treatment and the other not. However, I had difficulties finding a child who was not taking medication as treatment and who was receiving special services.

I sought and obtained information from the district office to conduct my study at North Hills Elementary School. I then obtained permission and the cooperation of the school principal and the special education resource person. The special education resource person assisted me by sending letters to families who had a child who has been diagnosed with ADHD, and who was in kindergarten, first, or second grade and who was receiving services. The one family who responded to the first mailing and agreed to participate had a child in second grade who was taking medication as the primary form of treatment. Seeking the second subject we sent the same letter to third, fourth, and fifth grade families who had a child with ADHD. We did not receive any responses. The special education resource person noted that the difficulty of finding the second subject was due to the fact that the majority of children who have been diagnosed and receiving special services were also taking medication as the primary form of treatment. The decision was made to limit the study to one child.

I asked and received permission from the school and the parents to have access to the child’s files. This helped me with forming the child’s developmental history. The parents also signed consent forms for themselves and their child before beginning the study. The child orally gave his consent as I recorded his voice. Once the child was identified I contacted the classroom teacher of the child and invited her to participate in the study. I asked permission to interview her and to observe in her classroom as well as the other classrooms that the child would be in. I was able to gain perspectives from both parents and teachers in order to examine the child in different contexts (Pellegrini & Horvat, 1995).
Data Collection Procedures

I conducted open-ended and semi-structured interviews with both the parents and teacher of the child. I also observed the child at home and at school. I began my study by interviewing the mother and then the teacher. I spent a couple of days reflecting on our conversations before beginning my observations. I observed in school three times in the morning and two in the afternoon. I waited a couple of days between each observation in order to reflect and analyze as I went along. I observed the child at home one time at night and three times on a weekend afternoon. I observed the child interacting with his mother, teachers, and other children for patterns of interaction as he participated in different activities. These observations provided additional information for determining parenting and teaching styles that may not have been apparent through the interviews. I also interviewed the child about his perspectives and feelings about being diagnosed with ADHD. I interviewed the mother and step-father together after I completed my observations, as well as the teacher, in order to ask new questions that I formulated.

Description of Instrumentation/Measurements

The questions that I asked explored the ideas of the child’s behaviors, the parent’s and teacher’s decision-making processes, parenting and teaching styles, and ways of helping the child achieve self-regulation in various situations. These questions also helped me gain an understanding of the developmental history of the child. The developmental history questions began with conception and continued through the present.

My role as the researcher was the primary form of instrumentation (Bogdan & Biklen, 1992). I conducted in-depth interviews with the parents, teacher, and child who has been diagnosed with ADHD. This enabled me to gather in-depth information about the parent’s perceptions, decision-making processes, parenting styles, and sources of information (Bogdan & Biklen, 1992; Kaufman, 1994). This also allowed me to examine the teacher’s and child’s perceptions. I also conducted observations of the child at both home and at school. This allowed
me to study the child in two different contexts (Pellegrini and Horvat, 1995). I wrote up field notes during and after each observation. I observed the different settings for behaviors that are associated with ADHD, interactions, environments, and parenting and teaching styles. Observing the child allowed me to view the child acting as he or she normally would in a natural setting (Bogdan & Biklen, 1992).

**Data Analysis Process**

I analyzed the data as I went along, after each interview and each observation. This allowed me to prepare for the next interview and/or observation with new questions, themes, or ideas and to clarify previous observations and comments (Bogdan & Biklen, 1992). The interviews were tape recorded and then transcribed. I also made notes during and after each interview and during and after each observation. The notes, along with the transcripts from the interviews, were read several times in order to look for common themes or ties to the literature (Bogdan & Biklen, 1992). I shared the transcripts of the interviews with the parents and teacher in order to have them respond to what they originally said and to be able to make corrections or additions. The data was coded according to similar themes and tied to theory and the literature. I also looked for themes in my observations and tied those to theory and the literature. I categorized my observations and ideas according to assertions and provided data to support and refute each one. I analyzed the findings using the two lenses of developmental contextualism and developmental appropriate practice, as well as the literature on ADHD, as I wrote up the findings. The names of the child, the parents, the teachers, the school, and the doctors have all been changed in an attempt to maintain confidentiality.
CHAPTER IV

DEVELOPMENTAL HISTORY

ADHD “Took my Brain Away”

Ethan is an eight year old boy in second grade. He was diagnosed with ADHD when he was six years old and in his second year of kindergarten. He has been taking Ritalin to help control his behaviors since he was diagnosed. Ethan has problems with his vision, he is near sighted in one eye and far sighted in the other. He also has tracking problems when he reads. He has an IEP and receives special education services.

Ethan’s mother, Nancy, did not plan to become pregnant with Ethan. “It was, to put it mildly, a shock to discover that I was pregnant.” She was married to her first husband, Peter, at the time. Nancy left him while she was pregnant with Ethan.

I left Ethan’s biological father when he was in my tummy, when I was pregnant. It wasn’t safe for us to stay there. Peter (Ethan’s father) I believe has untreated ADHD and he may or may not have some bipolar tendencies. And, I just felt that we were in mortal danger. We moved back in with mom and dad.

Nancy felt that she was in mortal danger because of the way Peter had treated her when they were together. “He had not actually struck me. He had threatened me. He had pinched my breasts and left bruises. Lots of emotional intimidation. Some financial intimidation. I was able to hang onto my paychecks but I don’t remember how.”

Peter remarried three months after he was divorced from Nancy. He is still married to the same woman, and Ethan has always had a step-mother. Nancy has full custody of Ethan, but Peter is allowed to have Ethan stay with him during vacations from school. As far as keeping in touch with Ethan, Peter has, according to Nancy, “tried to keep in touch with phone calls, not too much with cards and letters.”

Nancy did not realize that she had gall stones while she was pregnant with Ethan and experienced weeks of feeling extremely sick.
I lost 15 pounds the first two months I was pregnant. I was throwing up six to eight times a day and I could keep down, I believe, soda crackers and grapes. And that was about it. And I went back to the OBGYN and he said, “You’re 27, you’re in pretty good shape. You’re muscles just don’t want to let that baby grow.” I kept having pains and I kept throwing up.

Nancy was very caring and concerned about her baby even before he was born. While I was pregnant I would both sing and read to him. He’s had Shakespearean sonnets, many of the 18th century English classical prose. I read from the Bible. I think I even read some Winnie the Pooh things. All different kinds of things because I wanted him to hear the sound of my voice and someone had told me in the shelter that children who are born to mothers who are in violent homes tend to be lower birth weight and skittish, they have nervous problems. And so I wanted that soothing, reading, singing. Not the harsh and staccato and loud noises and things. It was very quiet in the house. Mom and Dad were at work. It was just me and him.

Nancy experienced some complications during Ethan’s birth:

I did not know that I had all of these gall stones and, because of the pain, I kept saying, “PLEASE give me a shot.” So, we got in there and they said, “Stop! Stop! Don’t push! Don’t push!” Because the umbilical cord had wrapped itself around his left leg and they were afraid that if they pulled him out they would rip it out of me and that would not do me any good. So, he quickly unwrapped it and got Ethan the rest of the way out. Ethan was six or seven weeks immature. We had a great neonatal doctor. And she did the little squeegee thing, shoved it down his throat, sucked it out and he did one thing -WAAAA- and went right back to sleep. She walked him over - he had his little cap on and his swaddling clothes - and she said, “Want to meet your new son?” And I said, “hello” and then they whisked him away. Ethan was born shortly after 11:00 in the morning on a Tuesday. And they patched me back together or whatever they do and took me back to my room.
So, I went to sleep and they said they were going to have to work on him and check him out and watch him and do all the medical stuff and I wouldn’t be able to see him for several hours. Well, I fell asleep and the next morning they brought me breakfast and I wasn’t very hungry because they didn’t bring me my child. And they didn’t tell me I could go see him. So, an hour goes by, and another hour goes by and finally this older nurse comes in and she says, “Honey, don’t you want to see your baby?” And I said, “Is he still alive?” And she said, “You mean they didn’t tell you?” And I was throwing the covers off looking for my house shoes. And then I went in and scrubbed and I got to go into the neonatal nursery. He had little tubes and a little monitor. And I had a little video, they were doing a fund-raiser for Children’s Miracle Network. And I was in the video and so was Ethan. And he had to have one of those special lights on him because his liver stopped functioning.

After Ethan was released from the hospital and brought home, Nancy experienced some difficulties in feeding him and getting him to grow.

Well, I nursed him at first until the milk stopped and then we started him on Infamil. Because when I came out of surgery we could not get my glands to start producing milk. And then for whatever reason, it did. That lasted about two weeks or so and it turns out that he is allergic to milk. Well, we tried everything. We didn’t know it was cow’s milk at first. We tried evaporated milk and Karo syrup. That didn’t help because it was still cow’s milk. Then we tried goat’s milk. Goat’s milk stinks to high heaven and tastes awful. I would not let him drink anything that I didn’t try. So, we ended up on soy. It was great stuff and he thrived on it. At the six weeks check-up - this was before we knew he was milk intolerant - the doctor told me, “I don’t know what you are doing with this child but he is thriving. Keep up the good work.” He had doubled in weight. He was born at five pounds eight ounces and had gone to sixteen pounds four ounces in six
weeks. I mean he just blew up. He was in the hospital for his first two weeks so that only gave me four weeks with him at home.

Nancy explains the type of care that she gave to Ethan when he was an infant.

While he was lying there sleeping I would pet him to let him know that his mother loved him because I understood from reading while I was flat on my back while I was pregnant that touch is extremely important in thriving and bonding. So I wanted him to know in a very fundamental, elemental way that he should thrive, and he did. I was just trying to do the right thing. So many moms don’t these days. That seemed to have worked up until recently. And now he is just everywhere at once. It is like there is two or three of him. So, while he was still in diapers he was just marvelous. You would just pack him up and off you go. Picnics, to church, to a friends house - he would crawl around. Yeah, he would be curious and get into things but all babies do that.

For Ethan’s first two years of life he stayed at home with either his mother, grandmother, or a lady they called a “day nanny.” He was two years old when he attended his first out-of-home care. This is when the first indications of ADHD were noticed.

You would walk through the door and feel the love in that place. He did challenge the teachers. Even at three. He was bouncy. Bouncy, bouncy, bouncy. And she (his teacher) commented to me that he would probably grow out of it. And not to be too excited.

His mother began noticing a few aggressive characteristics as well at this time.

When he was younger he used to hit me. But of course he was one-fourth my size and you just grab the arm and say, “No!” When he was like two or two and a half he bit me. Well, I had just finished reading an article that had addressed this situation and said that the mother is to bite the child back. So I did. And it worked. He never bit me again. I didn’t draw blood and I didn’t leave a bruise, but I let him know that if he bites me I will bite him back. I didn’t know any better. And nobody had said to me that if you bite your child we are going to call
child protective services. He was my first child and he is the only child I will ever have. I knew that then. So, it was like, this is the only shot I have and I better do it the best I know how. And read as much as I can all the time to do it right the first time. You don’t get any second chances. And so it worked, I lucked out on that one. I wouldn’t say to any other parent, “you should do this because it will work with your child.” All I know is it worked with mine.

Nancy met and married Stephen, her present husband, when Ethan was three years old. Stephen is who Ethan has known as a father figure almost his whole life. When asked about his family Ethan says, “I have two dads.” After Nancy married Stephen she switched Ethan to a new preschool.

One of his teachers at his new preschool also noticed Ethan’s hyperactive behaviors. She (Miss Patty) is also the lady that noticed the moving from activity to activity. And not putting things away. And by the end of the day he was spinning like a top. And this was during his preschool years. And I told you about the insurance saying “Oh, you can’t tell until they are in school, blah, blah, blah” Bologna! If it’s (ADHD) going to present itself - it's going to present itself from like two or three through the school years. And I believe it did in his case. I can’t say that it's that way for all children, but in Ethan’s case we suspected it at three. Miss Patty was the one who encouraged me to call the insurance. The insurance that said we can’t do anything - wait another two years.

