

AN INTERNSHIP REPORT AND COMPARATIVE STUDY  
OF EDUCATIONAL PSYCHOLOGISTS' PRACTICES  
PERTAINING TO ATTENTION DEFICIT HYPERACTIVITY  
DISORDER IN ST. JOHN'S NEWFOUNDLAND  
AND HARLOW, ESSEX

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AN INTERNSHIP REPORT AND COMPARATIVE STUDY OF EDUCATIONAL  
PSYCHOLOGISTS' PRACTICES PERTAINING TO ATTENTION DEFICIT  
HYPERACTIVITY DISORDER IN ST. JOHN'S, NEWFOUNDLAND AND HARLOW,  
ESSEX

by

Colleen Hickey, B.A.

An internship report submitted to the School of  
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## ABSTRACT

This report outlines an 11-week internship program completed in Harlow, England to comply with regulations set out for the degree of Masters of Education in Educational Psychology. The internship route was chosen by this intern because unique insights are gained and practical training is received through an on-site placement. This report is comprised of three chapters discussing this intern's placement and goals/objectives including rationale, implementation, and evaluation of same. In addition, a comprehensive literature review and an in-depth study of educational psychologists' practices as they pertain to Attention Deficit Hyperactivity Disorder is provided. A semi-structured interview schedule was utilized with four practising educational psychologists in St. John's, Newfoundland and four practising educational psychologists in Essex, England. Responses formed the basis for a comparative analysis. Results indicate that the referral and assessment of ADHD is seen to be ad hoc in both areas. Although the education systems are structured differently, the referral processes lack both structure and procedure. Results also indicate that Newfoundland psychologists rely heavily on standardized assessment tools while British psychologists place more importance on the child's environment. No individual interviewee reported completing a comprehensive battery for the assessment of ADHD. The diagnosis of ADHD is seen as the domain of the medical doctor in both Newfoundland and England. Educational psychologists in both areas feel they should have a greater input into the diagnosis. This non-collaboration



between health, education and psychology is a great concern to educational psychologists in both areas. The creation of a multidisciplinary team and more education are seen as answers for a complete and thorough evaluation of the child and his/her environment.

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# CHAPTER 1

## INTRODUCTION

### Rationale for the Internship

The Master of Educational Psychology programme at Memorial University of Newfoundland offers a very intensive and comprehensive course of study in the theory and practice of School Psychology. The programme is intended to consolidate awareness of psychological and educational theory with the development of professional skills. In addition to course work, the graduate student is expected to complete a research study. There are four possible routes under which this latter requirement can be fulfilled; i.e. thesis, internship, paper folio, and project.

The Graduate Internship route was the option of choice because this intern believed that practical experience was greatly needed. Previous work placements were short in duration and thus limited in scope. This intern hoped to develop professional competencies in the areas of problem-solving techniques, interviewing strategies and assessment protocol, to gain realistic insights in an authentic work site and to acquire research skills (Graduate Students Handbook, Faculty of Education, 1996). The internship route provides the opportunity for independent performance while at the same time offering supervision by on-site personnel. The internship setting fosters the synthesis of theory, research methodology and proficiencies in the area of School Psychology.

Introductions to the work place environment were provided in pre-practicum and

practicum experiences at the Career Information Resource Centre in St. John's and Paradise Elementary School, Paradise, respectively. The Career Information Centre provides a drop-in service to people requiring information on educational institutions offering particular programmes, various funding sources for training and prerequisite courses required for programmes. Help is also provided with resume writing. This Centre also stocks an extensive collection of books on career issues that can be borrowed by patrons.

Placement at Paradise Elementary school was very different from that experienced at the Career Information Resource Centre. Clients were school-aged children with a plethora of problems such as school anxiety, behaviour problems and low self-esteem, to name a few. Supervision of the intern was provided by the staff guidance counsellor. Initially, this intern's role was to assist the guidance counsellor and later to conduct personal counselling sessions and complete assessments. A parenting group was also organized and later co-facilitated by this intern in the evenings.

### The Internship Setting

The internship component of the Master of Educational Psychology program began on April 29, 1997 and extended for a period of 11 weeks. Approximately four days a week were spent at the work site while one day was reserved for research.

The setting for the internship placement was the West Essex Psychological and



Assessment Service located at Bray's House, Traceys Road in Harlow, England. The Psychology and Assessment Service in Harlow houses personnel from the Local Education Authority, the Multi-Disciplinary Behaviour Support Team, educational psychologists, and administration staff. The primary role of the Educational Psychology Service is to carry out the mandate of the Department of Education. They provide specialized help for school-aged children with special educational needs.

Supervision was provided by Mr. Allan Fuller, Senior Educational Psychologist. During the placement this intern had the opportunity to accompany and later collaborate with five educational psychologists: Mr. Allan Fuller, Ms. Ann Ricketts, Ms. Sara Day, Mr. Tony Murphy and Ms. Patricia Athey. All had completed graduate training in the area of Educational Psychology and have extensive experience working within the Local Education Authority (LEA). The LEA is responsible for identifying students' needs, devising an action plan to meet these needs and acquiring suitable arrangements for children with unique educational requirements.

The decision to travel to England to complete the graduate internship component was based on the professional goals of this intern. The opportunity to study in England was seen as a chance to develop and broaden competencies in the School Psychology field. For example, relevant literature states the educational psychologists in England place great emphasis on informal assessment. This is in contrast to North American psychologists who appear to rely much more heavily on formal testing (Cooper, 1996).

