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Relationship Between Preponderance of ADHD in the African American Community and How Teachers are Trained to Type Students as ADHD

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Relationship between preponderance of ADHD in African American community and how Teachers are trained to type students as ADHD

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ABSTRACT

The following capstone paper "Relationship between preponderance of ADHD in African American community and how teachers are trained to type students as ADHD" explores the epidemic of Attention Deficit Hyperactivity Disorder (ADHD) diagnosis in students and the prevalence of ADHD in the African American community. In recent years the number of African American children with ADHD have skyrocketed concerning parents about the over diagnoses and misdiagnoses of the disorder (Ahmann, 2016).

> A recent study by Getahun and colleagues found a 70 percent increase in the number of ADHD diagnoses among African American children, with a 90 percent increase among African American girls. This is compared to smaller increases in other groups- 60 percent among Hispanic youth and 30 percent among white youth. "(Dr. Wallace, 2013).

Diagnosing ADHD continues to become more prevalent in the African American community due to education and awareness, improvement in socioeconomic conditions, and societal factors (Ahmann, 2016).

Teachers and parents are usually the first people to recognize signs of ADHD in children. This paper will focus on teachers within the state of Illinois and their ability to identify ADHD in their classrooms, the protocol that they follow, and training that they receive to decipher ADHD from other types of learning disabilities. This research aims to provide a better understanding of the correlation between race and class and how they play a major factor in the diagnosis or lack thereof of ADHD?

Definitions & Keywords

Attention Deficit Disorder- Outdated term used to describe ADHD however it
excluded hyperactivity. The diagnoses was changed in 2013 by the American
Psychiatric Association.

Attention Deficit Hyperactivity Disorder- ADHD is one of the most
neurodevelopmental disorders of childhood. It is usually first diagnosed in
childhood and often lasts into adulthood. Children with ADHD may have
trouble paying attention, controlling impulsive behaviors (may act without
thinking about what the result will be), or be overly active. (American Journal
of Medical Genetics, 2002)

Behavior- Is defined as both behavior, which can be observed easily, and mental
processes such as thoughts and feelings. The focus is on the individual's
actions and activities in their surrounding. (Hutchinson, 2003)

Behavioral Disorder- Is an emotional disability characterized by the following: An
inability to build or maintain satisfactory interpersonal relationships with
peers and/or teachers. (Georgia Department of Education, 2015)

Cognitive learning theory- A broad theory that explains thinking and differing
mental processes and how they are influenced by internal and external
factors in order to produce learning in individuals. (Hutchinson, 2003)

Individualized Treatment Plan (IEP)- Is a plan or program developed to ensure
that a child who has a disability identified under the law and is attending an
elementary or secondary educational institution receives specialized

instruction and related services. (Disabilities, Opportunities,

Internetworking, and Technology, 2015)

Learning- Is defined as relatively lasting change in behavior that had its origin in

practice. The "we" we will talk about here also includes how we learn to

behave, to interact with other people and to think and feel. (Hutchinson,

2003)

Mental Health- is a state of well-being in which the individual realizes his or her

own abilities, can cope with the normal stresses of life, can work

productively and fruitfully, and is able to make a contribution to his or her

community. (Center for Disease Control, 2014)

Mental Illness- is defined as collectively all diagnosable mental disorders or health

conditions that are characterized by alterations in thinking, mood, or

behavior (or some combination thereof) associated with distress and/or

impaired functioning. (Center for Disease Control, 2014)

Medical Apartheid- is the history of medical experimentation on African

Americans. Harriet A. Washington developed the term in 2007.

Post Traumatic Stress Disorder- Post-traumatic stress disorder (PTSD) is a

mental health condition that's triggered by a terrifying event — either

experiencing it or witnessing it. Symptoms may include flashbacks,

nightmares and severe anxiety, as well as uncontrollable thoughts about the

event. (Mayo Foundation for Medical Education and Research, 1998-2016)

Social Ecological Theory- The notion of social ecology draws from the Aristotelian

concept of eudemonia (often translated as flourishing), that property of one's life when considered in its whole. A modern definition of social ecology understands it as the interactions within the social, institutional, and cultural contexts of people-environment relations that make up well-being. (University of California, Irvine 2016) The theory has 5 major components (listed below)

Individual- the personal attributes of the individual play a significant role in shaping the health and well being of the individual child. (Nemours Health & Prevention Services, 2006)

Interpersonal- At the interpersonal level, formal and informal social network and support systems- including family, workgroup, and peers networks- play a critical role in healthy development. (Nemours Health & Prevention Services, 2006)

Institutional Organization- factors are those influences and characteristics of the social institutions and organizations in which people participate. For example, childcare, schools, churches, healthcare, and recreational facilities are institutions that have a significant impact on children's healthy development. (Nemours Health & Prevention Services, 2006)

Community- factors are the relationships among organization and institutions. How well the systems are linked together to provide seamless support to children and their families is important to maintaining a positive influence on health outcomes for children. (Nemours Health & Prevention Services, 2006)

Policy- local, state, and federal policies and laws that regulate and support healthy

development. (Nemours Health & Prevention Services, 2006)

Introduction

As of September 2014 an estimated 6.4 Million American children ages 4-17

have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)

according to Healthline (Healthline, 2014). There has been a 42% increase in ADHD

diagnoses over the past 8 years (Healthline, 2014). ADHD is a behavioral disorder

that is commonly diagnosed in children. Symptoms of ADHD according to the

Center for Disease Control are: impulsiveness, distractibility, daydreaming,

inattentiveness, and fidgeting in addition to other symptoms (Center for Disease

Control, 2016). In recent years the number of African American children with ADHD

has skyrocketed, concerning parents about the over diagnoses and misdiagnoses of

the disorder (Ahmann, 2016).

> A recent study by Getahun and colleagues found a 70 percent increase in the
> number of ADHD diagnoses among African American children, with a 90
> percent increase among African American girls. This is compared to smaller
> increases in other groups- 60 percent among Hispanic youth and 30 percent
> among white youth. "(Dr. Wallace, 2013).

Diagnosing ADHD continues to become more prevalent in the African American

community due to education and awareness, improvement in socioeconomic

conditions, and societal factors (Ahmann, 2016). Teachers and parents are usually

the first people to recognize signs of ADHD in children. For this capstone I am going

to focus on the relationship between preponderance of ADHD in the African

American community and how teachers are trained to type students as ADHD.

ADHD is a topic that is very relevant and meaningful to me. I am one of the 6.4 million children that were diagnosed with ADHD. Back in elementary school and all throughout my childhood I was referred to as the energizer bunny because the energizer bunny just keeps going, and going, and going, and going and just when you think its about to stop it continues moving. I was a very bright kid however; I struggled with sitting still and fidgeting, impulsiveness, and distractibility. I went to a good elementary school with lots of resources and dedicated teachers. Although it was a good school we did deal with overcrowded classrooms and a lot of the students present families were considered lower class. I was never formally diagnosed as a kid, more then likely because there were other students in the class way more disruptive than me. I did learn in my adult life that several of my teachers suggested that I undergo testing but my parents declined.

During graduate school at SIT (School of International Training) I was forced to reflect on my life constantly, what type of impact have I made on this world, what type of impact will I make, how to think critically, and how to train and learn. After doing a series of exercises in a training design class for four months I decided to get tested. I was formally diagnosed in 2012, although I have known for a lot longer then that. I think I forfeited testing due to the negative stigma associated with ADHD. Attending SIT helped me to become more comfortable with accepting my learning style and embracing all the amazing things that come along with being ADHD. When talking to my parents about why they declined testing, my mother stated that she did not know a lot about ADHD at the time the teachers suggested testing. She did not want me to live with a label for the rest of my life. My mother

also stated that she felt like she was to blame as if ADHD is hereditary and passed on from parent to child and overall she thought my symptoms were a result of the social conditions we were living in.

Research Question

When I left SIT (School of International Training) back in 2012 I began my practicum at a youth residential home. The residential home where I work is a U.S. American privately funded residential home in the states for abused, homeless, neglected, and trouble children. Of the 134 young people living in our residential homes; 68% our African American, 24% Latino, 7% Caucasian, and 1% identified as other (Mercy Home for Boys and Girls, 2015). Over 50% of our youth have been diagnosed with a learning disability. On a day-to-day basis I work as a social worker, I deal primarily with children diagnosed with learning disorders and mental illness. A Majority of the youth I work with come in displaying ADHD symptoms. However post traumatic stress disorder symptoms are very similar to ADHD. While witnessing the many times that we as an organization have tried to figure out the proper diagnosis between the two I wondered the following which our my **research question: What is the relationship between preponderance of ADHD in African American community and how teachers are trained to type students as ADHD. Sub question, how were teachers able to decipher between ADHD and PTSD? And what types of training do teachers receive to type students as ADHD?** I know at my job we receive extensive training that is ongoing.

