DISABLING LABELING:

A SOCIAL WORKER'S RESPONSE TO ATTENTION DEFICIT DISORDER

by

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ABSTRACT

Attention Deficit Disorder (ADD) is a childhood psychiatric diagnosis that has exploded within the last decade. The literature written to address this topic is dominated by the medical perspective and for the most part contains few references from a social worker's perspective.

The goals of this paper are to question some of the fundamental assumptions of this disorder and explore the treatment strategies utilized in dealing with this problem. I then apply some of these treatment approaches to two separate groups of 6 to 9 year old children diagnosed with ADD. This project looks at how the treatment strategies evolved within my own practice and then provides some radical suggestions that social workers need to consider when working with this population of children.

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Preface

I believe that it is important for me to share how I came to select Disabling Labeling as my project topic. I began my MSW program with little thought on what my topic would be except to know that I wanted it to be in a clinical field with children. To accomplish this goal I chose a practicum placement at Intersect Youth and Family Services Society. At this agency I was able to work on my clinical skills with children and had the opportunity to co-facilitate several different children's groups. These groups included two treatment groups for children who had been diagnosed as having Attention Deficit Disorder (ADD). I was fascinated when I listened to the children's stories. They spoke of the conflicts that they were experiencing with their parents and within their school environments. During the course of this clinical work and through subsequent readings, I began to examine my own life experiences. I identified with these children and recognized some similarities between their lives and my own childhood experience. This encouraged me to engage in self-reflection into the meanings of these experiences. I recognized that if my circumstances were different I could have ended up being diagnosed with ADD and been on the other end of this clinical experience.

At this point I began having discussions with my parents who are both teachers. My mother works with special needs kids, some identified as having ADD. I asked her what she thought about ADD and whether or not she saw any of these behaviours in me when I was a young child. She shared some of the struggles that she had with me and related some stories about my educational issues. What made the difference in my situation was that I had parents who were very proactive and had knowledge and expertise within the educational system. When teachers identified a problem, my parents took the necessary steps to rectify it. I sometimes think about what the outcome would have been if my parents were not as well educated or if there had been other mitigating factors in my upbringing. I look back at my school years and recognize how fortunate I was not to have picked up a label.

Does this mean I had or have ADD? I don't know. In some ways it would explain some of the frustrations my spouse has with me at times. It might explain why it has taken me almost three years to write this paper. A diagnosis of ADD may provide a lot of insight for why I do the things I do. Is the diagnosis of ADD as concrete as many professionals suggest or are there other variables? What happens if someone does not quite fit the criteria but still has significant problems in certain situations? Does this mean that this person would not benefit from some of the services that are given to those children diagnosed as ADD? The process of asking these questions helped me understand the multiple factors that need to be considered when assessing and treating this condition. This insight also encouraged me to recognize and identify some of the resiliency within these children and how they, compared to other children, had more to overcome to experience success in their life. I also recognized how important it would be for these children to have significant people in their lives who refused to focus on their short-comings and instead focused on a positive future.

In hindsight, I believe that this project has been an invaluable experience. I have learned much about myself. I have come to terms with some of my short-comings and recognize that some of the traits that I have attempted to change in my life may never disappear, however I am still responsible to compensate and modify my situation in such a way as to minimize the impact these challenges have on my life. I also recognize how indebted I am to my parents for being patient and long suffering. They never gave up on the positive future they saw for me and provided me with the necessary love and acceptance. I am extremely thankful to my spouse who faces my short-comings on a daily basis and through it all refuses to give up and inspires me to become the person she believes I am. I cannot forget Baxter, Noah, and Jakob the three sons God has given me in order that I might remain humble and recognize that when all is said and done, I still have much more to learn about parenting, and life in general.

Introduction

As I poured over the thousands of pages written about ADD, sorted through pamphlets and watched videos, I began to have a sense of helplessness and despair for the future of children diagnosed as ADD. My experience and knowledge as a social worker told me that there was much lacking within this literature, especially from a social worker's perspective. I felt that it is paramount that I as a social worker advocate for the needs of children diagnosed with ADD and encourage others to do the same. I felt what was necessary for these children was for someone to believe in them and have a positive outlook for their future.

The first chapter of this report looks at the etiology of ADD and how this diagnosis has exploded within the last decade. This current diagnosis will be defined and described within the context of its evolution in the past century.

In chapter two I will look at what skills and tools social workers can offer children diagnosed as ADD. I will consider the following:

1. why social workers are well suited to work with these children and their families.
2. a continuum of treatment approaches available to a social worker and suggest why certain approaches may be more consistent with a social worker's values and knowledge base.
3. some suggestions as to why certain approaches appear to be more effective than others, an evaluation of these approaches from an ethical perspective, and an analysis of each approach using social work theory and practice.

In chapter three, I will show how these treatment approaches were put into practice in a mental health setting here, in Prince George along with the consequences of each approach to the lives of children and their families. I will also demonstrate how I struggled with each approach and resolved the conflict between knowledge and practice. The reader will see how the treatment evolved as it was applied in the context of two treatment groups.

Chapter four suggests that most approaches do not go far enough in creating hope for real change for children diagnosed with ADD. There are many pitfalls when working with this population and I suggest as social workers, it is important that we must continually reevaluate our practice and come to terms with the consequences of our methods and assumptions. It sometimes feels impossible for ethical social workers to balance the needs of their clients while meeting the goals and objectives of their employer. Finally, I will suggest areas that require further research and point out how this knowledge impacts social work practice.

Chapter One

Overview of diagnosis of Attention Deficit Disorder

Attention Deficit Disorder (ADD) is one of the most talked about, written about, and misunderstood childhood mental health conditions (Frick & Lahey cited in Cramond,1994). As of 1995, there were over 6000 scientific articles published on ADD and more than 50 books (Barkley, 1997). This does not take into consideration thousands of other books, articles and multi-media reports that refer to the ADD diagnosis. This being said, the label ADD, and subsequent medical intervention, continues to be quite controversial as professionals from various backgrounds argue over a basic understanding of how ADD should be defined and then how children diagnosed should be treated. While many professional groups suggest they have some expertise in this condition, the dominant view throughout the literature is from the medical perspective. It is the medical diagnosis that determines whether or not someone fits the criteria of ADD and it is the same profession that treats the disorder with medication (the most utilized treatment approach with these children). This being said, it is difficult to discuss this topic without referring to the medical diagnosis. I would hope that the reader keeps an open mind towards this controversy and a critical attitude regarding the viewpoints expressed from the medical perspective. In order to respond to the medical perspective it is important to see how ADD is currently defined and diagnosed.

The first place to look for a description of ADD is within the Diagnostic and Statistical Manual of Mental Disorders. (DSM-IV, 1994) This manual is published by the American Psychiatric Association and is the dominant reference manual for most medical practitioners. According to the DSM-IV

(1994) children with ADD display an inability to sustain attention, have a higher level of activity (although this may or may not be the case) and find it difficult to control their impulsive behaviour as compared to their same age peers. An estimated 3-5% of all children have this disorder (Barkley,1990). These children exist within all cultures although professionals may describe and categorize them differently. Barkley suggests that in Great Britain, children are told they have a "conduct problem," in eastern Europe they are seen as "undisciplined". Barkley argues that by labeling all of these children as having a conduct disorder, a misunderstanding is created suggesting that these children have a deficit of personal character as opposed to a neurologically determined condition. It has been widely accepted by the medical community that this disorder is primarily passed on genetically and not influenced significantly by environmental factors (Barkley, 1997). However environmental factors such as prenatal exposure to cigarette smoke and lead poisoning may contribute to the child exhibiting similar behaviours (Milberger, Biederman, Faraone, Chen, & Jones, 1996).

Throughout the past 100 years this label has gone through several transformations. As we will soon realize, the many labels created for these children provide some insight into what causes the condition. As etiological theory changes, so too do the labels used to describe these children. Each label provides some insight into how the medical profession viewed the cause and main symptomology of the disorder. One of the first people to categorize these children was Still (Barkley, 1990). In 1902, he observed a group of children that had similar behavioural characteristics that he considered a "defect in moral control". After Still's diagnosis of "defect in moral control", came other scientists; Shirley, Meyer, Beyer, Levin, Blau, Werner, and Strauss (cited in Barkley, 1990), who suggested that these behaviours were caused by some type of brain injury. Professionals challenged this view when it was recognized that most children who exhibited these difficult behaviours had not suffered a specific head injury. The theory was modified to suggest that these behaviours were as a result of a non-measurable injury. These children were then described as having minimal brain damage. This term later evolved into "minimal brain dysfunction" or MBD. After much time studying these children, the professionals began to question whether or not these children were actually born with this disposition. From this point forward, the term was changed to hyperkinetic reaction, which was later modified to the term hyperactive child syndrome (DSM-II,1968). After further research it was found that the consistent symptoms of these children were not their activity levels. What was found was some children were hyperactive and others were not. The issue that researchers focused on was the ability these children have in sustaining attention.

As a result, the label was modified and described as attention deficit disorder (DSM-III, 1980). A further change has resulted in the current label. The DSM IV (1994) specifies three subtypes of the disorder:

1. attention deficit/hyperactivity disorder combined (inattention and hyperactivity-impulsivity)
2. attention deficit/hyperactivity disorder primarily inattentive;
3. attention deficit/hyperactivity disorder primarily hyperactive-impulsive.