Exposure to the differences in ideologies was expected to provide a valuable learning experience. In addition, the research interests held by this intern could be accommodated through a comparative analysis of the Newfoundland and Essex School Psychology systems.

### The British Code of Practice

Professional competencies were developed and broadened as a result of this internship. This intern became familiar with the workings of the British education system as well as the roles and responsibilities of an educational psychologist within that system. The Code of Practice on the Identification and Assessment of Special Educational Needs is a very important document within the British education system. This legal document provides guidance to Local Education Authorities and school governing bodies on their responsibilities towards children with special educational needs. The Code is a progressive model. Stages 1, 2 and 3 relate to the school-based assessment. Placement at Stage 3 indicates that a student is having persistent and profound difficulties. Movement to Stage 4 involves consultation with the child's parents and the educational psychologist. At this point, schools submit evidence of the special educational provision made at Stages 1, 2 and 3 (Essex County Council, 1996, p. 2). Stage 4 is the statutory assessment by the LEA. Stage 5 relates to the issue and maintenance of a statement of special educational needs.

A statement is a listing of the student's special educational needs and a summary of the plan that is required in order to meet these needs. This is somewhat similar to an Individual Education Plan (IEP). Each successive stage involves more intensive assessment and increasingly earnest support provisions for the pupil. Specific placement criteria determines a student's progress from one stage to the next. Most children will have their needs met in the first three stages. This occurs in the school and, if the action taken is successful, will not proceed beyond the first three stages. If the Educational Psychologist determines that a child should be placed on Stage 4, the case is brought before an initiation panel. This panel is comprised of educational psychologists who discuss individual cases and determine if a statement is warranted. Statutory assessment is a very detailed examination of a child's strengths and difficulties. Yearly reviews examine progress made by the child and possible amendments to the Statement (Department of Education, 1994). Attendance at meetings of initiation panels to discuss statementing and statutory assessments was very informative for this intern. A greater understanding of the statementing and statutory assessment process was gained. As well, the role of the educational psychologist within this system was clarified.

### Supervision

Mr. Allan Fuller provided this intern with on-site supervision for the 11-week internship. Periodic meetings were held with Mr. Fuller to discuss adherence with stated

goals and objectives of the placement. As well, meetings with Mr. Fuller comprised of discussions concerning case reviews, internship experiences and day to day concerns and occurrences experienced by this intern.

Periodic meetings were held with Dr. Linda Phillips at the work site. On two occasions this intern met with Dr. Phillips and Mr. Fuller to discuss the placement and clarification of internship guidelines. This intern and Dr. Phillips also discussed concerns and other related topics.

Consultations with Dr. Patricia Canning via E-mail continued periodically throughout the duration of the internship. Valuable support and guidance was abundantly provided to this intern by all who were involved.

## CHAPTER 11

### GOALS AND OBJECTIVES

#### Rationale

The ultimate goal of any internship in the field of School Psychology is to provide the intern with an opportunity to develop professional skills, competencies and knowledge. An Educational Psychologist working in today's society must have a broad knowledge base in a great many areas. This intern desired to gain experience particularly in the areas of consultation, assessment procedures, test analysis, and report writing. The opportunity to learn about childhood disorders and to work with children directly added greatly to the decision to undertake the internship route. An internship provides one with a unique opportunity to accompany and later model a professional in the field. Functioning as a School Psychologist within the West Essex Psychology and Assessment Centre exposes one to the vast and varied roles of the professional within the British educational system. Such roles include problem solver, bureaucrat, consultant, trainer, counsellor, researcher and assessment personnel. Guidance is readily available from an on-site supervisor as well as the consultation opportunities with other experienced psychologists. Professional competencies and confidence are achieved through constructive feedback on performance. Over time, independence is the ultimate goal. The full range of responsibilities and activities are experienced in an authentic setting allowing

for professional and personal development of the intern. The internship experience was guided by the following goals and objectives.

### Goals and Objectives

#### Goals of the Internship

1. to develop skills and competencies necessary for proficient performance in the profession of School Psychology.
2. to develop consultation skills through working with parents, teachers, professionals and outside service agencies.
3. to increase personal knowledge and understanding of the various disorders/disabilities encountered by a School Psychologist.
4. to further develop skills in the use of formal and informal assessments.
5. to develop an understanding of the assessment process as it relates to school-age children.
6. to develop proficiency in test analysis and report writing.
7. to gain experience working with students at the primary/elementary and high school levels.
8. to develop an understanding of the English education system and particularly the role of the Educational Psychologist within that system.

### Objectives of the Internship

1. to accompany and assist a School Psychologist with work-related duties for several weeks .
2. to experience the work environment by interacting with other personnel.
3. to administer necessary assessments.
4. to develop proficiency in observational assessment.
5. to maintain a personal journal and time log.
6. to compile a resource inventory.
7. to become familiar and make contact with personnel from notable outside agencies.
8. to complete the research component of internship.

### Implementation of Goals and Objectives

The implementation of the aforementioned goals and objectives was realized through a series of stages. Prior to this intern's arrival in England, management of the Psychology and Assessment Service (PAS) held preparatory meetings with all educational psychologists working in the main office of the PAS. Individual psychologists were asked to tentatively schedule times when this intern could join in the performance of duties. The first two to three weeks consisted of introductions to schools included in the catchment area. This intern became acquainted with many school principals, Special Education Needs Co-ordinators (SENCOs), classroom teachers, students, and parents. This intern

was also provided with many opportunities to observe the individual psychologist's assessment skills, interview techniques, consultation procedures, and evaluation methods. Initiation into the British education system and the insights gained into roles of psychologists within the system proved very valuable.