There is a lot of research out there about ADHD but there is limited research

about how teachers go about distinguishing the symptoms in their classroom and the training and resources they receive in order to work with students diagnosed. According to the CDC, signs and symptoms usually appear before the age of seven (U.S. Department of Education, 2003) and (HelpGuide.Org, 2016). It can be very difficult to distinguish normal child like behavior vs. ADHD symptoms. The key to distinguishing the behavior is time. When I spoke with child psychologist Judith Baxter about ADHD she explained to me that teachers and doctors are taught to monitor the ADHD symptoms displayed by the child overtime (personal communication, October 2016). If a child displays minor symptoms periodically this is probably not ADHD and just normal child like behavior. However if a child displays several symptoms and continues to display symptoms over an extended time period, teachers should notify the parents to see if the parents are noticing some of these same symptoms at home and if there are any connections or reasons for the behavior. This is an indicator for ADHD. Therefore the parents should seek out medical assistance for testing purposes.

For the purpose of this research I will be using the criteria set forth by the fourth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) to detect the presence of ADHD in children. Furthermore I'm also going to use Murray Bookchin's social ecology theory to understand and analyze how multiple factors influence an individuals development to varying degrees and how this theory helps study the scope of the whole child and its environment.

Literature Review

What is ADHD?

According to the American Psychiatric Association, ADHD is the most diagnosed psychiatric children's disorder (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2013). Attention Deficit Hyperactivity Disorder is a behavioral disorder that is commonly diagnosed in children. Symptoms of ADHD according to the Center for Disease Control are: impulsiveness, distractibility, daydreaming, inattentiveness, and fidgeting in addition to other symptoms (Center for Disease Control, 2016). ADHD is believed to be a neurological disorder. Scientists are still conducting research to figure out exactly what causes ADHD. When ADHD first became a phenomenon it was believed to be caused by high sugar intake. Parents were told that their children were consuming too much refined sugar and food additives and this is why the children were experiencing hyperactivity (ADDitude, 2016). This is a myth. Refined sugar and food additives do not cause ADHD. What we do know about ADHD is that it is a "neurobehavioral disorder thought to be associated with structural and chemical alterations in the prefrontal cortex, the front-most portion of the brain responsible for many higher-order mental functions—including those that regulate attention and behavior" (Neurobiology of Executive Functions, 2005).

The brain is a very interesting, complicated, and dynamic structure. The frontal lobe is where the prefrontal cortex is located. The prefrontal cortex is responsible for people's behavior and judgment, attention, and emotional responses. It is believed that neurotransmitter level may help to impair the

prefrontal cortex ability to function. A neurotransmitter according to MedicineNet is a "chemical substance that is released at the end of a nerve fiber by the arrival of a nerve impulse and, by diffusing across the synapse or junction, causes the transfer of the impulse to another nerve fiber, a muscle fiber, or some other structure" (MedicineNet, 2010). To conclude a person with ADHD has structural differences in these three core areas and the neurotransmitter also plays a major factor. However these are all just theories, it is very difficult to test and track the origins of ADHD.

There is a major debate going on about whether ADHD is biological, environmental, or psychological. Scientist and doctors have found research to suggest that ADHD is genetic. According to the Child Development Institute "Studies indicate that 25 percent of the close relatives in the families of ADHD children also have ADHD, whereas the rate is about 5 percent in the general population. Many studies of twins now show that a strong genetic influence exists in the disorder" (Child Development Institute, 2016). Scientist and doctors are discovering new findings as they conduct research and search for a cure. Lately we learned that "children who have ADHD usually have at least one close relative who has ADHD. And at least one-third of all fathers who had ADHD in their youth bear children who have ADHD" (ADDitude, 2016). These findings are very influential in how we think about ADHD, its origins, and children diagnosed. Children often feel isolated and inadequate for being inattentive and not being able to sit still. This research lets us know that these children are not alone. Children diagnosed have someone they can relate to in their family and this helps us to understand ADHD better. The next phase

of research will be studying the parents of children with ADHD in depth to enhance our knowledge of its origin.

Teachers Involvement

One of the most important and influential jobs is being a teacher. A teacher is responsible for academic growth and social development for 15-30 students each school year (depending on the class size). Teachers are patient, working with students through their challenges and helping to celebrate their success. Teachers are role models. A teacher's job is to inspire and encourage students to achieve greatness. Based on my own experience as a student I would say teachers spend an estimated forty hours a week with students excluding after school programs. Forty hours is a significant amount of time. Teachers spend, as much time with students as parents do, this is one of the reasons why teachers and parents are usually the first people to recognize signs of ADHD in children. The average age of ADHD diagnoses is seven according to the U.S. Department of Education (U.S. Department of Education, 2003) and (HelpGuide.Org, 2016). Seven year olds are typically in first grade where they develop social, physical, and cognitive skills.

Even the best teachers sometimes face difficulty determining whether or not a child has ADHD. The purpose of this capstone is not to blame teachers. Teachers do amazing work when they have all the necessary tools and resources. The purpose of this capstone is to analyze how teachers type students as ADHD and find ways to improve the "typing system" and keep teachers updated on the new knowledge and practices. In order to be a teacher you must be committed and passionate about the

work that you do. Teachers care a great deal for their students. Recommending ADHD testing or suggesting that a student has ADHD can be a challenge for teachers as well. A lot of schools in low-income areas experience lack of resources, overcrowding, and there is pressure on the teacher to produce results (Chen, 2016) & (Children's Defense, 2004). A child with ADHD might pose a problem to the structure of the classroom, often times making the classroom a difficult learning environment for others. With the many demands of teachers, sometimes in situations like these it may be easier to try to diagnose the child or perhaps the behavior is ignored.

Not all teachers are trained to work with and type students as ADHD. Teachers that lack experience and knowledge about ADHD may misdiagnose the student or the behavior may be ignored. In these instances this may lead to some children being placed in special education that did not deserve to be there "The 1998 annual report of the federal Office of Special Education Programs noted that between 1980 and 1990, black children were placed in special education at more than twice the rates of whites" (Codrington, 2012). Sharman Dennis, a former special education teacher in Washington DC, agrees (personal communication, October 2016). "There are a large number of children in special education programs that may not need to be there"(Sharman Dennis, October 2016). Placing a child in special education that does not belong there can produce other symptoms such as depression and low self-esteem.

When diagnosing a child with ADHD it is important not only to analyze the behavioral symptoms, it is also important to analyze the child's environment and

home life. For example, some of the symptoms such as inattentiveness, disruptive, and impulsiveness are also symptoms of posttraumatic stress disorder. For low-income students, benefactors such as stress, trauma, not having access to adequate or well-balanced meals and living in violence stricken neighborhoods can all lead to distractibility, impulsiveness, daydreaming, and disruptive behavior.

Schools Systems

There are three types of school systems in Illinois, public, charter, and private schools. The participants of the survey worked at public and charter schools. According to Kyle Zinth, a representative of the Education Commission of the States "A public school is a school that derives its support, in whole, or in part, from moneys raised by a general state, country, or district tax" (Zinth, 2005). A couple of the challenges that public schools face is overcrowding, limited resources, and low test scores (No Child Left Behind, U.S. Department of Education, 2011) and (Chen, 2016). Majority of public school students live below the poverty line so public schools offer free lunch and health and dental accommodations for families that meet set criteria (Chen, 2016). The second type of school is a charter school. According to Uncommon Schools a charter school is "a publicly funded independent school with greater flexibility in its operation, in return for greater accountability for performance" (Uncommon Schools, 2016).

The main difference between public and charter schools are funding and enrollment. From my time working as a Parent Resource Coordinator in a charter school I learned some of the charter schools require parents to pay a monthly fee in

addition to government funding. The additional funding allows students to have better access to resources and have more trained school specialist. Charter schools also have selective enrollment (Uncommon Schools, 2016). Families are able to choose their schools unlike public schools where you must attend your neighborhood school. However before being enrolled in a charter school your child must also take and pass an admissions exam and pay a fee. Using these types of measures ensures that charter schools will get a certain type of student and denies certain families based on finances. If charter schools do not meet performance goals they may be forced to close. The last school system is private schools. According to the Webster's dictionary a private school is "a school that does not get money from the government and that is run by a group of private individuals" (Webster Dictionary, 2011). Private schools are similar to charter schools, however they receive no government funding and obey a different set of rules and regulations.