It can be assumed that this label will continue to transform as researchers and medical professionals modify their understanding of these children. This is why someone would find numerous labels describing the same condition. For the purpose of this paper I will use the label ADD. When looking at ADD, it is important to recognize that this is a label utilized by the medical professionals in North America and there continues to be dissention within this community. In addition, other professionals question the relevance of labeling. These opposing views suggest that the medical model is only one way of viewing these children and maybe if we look at other models we might create a more positive and productive way of seeing these children.

Chapter Two

Overview of treatment approaches

I believe that unlike most other professionals, social workers have several options when working with children who have been labeled ADD. These options or approaches include: 1) assessing and treating ADD within an individual perspective; 2) working from a broader multimodal perspective; 3) minimizing or attacking the ADD label while utilizing a strength-based approach. As you can see by the order in which I listed these approaches, there is a progression towards the most radical practice.

Individual Perspective

The early literature on ADD shows us that the first treatment strategy was treatment of the individual. The problem was defined in the context of the individual child's behaviour. This approach lacked consistency as outlined by Bogas (1993),

> For too many families, treatment remains fragmented: the diagnosis and treatment of a child and family still depend to a great extent on the discipline and training of the person from whom they first seek treatment

The reason is the diagnosis directs the treatment. With ADD, to a large extent, "the diagnosis is the treatment" (Hallowell & Ratey, 1994, p. 216). If a medical professional is the first one to assess the child, chances are the treatment option will be medication. A psychologist may look at information processing problems and treat the condition with behaviour modification and focus on compensating for skill deficits (Bogas, 1993). On the opposite side of the spectrum may be a family therapist who instead of focusing on the child's shortcomings, may focus on the family structures and communication strategies. The danger with any one of these perspectives is that the professional may attribute all the causality to one factor and not recognize the multitude of contributing variables. Social workers are the ideal professionals to evaluate and balance these factors (Bernier & Siegel, 1994). Social workers are trained in general systems theory and are encouraged to take a broader approach when looking at causality. This includes an assessment of the individual as well as the family, the environment, and broader structural factors.

Some present day examples of approaches used with these children that maintain an individual focus include such child centered therapies as play therapy, art therapy, cognitive/behavioural therapy, social skills training, educational strategies, psychotherapy, and pharmacological treatment. This is not to say that these methods cannot be utilized in conjunction with other methods. These individually centered approaches may be implemented one-to-one with the child or include a group focus. I would like to take a brief look at each of these therapies and suggest how they apply to children labeled ADD.

i) Play therapy and art therapy

Play therapy and art therapy are well accepted methods of working with children. What the therapist attempts to do in this approach is to use the medium of play and art to resolve problems the child is experiencing. The therapist and the child engage in this play together and in most cases, the parents are not involved directly within this process. Most play and art therapists also suggest that it does not take too long before the presenting problem behaviours are controlled within therapy. "I find it interesting that when I work with a child who is considered hyperactive, he is very rarely hyperactive in my office...there's very little of what's commonly thought of as hyperactivity in a one-to-one situation" (Oaklander, 1978, p. 224). This is consistent with what we know about this problem in that the symptoms are not apparent in all contexts, especially when the environment is unique and interesting for the child (Barkley, 1990). This explains why the symptoms seem to disappear in the therapist's office. The problem is that these changes do not always transfer to the school or home environments (Basu & Deb, 1996). That is not to say that art and play therapy are not effective tools in dealing with childhood depression, anger, self-esteem, grieving, and other issues that the child with ADD may be experiencing. For this reason, it is my belief that art and play therapy are effective methods of treating the secondary problems that arise within these children, however, they are not effective as a primary treatment tool.

ii) Cognitive, behavioural, and cognitive behavioural therapies

Therapies that were designed to deal directly with the symptoms of ADD include cognitive, behavioural, and cognitive behavioural therapy. Although I have placed these three similar therapies within the same category it is important to differentiate between each approach. In the cognitive approach, the therapist attempts to get children to "think and learn how they make choices that result in what and how they speak, and do things" (Roth, 1993, p. 41). In this approach, the therapist attempts to modify the dysfunctional beliefs the child may have towards their situation.

Behavioral therapy with ADD children includes reinforcement, environment restructuring, and time outs (Cocciarella, Wood, & Low, 1995). In this approach, good behaviour is rewarded and bad behaviour is ignored or punished.

A third approach is one that uses cognitive and behavioural theories and integrates them into a single therapy. Cognitive behavioural therapies appear sound on face value; however most of the research suggests that these approaches at best may only create marginal results with ADD children (Abikoff cited in Yelich & Salamone, 1994). My hypothesis is that the reason this treatment is ineffective is not due to the method but rather the individual focus and the resulting sense of blame these children may experience.

iii) Social skills training

Social skills training is another approach used to work with ADD children. The rationale for this therapy is that most children who have been labeled ADD have few friends and have difficulties responding to social cues. Sheridan, Dee, Morgan, McCormick, & Walker found that lack of peers can be a risk factor for later problems in life (1996). If it is possible to teach ADD children the necessary skills for making friends, then these future problems could be avoided. This therapy is usually applied with a group approach. A criticism of this approach is that social skills are only a small part of the problem ADD children experience and although the approach may be somewhat effective, it does not go far enough to create lasting change (Guevremont, 1990).

I have only included a short statement of the limitations of approaches discussed thus far since a thorough analysis of each approach could fill a paper such as this. At this time, there is no consensus in the general literature that suggests that any one of these approaches is the best way to treat ADD children. It is my intention for the reader to recognize that although therapists might experience success with some children using these treatment strategies, each approach has significant shortcomings when applied to all the children who have ADD.

iv) Pharmacological treatment

I stated in the previous summary of the first three treatment strategies that no one treatment is considered to be a stand alone treatment for ADD. There is one exception to this statement that should be noted: the use of medication to treat children who have ADD. This approach is the most dominant perspective in treating children labeled as ADD, however, I believe that this treatment option also has it's shortcomings. The treatment of children labeled as ADD has been highly influenced by the medical profession. In most situations, medication is the only treatment modality utilized for the child. Many strong proponents of this position suggest that in most situations, medication should be tried as a first treatment option and if the results are favorable, other strategies may not be necessary (Barkley, 1997). This attitude significantly limits many children and parents from seeking other treatment options. Although it is suggested that medication can have a positive impact on the child's behaviour, we must ask ourselves about the cost of this treatment. One such cost is having a child labeled with a mental disorder. While the benefits might outweigh the cost for some children, it is important that parents recognize that this is only one of many options in the treatment of their children.

Another limitation is the nature of the stimulant medication itself. Medication has been seen as highly effective for approximately 80% of children (Barkley, 1990). It is important to recognize that most stimulant medication, apart from the newer slow release medication, is only effective 4 to 6 hours following ingestion. One of the side effects of taking this medication is that it may inhibit sleep, and as a result, most children take their last dose shortly after lunch. This means that the effects are usually worn off by the time the children come home from school. This leaves the parent with a child who is not medicated (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993). The problem with this is that the school benefits from the medication but the parents do not. For this reason, many parents need additional resources in working with their children.

Hechtman, Weiss, and Perlman (as cited in Basu & Deb, 1996) have recently questioned the long term benefits of stimulant medication and now believe that it is more of a short term management tool. One of these findings comes from looking at the long term outcome studies of children on medication. These children were found to have similar rates of dropping out of school and being incarcerated as the untreated population (Diller, 1998). Weiss and Hechtman (1993) completed a summary of the outcome literature and found that:

> The hyperactives continue to have educational and work difficulties. Their increased residential moves, job changes, and debt may reflect their more impulsive lifestyles. They have more emotional problems and more problems with aggression ... stimulant treatment in childhood may not eliminate educational work, and life difficulties" (pp. 255-256)

In summary, as a social worker, I believe it is important to see how the individual approaches described above fit with our knowledge base and ethics. If we take a look at the history of the social work profession, we see that this conflict between the individual focus (micro perspective) and the broader system focus (macro perspective) has existed from the beginning. In the early years, it was Mary Richmond who argued that significant shortcomings resulted when workers maintained an individual focus. "Richmond translated her conviction about the importance of the family into her conception of practice ... good results of 'individual treatment would crumble away' if caseworkers failed to take into account the family" (Hartman & Laird, 1983. p. 13). In 1930, Robinson (cited in Hartman & Laird, 1983) suggested that the struggle was between broader sociological theory and the individual focus of psychology. Instead of looking to the value and meaning from an individual perspective he suggested that the focus should instead be on environmental circumstances.

In the 1960's, general systems theory emerged as the dominant theoretical framework for social work. "The development of systems theory and the integrative power of the general systems framework have given social workers the potential tools needed to fashion practice theory which can take into account the immensely complex reality of person/in family/in situation (Hartman & Laird, 1983). Although most social workers would subscribe to the importance of taking a broader macro focus when defining problems, in practice, most social workers get caught up with spending the majority of their time at interventions directed at the individual (Long, 1995). The consequence of this practice is that either change is short lived, or the child's condition is worsened as a result of being seen as "the problem". The reason for this is that the individual is only a small part of the greater system. In order to create lasting second order change, the therapist must address the ... systems of the children with ADD (Bernier & Siegel, 1994). "Practitioners must attempt to understand the complex interactions among family members and the societal institutions and forces surrounding them" (Bernier & Siegel, 1994, p. 142). As social workers, I believe that we have an obligation to acknowledge that the individual perspective is not consistent with the systems perspective nor does it make sense from an ethical perspective. If we also include our findings regarding the outcome of most of these individual approaches, we should conclude that this perspective should not be a primary option for social workers.