During the next four to five weeks, this intern participated jointly with individual psychologists on such specific duties as the administration of assessment protocols, the relay of information to parents/school and the writing of psychological reports. The relationship changed in that the intern worked more independently as time went on. Assessments were carried out under the supervision of the Educational Psychologist. Afterwards, in-depth discussions of facets of the case and performance issues took place. Feedback from the psychologist proved invaluable.

During the final weeks of the placement, this intern assumed responsibility for seven cases. Sole responsibility was assumed for the scheduling of meetings, assessments and consultation sessions. Psychological Advices Reports and School Summary Reports were completed under the direction of the supervising Educational Psychologist. Psychological Advices Reports are written summaries of individual cases. They list problem areas for a particular child and a description of assessments completed. Aims and suggestions are provided. These reports are later shared with school personnel and the child's parents. School Summary Reports are completed by educational psychologists after school visits. The report provides a concise synthesis of meetings, assessments



undertaken and action plans arising from the visit. This report is sent to the school as well as placed in the student's file.

The goal of this journey through the many weeks of the internship was the development and eventual achievement of competencies in all areas of school psychological practice.

### Evaluation of Goals and Objectives

The goals and objectives for this internship were devised under the direction of the academic supervisor and agreed upon by the field supervisor. During the internship placement, this intern met with Mr. Allan Fuller twice to review all goals and objectives to ensure all were being met. As well, constructive feedback, guidance, support, advice and evaluation were provided by the educational psychologists. Supervision by a professional was readily available. This intern found the working relationships and lengthy discussions with individual psychologists to be very informative and valuable. This intern achieved all goals and objectives outlined in the original proposal.

By virtue of a three-month work placement, there was exposure to many schools with diverse student populations. This intern observed and participated in a variety of assessments, both formal and informal. Formal batteries included the British Ability Scales, Wechsler Objective Language Dimensions (WOLD), the Wechsler Objective Numerical Dimensions (WOND) and the Wechsler Objective Reading Dimensions

(WORD) while informal assessments consisted of interviewing and classroom observation. Casework also included many meetings with school principals, SENCOs, teachers and parents. Consultation skills improved as a result of these meetings and discussions held with outside agencies, e.g., doctors and other personnel at Child and Family Consultation Services (CFCS), a multi-disciplinary agency dedicated to the care and support of children and families.

This intern practised skills in the areas of test analysis and report writing under the guidance of the principal educational psychologist. Exposure to many types of learning disabilities (e.g., Dyslexia, Auditory Processing Difficulties), physical impairments (e.g., Spina Bifida, Down Syndrome), emotional/behavioral difficulties (e.g., ADHD, Depression) and a variety of other disorders (e.g., Anorexia Nervosa, Bulimia) proved to be very educational. This intern worked closely with pupils from pre-school to senior high in mainstream and special needs schools. Visits to the Pupil Referral Unit (PRU) were also included. The PRU is an off-site unit which provides advice and support for pupils with behaviour difficulties in secondary schools (11-16 years). If there are persistent problems a student can be placed in this facility for a period of no more than two terms. During this time, intensive help is provided. Psychological Advices Reports and School Summary Reports were completed adding to the experience gained in writing assessment reports.

The intern was expected to participate in educational service days. Topics of such

meetings included Solution-Focused Brief Therapy and Equal Opportunity for Disabled Persons. During the last week of the placement, this intern was asked to present at a two-day conference that reviewed the various research projects undertaken by professionals working within the Essex Educational Authority. A discussion concerning the roles of an educational psychologist in Newfoundland was conducted by this intern at the conference for it was felt by the internship supervisor that British educational psychologists would find the topic informative and interesting. This intern also presented research in the area of ADHD.

## CHAPTER III

### THE RESEARCH COMPONENT

#### Introduction/Literature Review

##### The Nature of Attention Deficit Hyperactivity Disorder

According to Reid, Maag & Vasa (1993), " Not since the establishment of learning disabilities as a special education category has a condition so captivated both the professional community and general public as Attention Deficit Hyperactivity Disorder" (p. 198). The intense spotlight directed towards the disorder has induced many to unconditionally accept claims and assumptions as scientific fact in areas where no such evidence exists (Reid et al., 1993). ADHD represents one of the most common reasons children are referred to mental health practitioners in the United States. It is one of the most prevalent childhood psychiatric disorders in the United States (Barkley, 1990). Prevalence statistics range anywhere from 1% to 20% of the school age population in relevant literature (Szatmari, Offord, & Boyle, 1989). Quoted figures greatly depend on how one chooses to define ADHD, the population studied, the geographic locale of the survey, and even the degree of agreement required among parents, teachers and professionals (Barkley, 1990). Since ADHD cannot be rigidly defined and directly measured, the disorder's true incidence rate cannot be accurately determined. The

consensus of opinion, however, seems to be that approximately 3% to 5% of the U.S. childhood population has ADHD (American Psychiatric Association, 1994).