In his first year of kindergarten the same hyperactive behaviors persisted. Both his mother and teacher felt that testing him for ADHD would be the right thing to do. The counselor who tested Ethan at this time did not feel that he exhibited enough characteristics to be diagnosed with ADHD. Ethan received “need’s improvement” scores in the areas of “listens attentively,” “recalls information from a listening experience,” “follows oral directions,” “communicates ideas,” “identifies upper and lowercase letters,” “demonstrates knowledge of letter sounds,” “identifies some words in print,” “writes the numbers 0 -9,” “works well independently,” “begins/completes a task,” and “talks at appropriate times” in his first year of kindergarten. He received satisfactory
marks in all of the social/emotional, motor, and content areas. Ethan did not pass his first year of kindergarten. A different person evaluated Ethan during his second year of kindergarten and diagnosed him as having ADHD. His mother explains the diagnosis.

He was a Ph.D. who specialized in ADHD diagnosis. And he had this very interesting little device. I have no idea what it is. It is a device that blinks. And you had to look at it and you had to focus. And it blinked and you would do the pattern over here. And it was very simple, it was either the same pattern or different pattern. And it increases in speed as it goes along. The blinking part. And Ethan did better the faster the machine would go. And he said “that indicates to me that he is very likely ADHD.”

Nancy and Ethan’s teacher also completed observations according to the criteria on the DSM. And based on the doctor, the teacher, and the mother, Ethan had ADHD. At the end of his second year of kindergarten Ethan still received “needs improvement” grades in the areas of “writes the numbers 0-9,” “communicates ideas,” and “talks at appropriate times.”

Nancy received information about ADHD from Ethan’s preschool teacher who had given her a couple of handouts. She also researched the topic herself at the local library. She received treatment information from a doctor that was referred to her.

The doctor that diagnosed him was not a psychiatrist so he could not prescribe medication. Then we had to go to Dr. Brown. I want to say either a neighbor made a referral or someone at church made a referral. I’m not sure. But it was a person to person kind of a thing. I went to there from Mr. Franklin’s office. I mean, this is like three or four months later. After the first fellow said, “I can’t find any evidence that he is” And then Dr. Brown told me about the two drugs that were available at the time and the pros and the cons of each. Then we decided that we would try the Ritalin and if I noticed any tics or severe loss of appetite or if it disrupted his sleep, and the whole list of things to look for that we would immediately cease administrating. And I would call the office and he would come back in and we would return the drugs to him and something would change. He
did OK. We noticed a drop in appetite. We immediately noticed a change in behavior. He could focus, he could listen.

According to his files, Ethan’s reading and writing problems continued into first grade. An Individualized Education Plan (IEP) was formulated for Ethan during his first grade year and he was placed in a self-contained special education classroom. According to his IEP the rationale for this decision was “due to Ethan’s specific Learning Disability his needs can be met best in an LD self-contained classroom.” He was placed into a “self-contained class with mainstreaming into non-academic and/or extracurricular activities.” Nancy explained her view of the classroom situation:

As far as I know they did not have any children in wheelchairs, I mean they were in the school, but they were not in this particular classroom. And they had one child that was on oxygen. But they had a special classroom for those very special needs children. Even though they were mainstreamed, like for recreation, for lunch, I don’t know what the thinking behind it was. But here, there is a boy - he may have muscular dystrophy - in Ethan’s classroom. He has been around children that are in wheelchairs and he thinks that is sort of cool. But, the children in that classroom were primarily ADHD.

Some of the adaptations that were made for Ethan, according to his IEP, were special seating close to the teacher, visual and auditory support, and frequent praise and encouragement. The typical teaching methods in Ethan’s classroom included worksheets, workbooks, teacher made tests, and teacher directed activities.

At the end of Ethan’s first grade year, a summary of his year was written up in his IEP: Ethan has been a student in a regular first grade class with LD inclusion services. He has been diagnosed with ADHD for which he is prescribed medication. This medication has a positive impact on his attention and concentration. As the scores indicate, Ethan’s strength is in the area of math. Ethan recently had his eighth birthday, but the language arts scores show steady, but very slow progress. Ethan was prescribed glasses and receives vision therapy as well as weekly tutoring. His
weekly tutor and classroom teachers feel he works best with tactile/kinesthetic modes and activities.

He was having trouble reading and his mother felt that the phonics method was too fragmented for Ethan to understand.

I really had to be an advocate for Ethan in this area. They wanted to chop these words into bits and pieces and I’m like - that’s not working for him. It was just jumbled letters in his head. And I don’t know why they couldn’t see it. Ethan’s tutor told me that she had done as much as she could do, she didn’t see that it was going to help him, that it was just confusing him. And what she did was try to merge the two - phonetics and whole language by doing cards. That way he could see the whole word and realize that it would mean something.

Ethan began his second grade year at Longwood Elementary in another self-contained LD classroom. In November of Ethan’s second grade year Ethan and his mother moved to southwest Virginia. The reason for the move was because of Nancy’s job. Stephen works for the military and needed to remain in eastern Virginia. He may be able to retire soon, depending on whether or not we go to war. Ethan’s present second grade teacher, Mrs. Parker, felt “with as traumatic as the move was and leaving his step dad down there and the just the way they kind of plopped in one day and they were laying carpet on Sunday and in school on Monday and she was at work and trying to find daycare all in that same day. There was room to be rattled.” Ethan moved from a segregated classroom to an inclusive one. He also moved from a phonics approach to a whole language approach to language arts. Both Ethan’s mother and present teacher feel that he has come a long way since he has been in this setting. Ethan’s mother describes the changes she has observed in Ethan.

Under Mrs. Parker, and I told her this, I have never seen a child go up so fast in my life. He has just made great strides. So there is some element that I am unaware of between Longwood Elementary School and North Hills Elementary School that was the key that unlocked the door for English, for language arts, for this child. He is in an inclusive classroom now. One of the reasons that I think he
is doing so well now is because he is in with all of the so-called normal children. It's a mixed class. There are students that are gifted, there are students that are average, and there are students that need extra help. So he sees a whole spectrum of humanity and sees that everybody has worth. When he was at the beach they shut him into a room off at the other end of the building and all of the normal children were somewhere else. And he internalized that. I have fought for three years to preserve his specialness inside so he doesn’t feel different and he doesn’t feel less than.

Mrs. Parker explained similar feelings:

The writing is very difficult for him although he has blossomed in that area since he has been here. When he first came he would not answer a question, he would not attempt to write a word unless he was sure that it was right and my guess is that they expected everything to be right in his previous classroom and I don’t expect everything to be right. My philosophy is that you try and go back and correct it. So the most irritating thing was “I don’t know. I don’t know. I don’t know.” And without even trying. Just personally as a mother that is something I would not accept and as a teacher I do not accept it. Unless, if they tried and then they cannot do it. But, my philosophy is that you try first, you do the best you can and then I’ll come in and help. So for him initially he just needed adult support at his desk almost throughout the day in order to get through the day, because I think that is what he has had. I have weaned him away from that and to be very honest I don’t hear him say, “I can’t” maybe once or twice a day and all I have to do now is say, “yes, you can” and he will try. And if he makes a mistake that that I feel we need to correct, it doesn’t seem to bother him to make that correction. It is OK to make a mistake in my class. We try to take risks and we stretch ourselves, and the teacher comes in to make the general correction. He probably still does not like writing, but it's coming much easier for him to do. He’s writing complete sentences, we write a take home journal to our parents every Thursday where the
kids write about what they have done all week, and I respond and the parents write back to both the child and me. And he found that very difficult to really communicate with the reason and the purpose. He’s now getting two or three complete sentences appropriately written, readable by mother without any corrections, that was a major step for him. I think really he has blossomed and his mother seems very pleased with what we are doing.

Ethan agrees that the take home journal is difficult for him. When I asked him what about school was difficult for him he answered “take home journal.” His reason for not liking this activity was “because we have to write.”

Mrs. Parker explained a typical day in her classroom as well as a typical day for Ethan:

A typical day starts at 8:45 AM with about a half an hour before we start announcements. There’s lots of time at this point for socialization and visiting and getting caught up but we are also asking them to do a specific activity which isn’t much but its usually at least something they have to respond to on a piece of paper so that we have a record of whether they have done it or not. We go into literature which varies from week to week but it is usually consistent throughout the week. Some weeks we are doing whole group activities as we are doing this week. It’s an integrated curriculum with science, social studies, and literature. Other weeks we do ability group literature circles. I have four groups so there is a wide variety. And other weeks we do interest-based literature groups. We try to vary it so the children are involved with reading each day with the morning activities but it varies in how we go about it. Then we switch for math because it is policy for the gifted that we do ability group math. The other three second grades are mixed ability groups. Specials, class meetings, silent reading and all of those things fit into it throughout the time. Then after all our specials we are going into lunch. By now it is 12:48, so it's a long morning, late lunch. And we have recess, then we have spelling, which is a manipulative based kind of program where we do lots of picture cards and word sorts. We have writer's workshop in
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the computer lab a half hour every day every other week. The last half hour of the day is science and social studies. So that just sums up the schedule. Ethan’s schedule is the same frame as everybody else’s except for 9:15 - 10:00 when he has the pull out reading program, which is part of his IEP. We would prefer that he not be pulled out because of special services. For math Ethan goes to Mrs. Hamilton who has the special ed. support for math. His day really doesn’t have the extremes that the other children’s days can have. He takes his medication in the morning and he takes his medication just prior to lunch. Social times, snack times, morning times, and the free choice if we are inside are probably his most difficult as far as acting out.

A couple of days this year Ethan forgot to take his medication. Mrs. Parker explained how those days went.

We could see a big difference. It was behavioral in those more social, more free times. But during academic times he was able to remain in his seat, so that was not a big issue. It was more the focus on the written work and his mind was wandering but it wasn’t as much as all of the other things that you see in children, of not being able to stay in their seat, and getting up to wander around the room. But when the directions were very specific on those days that he didn’t have the medicine, he knew what he was supposed to do and he was able to get to his seat and do it. However, if he was up wandering around the room then the aggression came out. But that has really reduced tremendously.

Ethan also remembers the days that he did not take his medicine. He said that he could tell that he did not take it because “I act good sometimes, and if I don’t that means I didn’t take my medicine.” The days that he did not take his medicine he says, “I acted up” and “I didn’t pay attention.”

Ethan is aware of what ADHD is and how it affects his behaviors. He told me that having ADHD means that “you don’t listen very much.” He is also aware of when he “acted up” or
“didn’t pay attention” or “didn’t listen to the teacher” in class. Ethan is even aware of when he is daydreaming in school and describes this as something “took my brain away.”
I am framing my analysis and results in the developmental contextualist model that I designed in which the child is a central, yet interactive, factor of his or her development. Ethan should be seen as a child who has certain behaviors characteristic of ADHD, but it is impossible to stop there. In order to more completely understand Ethan and his behaviors it is important to examine the many aspects of his life and his development. In my analysis and discussion, I will refer back to the categories, based on the literature, that I included in my model, as well as new factors that have come up in the process.

The Child in Context

Factors that have been identified as important in the research on the child diagnosed with ADHD as important include age, characteristic behaviors, comorbidity, positive characteristics, race, ethnicity, gender, temperament/personality, and developmental history.

Demographics

Ethan is an eight year old boy in second grade. Ethan is Caucasian and he was born in the United States. He was diagnosed with ADHD at the age of six, during his second year of kindergarten. He takes Ritalin as his primary treatment for ADHD. He falls in to the category of children diagnosed with ADHD according to the DSM-IV. This criteria suggests that children with ADHD be diagnosed by the age of seven. The majority of children who are diagnosed with ADHD are boys. This leads me to question why this is so. Much of the literature has studied boys who have been diagnosed with ADHD and is consistent with the idea that the majority of children who are diagnosed with ADHD are boys (Hinshaw, Whalen, Erhardt, & Dunnington, 1989). Future research needs to explore why there is a gender difference in the diagnosis of ADHD.
Characteristic Behaviors

Ethan exhibits some of the typical behaviors of ADHD, including hyperactivity, impulsivity, and inattention. I will consider each of these characteristics separately.