> ... hyperactive children have a multiplicity of problems; however, no single treatment has had a satisfactorily broad therapeutic impact. Few studies have used concurrent treatments for an extended time, though a multimodal approach seems optimal (Weiss & Hechtman, 1993, p. 382).

Multimodal social work treatment

This brings us to our second approach to dealing with ADD in children. The second approach taken by social workers is to acknowledge the medical diagnosis, but utilize their systems framework to assess and treat the children in the context of their family and broader societal institutions. It is important to recognize that social workers do not have the authority to diagnose anyone using the DSM-IV (1994). The social worker is only directly involved in the diagnosis when the setting is multidisciplinary and they can contribute to a team assessment and treatment plan. In this approach, social workers would be working within the dominant paradigm of the DSM-IV (1994).

In order for us to determine whether or not it is appropriate for social workers to advocate the use of the multimodal treatment approach, it is imperative for us to understand what this treatment strategy looks like. Equally important is to ask whether or not it is effective in dealing with the child's issues along with related family and educational issues. As suggested in the previous chapter, the multimodal treatment theory arose when it was clear that a single treatment model would not create lasting change. A multimodal approach looks at treating several components of the system and if effectively implemented, can help create primary and secondary change in the individual and the relevant systems. This includes utilizing methods directed at the individual child, the parents, and the family system, as well as advocating for changes in the school system and broader social systems. Research has shown that parents of children diagnosed as ADD are more prone to the following problems (Bernier & Siegel, 1994):

1. family instability and marital disruption
2. conflict laden parent-child interactions
3. high levels of parental stress
4. maternal depression
5. decrease in parental self-esteem

As a result of these findings, professionals began to modify their approach and teach caregivers to use specific strategies in order that the gains made would benefit the context in which children spent most of their time. The interesting thing that researchers found was that although the children's behaviour rarely changed, (consistent with our understanding of this trait) parents noted improved communication and planning skills. This reaction could create a lasting change in how the parent viewed their child's behaviour. The method utilized to teach the parents these tools was from a psycho-educational perspective taught within a group setting. They attempted to provide the parents with the necessary tools to deal with children who were perceived to be difficult. I would suggest that these skills would be of benefit to any parent who is having difficulty parenting a child not only those who have children who are seen as having ADD.

These children might also experience decreased self-esteem and other related behaviour problems such as conflict with authority and rules. In addition, one cannot forget the serious lack of resources within the school systems which focusing on children's individual needs. To address some of these issues, a multimodal approach may include the following components: medication for the child, cognitive support and play therapy for the child to develop self-esteem and interpersonal problem solving skills. Day treatment including special education for children, art therapy, social skills training, and occupational training might also be beneficial for these children. For the parents, there is behavioural management training and supportive counseling along with psychoeducational groups where parents could be taught parenting strategies (Bernier & Siegel, 1994). This approach also includes family therapy in some cases (Grizenko, 1997). Teachers can also benefit from some of the strategies directed at the parents in order to develop the specilized skills necessary for dealing with children diagnosed with ADD. Obviously, this approach can be time consuming and demands good communication and planning skills. It requires all people involved to work towards a common goal. While this does not necessarily mean all people must have a similar theoretical framework, they must be committed to working as a team for the well being of the child.

Social worker's role within this approach

Social workers have much to offer the children and families where ADD is present. They can reduce the chance of misdiagnosis, they can provide case management skills, and they can advocate for change.

i) Reducing Misdiagnosis

Misdiagnosis can result from a number of factors: inexperienced clinicians, biased reporting, insufficient time spent on assessment and lack of collaboration on the information ie. relying on only one source, not recognizing confounding variables. For example, Edwards, Schulz and Long (1995) studied how long clinicians spent in assessing this condition. General Practitioners spend on average 38 minutes in the initial evaluation, and specialists spend 73 minutes. Within a multidisciplinary clinic, diagnosis occurs after as much as 18 hours of evaluation. Social workers are in an invaluable position in minimizing the chances that misdiagnosis occurs. As a result of their training and orientation, social workers tend to look at other variables when it comes to diagnosing ADD. A competent social worker would not allow a diagnosis to occur without a comprehensive assessment. This would include taking into consideration feedback from multiple sources and settings along with a thorough social/developmental history (Aust, 1994). Other co-morbid conditions would be ruled out by either being referred out to other specialists, or by completing a detailed and comprehensive assessment.

These co-morbid conditions include; depression, Fetal Alcohol Syndrome/Effect, borderline personality, bi-polar disorder, and hyper-thyroid effects. (Grizenko, 1997)

ii) <u>Case Manager</u>

The case manager's role is quite consistent with social workers' training and experience "(the case manager's role) includes assessment, planning, linking, monitoring, and , if necessary, direct provision of service" (Long, 1995, p. 47). The social worker's role within this group was to ensure that everyone (professionals and family) was informed and working towards the same goals. Social workers could also ensure that a balanced perspective be maintained by offsetting a child's limitations through including some of their strengths. When the focus of other professionals becomes directed only at the child's short-comings, the social worker can balance this viewpoint by including some of the child's strengths. As well, the social worker can remind the other workers to maintain a positive future outcome for the child in order to instill, within the child, a strong hope for their future. This becomes especially important when the parent or the child gets caught up in the negative outcomes suggested in much of the literature. Social workers can direct these people to tangible examples of more hopeful situations. As well, they can suggest ways in which real change can be achieved.

iii) <u>Advocacy</u>

The numerous advocacy roles are also important for social workers to consider. Since social workers have experience in community development, they could put some of this training to work by bringing parents, professionals, and community leaders together in order to break down some of the existing communication barriers. Social workers could work towards social change by advocating for societal awareness and adequate funding to deal with children labeled as ADD (Long,1995). This includes both work at a community level and societal level. Social workers could also work towards dealing with any misinformation that permeates from the assessment and treatment of ADD. They can advocate for other professionals to maintain a balanced perspective; also, they can advocate for changes in the broader system including changes in the schools, community groups, legislative and public awareness forums

An example of multimodal treatment model

To illustrate, Barkley utilizes techniques and principles from social-learning-based parent training programs, social cognitive psychology, and family systems theory (1990). Barkley suggests treatment for the child should include a children's group, parental strategies, medication, school based strategies, and family therapy. Barkley stated that the purpose of a children's group approach is to:

1. formulate, rehearse, and apply their own solutions to the problems being solved by parents
2. improve their understanding of peer and parent-child relationships,
3. increase their commitment to change
4. build the skills needed to solve problems collaboratively with parents and teachers and
5. familiarize themselves with the types of point systems that parents and teachers may implement.

It is reasoned that if the children learn about these skills in group, they are more likely to respond positively when the parents implement these approaches. In addition to a children's group, Barkley employs a cognitive-behavioural parental training program. This includes providing parents with tangible parenting strategies, including giving the parents homework assignments to practice with their child(ren), and creation of a context in the group to get feedback on how these strategies are or are not working. These strategies include: attending skills, giving commands effectively, teaching principles of behaviour management, establishing a home token system, using time outs, and tips on handling children in public places.

Strength based approaches

Although most social workers have been trained from a "strengths" perspective, few actually put it into practice (Saleebey, 1992). The reason that this is so important is because the language and the discourse of the other therapies rarely empower the client and usually result in immobilizing and stigmatizing them instead (Szasz cited in Saleebey, 1992).

> "When the adults who had been hyperactive were asked what had helped them most to overcome their childhood difficulties, their most common reply was that someone (usually a parent or teacher) had believed in them " (Weiss & Hechtman, 1986, p.378).

i) Impact of DSM Label

The multimodal systems treatment seems to fit much of the theory within social work, however, there is still one issue that remains unresolved. How is it possible that social workers can work within a perspective in which the dominant paradigm is based on a disease model? I believe that for many social workers, this issue is never seriously considered as being an ethical conflict and as a result, they use the DSM without question. Kirk and Kutchins

(1992), suggest that approximately 25% of social workers employed in clinical settings use the DSM daily. The argument supporting this approach is that social workers are an accepted partner within the mental health field and if they do not acknowledge or utilize this standard manual (DSM IV,1994) it would put their relationship with the mental health field at risk. If this would occur, social workers would relinquish their leadership position which would leave the mental health field without a useful and successful perspective in working with a challenging population (Anello, 1992).

