An ADHD Checklist for Teachers

In 2003, approximately 4.4 million children aged 4-17 years were reported to have a history of ADHD diagnosis; of these, 2.5 million (56%) were reported to be taking medication for the disorder.

— Centers for Disease Control and Prevention

By Stephen R. Herr

Many professionals follow specific protocols before taking action. A pilot completes a checklist to ensure that taking off is the right thing to do. A surgeon does the same thing before making an incision. Before tearing down a building, a contractor completes a demolition checklist to make sure the building is ready to come down. We expect that moment of pause, focus, and caution from other professionals, and we should expect the same of ourselves and our colleagues.

Over the last 40 years, the Attention Deficit Hyperactivity Disorder (ADHD) industry (clinicians, academics, publishers, pharmaceutical companies, etc.) and the American Psychiatric Association have done a great deal to redefine our role as teachers. This redefinition has led to a burgeoning pharmaceutical culture that is having an ever greater influence on our schools and our society. The role of educators in this shift has been primarily one of spectators and flunkies. At a time when we should have been extending

A diagnosis of ADHD will shape

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leadership, we have waffled and acquiesced. We have negated our values and traditions and embraced diagnostic theories though we know little about them. Before we go any further, we need to pause, focus, and wrestle with some difficult questions.

1. Are you willing to be part of a process that will label a child with a disorder for which there is no cure?

Before any decision about your role in the ADHD assessment process, consider the prognosis regarding a cure. According to the National Institute of Neurological Disorders and Stroke (2008), “There is no ‘cure’ for ADHD,” which means that a child labeled as having ADHD will be tagged with that wherever he goes. Since people don’t “outgrow” ADHD, such a diagnosis will shape that child’s sense of himself and how others view him for the rest of his life.

2. To what extent does witnessing an event or a behavior mean that you understand the cause of that behavior?

Teachers know that understanding the context in which a behavior occurs helps them understand that behavior and, in turn, that understanding helps teachers avoid “fundamental attribution error” (The tendency to overemphasize people’s attitudes as a way of explaining their behaviors, while underemphasizing environmental explanations).

For example, teachers are concerned with how well or poorly students do on their homework. The American Psychiatric Association (APA) is also concerned with how students do on their homework. The APA’s concern is expressed in the Diagnostic and Statistical Manual of Mental Disorders, which lists “often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)” (2000, p. 92) as one of the symptoms of inattention to be observed when diagnosing ADHD.

Teachers know that there may be many reasons why a child doesn’t complete his homework and that many of those reasons have little to do with the child, and often have a great deal to do with the circumstances of the child’s life. Teachers take attribution error into account every day. Unfortunately, when assessing ADHD, the teacher’s role in the assessment process does little to address attribution error and focuses almost entirely on symptoms. Why would teachers consider a child’s circumstances when evaluating a child in class but be willing to ignore a child’s circumstances during the diagnostic process?

3. When you see a symptom associated with ADHD, can you distinguish the cause of the symptom so that you can accurately link the symptom with the cause?

The National Institute of Mental Health (NIMH) notes that “Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD” (2009). But how will a classroom teacher know that ADHD caused the inattentive behavior in class and not something related to some other concern, such as depression, anxiety, substance abuse, or environmental factors? What if teachers are part of an assessment process that labels a child with ADHD, and the child is treated in accord with that diagnosis, but it turns out that the child doesn’t have ADHD but is actually expressing a normal developmental response to growing up with a parent who suffers from depression? The symptom of the two are almost identical, but medicating a child as a way of treating a parent’s condition would be absurd and certainly confusing to the child.

4. How will diagnosing a child with ADHD change how you work with the child in the classroom?

The consensus in the medical profession is that when it comes to treating ADHD, medical interventions are more likely to be successful when combined with behavioral therapy. Behavioral therapy for ADHD requires the active involvement of parents and teachers in any treatment plan. This puts the teacher in a difficult situation. The list of interventions to work with a child with ADHD is substantial, and a teacher’s time is limited. Even if a teacher were working with only one child, it’s unlikely that one teacher could design a program to meet all the needs of a child diagnosed with ADHD. So the question is: If you’re going to be part of a process that labels a child for life, how important is it for you to weigh your responsibilities in treating the child before making that diagnosis? And if you aren’t either able or willing to modify your classroom, your lessons, your instruction, and your behavior to meet the needs of the child, is it reasonable to suggest a diagnosis that requires you to do something you know you will most likely never do? And, again, if neither the parent nor you are able to make a significant commitment to environmental change for the child, asking children to take on the primary role of treating themselves seems exceptionally unrealistic, especially when working with a child who has trouble paying attention and completing his work.

5. How skilled are you at identifying normal behavior and at recognizing “clinically significant” deviations from that norm?

To diagnose a child as having ADHD, the APA states that “There is no ‘cure’ for ADHD,” which means that a child labeled as having ADHD will be tagged with that diagnosis for life. But how will a classroom teacher know that ADHD caused the inattentive behavior in class and not something related to some other concern, such as depression, anxiety, substance abuse, or environmental factors? What if teachers are part of an assessment process that labels a child with ADHD, and the child is treated in accord with that diagnosis, but it turns out that the child doesn’t have ADHD but is actually expressing a normal developmental response to growing up with a parent who suffers from depression? The symptoms of the two are almost identical, but medicating a child as a way of treating a parent’s condition would be absurd and certainly confusing to the child.

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It's important to remember that the same clinicians we've trusted to diagnose and treat millions of our children have no laboratory tests, neurological assessments, or attentional assessments to diagnose whether a child has ADHD, nor do they have evidence to support the belief that ADHD is either a disease or a neurobehavioral condition. What we're left with are highly suspect assessment tools whose validity is based almost solely on the observations of parents and classroom teachers, none of whom are trained to make clinical assessments.

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As teachers we can trace our history to the roots of every culture. Our history is long and grand, informed by millennia of practice and thought. Psychiatry and psychology as unique disciplines are wobbly legged children compared to us. They are professions rich with accomplishment, wonder, and possibility, but they're also riddled with a history of misdirection and sorrow. Some of psychology's great enthusiasts have lead to serious confusion and harm. Phrenology, eugenics, compulsory sterilization programs, and shock therapy all seemed like good ideas at the time. All of them gained popular support, and all of them ended up hurting a lot of people. To the degree that educators supported these practices, the harm they caused was exacerbated.

All teachers have the responsibility to make educational decisions for their students and to question those who might harm them or undermine their professional practice. To relinquish that right or absolve ourselves of that responsibility is shameful. In a recent study designed to assess the knowledge, opinions, and experience related to the diagnosis of ADHD, Vicki E. Snider, coordinator of the Program in Learning Disabilities at the University of Wisconsin-Eau Claire, found that, “Only five out of 13 items were answered correctly by more than half of the responding teachers” (Snider, Busch, and Arrowood 2003). If we don’t know what we’re talking about, we should stop talking; and if the professionals we’re working with can’t do their jobs, they shouldn’t count on us to do their jobs for them. In the end, it is not the job of educators to validate the work of clinicians. It is the obligation of clinicians to persuade us of the credibility of their work — before we give them control of our children or our classrooms.

REFERENCES


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