ADHD is a psychiatric diagnosis. Children and adults suffering from the disorder experience profound social and cognitive impairments in crucial sectors of their lives. Such areas include school, work and personal relationships. These difficulties can be linked to problems of impulse control, hyperactivity and attentional deficits (Barkley, 1990).

ADHD is a continuum disorder (Lyon, 1996). Children fall on all points of the activity, attention, and impulsivity spectrum. It is when these behaviours are excessive, pervasive and affecting the child in his/her environment that Lyon says ADHD should be considered as a possible diagnosis. This judgement, however, leaves a great deal of room for speculation and subjective conclusions.

Although disorders similar to ADHD have been discussed in relevant literature for over 30 years, the American Psychiatric Association coined the term Attention Deficit Disorder with or without hyperactivity in the Diagnostic and Statistical Manual 11 (DSM-11)(American Psychiatric Association, 1968) in 1980. According to the 1994 version of this manual, the DSM-IV (American Psychiatric Association, 1994), a total of eighteen characteristics are described under the headings inattention (nine symptoms) and hyperactivity-impulsivity (hyperactivity-six symptoms, impulsivity-three symptoms). A child will be diagnosed with ADHD when a minimum of six characteristic symptoms are

exhibited (See Appendix A for the full DSM-IV description). A diagnosis of ADHD requires that i) symptoms persist over a period of six months to such an extent that behaviour is considered maladaptive and developmentally incompatible; ii) symptoms be present before age 7; iii) clear evidence exist that symptoms significantly interfere with social, academic or occupational development and functioning; iv) symptoms be present in two or more settings (e.g. school (work) and home); and v) symptoms are not attributable to either a psychotic disorder (e.g. Schizophrenia) or other mental disorder (e.g. Personality Disorder).

Children suffering from ADHD are a diverse group. Generally, they differ in three main areas: symptom severity; pervasiveness of symptoms across situations and the degree of comorbidity with other disorders (Barkley, 1990). Inability to sustain attention in activities may manifest itself in the following behaviours: distractibility; inability to follow directions; difficulty with commencing and terminating work; disorganization and forgetfulness. Hyperactivity is evidenced in the high levels of fidgeting, inappropriate movement around a room and extreme talkativeness displayed by such children. Impulsivity is seen in the constant interruption of others' conversations and an inability to wait one's turn.

Erk (1995) describes ADHD as a life-altering condition. Persons with ADHD suffer academically, professionally and emotionally. As a consequence of symptoms, many experience school failure and poor peer relationships. Self-esteem is often

jeopardized. Depression may become chronic while abuse of alcohol and drugs becomes commonplace in later life. The prognosis for untreated ADHD for a child or adolescent is, at present, not promising. Erk advises that within this population of individuals there are frequent job changes and losses and extended contact with mental health and/or criminal justice agencies.

According to Goldstein (1996), "ADHD results from the inadequate, inconsistent or ineffective use of a variety of skills to meet the expectations of the classroom, family or social milieu. This is very clearly a disorder of inconsistency rather than out-right inability" (p.5). Families, peers and teachers of individuals with ADHD find this inconsistency and unpredictability very discouraging. They experience great frustration in attempting to control negative behaviour. Many family members may withdraw in an attempt to avoid conflict. In this arena of appeasement, aggressive and delinquent behaviours persist. Goldstein states that many researchers now view ADHD as a performance disorder. They believe that positive and competent behaviours can be molded by the correct and appropriate blend of reinforcers.

Barkley (1990) declares that

ADHD consists of developmental deficiencies in the regulation and maintenance of behaviour by rules and consequences. These deficiencies give rise to problems with inhibiting, initiating, or sustaining responses to tasks or stimuli, and adhering to rules or instructions, particularly in situations where consequences from such behaviour are delayed, weak or nonexistent. The deficiencies are evident in early childhood and are probably chronic in nature. Although they may improve with neurological maturation, the deficits persist in comparison to same-age normal children, whose performance in these areas also improves with development. (p.71)

The nature of ADHD remains a mystery. There are so many unanswered questions that a thorough assessment of ADHD is very complex and diverse. Although researchers have devised a thorough battery of testing, the value of some tools have been questioned by many in the field.

#### The Assessment of Attention Deficit Hyperactivity Disorder

Rogers (1996) states that a thorough assessment of ADHD should include the following:

- i. clinical history
- ii. parental interviews
- iii. teacher interviews
- iv. parental rating scales
- v. teacher rating scales
- vi. psychometric evaluation
- vii. tests for coordination and motor ability
- viii. cognitive testing
- ix. physical examination, including vision and hearing
- x. direct observation; home and school



Lerner & Lerner (1991) advise that a review of school records and peer assessment should also be included in a thorough assessment battery. Brown, Keene, & Middleton (1994) found that the diagnostic methods most commonly employed by a sample of child psychologists, school psychologists, family physicians and pediatricians in the assessment of ADHD in children were interviews and behavioral observations. This latter tool would include the use of behaviour rating scales. Rating scales, such as the Connors Teacher Rating Scale (Connors, 1969) and the Child Behaviour Checklist (Achenbach & Edelbrock, 1983) are a cost efficient way to obtain information from several informants. The Connors Teacher Rating Scale is a 39-item instrument which includes such factors as hyperactive, inattentive-passive and conduct problem factors. Erford (1995) found adequate to good internal consistency of factors ranging from .87 to .94 within the Connors Teacher Rating Scale. Barkley (1990) found only adequate test-retest reliability. Atkins & Pelham (1991) state there is evidence to indicate that teachers can distinguish between children displaying symptoms of ADHD and those without symptoms. This may be due to the fact that teachers have sex and age appropriate comparisons readily available in the classroom.