The opposing argument on the use of the DSM by social workers suggests that the process of diagnosis is very different when social workers complete an assessment. The problem is that the DSM is written from an individual perspective. By embracing it as a necessary tool, social workers minimize the impact of taking an ecological systems perspective. Although proponents of the DSM would argue that the last two axes contained in the DSM IV (1994) include other psychosocial factors, this aspect is underutilized and also inadequate from a social worker's perspective (Kirk & Kutchins, 1992). When researching this point, I was surprised by how little the social work literature speaks to this issue. The process of labeling a child as being ADD should not be considered a benign phenomenon and social workers must recognize the implications of such a practice. The social workers who do not use the DSM system must look to another approach when dealing with this population.

ii) Constructivist therapy

One option for social workers is to minimize the ADD label. This may be achieved by utilizing some of the constructivist models of helping. Social construction theory suggests that "belief and knowledge is socially, historically, and culturally situated" (Dean cited in Levine 1997, p. 198). Objective fact cannot be determined within this approach; what becomes important is the role that the therapist takes in constructing meaning for their clients. Instead of taking an expert position, these therapists provide alternative viewpoints or interpretations of events within the client's life. "Constructivist therapy is not so much a technique, as a philosophical context within which therapy is done..." (Anderson cited in Neimeyer, 1993, p. 268)

Included in social constructivist therapies are Narrative therapy and Solution Focused therapy. Narrative therapy attempts to reframe the problem and direct the child to name the label as part of the problem. The Solution Focused approach would discuss what the situation would look like if the problems associated with ADD did not exist or disappeared.

iii) Use of more empowering labels

The social worker may also choose to use more empowering labels. Historically, we know that children who now would be described as having ADD, would have been described in a predominantly negative way. Some of these informal labels are: "all boy", incorrigible, strong-willed, stupid, lazy, and undisciplined. These labels generally attempted to provide explanations as to why the child did not comply with societal standards. They rarely provided any insight or direction as to how to deal with these children and contributed to disabling the child and destroying any vision or positive future for these children. Barkley would suggest that once these labels were formalized and put within a professional context, most of the stigma was removed (1990). I would disagree with this perspective and remind the reader that these labels are not benign but have an incredible impact on how these children are perceived by others. This in turn impacts how the children perceives themselves. These labels are highly influenced by the social context in which they are formed. The societal value of conformity creates an expectation that "children should be seen and not heard". Instead of modifying our societal expectations we place the focus on the child's behaviours that we perceive as problematic. In researching this topic, however, I was able to find some authors who modified their individual expectations by having a positive outlook and instead of using the ADD label, they created positive labels. Some of these more positive labels include: spirited (Kurcinka, 1991); hunter (Hartmann, 1993); and creative (Cramond, 1994).

Kurcinka in her book "Raising your Spirited Child" differentiates between ADD children and "Spirited" children, although after reading her book, I believe that she is describing many of the same children, some of whom would fit into the DSM-IV (1994) and others who would be on that end of the continuum. Not only does she create a new label for children, but she takes each attribute and reframes it in a more positive light. For example, instead of using the term, "hyperactive" she refers to these children as having high energy levels; instead of "distractible" she sees these children as perceptive.

Hartmann (1993) takes a very different approach to these children. Although not attacking the medical profession directly, he provides an alternative approach regarding the etiology of these characteristics. He suggests that researchers still do not totally understand ADD. Within this lack of understanding, Hartmann creates a metaphor and places these traits in an historical context. He suggests that many of the qualities exhibited by an ADD person may have been more adaptive within a simpler society that is less technologically based in which the primary roles are hunting and gathering. For example, the qualities of impulsivity could instead be understood as the ability to think quickly and respond accordingly; restlessness or getting into trouble could instead be understood as risk-taking; distractibility may instead be described as hyper-focusing, which is an extremely valuable trait for a hunter. Hartmann suggests that as society became more agriculturally based, the virtues of patience, avoiding risks, and being focused on details became more valuable. One such example that embraces some of these positive traits came when he spoke with a professional from India and described characteristics that we would label ADD. He then asked this person if there existed similar people in India. This person acknowledged these characteristics and suggested that those people were considered very holy. It is believed that those people were:

> old souls, near the end of their karmic cycle . . . In our religion, we believe purpose of reincarnation is to eventually free oneself from the worldly entanglements and desire. In each lifetime we experience certain lessons, until finally we are free of this earth and can merge into the oneness of what you would call God. When a soul is very close to the end of those thousands of incarnations, he must take a few lifetimes and do many, many things, to clean up the little threads left over from his previous lifetimes. (Hartmann, 1993, p. 12)

Cramond (1994) suggested that when she took this approach, she found that many children who had been diagnosed as ADD were found to be highly creative. She argued that by providing a more positive label, like "creative" for these children, it could lead to a more positive outcome. Instead of the child seeing themselves as having a disorder, they would see themselves having a unique and highly regarded trait. Why is the label we use to describe these children so important? One obvious fact is that the labels that we use are not neutral and have consequences when applied to children.

> We must remember that the labels that we use reflect human values and, therefore, are a matter of culture and perception. (Wakefield cited in Maag & Reid, 1994, p. 6)

Cramond argues that the reason ADD is used instead of a label like creative is a result of pressures from schools and parents who focus on maladaptive behaviours. She argues that the same behaviour qualities can be interpreted in two opposite ways. A child can be viewed as participating in dangerous activity while at the same time may be seen as willing to step out and take chances. A child may have difficulty organizing their work, or they may be viewed as having a tolerance for ambiguity. Cramond suggests that in particular, the children who are bright and creative may not respond to the treatment regimes of more structure-breaking down tasks, since this creates boredom and may exacerbate the symptoms. These are the strategies that many experts recommend in treating ADD children. We may need to "rethink the labels that we assign to children, and search for the strengths in their differences" (Cramond, 1994).

Abandoning the ADD label

The last and most radical approach within a strength based perspective is one in which social workers do not allow the medical perspective to define the problem but instead, begin to look at the broader social systems and analyze how these systems contribute to the problem ADD children experience. These social workers do not focus all the attention at the individual child when trying to understand the situation; they look at structural issues that many families and children face. Some of these issues include: crowded and under-funded schools, poverty, children who have witnessed violence, overburdened families, and sexism (Levine, 1997). In addition it is important to recognize that cultural factors might influence an ADD diagnosis. (I have heard some anecdotal evidence that a high proportion of First Nation children are diagnosed as having ADD)

When we examine the broader issue of disability, it is clear that the concept is largely a social construction. Wendell (1996) stated that people with disabilities have a unique knowledge, perspective and experience that others in society should value. Instead these people are marginalized and isolated from mainstream society. Similarly Stratford (1995) argued that no person is truly disabled within the scope of their own existence, but they receive this label because of social beliefs and attitudes. This perspective has far reaching implications for any person who has received a label, whether it be ADD, Down syndrome, or Schizophrenia.

Once these issues are explored and understood, social workers challenge some of the basic assumptions of the medical label. Instead of accepting the status quo, they focused on good clinical intervention which included the construction of new, more empowering narratives in describing these children. It is important to remember that labels are not permanent but static. What is currently being suggested is that ADD may not even be a categorical disorder but should be seen more on a continuum. It is the "extreme of a behavior that varies genetically throughout the entire population rather than as a disorder with discrete determinants" (Levy, Hay, McStephen, Wood, & Waldman, 1997, p. 737).

Since the characteristics within the label ADD are found in all children to some degree, it is the comparable intensity and frequency of the behaviour that determines the label. The line drawn between a normal range of childhood behaviour and ADD is arbitrary and dependent on the criteria within the definition. There is also a measurement problem caused by observer bias and pre-determined standards of normal behaviours in each profession (Mann, Ideda, Mueller, & Takahashi, 1992). Although the medical profession is attempting to limit this problem by creating clearer criteria, we must remember that the behaviours that make up an ADD diagnosis continue to be defined within a social context (Edwards, Schulz, and Long, 1995). The professional completing the assessment is dependent on others for gathering information on the child's behaviour. The method most commonly employed for this task is the behaviour checklist, however, this method can be flawed in some situations as a result of observer bias. For example, it is well known that parents of difficult children suffer problems of self-esteem (Anastopoulos et al, 1993; Edwards et al, 1995) along with family stress and other psychological difficulties. We also know that depressed mothers tend to over-report behavior problems in their children (Richters, 1992 cited in Edwards et al, 1995). Parents who are trying to handle their difficult children are looking for external affirmation and any possible help. In order to get this help, they may exaggerate their child's symptoms.

I would suggest that the medical profession does not have a monopolistic perspective on these children. As a social worker, I believe that we can not immediately jump into treatment and accept the assumptions contained in this label, we must be part of the process that attempts to understand who these children are and look to developing more positive paradigms in describing these children. As social workers, we must first understand why this label is used to describe these children: who benefits by the use of this label? The first obvious group are the professionals for whom the label is of significance. According to these professionals, labels help to:

> summarize and order observations; to facilitate communication among professionals with different backgrounds; to guide treatment strategies in a global fashion; to put therapists in touch with a pre-existing relevant body of more detailed research and clinical data and; consistent with scientific goals, to facilitate etiologically, epidemiological-logical, and treatment outcome studies (Rains, Kitsuse, Duster, & Friedson, 1975).

Some people would argue that these reasons are just fancy rationalizations so that the professional can exploit their power and create a perception that they are the expert.

The most significant advocates for the use of this perspective are the parents themselves. I would suggest that this is typically because parents have been blamed by others and look to themselves as the cause of their child's misbehaviour. This perspective takes the focus off of the parents and suggests that these children are genetically different from most children. This removes much of the blame and misplaced guilt that these parents previously experienced (Bogas, 1993). The other group who strongly advocate the medical perspective are school personnel; schools benefit by using this label since it provides a legitimate explanation why some children perform so poorly.