Social Ecology Theory

Murray Bookchin was born in New York City in the Bronx back in 1921 to Russian Jewish immigrants, Nathan Bookchin and Rose (Kaluskaya) Bookchin. Both of Bookchin's parents worked long hours at blue collar jobs. Bookchin was looked after and spent most of his time with his grandmother Zeitel. Zeitel was a Russian radical. She was a member of the social revoluntaries in Russia. They were the largest socialist group in Russia at the time. The Russian political party aimed to be represented as an alternative to the Social-Democratic Workers Party. According to the British encyclopedia "The SR party carried out hundreds of political

assassination and never completely abandoned terrorist tactics (V. I. Lenin was wounded by an SR member in 1918)" (Encyclopedia Britannica, 1998). Zietel took her grandson under her wing and taught him everything she knew. By the age of 9 he joined the Young Pioneer program, which was a youth communist organization. Bookchin was a very educated man. Throughout his life he was involved in various organizations. Murray Bookchin is known for being an extreme leftist and a libertarian socialist (Bookchin, 2007). He has written many of books and essays over the course of his life but he is known best for being the founder of the social ecology theory and movement back in the 1970's.

Social ecology is an ideology about society that aims to reconstruct and transform our current outlook on the connectedness of social and environmental issues.

> Social ecology is based on the conviction that nearly all of our present ecological problems originate in deep- seated social problems. It follows, from this view, that these ecological problems cannot be understood, let alone solved, without a careful understanding of our existing society and the irrationalities that dominate it. To make this point more concrete: economic, ethnic, cultural, and gender conflicts, among many others, lie at the core of the most serious ecological dislocations we face today – apart, to be sure, from those that are produced by natural catastrophes. (What is Social Ecology by Murray Bookchin, 2007).

Bookchin's overall message is that ecological phenomena are caused by social phenomena and social phenomena are caused by ecological phenomena. There is a critical relationship between the two and we cannot solve one without critically analyzing and getting to the root cause of the other. For example in today's society we have a lot of environmental phenomena. We tend to blame overpopulation and technology for our environmental phenomena without analyzing the social

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component. The real social factor that we tend to ignore is that we are a nation that likes to consume and gain monetary assets, this directly impacts the environment, and one can't then blame technology. You can however blame the people behind technology and their motivation to continue to push technology beyond its limits.

Overtime Murray Bookchin's social ecology model has been adapted by scholars to explain topics surrounding public health and other world phenomena. Focusing on public health and more specifically emotional and behavioral health in kids, Bookchin's model helps us to understand how learning disabilities can be caused by an array of components that are devalued and often overlooked. For the purpose of this capstone we will examine ADHD. Analyzing and deconstructing how we perceive ADHD, Bookchin model would suggest we analyze how social factors influence children's physical and mental health. According to the website ADDitude "A large body of scientific evidence supports the belief that factors within the social fabric play a significant role in determining the physical and mental health of individuals beyond their behavior and genetics" (Nemours Health & Prevention Services, 2006). We must stop perceiving learning disabilities, mental health, and environmental issues as separate, as these three topics are interrelated. In order to improve learning disabilities and mental health we must first understand and examine the role the social environment has on each child.

Figure 2.1 (Appendix A) is a diagram of the Social Ecological model. The social ecological model uses circles within circles to demonstrate how each component influences the next and how they are all interrelated. The social ecological model also illustrates how individuals both influence and are influenced

by certain components of their environment. This model helps to see all the social influences that play a major factor on emotional and behavioral health. "The defining feature of the social ecological model of human development is the growth and change that occurs as a result of interactions between individuals and environmental influences, which include the family, school, peers, neighborhood, community, and nation" (Nemours Health & Prevention Services, 2006).

Let's begin by looking at the center of the model. The center of the model is the personal attributes of the individual. The personal attributes help to shape the health and wellbeing of the child. The next level is interpersonal. Interpersonal consist of formal and informal relationships for example; family, friends, school, church, social groups, etc. According to Nemours Health & Prevention Services "Individual behavior has a direct influence on and is influenced by these immediate relationships" (Nemours Health & Prevention Services, 2006). The third level is institutional and organizational. These are influences of social institutions and organizations for example; childcare, school, churches, healthcare, etc. All these places have impact on a child's development. The fourth circle is community. Community factors focus on relationships among organizations and institutions. According to Nemours Health & Prevention Services this is "how well the systems are linked together to provide seamless support to children and their families to maintain a positive influence on health outcomes for children" (Nemours Health & Prevention Services, 2006). The last circle is policy. Public policy is influenced by political policies and laws that regulate and support healthy development. The

policy circle is the farthest away because it has indirect impact (please refer to appendix A).

To conclude when analyzing the relationship between preponderance of ADHD in African American communities and how teachers and counselors are trained to type students as ADHD, it is imperative that we conduct a holistic evaluation before diagnosing.

> "Children are a particularly vulnerable part of the population and prolonged exposure to negative social factors can have serious consequences for their health and well-being. Because children experience rapid developmental changes, harsh social conditions and situations can lead to a host of poor emotional and behavioral health outcomes, including reduced school readiness, low educational attainment, problem behaviors, and emotional impairments as they age. (Nemours Health & Prevention Services, 2006).

Children are still in the developmental phase. Children must be monitored over time before typing or labeling them as ADHD or any other conditions. There are a lot of other factors to consider that can be causing the behavior. For low-income students especially, factors such as stress, trauma, not having access to adequate or well-balanced meals and living in violence stricken neighborhoods can all lead to symptoms that can be typed as a mental illness or learning disability. That's why it is important to evaluate the whole child in and outside of school.

Diagnostic and Statistical Manual of Mental Health Disorders

The specific DSM-IV criteria are set forth in the following chart.

DSM-IV Criteria for Attention Deficit/Hyperactivity Disorder

A. According to the DSM-IV, a person with Attention Deficit/Hyperactivity Disorder must have either (1) or (2):
(1) Six (or more) of the following symptoms of inattention have persisted for at least

6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

1. (a) often fails to give close attention to details or makes careless mistakes in school work, work, or other activities
2. (b) often has difficulty sustaining attention in tasks or play activities
3. (c) often does not seem to listen when spoken to directly
4. (d) often does not follow through on instructions and fails to finish schoolwork,

   chores, or duties in the workplace (not due to oppositional behavior or failure to

   understand instructions)

1. (e) often has difficulty organizing tasks and activities
2. (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
3. (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
4. (h) is often easily distracted by extraneous stimuli
5. (i) is often forgetful in daily activities

(2) Six (or more) of the following symptoms of hyperactivity-impulsivity have

persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

2. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
3. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
4. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
5. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety

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

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

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

Source: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

The chart above depicts the criteria set forth by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The criteria is the clinical definition used to determine the presence of ADHD. A person must display several symptoms and characteristics before clinically being diagnosed as ADHD. Five components are examined before diagnosing someone with ADHD, severity, early onset, duration, impact, and settings (Diagnostic and Statistical Manual of Mental Disorders, 2003). Severity is analyzing the behavior in comparison to other students in the same age group. Does the behavior occur more frequently in comparison to other students? The second component is early onset. At least some of the symptoms must have been present prior to age seven. The third component is duration. The criteria state that symptoms must be present for at least six months prior to testing and evaluation. The fourth component is impact. Impact basically states that the symptoms must have negative impact on a child's social and academic life. The last component is settings. Symptoms must be present in multiple settings for example school, home, church, extracurricular activities, etc.

All schools should have a copy of this resource packet from the U.S.

Department of Education and U.S. Office of Special Education Programs. Although

the schools may own a copy of the resource, it's not helpful unless the staff has gone

over the material and incorporated the criteria before they type students as ADHD..

The information was created to help teacher's type students as ADHD as accurately

as possible and provide resources and support to students typed.

ADHD as a Gift

A lot of people view ADHD as a bad thing. However everyday, people living

with the diagnosis have decided to reinvent the way ADHD is perceived. Instead of

perceiving it as a curse or a negative trait, people with ADHD are now starting to

view it as a gift. Back in 2013, I was first introduced to this concept and learned

about "The Gift of ADHD controversy" through an interview I read about a

motivational speaker, writer, and moderator of an ADD website, Bryan Hutchinson

(Psychology Today, 2013). Hutchinson discussed the set of gifts people with ADHD

typically have like creativity, exuberance, emotional expressiveness, interpersonal

intuition, ecological consciousness, and leadership (Psychology Today, 2013).