I have defined hyperactivity as constant moving as well as disruptive behavior. While medicated, Ethan exhibits hyperactivity mostly in the form of fidgeting. When he is not on his medication his small, close to the body fidgeting turns into larger gross motor activity. While I was observing him at home I was able to watch the process of his medication wearing off. He was involved in playing a basketball game in his living room that turned into a running, jumping, and slam-dunking episode within the hour. His mother warned me, “the last time he took his Ritalin was at 3:40. It should be wearing off around 8:00.” And it seemed to do just that. He also began doing gymnastics in the small hallway of their apartment, turning cartwheels and standing on his head. Mrs. Parker described similar behaviors at school.

It becomes very large motor for him when he is off his medication. His body is just everywhere. Whereas when he is on the medication it’s within his body space. I mean, he comes flying across the room and he’ll attack me and you don’t see that kind of behavior when he is on the medication. And in a classroom… second graders are not aware of body space. If you watch second graders trying to get across the room they have no perception. And his is even magnified more. I mean he can walk right into two people and not be aware that they were even there. So it is just a magnification of what I would consider typical second grade behavior.

However, despite his hyperactive behaviors, even when he is not taking his medication, he somehow manages to complete his required schoolwork. Mrs. Parker observed that “when the directions were very specific on those days that he didn’t have the medicine, he knew what he was supposed to do and he was able to get to his seat and do it.”

On the days that Ethan was taking his medication, he was able to sit in his seat but it did not appear to me that he was paying any attention. I defined inattention as the inability to concentrate on a certain task. To me, it seemed as if Ethan was not concentrating on his tasks at
ADHD

He frequently fidgeted by looking at his nails, scratching his head, twirling his pencil, looking through his desk, playing with his glasses, rubbing his head, rocking back and forth in his chair, or playing with his clothes. However, when he was called on he was able to appropriately respond to the question. I observed this behavior during a show and tell time in the classroom.

*Ethan is sitting in a chair playing with his shoe*

*he turns to talk to Billy again*

*Teacher:  “Ethan” (to get his attention)*

*he puts his thumb in his mouth*

*playing with shoe*

*squatting on a chair and looking at the show and tell item*

*he puts his hand out and says, “can I feel it?” “can I see it?” he gets it and says, “wow” then passes it along (it is some sort of green goo)*

*he lies down on the floor*

*he sits up and moves to talk to another boy*

*playing with his shoe again*

*throws a stuffed animal in the air*

*another boy takes it and they begin to play back and forth with it*

*12:43*

*Ethan moves closer to the girl with the next show and tell item*

*he sits and gets the stuffed animal again*

*he is playing with it again with the other boy and they are giggling*

*A girl is showing her watch and Ethan says, “I like your watch”*
he gets up to go see it and then sits back down and begins waving his arms and talking to another boy

now he is pulling on another boys leg (the other boy does not seem to mind)

sitting (still paying attention because a boy who is sharing is talking about how his computer shut down and Ethan said, “how did it happen? I hate viruses”

As an observer, I did not think that Ethan was paying any attention to the student who was sharing something. He surprised me by responding appropriately to the objects. I observed the same type of behavior at home. We watched three taped episodes of his favorite cartoon. While he was watching the show he was constantly doing something else, yet he could say to me “watch this part, this part is really funny!” I felt that he had to be paying attention to know what was going on. He would also laugh at appropriate times during the show even though he did not look like he was paying any attention. He was playing basketball, legos, and playing with other balls. His mother recalls this same experience. “Do you remember the time when you came over and he was watching his favorite cartoon and he was talking to you and he was playing and he was walking around. And if there was something he wanted you to see he would stop and say, ‘hey, watch that.’ Auditorily he could cue in and say ‘hey this is coming up.’” She agrees that he can appear to not be paying any attention to something and then he will prove her wrong by responding appropriately to the situation.

I have begun to question the definition of attention which I originally started out using, one in which I pictured a child who is sitting and listening and attending to one particular thing. However, is it possible that what appears to be inattention is actually not? Mrs. Parker agrees with my original definition of attention:

Well, as adults, I think a big thing is “all eyes on me” - part of it is a politeness issue but part of it is feeling like they are getting more if they are looking at you. And maintaining that eye contact. I guess I am of the old school but I still think that it really needs to be a direct interaction between the two people. However, they may get part of it I’m not sure if they get all of it or if they get the connections. And oftentimes, just because the teacher’s voice is louder and carries
I think they miss a lot of the conversations the other children contribute because those voices are softer. If they are daydreaming, the kids' voices do not break into that daydream that hopefully a teacher’s voice does. So, I often find that the kids can repeat back more of what I say than what the other children say. They may know what my questions are that I have asked but they may not know what the other children have given as answers. I find they are often not focusing on the speaker if the speaker is one of the children.

I have defined impulsivity as acting without thinking, interrupting others, and not thinking about consequences to behaviors. In my observations of Ethan, he has not shown any indications of impulsive behavior. Of course, I have to keep in mind that the majority of time that I observed Ethan he was medicated and that might affect his impulsivity. Mrs. Parker has noticed some impulsive behavior in Ethan. However, she feels that it could be better defined as compulsive behavior.

Originally it may start as an impulsive act that becomes compulsive very quickly. That focusing in on whatever. He can be very impulsive in that initial whatever - getting a book, or getting to the computer, or getting that particular thing out of the math tub. But then it becomes very focused and compulsive. Or appears to be compulsive where it appears to be impulsive when he is making those choices. And in making choices it appears to be very random. Now, I don’t know what is going on in his mind, if he is looking for something specific and he can’t find it. It appears to be wandering and finding things instead of sitting back and making up his mind. Then it becomes focused.

I have observed him becoming very focused on something that is not related to what he is supposed to be doing at the time. Two of the times that I observed him at school he was very concerned over a lost object of another child. He focused his energy on searching the room to make sure that the lost object was found. He seemed concerned that the other child was upset and appeared to want to help. This behavior is consistent with the type of compulsive behavior
that Mrs. Parker has observed in Ethan. What we perceive as impulsive behavior may actually make a lot of sense to him.

Nancy felt that the lack of impulse control was present in Ethan at an early age. At the age of four Ethan “did not know the meaning of the word ‘no.’” Nancy felt that she needed to resort to force or spanking in situations that dealt with safety in which Ethan needed to learn a quick lesson. Her examples included “running into the street. Or sticking something into electrical sockets. Or sticking your face into the water in the bathtub.”

A behavior that I have observed in Ethan that could also be considered a characteristic of ADHD is disorganization. Ethan’s mother explains a typical situation at home:

It becomes, “mom, what did you do with my hat?” Or “mom, where are my shoes?” And I have repeatedly told him “I don’t touch your hat. Wherever you took you hat off and put it down, that’s where it is.” I don’t move his glasses for the same reason. And we have had to reinforce, reinforce, reinforce, that the glasses cannot be on the chair, the glasses cannot be on the bed. I sat on them!

And we had to get a brand new set of frames because they were on the bed.

While observing Ethan at school I noticed the same type of disorganized behavior. He was having a conversation about his homework with his language arts teacher.

*Teacher:* (to Ethan) “*did you remember to get your homework done?*”

*Ethan:* “*no*”

*Teacher:* “*why?*”

*Ethan:* “*First it was math then lunch*”

*Teacher:* “*before you go to math you have about 10 minutes to do your homework. Ethan, why didn’t you use that 10 minutes?*”

*Ethan:* “*my teacher told me to do something*”

*Teacher:* “*what?*”

*Ethan:* “*I forgot*”

*Teacher:* “*well, I’ll leave it blank*”

Later that same morning:
ADHD

Time: 10:00 (ten minutes before the classes switch for math)

he walks into the classroom and begins talking to the other children

after two minutes he gets out his purple notebook that he is supposed to be working in

he leaves it and walks across the room to ask someone a question.

he then walks back to his seat and begins to write

he turns to look at me

(he looks as if he does not know how to get started)

he is chewing on his pencil eraser

he closes his notebook and puts it away

(he did not do his work)

Ethan’s language arts teacher suggested that he take that ten minute period of time to do his homework. He did not get his work done during this time. Maybe Ethan could use a reminder from the classroom teacher to use this time. I wonder if there is communication between the two teachers on this matter.

Ethan exhibits characteristic behaviors of ADHD including hyperactivity and inattention (Barabasz & Barabasz, 1996; Berk & Winsler, 1995; Lerner, Lowenthal, & Lerner, 1995; Saunders & Chambers, 1996; Silver, 1990). He also exhibits disorganization and compulsive behaviors in his actions. However, he is able to focus his attention if he is given specific directions or if he is interested, even if he has not taken his medication. However, his behaviors often resembled the behaviors of the other children in his class. He may vary in degree or intensity of his behaviors, but they seem to resemble other second grade behaviors.

Comorbidity

Oftentimes a child who has been diagnosed with ADHD has also been diagnosed with other disorders (Reid, Maag, Vasa, & Wright, 1994). These could include learning disabilities, conduct disorders, emotional disorders, or many others. In Ethan’s case, according to his IEP, he
ADHD has a learning disability as well as visual impairments. Ethan has a tracking problem with reading. He is also near sighted in one eye and far sighted in the other. I have begun to question how Ethan’s visual problems have affected his behaviors, especially those characteristic of ADHD. For example, maybe he is fidgeting with things close to himself because it is easier for him to see these objects. It could be possible that Ethan does not look at the teacher as much when she is talking because of his vision problems. It could also be possible that his difficulties with reading and writing are because of his tracking problems. These problems could frustrate him and cause him to act as if he is not paying attention. Nancy told me that she thinks he may need a stronger prescription but she has not found a doctor in town to take him to yet. The teacher is also aware of Ethan’s vision problems.

He has a very severe vision problem with tracking and being able to follow across a whole line or sentence. I’ve really not seen that that is any worse than some of my LD children, but it was something that was brought up to me, the time he moved in and again when I had the conference with his mom. So we are trying to be very cautious of that although it's nothing that I'm really making an accommodation for at this point.

This would be an important area to keep in mind when accommodating for Ethan as well as understanding some of his behaviors. Mrs. Parker has observed that Ethan “is very good at sitting down and attacking the worksheet.” Maybe he is able to sit and focus on something that is close to him easier than he is able to sit and focus on a teacher who is farther away from him. His vision problems could play an important role in his success at school. Also, when Ethan appears not to be listening because he is not looking at the teacher, he is able to respond appropriately. He is able to pick up auditory cues even if visually he is not focused. It is possible that he is compensating for his visual problems with auditory abilities.

Positive Characteristics

The literature on ADHD describes some positive characteristics that may be associated with ADHD. These include tirelessness, creativity, enthusiasm, and curiosity. They also tend to show great intensity when involved in an activity of interest (Henker & Whalen, 1989; Taylor, 1994). Mrs. Parker describes some of Ethan’s positive characteristics:
He is very intelligent. He has had a lot of experiences. He has a lot of adult language around him and a lot of adult conversation around him that I think he is able to keep up with and he understands. It’s only when something that triggers it that it makes those connections it’s not something that comes out in his classroom conversation a whole lot. But, if there is something that prompts a connection for him he is able to do that. When he was first here he didn’t make those connections or he didn’t verbalize those connections for us. He now is able to make a lot more of those connections and relate back to an experience that he has had or something that they have discussed at home that reflects back on something that we are talking about. And he is able to analyze in a way that I find is very interesting that I didn’t realize he had that ability. But, as he is becoming more and more verbal we are hearing and seeing that. Now, whether that is he is in a different type of classroom than he was in before or if it's a comfort level. Or realizing that those opinions are respected and allowed in the classroom.

Nancy agrees that “he is a highly intelligent individual.” She has also described situations in which Ethan is intensely involved in an activity of interest.

If he’s working with legos, an atomic bomb could go off outside the window and he would be oblivious. If he’s watching television, and it's something that he has never seen before but he is very interested, he does not want to be interrupted.