As well, this label suggests that intervention should take place at the individual child's level and remove the responsibility from the teachers and principals to modify the school environment in order for the child to succeed. Some suggest it is the schools who create much of the negative impact on these children.

> I strongly recommend that therapists do whatever they can to modify our educational system. This would be a good example of 'preventive psychiatry'. Otherwise we will just continue to 'pick up the pieces' and attempt to treat the necessary sequelae of an iatrogenic disorder that need not have existed in the first place. (Gardner, 1987, p. 89)

It is interesting to note that it is assumed that the child will benefit from the application of the medical label. I was unable to find any research that explores the impact that this label has on the child's sense of self. While it can be argued that a parent who seeks help to become a more effective parent will have a beneficial impact on their child, we must look to the impact this perspective has on the child's view of his or herself. It is well documented that children who have been labeled ADD have poor self-esteem (Bogas, 1993; Cramond, 1994). It is not clear, however, which part of this poor self-esteem is because of the child's adjustments to the outside systems, and which part is due to the impact of their label? I would argue that a child's self-esteem suffers in part because of the impact of the labelling process and how that impacts the children's view of his/herself. We know that the diagnosis of this model focuses on the weaknesses or deficits of the child and does not look to the areas of strength. Behaviour checklists are inherently negative in their focus; one approach that I found looked at taking a strength assessment approach. The other problem that children have within this perspective is caused by a misunderstanding of their condition. Many children that I came into contact with thought that this label suggested they were crazy or stupid or both. As well, parents attributed any positive behaviours the child had to the medication and the bad behaviour was more indicative of normal behaviour. Many of these attitudes came to be addressed within treatment, however, they came as a result of a system which is quick to label a child ADD and may never be able to provide the support and multimodal treatment.

In summary, in the literature I reviewed, I found three approaches for treating ADD children. The first approach was an individual perspective and the second, a broader multimodal perspective. In the third, strengths-based approach, it was suggested the social worker minimize or ignore the ADD label and embrace more positive metaphors for describing this behaviour. This last approach attacks the label ADD directly and focuses on changing the structures and institutions that reinforce the labeling process. In the next chapter, I will look at a case study of ADD-labeled children and the treatment of these children with the second multimodal perspective. As I implemented this strategy, I found this perspective lacking and began to de-emphasize the ADD label and use a more positive, constructivist approach.

Chapter Three

Case study

As part of my MSW program, I had decided to do a practicum at Intersect Youth and Family and Services Society. Intersect is the local agency mandated to provide children with mental health services within Prince George. Intersect utilizes a multi-disciplinary approach. Psychiatrists prescribe medication; psychologists test for disabilities and cognitive issues; social workers provide family therapy and child care workers offer individual support. I worked at Intersect from September 1995 - April, 1996. During this time at Intersect, I was involved in working with two groups of children who had been labeled ADD. In the first group, which ran in the fall of 1995, I worked along side a child psychologist, Dr. Laurie McKinnon, and learned the basic skills and techniques to help these children within a group setting. In the next group that was offered in the winter of 1996, I was able to lead a similar group along with a BSW student, Barbara Guay, who was doing her practicum at Intersect. It was during this time that I began to evaluate my current understanding of ADD and question whether or not it was in the child's best interest to provide them with a label and then attempt to provide treatment for them. The group treatment model that was developed at Intersect was an adaptation of the treatment approach utilized by Barkley. (As outlined in the previous chapter). I would suggest that Barkley and his perspective played a key part in the development and implementation of this group. The group was developed just five months after Barkley had come to Prince George and presented a workshop on ADD. Most of the therapists at Intersect attended this workshop as did I. As a result of this workshop, many more families came forward and sought help for themselves and their children. Several key people at Intersect determined that a group approach was the most effective way of handling these additional referrals. The group approach developed at Intersect employed five separate groups that met concurrently. There were three groups set up for the children labeled as ADD; the first group was for children ages six to nine; the next group ages ten through twelve, and a teenagers' group for children thirteen and older. There was a group for the siblings of these kids as well as a parent group. Each group met for a total of eight weeks with the exception of the parent group which met two additional times before the other groups started. These sessions were open to all parents who had contact with Intersect and were informative in nature. (see Appendix 1)

The parents' groups followed a psycho-educational model as suggested by Barkley (1990). An added benefit of this approach was that it could accommodate the high number of parents who were part of this group. As a result of the large group there was a limited amount of group interaction, however, there was some attempt to break into smaller groups when it came to the discussions. Many misunderstandings about ADD were addressed in this context, and positive parenting approaches were taught and modeled. (see Appendix 2) During the sessions some informal connections developed between parents in the group.

The siblings' group was set up to provide support and direction for a much neglected component within the family system. Siblings can play many different roles within this system. Sometimes these siblings play the "angel" role and create an even more significant contrast between themselves and their sibling who exhibits ADD characteristic behaviour. At other times, these siblings feel ignored and alone. Some siblings even report that the only way to get attention from their parents is to misbehave. As a result, it is not long before some of these children pick up a label of their own. The siblings' group played a vital role in helping these children both understand themselves and encouraged them to take a new perspective when looking at their ADD affected sibling. It was hoped that through group sessions, these siblings could develop greater empathy and understanding, and learn strategies to help them cope with their unique struggles within the family. (see Appendix 3)

At this point in my practicum, I was at the beginning of my learning curve in understanding these children. I was pouring through the literature and attempting to integrate my social work experience and knowledge base with these children. I was also looking to the numerous therapists who were involved with this group, trying to assess their abilities at working with ADD children. The background and training of the therapists was diverse. Conflict that arose between therapists in our weekly discussions was due to the divergent values of these therapists. For example, in one of the groups, the two co-facilitators were having significant difficulty. One therapist was trained in a very child centered, non-directive approach, the other therapist was much more hands-on and directive. Unfortunately this conflict did not resolve itself until one of the therapists bowed out. As the weeks progressed, we were able to resolve most of the conflicts and created consensus on some of our approaches. For the most part, the team did not hold fast to the medical model. They questioned the validity or usefulness of this approach and looked at ways in which this dominant framework could be modified to include a more positive strengths based model. It was my experience that before the group, there was not a clear theoretical orientation shared by these therapists and it was only during the running of these groups that some of the theoretical frameworks began to evolve. In hindsight, I now recognize that we were all struggling together to work with this challenging group of children and their families. It was not until my work was almost completed with these children that I felt clear about my own theoretical framework. I will describe how some of the theoretical knowledge expressed in the first part of the paper materialized into tangible practice.

Overview structure of the group (see Appendix 4)

Some of the goals I developed after working with the first group of children were to:

1. Help children recognize that they are not alone, that many other children and adults struggle with similar issues.
2. Provide a safe environment in which children can express their feelings they experience as a result of their unique characteristics.
3. Encourage the children to recognize the strengths within themselves along with providing them with a realistic view of their short-comings.
4. Encourage the children to take responsibility for their own behaviour when it effects others in a negative way. Focus on teaching the children to recognize the consequences their behaviour might have on others.
5. Have fun.

Another goal that I had when running the group the second time was to use a strengths perspective right from the first contact I had with these children. I was concerned that many of these children either had a negative perception regarding counselling or felt that this would just be another context in which they could be blamed for misbehaving. In the first session after introductions I gave each child a small box wrapped in gift paper. I told each child that the reason that they were here was because of this gift. In each box

I had written a piece of paper which stated that their gift was that they had ADD. When the kids opened up their gift they were quite confused. One reason is because they only got a lousy piece of paper, unlike a typical gift but they also were confused as to how their ADD was a gift. I explained to them that I believe that their ADD is a gift, and that although most of the time people talked about ADD as being bad that in group we were going to explore ways in which ADD could be seen as something unique and special. We then asked the children what they understood ADD to mean. We also asked them how they thought they had gotten ADD. I was quite surprised that not one of the children was clear about how they got ADD and what it means to have ADD. I had assumed that as a result of these children receiving a label, someone would have sat them down to explain to them in clear terms what their label means and why they have been labeled. It was at this point that I asked myself the question, who benefits from the label?

One of the activities in our group was to view a video. This video was used as a discussion starter for different aspects of ADD. One of the videos that we found useful and relevant for the kids was Robert Munsch's, "Pigs". Not only was this video entertaining for the kids in our group, but there were several significant themes that came out of the video. The video is a story about a girl who lives on a pig farm. One day her father asks the girl to go and feed the pigs. As part of his instructions to the girl, he warns the girl not to open the gate as the pigs are actually quite smart. The girl has little knowledge about pigs and assumes that these pigs are stupid, lazy, dirty with no redeeming qualities whatsoever. As she is feeding the pigs her curiosity gets the best of her and she opens the gate. Her theory that the pigs are stupid and non-attentive is put to the test as she does so and yells, “Hey you dumb pigs!” The pigs storm out of the gate and escape. She then turns her blame onto the pigs when she misses the bus and arrives late for school. The pigs end up creating total destruction and chaos as they overtake the home and school. In the process they drive the principal nuts and they make a total fool of the teacher. Throughout these circumstances, the girl realizes that the pigs don’t like being called stupid and get even more out of control when this happens. She also begins to recognize that one of the pigs is actually very intelligent at math. This pig’s unique abilities are not obvious to other people because of the disruption the other pigs create. At the conclusion of the video, the little girl names her pig Einstein and becomes lifelong friends with this pig. Some of the discussion questions we asked the kids were:

1. Why did the pigs get out of the pen?
2. What happened when the pigs got out?
3. What similarities did you see between your actions and the pigs?
4. How do you think the pigs felt when the girl called them dumb? Has anyone ever made you feel like this? What did you do?
5. What are your hidden gifts that people don’t often recognize?
6. How would you feel if people looked at your gifts instead of only focusing on your misbehaviour?
7. What would help you get your pigs in control?