> The "Gift of ADHD" is also used as an intervention; just by finding and
> focusing on gifts, people change in positive, noticeable ways. They feel better
> because of improved confidence and motivation. They are not focused on
> having a disorder that contributes to them feeling like something is wrong
> with them. They experience real world results- including better grades,
> higher income for entrepreneurs, better work reviews, and marriages that go
> from difficult challenges to highly satisfying". (Bryan Hutchinson 2013).

People diagnosed with ADHD that do not perceive it as a gift often struggle with the

diagnosis and the symptoms attributed to ADHD (Psychology Today, 2013). If they

believe in the negative stigmas associated with ADHD the negativity can become a

self-fulfilling prophecy and a gateway for other types of future problems

(Psychology Today, 2013).

The concept of ADHD as a gift is extremely important for kids. It is imperative

that children diagnosed are able to substitute the negative stigmas with feeling

empowered. Bryan Hutchinson stated

> Imagine kids self-talk after a diagnosis of ADHD being, "I have a gift to use"
> vs. "I have a disorder." The way to resolve the confusion is to recognize that
> ADHD is truly a gift that can be used in so many positive ways by children,
> teachers, and parents. The intervention by professionals is to help people see
> it and treat it as a "gift." (Bryan Hutchinson, 2013).

Bryan Hutchinson views remind me of Howard Gardner's Theory of Multiple

Intelligences (Gardner, 2010) and (Armstrong, 2010). The theory discusses the

many different gifts that people have. Howard Gardner's theory basically states that

there is eight different types of intelligences that people display; verbal-linguistic,

logical-mathematical, spatial-visual, bodily-kinesthetic, musical, interpersonal,

intrapersonal, and naturalist (Gardner, 2010). Gardner was opposed to labeling

people to specific intelligences. He believed that people could display and identify

with more then one type of intelligence. Could ADHD be a combination of a lot of the

intelligences listed or should ADHD be an ninth multiple intelligences added? I

believe It is crucial that we start viewing ADHD in a more positive light and see all

the good associated with it. Some celebrities that have openly come out and raised

awareness on the issue are: Will Smith, Gabrielle Douglas, Michael Phelps, Albert

Einstein, Bill Gates etc. These people are just as smart and capable as anyone else, at

times they just need a little help staying on task and completing the minute day to day tasks.

It is interesting to note that in low-income communities the schools rarely ever thought that maybe the students that they labeled as "ADHD", "trouble makers", and "special ed" were just acting out because they were bored and not challenged enough in class (Codrington, 2012) and "(Sharman Dennis, October 2016). Instead of placing them in special education classes they could have been placed in gifted classes. The idea that black children could be put into special education classes and therefore underrepresented in gifted classes is a travesty that needs to be changed as it undervalues and minimalizes the intelligence and agency of African American children.

Methodology

For the purpose of this research paper I surveyed ten fifth grade teachers who educate students between the ages of ten and eleven in public and charter elementary schools. The survey was conducted in person for four teachers due to the flexibility in their schedule. The remaining six were conducted online due to time restraints and preparation for report card pick-ups. All surveys were written and conducted in English (See Appendix C). I sampled two teachers from each school, so a total of five schools participated in the survey all together, two charter schools and three public schools. Due to the sensitive nature of the topic and reputation of the schools all personal identifying information will be confidential and kept anonymous in my writing.

A couple years ago I worked as a Parent Resource Coordinator at an elementary school. I was able to establish relationships with various Illinois schools through this job. I picked one school at random from the list of established relationships and then I relied on the snowball effect to gain other participants. Luckily the first set of teachers that participated in the survey was able to help guide me in the right direction and refer other teachers that might be interested in participating.

Limitations

While conducting this research I was limited in time because the research deadline was prior to December 2016. There were a lot of topics that emerged from my research that I will not have time to further explore in the paper but I will list some of them in the future research section of this paper. My second obstacle was getting access to teachers due to their busy schedules. Arranging time slots for teachers during report card pick-up and parent teacher conference time was an obstacle, which is why I opted for conducting surveys online as a data collections method. Initially I was going to interview counselors too but due to time constraints I decided to just focus on teachers.

Analysis of Data

The demographics of the participants were as follows:

Question 1: What gender do you identify with? 10% male and 90% female

Question 2: What is the age of the participant? 10% was between the ages of 25 and 30, 30% was between the ages of 31-35, 40% was between the age of 36-40, 10%

was between the age of 41-45, and 10% was between the age of 46-50. None of the participants were 51 and older.

Question 3: How many years have you been teaching? 30% has been teaching between 1-5 years, 50% has been teaching between 6-10 years, 10% has been teaching between 11-15 years, and 10% has been teaching 16-20 years. None of the participants have been teaching over 20 years.

Question 4: What is the highest level of education you completed? 30% of teachers completed their Bachelor's degree and 70% completed their Master's Degree. None of the participants completed a Doctoral degree. It is interesting to note when recording the data the trend portrayed show that all of the teachers that worked in charter schools had Master's Degrees while only half of the participants that worked in public schools had Master's Degrees.

The following survey questions are pertaining to school information and classroom logistics.

Question 5: What type of school do you work for? 60% of participants work at a public school and 40% of participants work at a charter school. None of the participants work at a private school.

Number of Children In Classrooms

3
15-20

**4**
21-25

3
26-30

0
31-35

**Question 6:** How many children are in your classroom?

The chart above illustrates how many children are in each teacher's classroom. 30% reported between 15-20 students in their classroom, 40% reported between 21-25 students in their classroom, and 30% reported between 26-30 students in their classroom. None of the participants reported having more then 30 students in their classroom. The chart shows at least 3 of the teachers deal with overcrowded classrooms. It is also important to note that the three participants that stated that they had between twenty-six and thirty students all work for public schools. While the participants that work at charter schools answered majority between fifteen to twenty students and one answered between twenty-one to twenty-five students.

The following survey questions are pertaining to knowledge about ADHD and school protocols and practices in place.

Question 7: Please check the symptoms associated with ADHD.
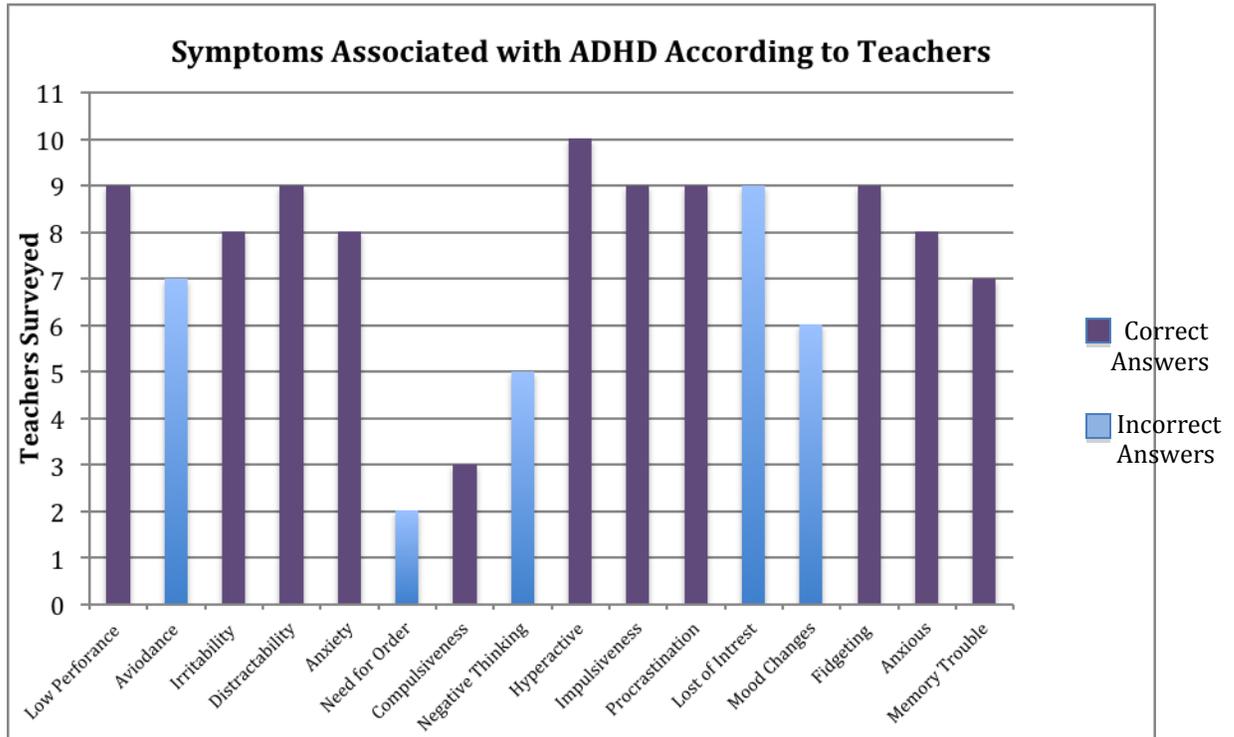
The chart above illustrates the symptoms that teachers associate with ADHD. The symptoms highlighted in purple are symptoms of ADHD according to the Center for Disease Control and Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The symptoms highlighted in blue are symptoms of posttraumatic stress disorder, obsessive-compulsive disorder, bipolar, and depression. Overall the participants did a great job at recognizing the core characteristics of ADHD. Although some of the participants had trouble distinguishing some of the characteristics for bipolar, depression, and obsessive-compulsive disorder.