I have observed the same type of intensity in Ethan when he is engaged in an activity of interest. During a guidance class that I observed, the children were watching a video about getting along with siblings. Ethan seemed to be extremely interested in this video, he did not exhibit any of the typical fidgeting behaviors that I usually observed. Nothing in the room distracted him from watching that video. When it was over he appropriately responded to what was happening in the video. This was one of the few times during my observations of him at school that he fit my original definition of attention where he sat still and focused on one thing for an extended period of time. Another time when I observed Ethan really engaged in an activity at school was when he was participating in a bingo game during math class:
he is now looking at his board and counting to himself

the children in the room are quietly working

he is looking at his board and whispering to himself

time:  10:30

he is still quietly participating in the game

he plays with his hair

he stands up and continues to look at his board

he places a chip on his board

he is whispering to himself

(he seems to need to talk to himself when he is really concentrating)

he is still standing and working

he and his partner seem to be helping each other

he is rubbing a chip on the desk

another child yells “Bingo!” and Ethan is still quietly working

he follows the directions of clearing his board and changing cards with someone

he looks at his board and begins counting “5, 10, 15, 20, 25, 30!”

he looks at his board for the number called (seven cents)

he looks then he turns to his partner “do I have seven cents?”

he is quietly working while standing

he is looking at his board, pointing, and whispering to himself

he is still standing and looking at his board

the teacher is coming around and asking if the children can count the change on their cards
while Ethan waits for his turn he flicks chips on his desk

his partner begins to do the same thing

he watches while the teacher talks to his partner

when Ethan is asked he correctly says “22 cents”

he is able to move to the next table

he moves to the other desk, sits down, scratches his head and looks at me

he then begins to stack his chips on top of each other

the group that Ethan moved to begins playing bingo again

Ethan is still playing bingo with the group

time 10:43

he can correctly identify the cards and correctly count the change on his bingo card

he is playing with his hair as he is quietly counting to himself

he stands up and is still playing

Ethan shared with me during our interview that he enjoys math. He seems to become very engaged in math activities. I observed Ethan during another math class that was more teacher-directed in which the children were at their seats copying off of the overhead. He was able to appropriately copy numbers off of the board and respond to questions that the teacher asked. Again, Ethan was able to pay attention and follow along successfully with the class. It appears that Ethan is able to concentrate on an activity for an extended period of time if it is something that he is interested in. In thinking about the various definitions of ADHD, it seems that Ethan may best fit into the definition of having an “attentional ‘bias.’” An attentional deficit connotes a lack of attention, whereas an attentional bias more correctly connotes adequate attention, memory, and comprehension, but associated with specific tasks, time period, and conditions” (Zentall, 1993, pp. 143). Ethan is able to focus on a task of interest and shows the abilities of
Remembering and comprehending. However, his ability to attend to something seems to be selective according to his interests.

When I observed Ethan at home I could see the same intensity in activities of interest. He would play with legos for 20-30 minutes at a time without changing his focus to another activity. He also played basketball for an extended period of time.

Ethan has also demonstrated creativity. His mother commented on his elaborate lego creations and informed me that he thought of the models on his own - he did not copy them from a picture. Ethan also demonstrates creative thinking at school. During a language arts session in which the topic of Spring and rain were being discussed, Ethan shared his creative thinking.

Another child (Brian) makes a sentence: “at the pool it is raining”

Ethan: “you would have to get out because of lightning”

Teacher: “Can someone tell me Brian’s sentence?”

Ethan: “At the pool it rained”

Teacher: “Who has a sentence with at or and?”

(Ethan raises his hand)

Ethan: “At the store the lights blink because of lightning”

Teacher: “That’s a good sentence but let’s think more about rain.”

Ethan: “At the store it flooded”

Teacher: “That was a very good one – think about places that could get flooded”

Ethan: “The duck pond could get flooded and the fish would be out on the road”

Teacher: “I like your idea of the pond”

Ethan went beyond the idea of Spring and rain to share the thoughts that he had on the topic. The teacher allowed for this creative thinking, yet kept him focused on the topic being discussed at the same time.

Temperament/Personality

As a baby, Ethan was very easy going and calm. Nancy explains his temperament at a young age:
ADHD

So, while he was still in diapers he was just marvelous. You would just pack him up and off you go. Picnics, to church, to a friend's house - he would crawl around. Yeah, he would be curious and get into things but all babies do that. Those were good days. He was just a very portable, wonderful kid. Every now and then we would have a challenge where “I don’t want to get dressed” And then sometimes, ‘I don’t want to put on clothes to go to bed, I want to run around naked” Very normal. So, he had a great babyhood and childhood.

Ethan did not exhibit any characteristic behaviors of ADHD during his first two years of life. Nancy feels that he was a very easy-going, calm baby. Is it necessary to exhibit characteristics of ADHD in the first few years of life? In Ethan’s case, he did not. However, this may not be true for all children.

Developmental History

Ethan exhibited early indications of ADHD, but it was difficult to diagnose with certainty. His parents and teachers were debating whether his behaviors were just typical of a young child or characteristic of ADHD. When Ethan was in preschool his teachers noticed that he was “bouncing” from one activity to the next. He was having problems with free choice time in which a variety of activities were presented to him. Mrs. Parker observed that when Ethan did not take his medication he had difficulties during the less structured, free choice times of the day. This pattern has followed Ethan from preschool into elementary school. However, Mrs. Parker observed that he was able to sit down and get to work when he was told to do so. Maybe Ethan needs more structure to be able to exhibit age appropriate behaviors. His individual need may be to have more structure and guidance in school with limited choices. However, it would be beneficial to him if teachers could focus on his positive behaviors when he is not taking his medication. This would help him to understand that he can act appropriately and self-regulate without the use of medication. Ethan is aware of what the mediation does to him and may feel that he needs to have it to act appropriately. Parents and teachers could help him understand that he does have the ability to act appropriately by giving him positive reinforcement when he is able to do so.
It is difficult to determine which of Ethan’s behaviors are characteristic of ADHD and which are typical of a second grade boy. Ethan may require more structure at home in terms of parenting, as well as at school. His mother mentioned that he has recently become very defiant before bedtime. “It is particularly at bedtime, the challenging, the running around, the defiance, not wanting to pick up toys, not wanting to take a bath.” She mentioned this as a new behavior that she is learning how to deal with. However, is this behavior part of ADHD or is it a typical behavior of a second grade boy. It is hard to tell the difference and sometimes it may be easier to attribute all negative behaviors on ADHD.

Processes that Influence the Individual Child

Decision-Making

Decision-making processes can be affected by a number of variables. In Nancy’s case, she relied on friends, family, religion, acquaintances, teachers, literature, and counselors to help her make decisions about Ethan. Nancy read about parenting during the time that she was pregnant with Ethan.

While he was lying there sleeping I would pet him to let him know that his mother loved him because I understood from reading while I was flat on my back while I was pregnant that touch is extremely important in thriving and bonding. So I wanted him to know in a very fundamental, elemental way that he should thrive, and he did. I was just trying to do the right thing. So many moms don’t these days.

Nancy relied on articles that she had read when dealing with discipline issues as Ethan grew older.

When he was like two or two and a half he bit me. Well, I had just finished reading an article that had addressed this situation and said that the mother is to bite the child back. So I did. And it worked. He never bit me again.

Nancy also relied on the opinions of friends and coworkers in her decision-making processes about parenting, even before Ethan was born. “Someone had told me in the shelter that children who are born to mothers who are in violent homes tend to be lower birth weight and skittish, they
Nancy decided to provide Ethan with a quiet, calm environment while she was pregnant with him. She also chose to read and to sing to him with soothing stories and songs, based on the advice she had been given.

Nancy refers to the Bible and her faith for guidance.

But, you know, if you are stricken -if somebody unprovoked strikes you - you have my permission to strike back because that is self defense and even the Bible says that. Even if you kill him you are defending your own life. God put that self preservation instinct in there for a reason. And I told him if that happens that is OK - I will come to your defense, we will face the punishment that they give you together. That’s not to say they won’t give you punishment because they will. But that’s OK because if you are doing the right thing and you get punished anyway then that’s all right. Society today is hard enough for the non-ADHD child.

When Ethan was diagnosed with ADHD, Nancy could not turn to Peter for advice, he did not want to accept that his son had ADHD.

And Peter is the one who was really majorly in denial. And said that if I put him in a special class, he called it a class for dummies, that he would challenge my custody. So for like a year or a year and half we kept it secret - that he was in any kind of special ed. Or that we had an individual education plan for him or anything. I think Peter has come to realize after last summer that Ethan is different. And as far as I can tell he does give him the medication appropriately, like morning and lunch and late afternoon and tries to keep him on a schedule. But when Ethan comes back from Peter and Holly’s it does take a week or so for him to get back in the groove. And that’s, I understand, normal.

The psychologist who diagnosed Ethan suggested that Nancy try behavior modification with him. She tried using this technique before trying medication.

I learned behavior modification from the Ph.D. psychologist and that I could not give Ethan a list of two or three or four things to do, You know, “go up to your
room, pick up your toys, and get your pajamas”. It had to be one - done, two -
done, three - done. It was a real challenge for me. Because “I want you to hear
and obey.” “comply”. I’m an old dog and I don’t learn new tricks. I have really
tried to modify and I am not there yet. I have to learn new things all the time.
And I don’t always implement them. And I’m still working on it. And I’m not a
perfect mom. I’m very caring but it doesn’t always translate into appropriate
practice. I yell a lot! (she laughs)

Friends gave Nancy their referrals for a doctor who could prescribe medication for Ethan. She
searched for a doctor that would prescribe medication for him, after she had found someone that
would diagnose him. The doctor informed her of the side effects to the Ritalin and she monitored
Ethan closely when he first took it. She did not notice any major side effects so she decided that
Ethan should continue to take the medication.

Nancy received advice from many different sources and as a caring mother she acted on
the advice that she received. She sought out many different opinions from various sources before
she tried something new with Ethan.

Parent-Teacher Communication

Ethan’s preschool teacher, Miss Patty, was also a source of information for Nancy. She
shared her observations of Ethan and made assumptions about his behaviors. Nancy remembers
Ethan as a preschooler:

He did walk on his tippy toes. And he fell down, not a lot, but I think a lot more
than the average child. Miss Patty said that I needed to be on the lookout because
it could be an indication that there was a learning disability present. She is also the
lady that noticed the moving from activity to activity. And not putting things
away. And by the end of the day he was spinning like a top. And this was during
his preschool years. And I told you about the insurance saying “Oh, you can’t tell
until they are in school, blah, blah, blah” Bologna! If it's going to present itself -
it's going to present itself from like two or three through the school years. And I
believe it did in his case. I can’t say that it's that way for all children, but in Ethan’s case we suspected it at three.

The same teacher encouraged Nancy to take action about her concerns for his behaviors. Nancy explained that “Miss Patty was the one who encouraged me to call the insurance.” Then, when Ethan went to kindergarten Nancy remembers that his teacher, “brought it to our attention, and we attempted again to get him diagnosed and the first counselor said he could find no evidence of ADHD.”

When Ethan was finally diagnosed for ADHD Nancy turned to Ethan’s teachers for information on the subject. She also did her own research by checking to see what the local library had to offer.

Miss Patty pointed me in the right direction. She gave me a couple of handouts. But every time I would go to the local library - it was not a very large one - the books would all be gone. It is a very educated area. They just couldn’t keep them in. I got frustrated and I didn’t understand it. I didn’t really understand it and I didn’t really go into denial. I knew there was something different about him.

Nancy read as much as she could and talked to as many people as she could about parenting and how to help Ethan with his behaviors. The problem is that she received such a wide variety of information from many different sources. The question is, who can parents trust and where can they turn for help and reliable information? Nancy read information that told her that biting a child back is the best way to stop the biting behavior. She read other information that explains why touch is so important to infant development. She talked to one teacher who predicted a Learning Disability in Ethan because he walked on his tip toes. A different teacher assured Nancy that Ethan would grow out of his hyperactive behaviors. As a caring and concerned parent she trusted information given to her and acted on it. How is she supposed to know that maybe a teacher could be wrong or that she read something inappropriate?
The Influence of the Family

Stressful Family Situations

Nancy’s story of Ethan’s life included many stressful family experiences:

I left Ethan’s biological father when he was in my tummy, when I was pregnant. It wasn’t safe for us to stay there. I was in a shelter for battered women. And he had not actually struck me. He had threatened me. He had pinched my breasts and left bruises. Lots of emotional intimidation. Some financial intimidation. I was able to hang onto my paychecks but I don’t remember how. Someone had told me in the shelter that children who are born to mothers who are in violent homes tend to be lower birth weight and skittish, they have nervous problems.