Several researchers, however, report problems with the use of rating scales. Reid et al. (1993) state "There is no valid cut off point on a behaviour rating scale that empirically identifies a student as having ADHD" (p.201). Researchers such as Reid & Maag (1994) ask "what is a fidget?" To what standard does one determine excessive

talking and significant amount of interruptions. Both behaviours have been used in various rating scales to determine the existence of ADHD. Such adjectives as excessive, significant and even the word fidget are not operationally defined.

Spenciner & Cohen (1995) report a "lack of technical adequacy" with assessment tools in general. They explain that commonly used tools are neither precise nor accurate in an ADHD diagnosis. Raggio, Rhodes & Whitten (1994) supports this claim by stating that the tools and criteria used in the diagnosis of ADHD are not stringent enough to warrant a label of ADHD. Most instruments contain ill-defined descriptors such as never, seldom, occasionally, often or frequently. Searight, Nahlik, & Campbell (1995) further add that "halo effects" may contribute to application of the labels "very good" or "very bad." Goldstein (1994) states "Evaluation of these symptomatic problems is complicated because there is no litmus test for ADHD" (p.111). Professionals must rely on imprecise, subjective and culturally-based assessment tools to identify a medical problem.

Sabatino & Vance (1994) declare that attention deficit disorders have become "parent and school championed disorders" in North America. They feel that high inter-rater reliability scores on rating scales ( $r=.83$ ) between parents and school personnel indicate collaborative reporting and evaluations, not evidence for the adequacy of assessment tools. Sabatino & Vance stated their belief that parents and teachers, together, determine appropriate classroom behaviours. They also reported that parents and teachers most often complete the evaluations during periods when the child is behaving poorly.

Good and bad periods are not given equal weight. This result indicates a lack of standard observation procedures which would allow the determination of a range of behaviour.

The DSM-IV-R was used in this study.

### The Complexity of Attention Deficit Hyperactivity Disorder

At present, there is no single theory to explain ADHD. The manifestation of symptoms appears to be caused by an interaction of various factors. Schwiebert, Sealander, & Tollerud (1995) listed the following factors: brain damage; poor or inadequate prenatal nutrition and care; maternal alcohol or drug consumption during pregnancy; malnutrition; abusive home environments; genetic factors; high levels of stress; food additives or allergies; and physical, neurological, or psychiatric conditions. Barkley (1990) has asserted that heredity or the nature aspect of the condition is more prevalent than the environmental or nurture side. Searight et al. (1995) discussed two current trends of research in the etiology of ADHD. The first area of research concerns deficits in the frontal cortex of the central nervous system. Deficits in these specific areas have been posited as a cause for ADHD due to positive results using neuropsychological testing. The second promising area of research deals with the effect stimulant medication has on the neurotransmitters dopamine and norepinephrine. Children's positive response to stimulant medication lends credence to the theory that these neurotransmitters have a causal effect.

Some social critics have challenged the existence of a disorder known as ADHD since it cannot be diagnosed using concrete, scientific methods. Reid & Maag (1997) state "Conceptually, ADHD is a tautological disorder- children have ADHD because they exhibit a certain number of behaviours and they exhibit the behaviours because they have ADHD. Thus ADHD literally defines itself- the symptoms are the syndrome" (p. 12). An individual's behaviour is measured somewhat by social norms. Anderson (1996) states that critics believe hyperactive and impulsive behaviour is the sole result of permissive parenting. The label ADHD is nothing more than the transference of guilt onto an unknown medical entity. The lack of scientific proof is seen as validation.

Controversy abounds concerning the exact relationship or connection between ADHD and learning disabilities (Searight et al., 1995). It is not known whether ADHD coexists with learning disabilities; ADHD exaggerates an existing problem; or is a learning difficulty in and of itself. In cases where ADHD and learning problems exist together, both may possibly be linked by a speech or language disorder (Connor, Epting, Freeland, Halliwell, & Cameron, 1997). It is estimated that approximately 20% of children with ADHD exhibit a learning disability in reading, spelling and mathematics (Searight et al., 1995).

Research in the U.S.A. shows that children with ADHD are predisposed to other emotional and behavioral difficulties that may not be directly related to ADHD, but may negatively affect learning and adjustment. Searight et al. (1995) estimate that

approximately 40% of children with ADHD and 65% of adolescents with the disorder exhibit symptoms of Oppositional Defiant Disorder. Between 21% and 45% of children and 45% to 50% of adolescents with ADHD meet the diagnostic criteria for Conduct Disorder. (See Appendix B for the DSM-IV diagnostic criteria for Conduct Disorder and Oppositional Defiant Disorder). Comorbidity is a pivotal factor when discussing the controversy surrounding ADHD. It is often extremely difficult, if not impossible, to differentiate the disorder from others in terms of etiology and symptomatology (Reid et al., 1993).