Prior Knowledge of Student Diagnosis
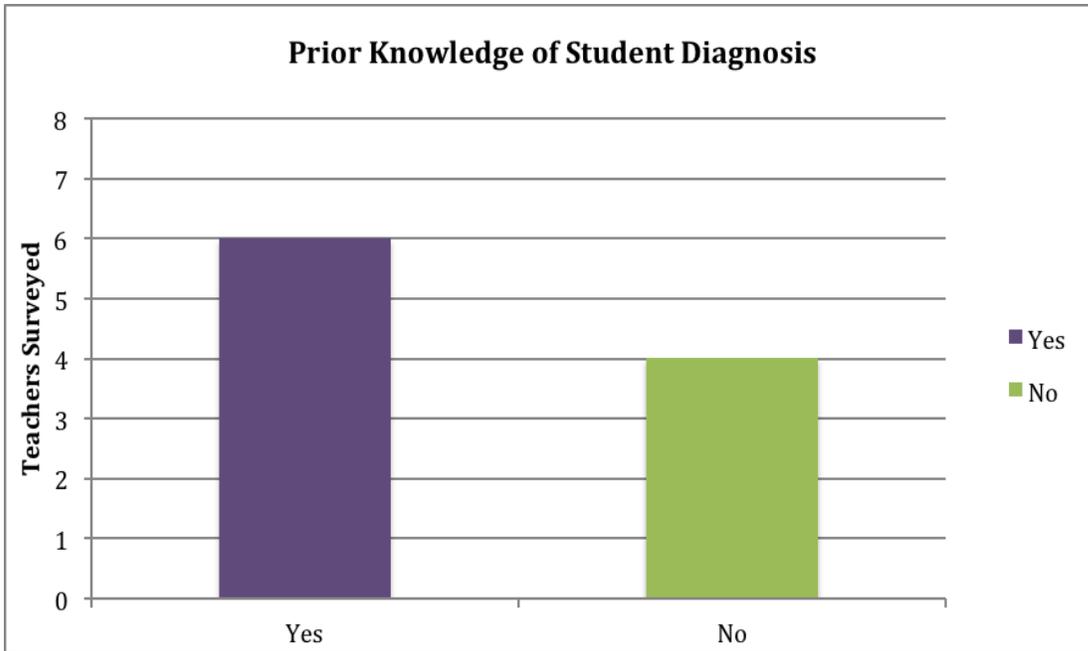
Question 8: Do you have any prior knowledge of any of your students being diagnosed with ADHD?

The above chart illustrates teacher's prior knowledge of any of their students being diagnosed with ADHD? 60% of participants reported yes and 40% reported no.

Teachers Detection of Having ADHD Students
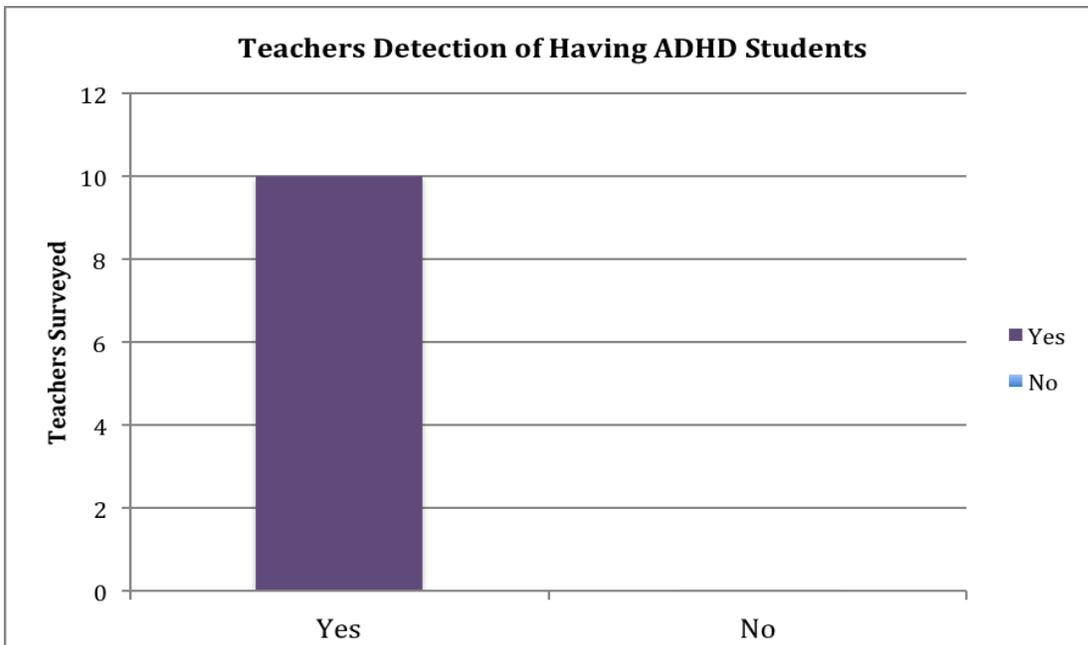
Question 9:   Have you ever detected that one of your students have or had ADHD?

Although only 40% of participants reported no to having prior knowledge of students diagnosed with ADHD in their classroom. 100% of the teachers surveyed detect that at least one of their current and previous students have had ADHD.

Question 10: If you circled yes to the previous question, what steps did you take after detecting the behavior?

Participant 1: Parent teacher conference, encouraging testing, and an intervention.

Participant 2: Notifying the school guidance counselor and the parents.

Participant 3: Speaking with the student and reaching out to the parents.

Participant 4: Parent teacher conference

Participant 5: Reaching out to the guidance counselor and recommendation for IEP (Individualized Education Plan) testing.

Participant 6: Speaking with guidance counselor and school crisis worker.

Participant 7: Contact parents

Participant 8: Parent teacher conference

Participant 9: Reach out to additional staff to see if the behavior is consistent in each class before reaching out to parent and guidance counselor.

Participant 10: Notifying guidance counselor, school crisis worker and contacting parents for a meeting to discuss the behavior and possible next steps IEP etc.

Question 11: What symptoms did you see present if you circled yes for question 9? 100% of participants reported yes to question 9 below are their responses.

Participant 1: Student was very hyperactive and very easily distracted.

Participant 2: Student displayed all of the symptoms from question 7.

Participant 3: Student was very anxious, hyperactive, and irritable.

Participant 4: The child's behavior was very disruptive to the class.

Participant 5: The student had symptoms of anxiety, low concentration, and was easily distracted. The student was very disruptive in class, had trouble sitting still, and was beginning to perform below average.