Mrs. Parker also gave some insight into the family situation. She understood that moving was difficult on both Ethan and Nancy. He was quickly placed into a new school in the middle of the year and she knew that this could be stressful for him. She also knows about other issues the family is dealing with.

His step dad is in the service and it is possible that he may be deployed. So that’s an issue they are dealing with. I think that Ethan deals with also a lot of other kinds of issues. And I’m not sure what his father does and I’m not sure how much involvement there is.

Mrs. Parker realizes the importance of understanding a child’s family situation and how this may affect the child. She has taken the time to find out important information about Ethan’s life in order to understand him as an individual, not just a child with ADHD.

Parenting styles

Both Nancy and Peter have exhibited characteristics of authoritarian and authoritative parenting styles. I have been thinking about parenting in terms of specific styles and that most people probably fall into one category or another. I have realized that a more realistic view of parenting is one in which the style or behavior varies with the situation.
In thinking about Nancy’s style of parenting, in terms of the three styles categorized by Baumrind (1971), I would classify her as oscillating between authoritative and authoritarian. She has shared with me examples of each style. She explained to me:

These skills that you and I take for granted are an extra effort on his part and I try to reward that. He tells me a story, ‘well so and so did such and such’ and I will ask him what he did about it and if tells me a non-aggressive and an appropriate response then I try to do something extra special with him. I’ll hug him tight when we get ready for bed and I’ll say, ‘you know, you made the right decision and I’m glad you are my little boy.’ To reinforce that behavior.

This example demonstrates a loving exchange between mother and son in which she takes the time to discuss the situation with him. This is characteristic of the authoritative style of parenting. She gave another example of similar behavior.

Last weekend, I went into my bedroom and I sat on the edge of the bed and I got very quiet. He wanted to know why I wasn’t talking to him. And I said, “because if I talk to you I will say something I will regret. And I am trying to be grown up about this and you have hurt my feelings and you’re not complying, you’re not entertaining yourself, and I have work to do.” I have to work at home because we have just launched the web site and there is still a lot to be done. And I said, “I love you, but you need to entertain yourself some more.” Then he went away. Then he came back. And I started crying. I’m still in my bedroom sitting on the end of the bed. And that’s when he broke down and he said he was sorry and he petted me on the shoulder and said he would go and find something to do and he did. So that worked and I will probably do that again - without the crying I hope. But, like I said, sometimes I yell. That’s not effective. It makes me feel better but it doesn’t help the situation. He has outgrown time out. So, I have to be the one who made need the time out now.
Nancy explained that she used to use time out as a form of discipline for Ethan. She does not feel that this method is effective anymore for him. However, she feels it is helpful if she takes time away from a situation to regain control.

When Ethan was an infant, Nancy wanted to express to him how much she loved him. During her pregnancy, when she had to stay in bed, she read about being a mother and how to help an infant feel loved. She expressed her feelings through touch. Nancy also gave examples of how she offers Ethan choices in terms of discipline and helps him realize the natural consequences to his behaviors. She explained that she “will tell him ‘if you don’t brush your teeth you will get cavities and it will hurt’ and usually he will brush his teeth. And he has never had a cavity.”

He (Ethan) says, “don’t get me up before seven” And I say, “if you don’t want to get up before seven then we don’t have time to cuddle and goof off and giggle and tickle… so you have to make a choice - if you want to get up at 6:45 then we can goof around a little and then get up and get ready to go.”

Nancy offered Ethan choices even at a very young age.

I would just say “its time to settle down’ or there will be consequences. “ you will go into your crib or you will go into time out” or “you won’t get a bedtime story”. Just, you know, taking away privileges. That’s the way we wanted to handle it.

Nancy also explains her feelings about Ethan. “Ethan is a loved child. Even though he was unplanned. He is very much loved. And we are doing everything we can to help him obtain the skills he needs to succeed when he grows up.”

On the other hand, Nancy explained situation where she used force to “control” Ethan. There have been times when she has just wanted him “to listen and obey.” The following examples are characteristic of authoritarian parenting.

Oh yeah, we have had to physically remove him, and to physically restrain him. You can’t show weakness. There were occasions when we had to use force. But we tried to reserve that for safety issues. Like running into the street. Or sticking something into electrical sockets. Or sticking your face into the water in the
ADHD

We didn’t want him to do that yet because he wasn’t ready to learn to swim and turn his head and all that stuff.

When he was younger he used to hit me. But of course he was one-fourth my size and you just grab the arm and say, “No!” Lately he hasn’t hit me. It’s a concern as he grows older so I don’t know how I’m going to deal with it. When he was like two or two and a half he bit me. Well, I had just finished reading an article that had addressed this situation and said that the mother is to bite the child back. So I did. And it worked. He never bit me again. I didn’t draw blood and I didn’t leave a bruise, but I let him know that if he bites me I will bite him back. I didn’t know any better. And nobody had said to me that if you bite your child we are going to call child protective services. He was my first child and he is the only child I will ever have. I knew that then. So, it was like, this is the only shot I have and I better do it the best I know how. And read as much as I can all the time to do it right the first time. You don’t get any second chances. And so it worked, I lucked out on that one. I wouldn’t say to any other parent, “you should do this because it will work with your child.” All I know is it worked with mine.

But, you know, if you are stricken - if somebody unprovoked strikes you - you have my permission to strike back because that is self defense and even the Bible says that. Even if you kill him you are defending your own life. God put that self preservation instinct in there for a reason. And I told him if that happens that is OK - I will come to your defense, we will face the punishment that they give you together. That’s not to say they won’t give you punishment because they will. But that’s OK because if you are doing the right thing and you get punished anyway then that’s all right. Society today is hard enough for the non-ADHD child.
Nancy realizes that although she is a caring mother she does not always act in the most appropriate ways. As I mentioned earlier, the mother’s parenting style seems to be somewhere between authoritative and authoritarian. The same is true for Ethan’s step-father, Stephen.

It has been a learning experience since he has come along in my life. And I have enjoyed it. I still have a few more years to try to master him. I am the only one who can control him.

In the morning, though, you have to know how to handle him. In the morning you can’t go in and dictate to him because he is not on the lines that you are first thing in the morning. So you have to go in and play games with him.

I’m just saying to get him up you have to go in there and tickle his toes and play with him and get him out of bed and he thinks he’s having fun. That’s one of the things - you’ve got to learn how to master him. And you have a different style (to Nancy). You want to go in there and dictate what time to do what. On the same line, you have to be very flexible and versatile with what you do. A case in point, sometimes I will take TV privileges away, but if it is like 8:00 at night we don’t count that night. I will change the rules to suit what is happening. Whenever you are dealing with punishment and stuff there is just such a wide range of things you can do. And sometimes you can get tough with him and sometimes you can shrug and say “go ahead.” I was just thinking about how he was that day in 1993. The Macgyver story. When he was laying on the bed and I came home that night and told him to go to bed and he was laying on the bed watching Macgyver. He said, “no I am watching Macgyver.” And he fought his ground there. And it got to the point where I was either going to kill him or he was just going to get beat to death in the process. I just picked him up and carried him upstairs and he just fought all the way to the bed and he was determined because that was his favorite program.
Stephen expresses that he and Nancy, “are just hoping we can raise Ethan to the level that we want him so he won’t be a burden to society. We want him to be a good citizen.” Nancy agrees with Stephen about raising Ethan to be a good citizen.

We focus a lot on citizenship. You know, we are not put on earth to take from, we put in then we take out. Not communism, but just if you have extra you give to those who have less. And so I look at Ethan - and I don’t want some teacher to come at the end of a busy hard day and to think ‘that Ethan is going to be the death of me yet.’ I want her to say ‘boy, his home life must be more like what I was raised in’ or ‘he has a responsible set of parents.’

Parenting can be seen as an interactive process between the parent and the child depending on the situation. The parents and the child accommodate to each other’s behaviors (Thompson, 1998). The child’s actions may affect the parent’s choices and the parent’s action may affect the child’s choices. However, I wonder if any sort of inconsistency in parenting can be confusing to the child. I suppose that if the parent is at least consistent in the area of concern then maybe the child will be able to internalize the appropriate behaviors. Nancy shared a joke with me that she felt fit Ethan perfectly.

Somebody just sent me a joke that is just perfect and precious and perfect. And it fits my son. A father puts his little boy to bed and the boy says, “daddy I’m thirsty can I have a drink of water?” and the father says, “no, its time to go to bed, its too late for water, just go to sleep.” So the little boy gets up and walks out of his bedroom and the father says, “you’re out of bed!” “But I’m thirsty and I really need a drink of water” “If you don’t go back to bed I am going to spank you” So he lays back down to go to sleep. A few minutes later he says, “Dad, when you come in here to spank me will you bring me a glass of water?”

Ethan seems to need the combination of different parenting styles. The parents seem to be choosing the specific reaction based on Ethan’s behaviors. Ethan could be categorized as a difficult child, and as Kuczynski and Kochanska (1995) suggest, parents may react differently to what they consider to be a more difficult child, depending on the child’s specific behavior. On the
other hand, Ethan reacts to the specific behaviors of the parents. Maybe parenting consistency is not the important issue. Maybe it is important for the parent and child to react to the specific situation. This would be a more interactional style of parenting between the parents and the child instead of just coming from the parents.

**Marital Relationship**

Nancy left Peter, her first husband, when she was pregnant with Ethan. Peter remarried a few months later and Ethan has always had a step-mother in his life. Nancy remarried when Ethan was three and Stephen had been Ethan’s step-father ever since. While married to Peter, Nancy felt as if she was in “mortal danger” because of the abusive situation. She was afraid this would affect Ethan. Someone in the shelter for battered women had told her that “children who are born to mothers who are in violent homes tend to be lower birth weight and skittish, they have nervous problems.”

**Birth Order/Siblings**

Ethan is an only child. Nancy mentioned that she has no one to compare him to in terms of his behaviors. She feels that this is her only chance at being a parent and she wants to do the best job that she can. Mrs. Parker feels that Ethan being an only child may contribute to some of his behaviors.

I think that is a lot, being an only child, use to being able to doing that, being given undivided attention. He's still going to be able to go off and do his own thing as opposed to being forced into interacting with a large group of children his own age.

Mrs. Parker feels that Ethan would choose to be alone to play rather than interact with other children in the classroom.

**Friends**

Oftentimes a child who has been diagnosed or labeled with some sort of disability is seen as not capable of making and keeping friends, or even being able to appropriately interact in friendly situations. In my observations I have seen Ethan interact with others in group games as
well as one on one. I have also observed him successfully initiate interactions with others. The following is an example of Ethan involved in a playful interaction with another child.

*he sits up and moves to talk to another boy*

*playing with his shoe again*

*throws a stuffed animal in the air*

*another boy takes it and they begin to play back and forth with it*

12:43

*Ethan moves closer to the girl with the next show and tell item*

*he sits and gets the stuffed animal again*

*he is playing with it again with the other boy and they are giggling*

I also observed Ethan interacting with children on the playground. The following example is of a boy initiating play with Ethan.

*Ethan runs outside with the rest of the class*

*when he gets outside - a boy puts Ethan on his back for a piggy-back ride*

*then they run to the jungle gym and climb to the top together*

During the same recess, Ethan becomes involved in a playful interaction with a different boy.

*he hooks up with a boy and they slide down together*

*climbs up again*

*slides down*

*climbs up the slide*

*seems to be playing with one other boy*

*they climb up the slide together*
talking to each other

hanging and swinging from a bar together

goes down the slide on his feet

climbs back up the slide

still seems to be playing with the same boy

following each other on the equipment

they are climbing up and down the slide

they are both hanging form the bar

still playing on the equipment

now Ethan is running around with three other boys

he pushes one of them

they are running again

Time 3:01

still running and yelling

still seems to be playing with the same boy

seems to be hiding under the slide

a boy “finds” him and they start running

still running

they seem to be tapping each other

still running

still running

he “tags” another boy
someone “tags” him

he is standing and talking to another boy

climbing on equipment

gets down

talking with two other boys

he runs to the door to wait to go inside

talking to the boy he has been playing with

still talking

time 3:13

still by the door talking to that boy

they are throwing a basketball back and forth

bouncing it back and forth

still bouncing it back and forth

still bouncing it back and forth

The teacher calls the children to come in

This example illustrates Ethan involved in play with one other boy as well as with three other boys in some type of voluntary group game of tag. The next example shows Ethan successfully initiating and sustaining play with another boy.

he picks up a paddle and plays paddle ball with another boy

still hitting the ball back and forth with another boy

2:05

still playing ball
While I was observing Ethan on the playground children would come to talk to me. One of the girls expressed her feelings of friendship towards Ethan.