We found that the pigs metaphor provided a wonderful opportunity for the children to vent some of their frustrations. Children who had difficulty expressing their own feelings of pain and rejection were able to speak through this powerful metaphor. Once they felt safe in exploring this feedback within the group, many of them were able to go on and express their own negative experiences and feelings. All of the children could relate to getting in trouble at home, in their classroom and with the principal. Once the children expressed their feelings they were more open to explore positive solutions that could help them keep their pigs in control. The pig metaphor used in group allowed the children to see themselves as separate from their behaviour. This video was one of the building blocks used within the group to encourage the children to look at their abilities and gifts and recognize why others get hung up on their shortcomings. For many of these children this was a very new way of looking at themselves.

In addition to the videos we used art materials to provide another medium for children to express their thoughts and feelings. Given the age of participants of this group it was determined that it would be of benefit to utilize these other methods. These children used these tools to express their feelings and helped us gain further insights into the child's world. Some of the activities included:

1. asking the children to draw an animal that would describe their ADD.
2. asking the children to draw what they looked like before and after taking their medication.
3. asking the children to describe their ADD story or how they were diagnosed with ADD.

The other method that was beneficial in helping modify the children's view of themselves was the use of the ADD game. This was a cognitive strategy that was developed by Dr. McKinnon when she ran the previous children's group with me. The goal of this activity, using a board game format, was to encourage the children to think about their assumptions about ADD. They would roll the dice and move around this game board each time taking a card with a question on it. These questions attempted to debunk some of the myths that are perpetuated regarding ADD. I have included a list of these questions in Appendix 5. The children appeared to get into the spirit of the game and enjoyed the competition. This game format was very successful in gaining all of the children's interest; the kids enjoyed the game to the point that many of them requested they be able to play it during the last session of group. This was when the children were given the choice to play any game they chose. They were eager to share their answers with their teammates when they were stumped. I think that this was a fun method to teach these children that may have a long lasting effect on their view of themselves.

Another goal I had for the group was to have them determine the rules and ways to enforce those rules. Given the age of the participants, the co-facilitators helped the group define the rules and determined some positive consequences for obeying these rules. What we came up with was that after every 15 minutes, we would stop the session and assess how everyone had done during this time. The kids would vote on who should get a Pog (this was the reward that had been decided at the beginning of group). I had decided that once a child earned a Pog, that it could not be taken away for disruptive behaviour. I found it interesting that many of the kids during the group feedback were very punitive and harsh towards their fellow group members. It was my belief that they were modeling some of the behaviour that had been used with them for most of their life. As co-facilitators, we found it important to reframe some of the questions and ask how a certain child's behaviour had improved since the last time frame and reminded the child that he or she had an opportunity to vote on his or her own behaviour. This helped deal with some of this negative feedback. Please note that I am consciously using the term “disruptive behaviour” and not misbehaviour because I felt that their behaviour would only be a problem if it distracted others from benefiting from the group. I am sure that if most people joined our group during certain times they would have assumed that the group was totally out of control. For example, at the end of every group we would allow the children to freely interact with each other (while we were waiting for their caregivers to pick them up). Sometimes this interaction was relaxed and conversational, other times it included making paper airplanes and throwing them around the room. There were a few times in which we had to intervene to ensure the safety of the children but otherwise we let them make their own choices. We also felt it was important for the group to be interesting and rewarding so that the opportunity for misbehaviour would be reduced.

Another good example of “appropriate behaviour” would be to insist that the kids remained in their seats at all times ...we did not enforce this standard. One child in particular had a difficult time sitting still. I remember on one occasion he was sprawled spread eagle across the table. At this point, I asked this child a question regarding what we were currently discussing and this child responded in such a way that it was obvious that they were attending to the discussion. It was also important to note that their behaviour was not disruptive to the other members in the group. As a result, I felt that if this child could participate fully and not create a disturbance to the other members of the group, I should not focus on this behaviour. I did wonder how this child coped with being placed in a more structured environment like school.

Another child had a strong oppositional disposition; this was readily apparent after meeting with the child for the first time. This child purposefully told us that they were going to misbehave in group. The child appeared to take pleasure in pushing the limits and disregarding the direction we were trying to encourage with the other children. One thing that I noticed is that when this child would misbehave, he would be scanning the faces for their reactions. What seemed to work well for this child was peer feedback. His misbehaviour would escalate when the other kids in group would acknowledge and participate with this child. At other times, the behaviour would come to an abrupt end when the child received negative feedback from another group member. It was our goal to create a safe context and encourage the other children to be honest with their feedback when they felt this child's behaviour to be inappropriate and to the point of impacting them in a negative way.

One of the struggles that I had working with these children was when the parents would come and pick them up. A limitation of this group was that there was little time to interact directly with the parents apart from the short time before and after group when they dropped off or picked up their child. When the parents would come to the room to pick their child up, if there was feedback to be given I would try to focus on the more positive attributes of the child. In some cases this feedback was acknowledged but in several situations the parent would try to rebut this and provide additional examples of the child's shortcomings. I remember one parent in particular who appeared to have little hope for their child. Through the course of my brief encounters with this parent there were several comments that suggested that they had little hope their child would graduate from school and that their child would probably end up in jail anyway. It was also interesting to note that this child's parent once dropped them off at the beginning of one of the sessions and suggested that they would be well behaved today since they took an extra dose of medication before coming to group. I was caught off guard by this comment and unfortunately, was not quick enough to come up with a response. I realized later how significantly this attitude contributed to this child's problem. This statement suggested that when this child is good it is as a result of the medication, no reflection on the child making good choices. When the child is bad, it is because their medication is wearing out or there is a need to increase the dosage or change the medication. With both scenarios the child does not own up to the outcome. There is little motivating the child to improve their choices.

Chapter Four

Summary

This project has taken the very complex, multifaceted issue of ADD and attempted to summarize some of the current treatment approaches. It is unfortunate that most therapists spend the bulk of their energy and time utilizing treatment strategies that are incomplete or inappropriate at creating lasting change for these children and their families. One of the reasons that I believe that this occurs is because the treatment of ADD is dominated by the medical model. One must really search through the literature in order to find alternative approaches that do not subscribe to this dominant paradigm.

Within my case study I looked at the group treatment of 6 children who had been diagnosed as having ADD. This approach initially utilized an approach presented by Barkley (1990), however, by the end of the second run of the group, many changes had taken place. As a result of the fact that most of the therapists were social workers by training, the model evolved towards integrating more social work principles. Some of these principles included, 1. de-emphasis of the disease model, 2. the inclusion of strengths assessments and, 3. the recognition of individual differences among these children. I think that as social workers, we cannot emphasize this perspective enough. "We need a list of strengths as powerful and as validating as the florid vocabulary of diseases found in the DSM-IV to combat our national obsession with pathology" (Wolin & Wolin in Selekman, 1997, p. 24). After completing this project, I recognized that much more significant changes need to be implemented to truly take a complete social work approach to this problem.

In addition to these broader changes, I also recommend making the following modifications to the group treatment approach to ensure a more positive outcome for this population. First, children and families can benefit from a thorough social work assessment before joining the groups. I think one of the most significant things that we learned in these groups was that more time needed to be spent in the screening of these individual children and their families. What we found in the running of the groups was that a few children had been misdiagnosed, other children were deemed inappropriate in group, and still other children felt forced into group by either their therapist or caregiver. Dealing with some of these issues before the children started group could have ensured a more positive outcome.

Second I believe that we could have spent more time focusing on creating a positive future for these children; we should spend more time talking about their goals and dreams. As therapists, it is important to encourage the parents to think about past successes and have them try to visualize what a more positive future would look like and then work towards that view (Selekman, 1997). As well, we could have included examples of successful people who have been diagnosed as having ADD. These people could explain how their unique personalities have provided the opportunity to excel within their particular job. I also believe that parents need to receive this message since they are in the most influential position for their children. I would suggest that their aspirations for their children have a direct impact on how their children turn out. Obviously, this is an area that would require more research with groups of families.

Implications for social work practice.