Participant 6: Hyperactive, poor organization skills, and easily distracted.
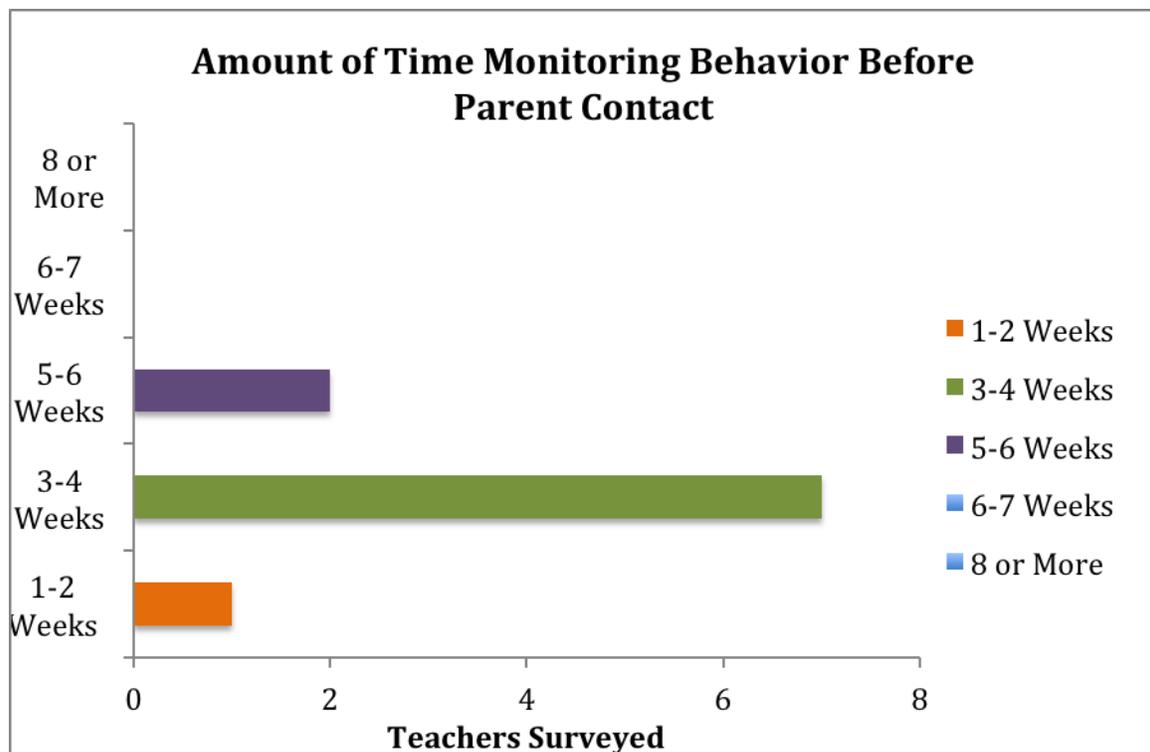
Participant 7: Student displayed a lot of the symptoms described on the survey.

Participant 8: Procrastination, loss of interest in school, and disruptive behavior. The student also struggled to complete classwork and pay attention in class.

Participant 9: The student was very loud and disruptive in class.

Participant 10: Hyperactive and impulsiveness.

Question 12: How long did you monitor the behavior before contacting parents?

The chart above illustrates the amount of time each teacher monitors the behavior before contacting parents? 10% reported waiting between 1-2 weeks, 70% reported waiting between 3-4 weeks, and 20% reported waiting between 5-6 weeks. None of the participants reported waiting longer then 7 weeks. According to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) teachers and parents should monitor the behavior and see symptoms present for six months prior to testing (Diagnostic and Statistical Manual of Mental Disorders, 2003). Anytime before that could be due to children displaying child like behavior, social conditions, or other outside circumstances that the teacher or parent may be unaware of. All of the participants typed the students too quickly. It is alarming that none of the participants even came close to the appropriate amount of time before recommending testing.


Does the School Have Set Criteria for Detecting ADHD?
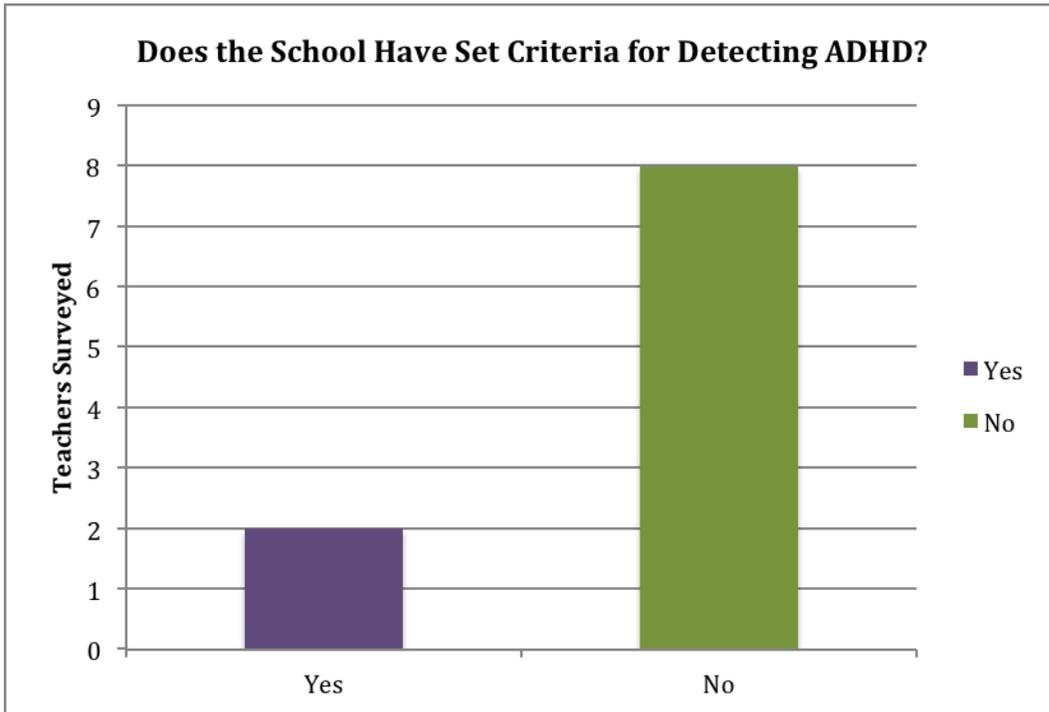
Question 13: Does the school have set criteria for detecting ADHD?

The chart above illustrates whether or not each school has set criteria for detecting ADHD? 20% of participants reported yes and 80% of participants reported no. Unfortunately the participants that worked at a school that had set criteria both worked at the same charter school. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) resource packet is available to all schools and each school can easily incorporate the criteria outlined into how they detect and type students as ADHD. It is surprising that 80% of participants reported no when the resource packet is made available to everyone free of charge, even I was able to access it with a click of a finger.

Question 14: If you answered yes to the above question please explain. 20% of participants reported yes to this question and 80% reported no. Below is the answers recorded from the 20%.

Participant 1: I personally do not know the school criteria. However, we have trained staff who have experience with mental health and making recommendations for treatment.

Participant 2: I know the school has set criteria and protocol to follow. The guidance and crisis intervention counselor usually handles these situations.

Teachers Received Training on ADHD During Higher Education
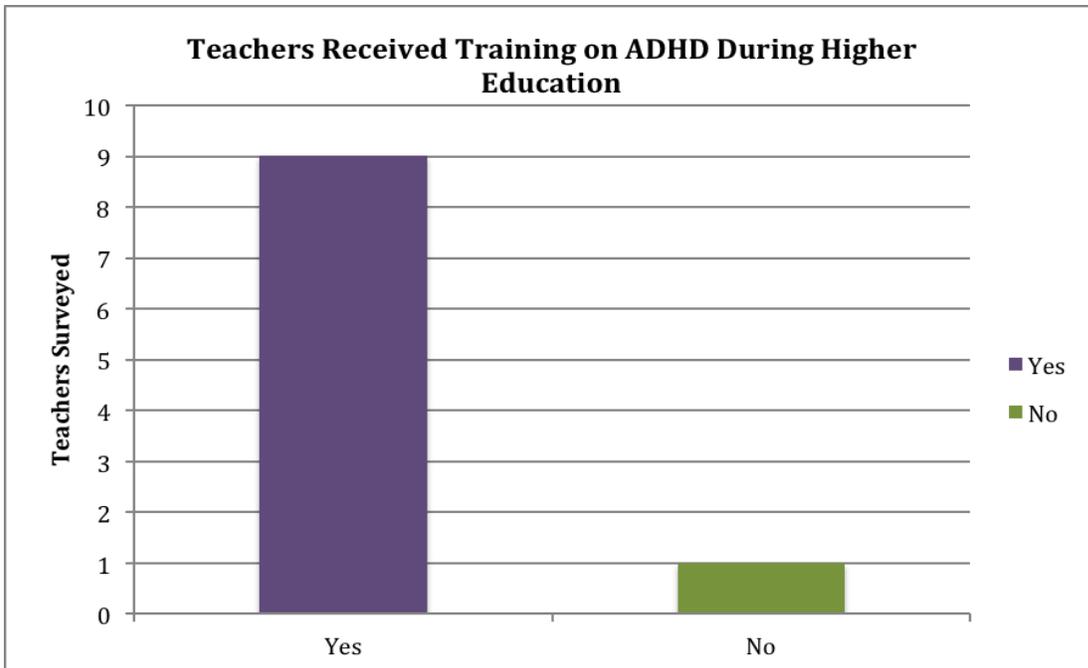
Question 15: Did you receive any training on detecting and working with children with ADHD while you was in school?