_Ethan walks up to me and tells me how hot he is_

_Four girls bring me flowers and one sits in my lap_

_I say thank you and ask the girl in my lap her name_

_she says, “Megan”_

_Ethan says, “she’s my best friend - she used to sit beside me”_

_Megan says, “that’s right”_

When I discussed Ethan’s friendships with Nancy and Stephen, Stephen immediately responded, “Everybody is a friend.” Nancy responded:

Every now and then he will talk about one or two children who pick on him, knock the hat off his head, call him names - gopher, beaver, rabbit… And I have tried to explain to him non-aggressive ways to deal with that behavior.

She also shared a recent experience in which Ethan had no problems making friends.

So, it was a beautiful weekend and I really needed to sit down at the computer so I said, “go outside to play.” So he went outside to play and I didn’t see him for an hour. I lost track of time and I was frantic. I ran outside and he comes barreling in saying, “mom! Mom! I made two new friends! I joined their club!” I said, “what kind of club?” And he said, “it’s like a army club and I am the spy.”

In my interview with Ethan he mentioned some of the friends that he had made at school. He told me that lunch was his favorite time of the day because he could sit by his friends. He then named some of his friends, “Lisa, Alicia, Kelly, Susan, and Megan.” I told him that I noticed he was playing with some boys on the playground and asked if they were his friends. He responded, “Yeah -sometimes I play with…….I forgot what the little boy’s name was …..Jacob.” Ethan is aware of his friendships and the children that he interacts with at school. Nancy agreed with the names of friends that Ethan mentioned. She said that he often talks about those girls at home.
Mrs. Parker had a different perception on Ethan’s friendships and interactions with others:

He doesn’t really have a close friend. And I’m not sure why, but I think that in my class that most of the kids have been together so long, he’s not with them for reading and I really do think that’s part of that. We try to do collaborative/cooperative kinds of things and he works well within the group as well as anyone else does in second grade. But, If I were to look closely at his play, I’m not sure that I would find true interaction. Just initially, I do no associate him with anybody. In all the indoor recesses he tends to play with the pattern blocks or labels or whatever. He’s building his own creation, he’s in the groups, but he’s not really interacting with the other children. Almost to the level of parallel, and that’s not to say I really sat and analyzed him. But for someone to come in and do that they might sense like a two year old reaching for the same block and then we get an interaction. But as long as there is no conflict, there’s very little interaction.

Mrs. Parker seems to be very knowledgeable about children’s levels of play development. She sees Ethan at the level of parallel play in which he prefers to sit near other children and engage in similar activities rather than interact with the children in play. From my observations, I have seen Ethan interacting on more that just the parallel level of play. He seems to be able to make the initial interaction of playing with others and has successfully sustained those interactions. Making friends does not seem to be a problem for Ethan. If he is playing alone sometimes that may just be his choice. This preference could be due to a number of factors including his temperament, the fact that he is an only child, or his high intelligence level. Also, Ethan seems to connect more with others at the physical level. Most of the positive friendship interactions I observed happened on the playground. Maybe he is physically at the level of his peers more than anything else.

The School Environment

Teaching styles/Developmentally Appropriate Practice

Teaching styles can be characterized by the same categories as the parenting styles: authoritarian, authoritative, and permissive. Authoritative teaching is consistent with
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Developmentally Appropriate Practice in which there is a high level of warmth and demandingness. Children are allowed to make choices and have some say in their education, as opposed to being told everything to do. According to DAP, the classroom environment and teaching style should meet the developmental needs of the children. For example, young children should not be expected to sit and do seat work (ex. worksheets, tests, workbooks) for long periods of time. This would not be developmentally appropriate for a young child. Instead, children should be involved in a variety of activities that encourages active learning. In my observations of Ethan at school I have mostly seen examples of authoritative teaching and DAP. However, this is not always the case. The first example is of the children involved in a group game about study skills. The teacher allows everyone to participate and the children are able to get up and move around.

_The children come and sit on the floor around Mrs. Hamilton who is in the rocking chair she is talking about Shel Silverstein’s book _Where the Sidewalk Ends_

She begins to read poems from the book

_Ethan is sitting and looking at the teacher - he appears to be listening_

_Ethan: “that poem was short!”_

_She reads another_

_he is still sitting and looking at the teacher_

_still sitting_

_picking his nose_

_still sitting and looking at the teacher_

_rubbing his forehead_

_playing with his glasses_

_sitting and looking at the teacher_

_(the teacher asked a child in advance to be distracting during the group time - now the teacher is discussing this with the class)
still sitting and looking at the teacher

still sitting

pulls his shirt over his knees

The teacher asks, “What are reasons that we need to sit and listen?”

Ethan raises his hand

Ethan: “you might not hear”

a student writes his comment on the large paper

Teacher’s directions: each persons will come up and say things about themselves for 30 seconds and afterwards they need to each remember one thing about each person

The children each take turns telling about themselves

This example involved the children in a game to help them actively construct their understanding of the importance of listening and paying attention. I was very interested to see how much Ethan could remember about the other children and to see how much he had been paying attention. Unfortunately, even though he kept his hand raised to be called on, he never got a turn to try.

Ethan seems to respond well to large group discussions. One day Mrs. Parker was discussing something of interest to Ethan and he became an active participant in the group discussion.

Mrs. Parker: “what is the difference between a tornado watch and a tornado warning?”

Ethan raises his hand

the teacher calls on another child to answer what a warning is

she calls on Ethan next

Ethan: “A watch means that they are just watching to see if a tornado will form”

Mrs. Parker: “That’s exactly right.”

he is playing with his pencil
Ethan: “I’ve been in a hurricane”

Mrs. Parker: “That’s right because you used to live at the beach.”

Ethan seems to respond very positively to this type of teaching. His parents feel the same way. When I asked them what type of teaching they thought Ethan would respond to best Stephen replied, “You have got to coach him” and Nancy said, “He is looking for a partner, someone he can work with.” This indicates to me that they feel that Ethan would respond best to an authoritative type of teaching in which the teacher works with the child instead of just talking to the child. However, in our discussion about teaching, Stephen talked very differently about teachers in general.

At the beach they are driven to hiring male, ex-military people as teachers and to put the females out of business because females cannot handle people. Their skills are not there. If you are male and ex-military and you want to teach your name goes to the top of the list. That’s what they want. They want the authority type person there instead of the person that looks good and smells good and all that. Kids won’t listen to that type of person.

Other examples of teaching styles in Ethan’s classroom include centers, small group work, partner work, hands-on science or art activities, manipulatives for math and spelling, and interest-based literature groups. This wide variety is consistent with DAP and also covers a wide range of individual learning styles.

While observing Ethan’s math class I felt that his teacher gave the children a lot of individual attention and warmth. She allowed them to be active and talk quietly while doing their work.

The teacher walks around the room a lot to help individual children - very warm and supportive - does a good job of keeping the children focused on the lesson. Some children are sitting on desks and that seems to be okay with her. There is a very quiet hum in the room - children are only talking to themselves if talking. Lots of children seem to be fidgety.
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I have also seen examples of authoritarian teaching styles and practice that is not developmentally appropriate. During my interview with Ethan he indicated a discipline style that is not consistent with DAP. When I asked him what happened to him if he got in trouble he told me that the teacher would “take time off my recess.” Taking time off of a child’s recess does not seem to be consistent with the needs of an active, eight year old boy. Ethan indicated that he gets in trouble for talking and not listening to the teacher. As mentioned earlier, Mrs. Parker explained that she feels that listening and looking at the teacher are very important skills for the children to have.

According to Ethan’s files, the teaching methods used in his former school included worksheets, teacher directed activities, student text activities, workbooks, unit tests, teacher made tests, commercially made worksheets and tests. This is not consistent with DAP. Also, Ethan was placed in a “self-contained class with mainstreaming into non-academic and/or extracurricular activities.” The rationale for this decision was because it was considered to be the most appropriate learning environment for him. However, since he has moved to a school with inclusion his mother and teacher feel that he has blossomed. Unfortunately, he is in a pull out language arts program which Mrs. Parker does not agree with. This is the only time of day that is different from the rest of the students in his language arts class.

In his former school he was placed in a self-contained special education classroom because they felt that this was the most appropriate learning environment for him. However, he experienced difficulties in the areas of reading and writing. His mother also felt that he was having problems with self-esteem because he knew that he was different than the other children.

He is in an inclusive classroom now. One of the reasons that I think he is doing so well now is because he is in with all of the so-called normal children. It's a mixed class. There are students that are gifted, there are students that are average, and there are students that need extra help. So he sees a whole spectrum of humanity and sees that everybody has worth. When he was at the beach they shut him into a room off at the other end of the building and all of the normal children were somewhere else. And he internalized that. I have fought for three years to
preserve his specialness inside so he doesn’t feel different and he doesn’t feel less than.

And now Ethan is doing much better in the areas of reading and writing. In his present second grade classroom, Ethan is learning to read and write under the whole language approach. In his former school Ethan learned to read and write with the phonics method. Nancy did not agree with this method to teaching language arts. She felt that with the phonics approach he was confusing letters in his head. Nancy thinks that whole language makes more sense to him. Nancy understands the individual needs of her child and what type of learning style he has.

Ethan may need a combination of teaching styles to succeed in school. He seems to need structure in order to accomplish his assignments. With specific instructions and guidance, Ethan was able to complete his work on the days that he did not take his medication. DAP stresses the importance of focusing on the child as an individual and Ethan needs individual attention and guidance. He has proven that he can be part of a regular education classroom and succeed. He seems to also do well when given higher expectations and when activities are interesting to him. He has moved from a self-contained classroom into an inclusive classroom with higher expectations and he has “blossomed”. He is also succeeding in math, his favorite subject. As with any child, Ethan can succeed if given the right combination of structure and guidance as well as high expectations.

School Accommodations

Mrs. Parker feels that each child should be seen as an individual learner and that individual accommodations come naturally with that view.

The social skills group is one thing that we do for all the kids and that's something that we haven't done specifically in this fashion previously, in the last four years, this is the first time that I have had to do something like that. And, that is something very appropriate for him. I think just the close monitoring that I do, just checking in with him periodically, that I don't even think about anymore that's just part of the style of how things are going and how was math today and walking down the hall to PE or whatever, I just take that opportunity to talk to him partly
ADHD

to control his behavior walking down the hall, but just that constant reinforcement. He had some accommodations that we are doing because of his vision, either we blow it up or whatever, sitting closer to the board, those types of accommodations that we automatically make for a child. When you stop and think about what you have do it is so routine, that maybe it's the primary background is just, you accommodate for these children no matter whether they have IEP’s or not, and you cater to the individual learner no matter who it is.

This is a very positive, helpful attitude towards accommodations. She is a teacher who does not just teach to “the middle” of the class. She thinks about each child as an individual. The special education resource person and the classroom teacher worked together to create specific accommodations for Ethan. Ethan sits closer to the teacher and the board, and in math class he sits at his own table. Mrs. Parker also referred to Ethan’s IEP to find out what techniques have been used with him in the past. However, she waited a couple of months before doing this. She wanted to get to know Ethan before reading what other people thought about him. She did not want his label to interfere with seeing him as a person.

Environment

In his former school they accommodated for him by giving him special seating (near the teacher), frequent praise, and visual and auditory support. His new school is providing the same accommodations, but in an included classroom. In his regular classroom, Ethan sits at a cluster of desks with three other children, near the front of the room and near the teacher’s desk. His mother likes the idea of him sitting in a group with other children and feels this will help him socially. When he is pulled out of the classroom for language arts he is in a small room in the back of the library at a table with three other children. This is a very quiet setting with very few distractions. When he changes classes to go to math he sits at a table by himself by the window. The first time I entered his math class he looked at me and said, “I have to sit over here.”