More boys than girls are identified as having ADHD. Lerner & Lerner (1991) quote studies that estimate the ratio of boys to girls is 2:1 to as high as 8:1. Although many of the clinical characteristics are similar between males and females, some differences do exist. It has been found that girls display greater cognitive, language and social deficits (Barkley, 1990). Boys with ADHD manifest greater physical aggression and loss of control (Barkley, 1990). The reasons for such discrepancies are unknown but a number of hypotheses have been formulated. Biology and/or cultural conditioning may play a part (Barkley, 1990). Classroom referral patterns show that boys are disciplined more often because of disruption. Traditionally, boys feel great pressure from their environment to succeed. As a result, they may exhibit signs of stress. Girls, on the other hand, are culturally conditioned to be subservient and quiet. The value placed on education for females is less when compared to males. Girls often exhibit signs of

daydreaming in the classroom which does not demand attention from the class teacher.

Due to their particular behaviours, girls with ADHD may be an unidentified and underdiagnosed group.

### The Diagnosis of Attention Deficit Hyperactivity Disorder in North America and Great Britain

The diagnosis of ADHD should be a best estimate diagnosis according to Schaughency & Rothlind (1991). Sabatino & Vance (1994) believe that ADHD is overdiagnosed in North America. Support for this claim is derived from the difference in prevalence rates between North America and Great Britain. It is reported that British psychologists employ the International Classification of Diseases (ICD-10) where the term Hyperkinetic Disorder is listed. The terminology is considered parallel by British psychologists although writings on the subject lead the reader to believe that professionals differentiate between the terms. (See Appendix C for the ICD-10 description of Hyperkinetic Disorder). As stated earlier, it is estimated that 3-5% of the school-aged population in the United States suffers from ADHD. The extremely high rate of diagnosis for ADHD that is found in North America is not present in the English population. Taylor (1987) estimates that there is as much as a twentyfold difference in the United States and Great Britain in the diagnosis of hyperactivity. In the United Kingdom, prevalence statistics show approximately .1% of the school population suffer from Hyperkinetic

Disorder.

The literature indicates that the United States and Britain use different diagnostic criteria to determine the presence of ADHD. Although the terms ADHD and Hyperkinetic Disorder may be used interchangeably, the understanding as to whom the terms are applied differs greatly. Anastopoulos, Barkley, & Shelton (1994) state that, in England, a child who displays developmentally extreme levels of inattention, impulsivity, and/or hyperactivity may receive a diagnosis of Hyperkinetic Disorder or Conduct Disorder while in the United States the same child would receive a diagnosis of ADHD. The ICD-10 requires widespread inattention and restlessness across situations (home and school), behaviours persistent over time which can be demonstrated by direct observation and are not caused by other disorders such as autism (Roth, 1994). British psychiatrists tend to reserve the term "hyperactive" for a very small group of neurologically abnormal and impulsive children. These cases are the primary domain of medicine. Less severe cases, comprising of more general maladaptive behaviours, are treated as a psychosocial problem. In North America, the term hyperactive is commonly used to describe overactive children. One need not be neurologically abnormal. The scope defining maladaptive behaviour is much more encompassing. Behaviours described as maladaptive in Great Britain may be viewed as symptomatic of ADHD in North America and therefore a medical problem.

Reid & Maag (1997) report that the differing diagnostic standards and practices of

the ICD-10 and DSM-IV are becoming increasingly congruent. However, diagnostic agreement between American and British clinicians remain low even when identical criteria are employed. Reid & Maag point to deeply rooted cultural differences to explain the differing views and therefore the different prevalence rates. In the United States, the concept of ADHD focuses solely on characteristics inherent in the individual. In a nature/nurture debate, Americans tend towards the nature side. The widespread use of drugs to control symptomatic behaviour in North America reinforces the notion that the presence of maladaptive behaviour is considered a medical rather than an environmental problem. British professionals believe that both explanations must be considered when assessing for ADHD. Cooper (personal communication, June 1997) states that between 1950 and the 1970s, there was a conscious effort on the part of British educational psychologists to de-medicalise special education. There was a general rejection of the medical model. British psychologists favour a model that emphasizes the importance of social and other environmental influences. Cooper stresses a combined educational-medical approach to ADHD ".....whilst biology may create propensities for certain social and behavioral outcomes, biology is always mediated by environment and culture" (Cooper, 1997, p.37).



### Rationale

This intern decided to research ADHD because of the amount of controversy which surrounds the disorder and the plethora of unanswered questions and uncertainties which abound. One of the key problem areas in ADHD concerns the unknown etiology of the disorder. Behaviours such as inattention and hyperactivity may have many causes. ADHD cannot be diagnosed using concrete, scientific methods but must be assessed using "intangible" psychological methods. Such testing is seen to be inconclusive because of imprecise measurements. Many professionals involved in the assessment of ADHD use checklists and rating scales which are often viewed as ill-defined and subjective (Reid & Maag, 1994; Spenciner & Cohen, 1995; Sabatino & Vance, 1994; Raggio et al., 1994). In Canada and the United States, many experts question the validity and reliability of standardized testing which is heavily utilized in both countries. They are not satisfied with a best estimate diagnosis.

Another area of confusion concerns the comorbidity factor and the exact relationship between ADHD and learning disorders such as problems with reading, spelling and mathematics (Connor et al., 1997). It is also well documented that ADHD is very similar to, and hard to differentiate from, Conduct Disorder and Oppositional Defiant Disorder (Searight et al., 1995). How can one be sure of the diagnosis when different disorders are so similar in symptomatology and with no concrete means to assess?

The last area of interest for this intern is how gender is related to ADHD. The

ratio given in relevant literature is 2:1 or as high as 8:1 boys to girls (Lerner & Lerner, 1991). Why is this so? Although there have been hypotheses formulated such as the male tendency toward aggression versus the female inclination toward daydreaming behaviour, answers have not been forthcoming.