The chart above illustrates whether or not each teacher received any training on detecting and working with children with ADHD while pursing higher education. 90% of participants reported yes and 10% of participants reported no. It is great that participants are learning about ADHD during higher education. For majority of the participants this is the only place they have received training on

ADHD unless they have sought out personal training at their own expense.

Teachers Received Training on ADHD at Work
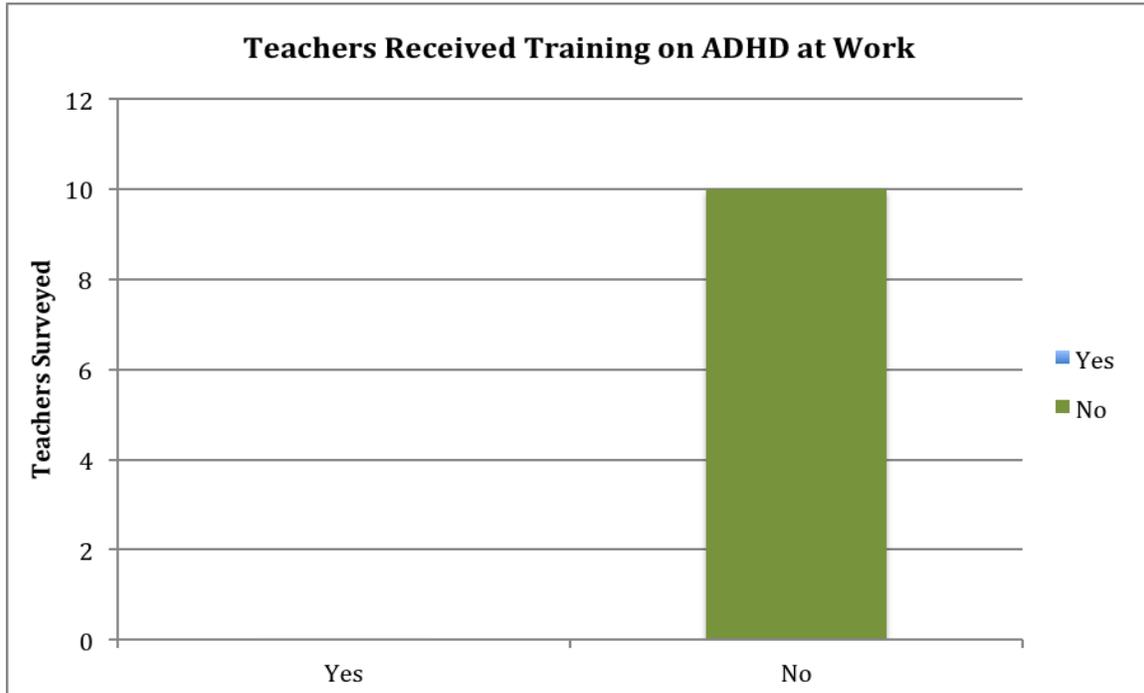
Question 16: Did you receive any training on detecting and working with children with ADHD at the school you currently work for?

The chart above illustrates whether or not each teacher received any training on detecting and working with children with ADHD at the school they currently work for? 100% of participants reported no. Schools should be doing a better job at providing ongoing training for teachers working with students with behavioral and learning disabilities. Counselors should not be the only ones educated and equipped to work with and provide support to students typed as ADHD. The government should do a better job at ensuring that schools are following proper policies and protocols.

Question 17: What resources do the school provide to families and children diagnosed with ADHD?

Participant 1: Pamphlets and brochures.

Participant 2: A list of testing facilities, child psychiatrist, and recommended reading.

Participant 3: We have a guidance and crisis intervention counselor. Both are available to the students and families. We make special accommodations in each class, we offer pamphlets about support groups and reading materials and the nurse is also able to administer medication if prescribed for the student.

Participant 4: A list of referrals and pamphlets.

Participant 5: Pamphlets and handouts.

Participant 6: A reading list and special accommodations for the student.

Participant 7: The guidance counselor handles these matters.

Participant 8: IEP (Individualized Education Plan) for each student and each teacher follows this plan. Every marking period we review the plan and adjust as needed with the parent and counselors input.

Participant 9: I'm not sure.

Participant 10: A list of books and magazines that may offer some support and additional information.

Have You Ever Been Unsure About Reccommending ADHD Testing?
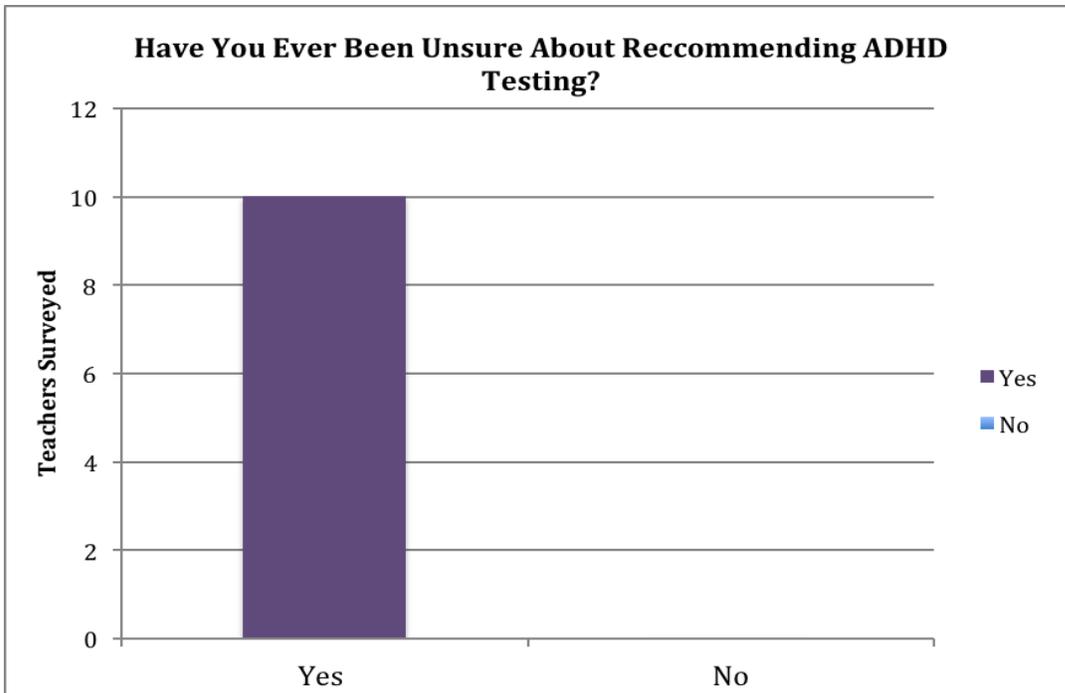
Question 18: Have you ever been unsure about recommending ADHD testing to a parent?

The chart above illustrates rather or not each teacher has ever been unsure about recommending ADHD testing to a parent. 100% of participants reported yes. The fact that 100% of participants reported yes means that more measures need to be taken to ensure that teachers feel confident and are equipped to accurately type students as ADHD. Schools must provide ongoing training to keep teachers updated with all the new findings and practices for typing and working with students typed as ADHD.

Question 19: Does your school provide outdoor recess to students? 60% of participants reported yes and 40% of participants reported no.

Conclusion

ADHD diagnoses in African American communities continue to skyrocket (Ahmann, 2016). After conducting this survey (see Appendix C) I learned a lot of things pertaining to teacher's knowledge about ADHD and how they type students. A couple of things really stood out in the data. One of the things that was surprising was the number of students in each classroom. For public schools the classroom sizes appear to be larger and for charter schools the classroom sizes were smaller. The main trend here is finances and resources. Charter school restrictions often deny access to families based on class and academics, that is one of the reasons they have smaller class sizes and more one on one attention. A couple of the participants also reported that their school has crisis counselors as an additional resource of support in additional to guidance counselors.