Guidance Counselor

During my interview with Ethan he informed me that guidance was not one of his favorite parts of the day. When I asked him what he liked least about school he answered “guidance”
because “it's boring.” I decided to investigate this area further and try to figure out why Ethan did not like this time of the day. I talked with Mrs. Parker and her student teacher about why he might be feeling this way. I also talked to Linda, the guidance counselor, to see if she had any insight to this situation. I then decided to come back for a guidance class observation. For guidance, the guidance teacher comes to the classroom for a half-hour on Wednesdays. Ethan mentioned that he hates Wednesdays “because we go to music but we don’t go to lunch - like Mondays we go to music and then to lunch, but it's different because we have to go back to the classroom to do something until lunch.” After investigating, I figured out that the “something” they have to do after music and before lunch is come back to the classroom and have guidance. Each teacher had a theory as to why Ethan hates this time of day. Mrs. Parker feels that the guidance student teacher does not have very good control over the class. They don’t listen to her very well and she doesn’t know all of their names. She had told me that one week the student teacher for guidance did not give Ethan a care bear and he became very upset because he felt he deserved one. The children get to hold care bears if they behave well during guidance. She felt that could be a reason why he doesn’t like guidance. The student teacher (regular classroom) felt that maybe he didn’t like it because they often discuss families during guidance and this might make him feel uncomfortable. Linda, the guidance counselor, said Ethan is usually very difficult, doesn’t pay attention at all, very disruptive and a “very classic case of ADHD.” I asked if she had any more insight about Ethan that she could share in an interview and she said she didn’t think she would say anything different than what Mrs. Parker was telling me.

However, when I observed the guidance class Ethan acted better than I had ever seen him before. He did not fidget or talk out of turn or do anything that would disrupt the class. Linda was teaching that day and I wonder if that had anything to do with it. Also, they were watching a video and Ethan seems to be very interested in watching videos. This class could have been particularly interesting to him. I talked to Linda after class and she told me that this was not typical behavior for him.
ADHD

Services for the Individual Child

Diagnosis

Nancy felt that Ethan was exhibiting characteristics of ADHD by the age of three. The insurance company that she was dealing with did not agree with her. However, Nancy continued each year to try to get him diagnosed. The first year he was in kindergarten, the person who tested him did not think that he should be diagnosed with ADHD.

And of course when he entered kindergarten, Miss Miller brought it to our attention, and we attempted again to get him diagnosed and the first counselor said he could find no evidence of ADHD. He is a licensed clinical social worker and is very good at what he does. But, I think he missed on this one.

Ethan was diagnosed when he was in his second year of kindergarten. He was diagnosed based on his mother’s and teacher’s observations of his behaviors, according to the DSM, as well as his performance on his doctor’s blinking device. It seems as if Nancy had suspected that Ethan had ADHD for a few years, but could not find a doctor to confirm her suspicions. Ethan’s teacher’s had been informing her about Ethan’s hyperactive behaviors at school and encouraged her to get him tested for ADHD. She continued to try until finally he was diagnosed. I am not sure if Ethan should have been diagnosed with ADHD. It seems as if he has many individual needs in his life that could be accommodated for, without having been diagnosed with a disorder. For example, his eyesight and tracking problems could be helped and they could be large contributors to Ethan’s ADHD-like behaviors.

It is important to consider how the label of ADHD may affect the child. Children are aware of the negative connotations that a label carries and they begin to see themselves negatively because of the label. Ethan is aware of his label and that it means he “doesn’t pay attention.” He is aware of his changing behaviors when he is on medication. He has bought into the idea that there is something different about him and that medication will control whatever is wrong with him. In his former school he was treated differently because of the label and placed in a separate classroom away from the “normal” students. Nancy felt that this affected his perception of
himself. If diagnosing and labeling a child is supposed to help the child, we need to be aware of the negative perceptions that go along with that label. It is important to help children feel confident about themselves and not feel different because of a label.

Medical Treatment

Ethan receives medical treatment for ADHD. He has been talking Ritalin for the past year and a half. His parents and teachers feel that this helps him control his behaviors. Ethan feels that his medication “sometimes” helps him listen in school and that it helps him with his schoolwork. He also said that he can tell when he has taken it because, “I act good sometimes, and if I don’t that means I didn’t take my medicine.” He remembered a day at school when he forgot to take his medicine. He said he “acted up” that day and that he “didn’t pay attention.” Mrs. Parker could tell that he had not taken the medication and noticed a big change in his behavior during the free time during the day. She felt that his behavior was more “large motor” than when he was on the medication. However, she felt that he was still able to get to work and accomplish what needed to be done. I wonder if the medication helps him to get focused. He was able to become focused and do his work on the days he did not take his medication. On those days he was more active during free times and transitions. I wonder if he needs the medication to do his school work? Or could he be all right with just some more help and attention during the more open times of the day? This would definitely be more challenging for his teachers, but I wonder if it would work. His teachers have all commented on his high activity level, ever since preschool. But, he is able to accomplish his work. Also, he has shown that he can become very engaged in an activity when it is of high interest to him, so he does have the ability to focus when he wants to. The trick is, how can he be taught to focus when someone else wants him to?

Nancy and Stephen think that he will continue to need medication to control his behaviors throughout life. Stephen explained, “She (Nancy) would like to see him continue on because she cannot handle him without Ritalin, whereas it does not bother me one way or the other.” He agrees with Nancy by saying, “I think he is going to need to be on it.”
Mrs. Parker feels that he is learning appropriate self-regulation behaviors by taking the medication. She thinks that by taking the medication he is able to learn appropriate behaviors and maybe not need to take it for the rest of his life.

I’ll try to follow up on those kids that I have had in second grade and see how they are doing. There are some who are able to work themselves off of the Ritalin and still maintain the appropriate behaviors. Because I think we take the time to give them more strategies, maybe, ….we break it down and things that we don’t always do for all children. Even something like folding their paper so they just do that first row of math problems and they are not overwhelmed by the rest of them. They are still doing everything that everybody else is doing, but they know that there are those visual things that they can do to make it easier.

Mrs. Parker does not think that medication is for everyone. She feels that it works for some families but not for others. However, she will recommend to a family to find a doctor to prescribe it just as a test run before going through all of the testing the school requires.

I don’t think Ritalin works for every child. It certainly doesn’t work for every parent. I almost am one that will say to a parent if they really are pushing me for answers - “go to your doctor, have them monitor him on medication for a month, or whatever and if we see a difference then we know this is the answer.” Because I find it very difficult for a lot of the families to go through all the testing that the school requires. To go through all the psychological and all of that when we really don’t think that’s the problem. I find that is very traumatic for some families to even accept the fact that it could be something beyond just the physical needs of a child and they can go and get the doctor to say to try the medicine and find out if it’s just this physical thing. But to go through the psychological, to go through the home visits, to go through all that social stuff, parents find very intrusive to their lives. But a lot of the doctors only prescribe it during school hours so they don’t see the changes that we see unless we can convince them to do it out of school. To try it and see. I think sometimes if they don’t want to do the medication some
counseling does work. I have seen some who have had to go as a family for
counseling and they have put him on behavior modification. That is sufficient.
And it gets the parents working together because oftentimes there is no structure
and it becomes more routine. The routine becomes more strict. That has worked
for some families. Obviously not with the most severe, high level attention
problems. Oftentimes teachers are asked to be the counselor, to create that
schedule, to give those parenting things and sometimes it is just a lack of
parenting. For some of those who are borderline who really need structure.

Both Nancy and Mrs. Parker are aware of the side effects that Ritalin can cause. Nancy
remembers the doctor explaining them to her and telling her to monitor Ethan closely for any
major changes. The only negative effect that Nancy noticed was a loss of appetite. Ethan is
aware of his small appetite. When I observed him at home during dinner time his mother asked
him if he wanted more pizza and he said, “no, you know I don’t eat very much.” Ethan’s growth
is also an issue. When Stephen came to see Ethan and Nancy after being away for months he
thought that Ethan had not grown in the past year. He is worried that the medication is affecting
Ethan’s growth.

Mrs. Parker informed me that another child in the school was taken off of Ritalin because
he picked at his eyebrows. She had noticed a similar behavior with Ethan and wondered if this
was a concern.

One of the reasons that they took him off the Ritalin was the side effect of
plucking the eyebrows. And I didn’t know that was a side effect. I had never
heard that before. But that was the physical thing that they could see that was
occurring. I want you the next time you work with Ethan to look at his eyebrows.
They are very thin on the outside arch.

I then asked Nancy and Stephen if they noticed this behavior and they said that Ethan does
pick at his at his eyebrows. However, Nancy is not sure that this is a side effect of the
medication. She thinks that the Ritalin dries out his eyes and they hurt so he picks at them. She
ADHD

also thinks he might be having headaches but does not know how to verbalize this. This behavior could also be a result of his vision problems, which could cause him to have headaches.

As for the other side effects that are associated with Ritalin, Ethan does not seem to have any of those. He sleeps fine through the night. Stephen and Nancy disagree about whether or not his growth has been slowed down. Stephen thinks that Ethan has not grown in over a year and Nancy thinks he is growing fine.

Legal Services

Ethan receives special education services. His IEP states that he needs to be pulled out of the classroom in order to be in the most appropriate learning environment. The IEP was written when Ethan attended his former school. Since he has moved to a school with full inclusion he has blossomed. Mrs. Parker does not agree with the pull out recommendation in his IEP. She would rather he remain in the classroom.

Reflections and Recommendations

ADHD is a label given to a child who may exhibit the characteristics of inattention, hyperactivity, and impulsivity (American Psychiatric Association, 1994). However, this may not be true for every child who has ADHD. The characteristics and causes of ADHD are so diverse that it is necessary to move beyond just knowing that a child has ADHD in order to help that child. Knowing that a child has ADHD does not tell me much about that child, except that the child has been diagnosed with ADHD. This information tells me nothing about the child as an individual or how to parent or teach this child. The label of ADHD does not even tell me exactly which behaviors that the child might be exhibiting. All I know is that the child has been labeled. If I want to know more about this child, I need to know the child as an individual, not as a child with a disability. In order to help a child who has been diagnosed with ADHD I need to know the child and the life that he or she has experienced. Many factors in a child’s life may be affecting that child as a person today. In order for me to help that child I need to know about parenting, family, health, and school situations in that child’s life.
A positive aspect of being labeled ADHD is that it will provide the student with special education services in school. Only a small percentage of children with ADHD are labeled under the Individuals with Disabilities Education Act (IDEA), other health impaired, and these students receive special education services in school. Most students who are labeled ADHD are not under IDEA and do not receive any school funding. However, even if the student is labeled under IDEA and receives services, the label does not come with instructions on how to help that child, it only provides an awareness that help is needed. There is no cookbook solution for helping a child who has been diagnosed with ADHD. The label can alert the teacher to that fact that the child has individual needs.

We live in a quick fix society and we want a quick solution to problems. Oftentimes, parents and teachers go for the quick fix of medicating the child instead of taking the time to go through the long process of trying to collaborate, change the environment, try new parenting and/or teaching styles, or other possible solutions. The process of investigating the problem and exhausting all possible solutions should come before medicating the child. Each child deserves the careful investigation into his or her individual problems before a quick decision is made to medicate. A child may be quickly medicated without ever knowing if alternative accommodations or treatments would have worked. This could help with the problem of overmedicating children (Barabasz & Barabasz, 1996; Saunders & Chambers, 1996). Unfortunately this is not the case. Research has shown that medication provides results and this makes it easier for families and teachers to choose medication as the first type of treatment (Henker & Whalen, 1989). This is not necessarily the fault of the families and teachers. Our society encourages fast results and promotes medication as a quick solution.

The prevalence of ADHD is on the rise in our country (Barabasz & Barabasz, 1996; Goodman & Poillion, 1992; Reid, Maag, Vasa, & Wright, 1994; Saunders & Chambers, 1996). This case has caused me to reflect on whether or not Ethan really has ADHD. From the time he was in preschool, his teachers suggested that he may have a problem. In his case, this initial suggestion may have become self-fulfilling. Once he was diagnosed he was quickly medicated. Ethan has other problems that may be affecting his behaviors. I think that these specific problems
ADHD

should be accommodated for before medication is given. Both his mother and present teacher feel that medication should be tried without a long process of other treatments. I cannot help but think that there may be children in this country who were quickly diagnosed with ADHD and treated with medication before other options were explored.