I believe that this project has significant implications for social workers who are working with these children and their families. I began this work being quite ignorant about ADD. In time, I became fascinated with the dominant treatment approach and was a strong proponent for it. This was before I began to take a broader focus and look at the impact this approach has on the children themselves. I also started to recognize that "this problem" that I believed was an individual and family issue, was actually more symptomatic of problems that have become increasingly obvious within our society. The more I focused my attention on analyzing the broader systems, the more I became aware that for lasting change to occur for these individuals, more change must occur at a systemic level. Real change cannot occur at this level as long as we frame this problem as residing in individual children. The ADD label supports this individual viewpoint and therefore, must be eventually abolished in order to place the focus where it belongs, at the broader social systems level and within the dysfunctional beliefs and attitudes we hold as a society. In hindsight, this is quite an obvious conclusion, especially for someone who has been trained as a social worker. I cannot understand why it was not apparent to me sooner. I can only presume that the same biases that precluded me from seeing this sooner, also are present for most of the social workers who work with these children and families on a daily basis. The metaphor "can't see the forest for the trees" describes this problem most succinctly. If my assumption is correct, the next obvious question is, "what would be the most effective way to spread this new paradigm?" While we work to accomplish this task, the realist in me also questions what should be done in the meantime to continue to provide help for the numerous families in crisis. I believe that to be ethical social workers, we must work on these two issues concurrently without neglecting either goal.

The first obvious step I believe is to minimize, as much as possible, the misdiagnosis of this condition. There are numerous factors that contribute to the misdiagnosis of ADD, many of them, I have already briefly discussed in this project. Some of the medical factors include:

1. Many professionals do not spend the necessary time gathering the information and doing a comprehensive assessment.
2. Most children are diagnosed by a family doctor who may not have the expertise and training to diagnose this condition. It is understandable why these professionals are eager to diagnose this condition; they are on the front lines, hearing the complaints and concerns of the parents. Their expertise and competence is with treating biological conditions, not emotional and psychological conditions.
3. The system is set up to financially reward physicians who can "successfully treat" clients in the least amount of time. This same system is structured to create professionals who are quite independent and who are not accountable to professionals from different backgrounds.
4. The specialized system that has been set up to deal with mental health issues is "crisis orientated" and is primarily directed at more serious chronic mental health disorders.

In order to remedy these problems, the solutions are obvious, however, they have far reaching implications and challenge some of the traditions of the medical profession. My first suggestion would be to limit the number of professionals who would be allowed to diagnose ADD. The best case scenario would be that no diagnosis could be made outside of a multidisciplinary mental health team. This would ensure that all factors would be taken into consideration to ensure an accurate diagnosis is obtained. Opponents of this position would state that this option would not be feasible given the number of children who fall within the categories of the DSM-IV (1994). I would agree with them. I would also suggest that it is unethical for any professional to provide a diagnosis when comprehensive treatment is not readily available. As a result of this recommendation, it would be hoped that eventually, the entire label of ADD would be deemed inappropriate and subsequently ignored or thrown out of the DSM all together.

I would hope that the reader does not conclude that I believe family doctors and some medical professionals are incompetent or unethical. Most of these people are genuinely caring and have pure motives. The problem as I see it, exists in the systemic structures in which these professionals work. It also is important to recognize the contributions that social workers have had to the problem of misdiagnosis. It has been noted that in some situations, social workers overdiagnose certain psychiatric conditions in their clients if it would enable the client to receive additional services not previously available (Sands, 1991).

The schools also have to take responsibility for contributing to the pressure exerted on the parents and the medical profession to label children as ADD and medicate them. Given the demands of an overburdened school system with crowded classrooms, it is no wonder that some teachers see the medicating of children as a tool to help them cope with the classroom demands. Administrators have a responsibility to ensure that their staff are adequately trained in having a balanced perspective on ADD. We also know that teachers are in a highly influential position of observing and noting ADD behaviour in children. Should teachers abuse their position and suggest that a high number of children are exhibiting ADD symptoms (far above any statistical anomaly), it would be the administrator's role to monitor and respond to this situation. In order to remedy this situation, social workers employed within the school system or who come into contact with this system have a significant role. They can provide some of the checks and balances on a case by case basis to ensure that problem teachers and schools can be identified. As well, they can work with parents to ensure that they are aware of other educational options that might be available should problems not be addressed appropriately. Another option is for social workers to advocate accountability within the classroom regarding ADD children. By creating a process that keeps track of the number of children labeled as ADD, and including ways in which these children could be followed, there would be ways in which problematic areas could be located and addressed.

When it comes to the treatment of children who have already been labeled as ADD, I believe that it is important for social workers to move towards the evolving approaches I outlined within the literature review. Instead of focusing on individual treatment approaches, social workers should move towards a more macro practice model. It is important to recognize the impact the labeling process has on these children and to minimize the damage of this approach. This can be accomplished by focusing on the individual strengths of the child and on the more constructivist ways of helping. I also looked at how this treatment approach would be operationalized with a group of children labeled ADD. I found that the traditional treatment approach does not go far enough in dealing with the issues of all of these children. If we are to create lasting change in these children, we must turn our focus towards changing the structures and systems that support the ADD label. I think that as social workers we must continue to dialogue and discuss this perspective in the context of our ethical commitment to our clients.

REFERENCES

American Psychiatric Association. (1968). Diagnostic and statistical manual of mental disorders (2nd ed. DSM-II). Washington, DC: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed. DSM-III). Washington, DC: Author.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed. rev. DSM-IIIR). Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorder (4th ed. DSM-IV). Washington, DC: Author.

Anastopoulos, A. D., Shelton, T. L., DuPaul, G. J., & Guevremont, D. C. (1993). Parent training for Attention-Deficit Hyperactivity Disorder: Its impact on parent functioning. Journal of Abnormal Child Psychology, 21 (5), 581-596.

Anello, E. (1992). Should social workers use the DSM-III? In E. Gambrill, & R. Pruger (Eds.), Controversial issues in social work. (p. 139-145). Toronto: Allyn & Bacon.

Aust, P. H. (1994). When the problem is not the problem: Understanding Attention Deficit Disorder with and without hyperactivity. Child Welfare, 73 (93), 215-227.

Barkley, R. A. (1990). Attention-Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment. New York: Guilford.

Barkley, R. A. (1997). ADHD and the nature of self-control. New York: Guilford.

Basu, S & Deb, A. (1996). Parent training in children with Attention Deficit Hyperactivity Disorder: An integrated approach for greater effectiveness. Individual Journal of Clinical Psychology, 23 (2), 184-191.

Bernier, J. C., & Siegel, D. H. (1994). Attention-Deficit Hyperactivity Disorder: A family and ecological systems perspective. Families in Society: A Journal of Contemporary Human Services, 75 (3), 142-151.

Bogas, S. M. (1993). An integrative treatment model for children's attentional and learning problems. Family Systems Medicine, 11 (4), 385-396.

Coccciarella, A., Wood, R., & Graff Low, K. (1995). Brief behavioral treatment for Attention- Deficit Hyperactivity Disorder. Perceptual and Motor Skills, 81, 225-226.

Cramond, B. (1994). Attention-Deficit Hyperactivity Disorder and creativity- What is the connection? The Journal of Creative Behavior 28 (3), 193-210.

Diller, L. H. (1998). Running on Ritalin: A physician reflects on children, society, and performance in a pill. Toronto: Bantam Books.

Edwards, M. C., Schultz, E. G., & Long, N. (1995). The role of the family in the assessment of Attention Deficit Hyperactivity Disorder. Clinical Psychology Review, 15 (5), 375-394

Gardner, R. A. (1987). Hyperactivity, The so-called Attention-Deficit Disorder, and the group of MBD syndromes. Cresskill, NJ: Creative Therapeutics.

Grizenko, N. (1997). Outcome of multimodal day treatment for troubled children. American Journal of Orthopsychiatry, 665 (3), 434-438.

Guevremont, D. (1990). Social skills and peer relationship training. In R. A. Barkley (Ed.), Attention-Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment (pp. 541-573). New York: Guilford.

Hallowell, E. M. & Ratey, J. J. (1994). Driven to distraction: Recognizing and coping with Attention Deficit Disorder from childhood through adulthood. Toronto: Simon & Schuster.

Hartman, A., & Laird, J. (1983). Family centered social work practice. New York: Free Press.

Hartmann, T. (1993). Attention Deficit Disorder: A different perception. Lancaster, UK: Underwood-Miller.

Kirk, S. A. & Kutchins, H. (1992). Five arguments for using DSM-III-R and why they are wrong. In E. Gambrill & R. Pruger (Eds.), Controversial Issues in Social Work. (p. 145-154). Toronto: Allyn & Bacon.

Kurcinka, M. S. (1991). Raising your spirited child. New York: HarperCollins Publishers.

Levine, J. E. (1997). Re-visioning Attention Deficit Hyperactivity Disorder (ADHD). Clinical Social Work Journal, 25 (20), 197-209.

Levy, F., Hay, D. A., McStephen, M., Wood, C., & Waldman, I. (1997). Attention-Deficit Hyperactivity Disorder: A category or a continuum? Genetic analysis of a large-scale twin study. Journal of the American Academy of child and Adolescent Psychiatry, 36 (6), 737-744.

Long, D. D. (1995). Attention Deficit Disorder and case management: Infusing macro social work practice. Journal of Sociology & Social Welfare, 45-55.

Mann, E. M., Ikeda, Y., Mueller, C. W., Takahashi, A., Tae, K. T., Humris, E., Li, B. L., & Chin, D. (1992). Cross-cultural differences in rating hyperactive-disruptive behaviors in children. American Journal of Psychiatry, 149 (11), 1539-1542.