The number of children being diagnosed with ADHD has been described as epidemic in North America when compared to the relatively low numbers in Great Britain (Taylor, 1987). Although differences in classification systems and assessment techniques do exist between North America and Great Britain, these discrepancies are not believed to fully explain the vast differences in prevalence rates. The literature would lead one to believe that British professionals advocate and practice the biopsychosocial approach to explain a child's successes or failures. It is documented that North Americans, however, rely greatly on the medical model to identify a problem or disability that could be offered as explanation for school-related problems (Ideus, 1994). The differences in approaches are expected to influence the referral, assessment and diagnostic procedures surrounding ADHD.

It is not within the scope of this report to examine each area of controversy surrounding ADHD. The complexities of the disorder were discussed in the literature review to highlight the many unanswered questions that remain to this day. Since educational psychologists are intimately involved in the psychological services schools provide to children, this intern wished to focus in on and examine the level of

understanding educational psychologists in Newfoundland and England possess in the area of ADHD and to observe how educational psychologists in both areas managed referrals, completed assessments and diagnosed ADHD. Through the practical component of the Master of Educational Psychology program, opportunities would exist to study the referral, assessment and diagnosis of ADHD of two School Psychological services. As well, how both groups differ in their understanding of the concept of ADHD was examined. The differences and similarities in these two types of services were investigated and a comparative analysis conducted.

## Method

### Sample

Eight educational psychologists participated in this study. Four were employed with the Psychology and Assessment Centre at Traceys Road, Harlow, Essex, England and four were employed with the Avalon East School Board located on Water Street, St. John's, Newfoundland. All are fully qualified within their field holding a Master's degree in Educational Psychology. They are professionals who have an active and diverse caseload. There were two males and six females.

In order to ensure the anonymity of the interviewees, the sample from Newfoundland was given the descriptives Psychologists NF1, NF2, NF3, and NF4. The

Educational Psychologists from Essex were given the descriptives Psychologists UKA, UKB, UKC, and UKD.

### Procedure

The Faculty of Education Ethics' Review Committee issued permission for interviews to be conducted with educational psychologists in Essex, England and St. John's, Newfoundland. A list of 15 interview questions was devised to be used in a semi-structured interview with eight psychologists. The questions were formulated by this intern and approved by the internship supervisor. Interviews were conducted with British psychologists throughout the months of June and July, 1997. This intern, while working at the Psychology and Assessment Centre in Britain, established many contacts with professionals associated with the office. This intern was approached by two psychologists who communicated their awareness of the research project being undertaken and expressed a willingness to participate. During this initial meeting, both psychologists were advised that their participation was completely voluntary. It was also made known to them that the interviews would be audiotaped. Times and dates for the interviews were arranged, assurances of confidentiality were provided, and consent letters were reviewed. The remaining two Educational Psychologists were referred to this intern by the on-site supervisor. He advised that two qualified psychologists within the Essex Local Education Authority held a particular interest and knowledge in the area of Attention Deficit

Disorder and had expressed an interest in becoming part of the study. Through telephone conversations with these individuals, dates and times for interviews were confirmed as well as informed consent issues discussed. The assurances of confidentiality and voluntary participation were again provided. All interviews with British psychologists were conducted at the Psychology and Assessment Centre in Harlow. Consent letters were signed at the time of the interview. (See Appendix D)

This intern contacted the Department of Education and obtained a listing of educational psychologists employed with the Avalon East School Board in St. John's, Newfoundland. Four Educational Psychologists from this board were contacted via telephone. All contacted agreed to participate. A brief explanation of the focus of the research was provided as well as approximate time needed for the interview, the provision of audiotaping, assurances of confidentiality and voluntary participation. Dates and times for interviews were established during the telephone conversation. All interviews were conducted in the offices of the respective Educational Psychologists. Consent forms were signed on site. (See Appendix D)

The interviews were approximately one hour in length. Each interviewee was presented with the standard set of questions. Audiotapes were transcribed after the interviews and later destroyed.

### Interview Questions

A 15-item question list was devised by this intern for use in this study (See Appendix E). The focus of these questions was determined after much research on the topic of ADHD. The questions were provided to this intern's supervisor who approved their use within the study. The questions surround four main areas: (1) general category outlining classification, characteristic features and observable behaviours of the disorder; (2) the referral process addressing procedure, consistency, efficiency and future changes as they pertain to ADHD; (3) the assessment process examining procedure, utilization of formal and informal tools, as well as efficiency, consistency and future changes; and (4) the diagnosis of ADHD which reviews classification systems and professional involvement.

### Results and Discussion

The research question considered by this intern was 'what differences exist in the understanding of the nature of ADHD and in the referral, assessment and diagnostic practices in the educational systems of Essex, England and St. John's, Newfoundland?' This research question determined the focus of all interviews. A summary, comparative analysis, and a discussion of the implications of findings are presented. The findings form the basis of a comprehensive protocol that will allow for a collaborative and cooperative referral, assessment and diagnostic procedure of ADHD.