Parenting any child is challenging, but parenting a child with ADHD is even more challenging. Typical parenting styles may not work with a child with ADHD. The parents may need to adapt their parenting behavior according to the situation. Parenting a child with ADHD may need to be seen as more of an interactive process between the child and the parents. The child’s behaviors may be inconsistent and this may cause the parents behaviors to be inconsistent. The child may need more structure and authoritarian parenting in some situations and more freedom and authoritative parenting in others.

Teaching a child with ADHD can be a challenge. However, to be able to help that child, the teacher needs to know more than just the child’s label of ADHD. The teacher needs to take the time to get to know the child as an individual and figure out which teaching styles work best with that child. As with parenting, the child may need more structure in some situations and more freedom in others. However, the teacher would not know this if she only saw the child as a label. Because increasing numbers of children are being diagnosed with ADHD it is necessary to examine the environments that influence the children (Barabasz & Barabasz, 1996; Goodman & Poillion, 1992; Reid, Maag, Vasa, & Wright, 1994; Saunders & Chambers, 1996). If so many children are having trouble adapting to the school environment it would make sense to change the environment to meet the needs of those children, instead of trying to change the child to fit the environment (Pellegrini & Horvat, 1995).

Diagnosing a child with ADHD may take more than a short visit to the doctor’s office or checking off a few characteristics on a DSM checklist. Again, it takes a lot of thought and background information about the individual child. And once the child is diagnosed, treating the child can be a difficult issue. Just because a child has ADHD does not mean that there is one treatment for the one label. The treatments should be as individual as the child. Since each child
ADHD

exhibits individual characteristics and behaviors, the treatments should match the child’s individual needs.

The developmental contextualist model that I created can be helpful when working with any child who has been diagnosed with ADHD. It provides a framework of aspects in a child’s life that need to be examined in order to understand the child as an individual and not just a child who has been labeled. Future research on children with ADHD needs to examine the child from a developmental contextualist framework. This model can also be used with any child with a disability, stressing the importance of the child in context, not just a child with a label.
REFERENCES


ADHD


ADHD


APPENDIX A
LETTERS TO PARENTS AND TEACHERS

January 5, 1998

Dear Parents,

I am a graduate student in the Department of Family and Child Development at Virginia Tech. I am conducting a study for my thesis on children who have been diagnosed with ADHD. It will be a case study of 2 children, their teachers, and their families. I am asking you and your child if you would like to participate in this study.

In general, the study will involve interviews with the parents, teachers and children as well as observations of the children in a variety of settings, including their school.

If granted permission to conduct the study, involvement of your family would entail:

• Permission to interview you. I would like to be able to interview you at least two times in order to learn about your child’s developmental history, your feelings about ADHD, your child’s behaviors in school and at home, and your decision-making processes.

• Permission to observe your child in your home and at school, doing everyday activities. This is to give me a chance observe your child in different settings and at different times of the day. The observations will be as non-intrusive as possible and scheduled well in advance and at the convenience of you and your child.

• Permission to interview your child. I am interested in hearing your child’s point of view on the topic.

If you choose to participate in this study, please sign the consent form for both you and your child and return it to me.

If you have any questions, or would like more information, please feel free to contact me at (540) 961-6268 or my committee chair, Dr. Janet Sawyers at (540) 231-3194. I appreciate your consideration of this request.

Sincerely,

Suzanne Natili
Dear Teacher,

I am a graduate student in the Department of Family and Child Development at Virginia Tech. I am conducting a study for my thesis on children who have been diagnosed with ADHD. It will be a case study of 2 children, their teachers, and their families. I am asking you if you would be willing to participate in this study.

In general, the study will involve interviews with the parents, teachers and children as well as observations of the children in a variety of settings, including their school. If granted your permission to conduct the study, involvement of you and your classroom would entail:

- Permission to interview you. I would like to be able to interview you at least two times in order to learn about your perspective on the child, your thoughts about ADHD, your teaching style, and your support systems in the classroom.
- Permission to observe the child in your classroom, doing everyday activities. This is to give me a chance observe the child in different settings and at different times of the day. I would like to observe the child at least two times in the morning and two in the afternoon. The observations will be as non-intrusive as possible and scheduled well in advance and at the convenience of you.

If you choose to participate in this study, please sign the consent form for both you and your child and return it to me.

If you have any questions, or would like more information, please feel free to contact me at (540) 961-6268 or my committee chair, Dr. Janet Sawyers at (540) 231-3194. I appreciate your consideration of this request.

Sincerely,

Suzanne Natili
Title of Project: An Investigation of ADHD: Two Case Studies

Investigator: Suzanne Natili

I. The Purpose of this Research

You are invited to participate in a study of two children who are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). I want to talk with you about how you acquired your knowledge about ADHD, medication, and alternatives to medication. I will talk with you about your child’s developmental history, initial diagnosis of your child’s ADHD, your decision-making process about treating ADHD, your child’s transition from preschool to elementary school, and parenting styles. The number of participants in this study will be 10, including 2 children, their parents, and their classroom teachers.

II. Procedures

You will be asked open-ended questions about discipline, the child’s behaviors, how you made your decision about treatment for your child, parenting styles, and your child’s developmental history.

I will also observe your child interacting with you at home, as well as with teachers, and other children at school. I will observe your child at four different times in school for approximately 2 hours each time. This will include two times in the morning and two in the afternoon in order to observe the child at different times of the day. I will try to observe your child during different activities during the day. I will also observe your child at home four different times for approximately 2 hours each time. This will include two times during the week and two on the weekend.

III. Risks

I do not anticipate any risks to you for participation in this study.
IV. Benefits of this Project

A benefit for participation in this study is being able to talk about having a child who is diagnosed with ADHD with another person. Potentially, publications could come from this research project that could help other parents who have children that are diagnosed with ADHD. I will also share any resources that I feel may be helpful, such as books or other references.

V. Extent of Anonymity and Confidentiality

Your child will be assigned a pseudonym to ensure confidentiality. The interviews will be tape recorded and then transcribed by me. I will be the only person who has access to the tapes.

VI. Compensation

For participation in this study I will share your child’s case study with you and the child’s classroom teacher when completed.

VII. Freedom to Withdraw

You are free to withdraw from this study at any time. You are free to not answer all questions.

VIII. Approval of Research

This research has been approved, as required, by the Institutional Review Board for Research involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development and Montgomery County Public Schools.

IX. Subjects Responsibilities

I voluntarily agree to participate in this study.

X. Subject’s Permission

I have read and understand this consent form and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time.

__________________________                                 ______________________
Signature                                                                        Date
Should I have any questions about this research or its conduct, I may contact:

Suzanne Natili, Investigator     961-6268

Dr. Janet Sawyers, Faculty Advisor   231-3194

H.T. Hurd, Chair, IRB, Research Division   231-9359
Title of Project: An Investigation of ADHD: Two Case Studies

Investigator: Suzanne Natili

I. The Purpose of this Research

Your child is invited to participate in a study of two children who are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). I would like to talk with your child about his or her thoughts and feelings about ADHD. I also would like to observe your child at both home and school. The number of participants in this study will be 10, including 2 children, their parents, and their classroom teachers.

II. Procedures

I will also observe your child interacting with you at home, as well as with teachers, and other children at school. I will observe your child at four different times in school for approximately 2 hours each time. This will include two times in the morning and two in the afternoon in order to observe the child at different times of the day. I will try to observe your child during different activities during the day. I will also observe your child at home four different times for approximately 2 hours each time. This will include two times during the week and two on the weekend. I will also interview your child about his or her thoughts and feelings about being diagnosed with ADHD.

III. Risks

I do not anticipate any risks to your child for participation in this study.

IV. Benefits of this Project

It may be beneficial for your child to discuss his or her thoughts and feelings with another person.
V. Extent of Anonymity and Confidentiality

Your child will be assigned a pseudonym to ensure confidentiality. The interviews will be tape recorded and then transcribed by me. I will be the only person who has access to the tapes.

VI. Compensation

Other than my sincere appreciation, there is no compensation for your child.

VII. Freedom to Withdraw

Your child is free to withdraw from this study at any time. Your child is free to not answer all questions.

VIII. Approval of Research

This research has been approved, as required, by the Institutional Review Board for Research involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development and Montgomery County Public Schools.

IX. Subjects Responsibilities

I voluntarily give my consent for my child to participate in this study.

X. Subject’s Permission

I have read and understand this consent form and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for my child’s participation in this project.

If my child participates, he or she may withdraw at any time.

__________________________                                 ______________________
Signature                                                                        Date

__________________________                                 ______________________
Signature                                                                        Date

Should I have any questions about this research or its conduct, I may contact:

Suzanne Natili, Investigator      961-6268
Dr. Janet Sawyers, Faculty Advisor  231-3194

H.T. Hurd, Chair, IRB, Research Division   231-9359
Title of Project: An Investigation of ADHD: Two Case Studies

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I. The Purpose of this Research

You are invited to participate in a study of two children who are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). I would like to talk with you about how you acquired your knowledge about ADHD, medication, and alternatives to medication. I will talk with you about teaching styles and the child’s behaviors. I will also talk with you about your participation in the diagnosis and/or treatment of ADHD, as well as your thoughts and feelings. I would also like to observe the child who is diagnosed with ADHD at different times at school. The number of participants in this study will be 10, including 2 children, their parents, and their classroom teachers.

II. Procedures

You will be asked open-ended questions about discipline, the child’s behaviors, your teaching style, your participation in the diagnosis and/or treatment of ADHD, and your thoughts and feelings as a teacher of a child who is diagnosed with ADHD.

I will also observe the child at school. I will observe the child at four different times in school for approximately 2 hours each time. This will include two times in the morning and two in the afternoon in order to observe the child at different times of the day. I will try to observe the child during different activities during the day.

III. Risks

I do not anticipate any risks to you for participation in this study.

IV. Benefits of this Project

A benefit for participating in this study is being able to talk about having a child who is diagnosed with ADHD in the classroom. Potentially, this study could produce publications that would help other teachers who have children diagnosed with ADHD in their classrooms. I will also share any resources that I feel may be helpful, such as books or other references.
V. Extent of Anonymity and Confidentiality

You will be assigned a pseudonym to ensure confidentiality. The interviews will be tape recorded and then transcribed by me. I will be the only person who has access to the tapes.

VI. Compensation

For participation in this study I will share the child’s case study with you when completed.

VII. Freedom to Withdraw

You are free to withdraw from this study at any time. You are free to not answer all questions.

VIII. Approval of Research

This research has been approved, as required, by the Institutional Review Board for Research involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Family and Child Development and Montgomery County Public Schools.

IX. Subjects Responsibilities

I voluntarily agree to participate in this study.

X. Subject’s Permission

I have read and understand this consent form and the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time.

__________________________                                 ______________________
Signature                                                                        Date

Should I have any questions about this research or its conduct, I may contact:

Suzanne Natili, Investigator 961-6268

Dr. Janet Sawyers, Faculty Advisor 231-3194

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ADHD

VITA

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EDUCATION

Master of Science, Child Development, Virginia Polytechnic Institute and State University, May 1998

Bachelor of Science, Family and Child Development, concentration in Early Childhood Education, Virginia Polytechnic Institute and State University, May 1996

PROFESSIONAL EXPERIENCE

Head Teacher, Virginia Tech Child Development Laboratory School, Toddler Room, August 1996 - December 1997
Combo Room (ages 3-5), January 1998 - May 1998

Study Abroad, Reggio Emilia, Italy, January 1998
Study Tour of Internationally Renowned Preschools in Reggio Emilia, Italy

Student Teacher, First grade, Kipps Elementary School, Blacksburg, VA August-December, 1995
Third grade, Gilbert Linkous Elementary School, Blacksburg, VA January - May 1996

RELATED EXPERIENCE

Presenter, VAECE Conference
- Presented “Uncovering the Curriculum in an Infant / Toddler Classroom” March 1998

Co-Chair, Workshops, VAECE Conference Planning Committee, 1999
ADHD