Maag, J. W. & Reid, R. (1994). Attention-Deficit Hyperactivity Disorder: A functional approach to assessment and treatment. Behavioral Disorders, 20 (1), 5-23.

Milberger, S., Biederman, J., Faraone, S.V., Chen, L., & Jones, J. (1996). Is maternal smoking during pregnancy a risk factor for Attention Deficit Hyperactivity Disorder in children?. American Journal of Psychiatry, 153 (9), 1138-1142.

Neimeyer, R. A. (1993). Constructivist psychotherapy. In K. Kuehlwein & H. Rosen (Eds.). Cognitive therapies in action: Evolving innovative practice. San Francisco: Jossey-Bass Publishers.

Oaklander, V. (1978). Windows to our children. New York: The Gestalt Journal Press.

Rains, P. M., Kitsuses, J. I., Duster, T., & Friedson, E. (1975). The labeling approach to deviance. In N. Hobbs (Ed.), Issues in the classification of children (pp. 88-100). San Francisco: Jossey-Bass Publishers.

Roth, E. E. (1995). A clinical and cognitive approach to Attention Deficits. Therapeutic Care and Education: The Journal of the Association of Workers for Children with Emotional and Behavioural Difficulties, 4 (1), 41-59.

Saleebey, D. (1992). The strengths perspective in social work practice. New York: Longman.

Sands, R. G. (1991). Clinical social work practice in community mental health. Toronto: Collier Macmillan Canada, Inc.

Sheridan, S. M., Dee, C. C., Morgan, J. C., McCormick, M. E. & Walker, D. (1996). A multimethod intervention for social skills deficits in children with ADHD and their parents. School Psychology Review, 25 (1), 57-76.

Selekman, M. D. (1997). Solution-focused therapy with children: Harnessing family strengths for systemic change. New York: Guilford Press.

Stratford, B. (1994). Down syndrome is for life. International Journal ofDisability, Development and Education, 38 (1), 3-13.

Weiss, G. & Hechtman, L . T. (1986). Hyperactive children grown up: ADHD in children, adolescents, and adults. New York: The Guilford Press.

Wendell, S. (1996). The Rejected Body. NY: Routledge.

Yelich, G. & Salamone, F. J. (1994). Constructivists interpretation of Attention-Deficit Hyperactivity Disorder. Journal of Constructivist Psychology, 7 (3), 191-212.

Appendix 1

ADHD Family Support/Training Program

Information Evenings

The purpose of these two information evenings will be to focus on general information regarding Attention Deficit Hyperactivity Disorder. Some of the topics to be discussed include:

- What is ADHD and how is it diagnosed
- General Parenting Strategies
- General strategies for success in school
- Medication
- Dealing with related issues. For example: difficulty with bladder or bowel control, oppositional defiant disorder, etc.

There will be time allotted for specific questions. Parents must attend these workshops in order to participate in the 8 week parent training program.

Appendix 2

ADHD Parent Group

Group Overview

Objectives- What parents will acquire from this group:

- Gain information on ADHD as a disability.
- Develop successful parenting strategies to deal with this disability
- Improve strategies for helping children be successful in the school environment.
- Increase positive communication between family members.
- Enhance actions that promote self-esteem

Group Outline:

Session 1:
  A. Introduction/logistics for group
  B. ADHD: reframe as a disability
  C. Grief and loss associated with ADHD
  Homework: Home proofing for success

Session 2:
  A. Analogy of house structure to successful home environment.
  B. How positive and negative reinforcement affects behavior.
  C. 20 minute exercise to teach positive attending.
  Homework: Practice 20 minute exercise with child.

Session 3:
  A. Act don't Yack: emotional distancing (123 Magic).
  B. Successful strategies for adapting environment.
  C. Brainstorm strategies that have worked.
  Homework: Try something new

Session 4:
  A. Training parents in methods of attending to positive child behavior while differentially ignoring negative behavior.
  B. Identify strengths in family-worksheet.
  Homework: Family worksheet

Session 5:
  A. Discuss benefits of token system for ADHD children.
  B. Discuss format for creating token systems.
  Homework: Develop token systems.

Session 6:
  A. Continuation of discussion on token systems.

Session 7:
  A. Discuss solution resource book
  B. Exercise on using solution book.
  C. Discussion on effective school strategies.

Session 8:
  A. Wrap up, where to go from here
  B. CHADD
  C. Evaluation of group.

Source:

Del Mar, W. (1986). Outline of structure and plan for group at Intersect Youth and Family Services Society.

Appendix 3

ADHD Sibling Group

Goals, objectives, and tasks:

1. Know what ADHD is:
   - Brainstorm the behaviors (or lack thereof) of the ADHD-affected sibling, that are bothersome. Then, using this list, divide them into groups and write up as three ADHD dimensions (hyperactivity, inattentiveness, and attention – deficit).
   - Show video "Jumping Johnny"
2. Know if they are ADHD.
   - Complete ADHD rating scale.
   - Score and discuss ADHD as a dimension.
   - Create a huge scale of the three main components and have them place self and sibling on it.
3. Know how ADHD affects their lives.
   - Pros and cons of having a sibling with ADHD.
   - Fighting for parents time.
   - Able to get away with more (the "angel").
   - Use popular video to demonstrate how "angel" can get away with stuff.
   - Use book "My brother's a world-class pain"; show on overhead.
4. Understand changes at home, both due to implementing behavioral modification strategies and the use of medication.
   - Explain behavior modification charts. Create one for self (to track parent's attention, their own behaviors, behaviors towards siblings).
   - Discuss various types of medication and their effects. Clear up any myths. Again, may create overhead from book, "my brother's a world-class pain"
   - Use the analogy of inoculations or diabetes.
5. Know how to handle their ADHD—affected sibling.
   - Time-outs for self.
   - Behavior modification chart for self and for ADHD—affected sibling
   - Identify times of day and situations which are the most difficult. Problem solve
6. They will feel better about selves.
   - Hear and acknowledge their concerns/stresses, questions, issues, fears, hopes.
   - They partake in the new home strategies.
   - Enjoyable activities.
   - Self-care: enjoying some privacy/quiet; spending some time with parents; their own activities, hobbies, interests, friends, etc.

Session structure:
Opening activity: ice-breaker/energizer.
Check in: Everything for the past week. Then re: ADHD
Topic:
Closure: What's one thing you want to remember from tonight?

Source:

(1996). ADHD Sibling Group. Outline of structure and plan for group at Intersect Youth and Family Services Society.

Appendix 4

ADHD Children's Group: Age 6-9

Group Outline

- Session 1: Introduction and Overview for group
    - A. Create name tags.
    - B. Presentation of "the gift" (this answers the question why children are here?)
    - C. Introducing Pog chart
    - D. Develop Group rules
    - E. Good news/ bad news
- Session 2: Understanding your ADHD
    - A. Jumping Johnny video and discussion
- Session 3: Understanding how your behavior impacts your parents
    - A. Brainstorm activities for creating a tool to control behavior
    - B. Mrs. Doubtfire video
- Session 4: Building self-esteem
    - A. Write your ADHD story
    - B. Share story with group
- Session 5: Controlling and externalizing behavior
    - A. Traffic signs
    - B. Sharing what situations are difficult to stay in control.
- Session 6: Mastery of your ADHD
    - A. Playing the ADHD board game
    - B. Pigs video
- Session 7: Medication
    - A. Discussion of medication.
    - B. Draw picture of before and after take medication.
    - C. Plan party for last group
- Session 8: Celebration and Summary
    - A. Kid planned activity (show and tell hobbies, play favorite games, etc.)
    - B. Awards presentation
    - C. Party

Session Structure

- Good News// Bad News
- Behavior Pog chart check in every 15 minutes
- Agenda
- Pog trading time and free time

<u>Source:</u>

Goerz, B. & Guay, B. (1996). Outline of structure and plan for group at Intersect Youth and Family Services Society.

Appendix 5

Summary of ADHD Game questions

Does your ADHD mean that you are not smart?
How old were you when you found out you had ADHD?
If your ADHD was an animal what animal would it be?
If your ADHD was a color what color would it be?
Do you have friends who have ADHD?
When is the hardest time to stay in control?
What is one way you can stay in control?
What is the best part of having ADHD?
What is the worst part of having ADHD?
If you could change something about yourself, what would it be?
What names have you been called when you are not in control?
What kind of car would your ADHD be?
Does anyone else in your family have ADHD?
What is the best day of your life?
How does your ADHD make you different?
What was the worse day of your life?
What is something you do well?
What is something you do not do well?
Does having ADHD make you a bad person?
What does your parent say when you are not in control?
What does your teacher say when you are not in control?
What street sign helps you stay in control?
If you could get rid of your ADHD magically, how would you do it?
If you could bury your ADHD, where would you bury it?
If you could throw your ADHD away, where would you throw it?
If your ADHD was a bullet, how far would it go?
Do you have ADHD when you are sleeping?
Does ADHD ever go away?
What is your favorite food?
What is your favorite color?
Do others make fun of you because you have ADHD?
What happens when you have too much sugar?
Have you ever made someone mad because of your ADHD?
Have you ever made someone sad because of your ADHD?
How are you different than others who do not have ADHD?