A couple of other mentionable facts concluded from the survey were the steps taking after detecting behavior and typing students as ADHD. Just about all the participants stated that they would contact parents and guidance counselors. A couple of participants even suggested getting an IEP (Individualized Education Plan) for the student. What was alarming was one of the participants used the term intervention as a method for discussing the behavior. In my opinion intervention seems like a poor word choice. The way the participant used the term seemed very judgmental toward the student. In order to breakdown the negative stigmas associated with ADHD we must first change the way we view ADHD and the language/ vocabulary that we use. It's just like Bryan Hutchinson said, if you view ADHD as gift instead of a disability or a mental health issue the person with ADHD

will view it differently and society will start to view it differently as well. Maybe one day society might even just view ADHD as another learning style. Another point that was really surprising was the amount of participants that used the term disruptive to describe the student's behavior. 50% of participants used the term. Being disruptive in class can mean a lot of things, it does not necessarily mean that a child has ADHD, the child could just be crying out for attention or dealing with other things at home.

This capstone has only begun to scratch the service and determine the underline explanation for the increase in diagnosis and how teachers type students. The participants had a lot of knowledge about what ADHD was and identifying symptoms in students. Unfortunately some of the symptoms overlapped with additional learning disabilities and mental illnesses and the teachers were unable to clearly distinguish between the symptoms.

I would recommend further studies be conducted on a larger scale to see how many schools actually have a copy of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) on file and incorporate the criteria when typing students. All schools should have a copy of this resource packet and the U.S. Department of Education should do a better job at ensuring that schools are following proper policies and protocols. Although the schools may own a copy of the resource, it's not helpful if staff has not gone over the material and incorporated the criteria in order to type students. 100% of the participants reported detecting that at least one of their students had ADHD. However all of the participants made diagnosis too quickly based on the Diagnostic and Statistical Manual of Mental

Disorders (Diagnostic and Statistical Manual of Mental Disorders, 2003). The resource handbook was created to help teacher's type students as ADHD as accurately as possible and provide resources and support to students typed. I am also curious about the effect that utilizing the resource packet would have on the number of referrals and diagnosis in the school.

For future studies I would recommend comparing budgets, classroom size, demographics, ethnic and racial backgrounds, and location to the amount of students diagnosed with ADHD in a school. I also asked in the survey if their school provides outdoor recess. Studies have shown that outdoor recess helps overall with behavioral issues and learning disabilities and I think this would be great to compare (Pankseep, 2008) and (Kuo, 2009). I have learned so much and I am so thankful for this experience. I hope to further my studies about "relationship between preponderance of ADHD in African American community and how teachers are trained to type students as ADHD".

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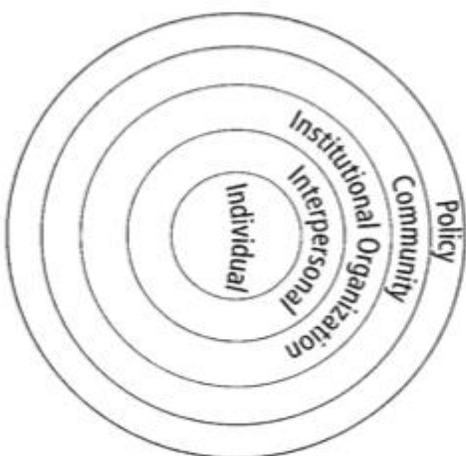
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Appendix A: Social Ecological Model

Figure 2.1 is a diagram of the Social Ecological model

Figure 2.1: Social Ecological Model

The social ecological model is often illustrated as a series of circles within circles, each influencing an individual's development to varying degrees. Figure 2.1 depicts the social ecological model as it is often presented in the scientific literature. At the center of the model are the personal attributes of the individual. These personal attributes play a significant role in shaping the health and well-being of the individual child.

At the interpersonal level, formal and informal social network and support systems—including family, workgroup, and peer networks—play a critical role in healthy development. Social support is conducive to healthy development and receipt of support is crucial for managing day-to-day stressors and adversities. Relationships with immediate social systems such as family, friends, neighbors, social groups, churches, and school are in the circle(s) closest to the individual. Individual behavior has a direct influence on and is influenced by these immediate relationships.

Institutional and organizational factors are those influences and characteristics of the social institutions and organizations in which people participate. For example, childcare, schools, churches, health care, and recreational facilities are institutions that have a significant impact on children's healthy development.

Community factors are the relationships among organizations and institutions. How well the systems are linked together to provide seamless support to children and their families is important to maintaining a positive influence on health outcomes for children.

Finally, public policy influences are the local, state, and federal policies and laws that regulate and support healthy development. An individual's relationship with the policy level is less direct but no less important than an individual's immediate interpersonal relationships. For example, an individual may not be involved in developing policies or laws, but those policies and laws have an impact on the individual's behavior (seat belt laws, for example).

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Appendix B: Statement of Consent

Date _____

Dear Participant,

I am working on my Master's in Multicultural service, Leadership, Management at SIT Graduate Institute, and I am doing a capstone research project on the relationship between preponderance of ADHD in the African American community and how teachers and counselors are trained to type students as ADHD?

I am interested in learning about the criteria used to detect ADHD in the classroom and the educational resources you provide to families that have children with ADHD. I would greatly appreciate the opportunity to learn from you in a questionnaire and interviews on the topic.

I would like you to participate in this questionnaire (and/or interviews) which should take approximately 15 minutes and at your convenience. I would appreciate a return by October 31 or a time to interview you before October 31st. I am very interested in your perspective!

At the conclusion of the project, I will present the findings at a capstone seminar of graduating Master's students, professors, and guests at SIT Graduate Institute. I will be writing a research paper and I will maintain your privacy and confidentiality in reports by removing your name and any identifying information from the findings. With your permission, I may quote directly from what you have said in both my research report and my presentation, but I will remove any identifying information from what you have shared.

Please understand that you may withdraw from the study at any time. I appreciate your participation in this project. If you have any questions, please feel free to contact me, my advisor (Dr. Karen Blanchard Karen.Blanchard@sit.edu) or SIT's institutional review board (irb@sit.edu) at any time.

Thank you,

Elacsha Madison   Miranda Davis   SIT IRB
1-773-816-0829   802-336-1616
Elacsha.Madison@mail.sit.edu   irb@sit.edu

I have read the above and discussed it with the researcher. I understand the study and agree to participate.

_____   _____
        (signature)   (Date)

Appendix C: Survey

1) Which gender do you identify with? _____

2) How old are you? (Please circle one).

a) 25-30   b)31-35   c)36-40   d)41-45   e)46 and above

3) How many years have you been teaching? (Please circle one).

a) 1 to 5 years   b) 6 to 10 years   c) 11 to 15 years   d) 16 to 20 years

e) More then 20 years

4) What is the highest level of education you completed? (Please circle one).

a) Bachelor's Degree b) Master's Degree   c) Doctoral Degree

5) What type of school do you work for? (Please circle one)

a) Public School   b) Charter School   c) Private School

6) How many children are in your classroom? (Please circle one).

a) 15-20   b) 21-25   c) 26-30   d) 31 or more

7) Please check the symptoms associated with ADHD.

a) Poor school performance   b) Avoidance c) Irritability   d) Distractibility

e) Anxiety   f) A need for order   g) Compulsiveness   h) Negative thinking

i) Hyperactive   j) Impulsiveness   k) Procrastination   l) Loss of interest in

activities m) Mood changes n) Fidgeting   o) Anxious   p) Trouble with memory

8) Do you have any prior knowledge of any of your students being diagnosed with

ADHD? (Please circle one).   a) Yes   b) No

9) Have you ever detected that one of your students have or had ADHD? (Please

circle one).   a) Yes   b) No

10) If you circled yes to the previous question, what steps did you take after

detecting the behavior? _____

_____

11) What symptoms did you see present if you circled yes for question 9? _____

_____

12) How long did you monitor the behavior before contacting parents? (Please

circle one).   a) 1 to 2 weeks   b) 2 to 4 weeks   c) 4 to 6 weeks

                     d) 6 to 8 weeks   e) More then 8 weeks

13) Does the school have set criteria for detecting ADHD? (Please circle one).

     a) Yes   b) No

14) If you answered yes to the above question please explain. _____

_____

15) Did you receive any training on detecting and working with children with ADHD

while you was in school? (Please circle one).   a) Yes   b) No

16) Did you receive any training on detecting and working with children with ADHD

at the school you currently work for? (Please circle one).   a) Yes   b) No

17) What resources do the school provide to families and children diagnosed with

ADHD? _____

18) Have you ever been unsure about recommending ADHD testing to a parent?

(Please circle one).   a) Yes   b) No

19) Does your school provide outdoor recess to students? (Please circle one).

     a) Yes   b) No

<div align="center">**Thank You!!!**</div>