### General Category

Newfoundland and British psychologists involved in this study appear to have a competent understanding of ADHD. All subjects, in discussion, included the terms attention, hyperactivity and impulsivity. One Newfoundland psychologist, for example, described the disorder as both neurobiological and biopsychosocial. Both Newfoundland and British psychologists use the DSM-IV as the defining reference for ADHD. They utilize the DSM-IV in the identification of ADHD by forming 'behavioral clusters' (UKA) derived from this description. Behavioral clusters are classroom behaviours exhibited by children that are readily identifiable and indicative of ADHD. Examples include excessive talking, moving from seat to seat, and blurting out answers.

No British psychologist interviewed utilized the ICD-10 in their professional practice. This is contrary to literature on the subject where it is noted that the ICD-10 has traditionally been used (Anastopoulos et al., 1994). This sample of educational psychologists appears to be representative of the larger professional population in Essex. Just previous to the beginning of this intern's placement, a professional service day was held dedicated to the topic of ADHD using the DSM-IV descriptive criteria. I was advised by various participants that all psychologists employed by the Essex County Council attended this meeting and all reported using the DSM-IV as the defining criteria for ADHD.

Generally, British psychologists appear to be more aware of the complexity of ADHD. Although NF1 and NF2 discussed the need to search for possible causes of the maladaptive behaviour and the importance of determining the degree to which the inappropriate behaviour is cross-situational, it was the British interviewees who discussed several of the difficulties surrounding the identification of ADHD. For example, UKA noted the problem of comorbidity with Conduct Disorder and Oppositional Defiant Disorder. Searight et al. (1995) estimated that approximately 40% of children with ADHD and 65% of adolescents with the disorder exhibit symptoms of Oppositional Defiant Disorder. Between 21% and 45% of children and 45% to 50% of adolescents with ADHD meet the diagnostic criteria for Conduct Disorder. UKA also addressed the fact that learning disabilities are often present with ADHD, particularly dyslexia. As discussed earlier, Searight and colleagues (1995) noted that approximately 20% of children with ADHD exhibit a learning disability.

The tautological nature of ADHD was another difficulty surrounding the identification of ADHD discussed by British interviewees. UKD remarked "They (professionals) are tending to look for the condition and therefore they're looking to find aspects of the child's behaviour that nice and neatly fit." This comment is in accordance with Reid & Maag (1997) who profess that one must be cognizant of this bias.



### Referral Process

Both groups of educational psychologists described three routes which could be pursued when referring a child suspected of having ADHD. According to all interviewees, the choice of referral route for ADHD is ad hoc. NF1 stated there is no policy in place at the board level on where or how to refer children with ADHD both within the education system and beyond. It is a commonly held belief by educational psychologists in Newfoundland and England that a doctor is needed for confirmation of suspicions for a diagnosis of the disorder. Although it is not written in policy, the professionals carry out the practice of referring to doctors even though it is not necessary by education standards. It would appear that educational psychologists either do not realize they can state in reports that a child suffers from ADHD or they are unwilling to do so for various reasons.

There are three general routes that may be taken when a suspicion of ADHD exists with a child in Newfoundland. In routes one and three, the pediatrician/family doctor and educational psychologist are in brackets because school personnel and parents may not make a referral to these professionals. The three referral routes are:

- (1) Teacher/parent - guidance counsellor- (educational psychologist)- (pediatrician/family doctor)
- (2) School/parent- pediatrician/family doctor
- (3) Program Planning Team- (educational psychologist)- (pediatrician/family doctor)

(1) Teacher/parent - guidance counsellor- (educational psychologist)- (pediatrician/family doctor)

If a teacher suspects that a child is exhibiting symptoms of ADHD, a referral is made to the guidance counsellor. The guidance counsellor may be on-site full-time or may be part-time for he/she is responsible for guidance duties in several schools within the board. The roles of the individual guidance counsellor and educational psychologist are oftentimes difficult to differentiate. The extent of this overlap varies greatly among schools and individuals. In several schools, a guidance counsellor completes all observations and assessments. Upon receiving the referral, the guidance counsellor will complete classroom observations using standardized forms.

The criteria used to determine if a referral is warranted also varies across the individual schools. The guidance counsellor may or may not refer to an educational psychologist. Psychologists will only be consulted if another opinion is deemed to be necessary; additional teaching personnel is required; or advice is desired in the development of a behaviour program. Severity of aggressive behaviour will also determine if an educational psychologist is consulted. Another reason for requesting a consultation with an educational psychologist is to receive support for a referral to an outside agency. In cases where ADHD is suspected with a child, a report is written to a general practitioner or pediatrician by the educational psychologist.

(2) School/ parent - pediatrician/ family doctor

Similar to England, a parent, independently or in conjunction with the school principal or vice-principal, may consult a pediatrician or a general practitioner if a suspicion of ADHD exists. The school guidance counsellor or the educational psychologist may not be included within this process.

It has been noted in relevant literature that the examination given by medical personnel is very limited (Goodman & Poillion, 1992). Psychologists in this sample said that many doctors are now requiring parents to have assessments completed by school personnel before children are examined by medical personnel because of the vast amounts of referrals that are received.

(3) Program Planning Team -(educational psychologist)- (pediatrician/family doctor)

Policy 2.D.2 of the Special Education Policy Manual (1992) devised by the provincial Department of Education stipulates that "each school district must establish, at the school level, program planning teams responsible for programming and monitoring". The team ensures that appropriate programs are provided for students with exceptionalities in each school. The core team should comprise of the school principal or vice principal, applicable teachers and parents. Depending upon the resources of the school and the special needs of the student others such as the school counsellor, special education coordinator, speech language pathologist, itinerant teacher and educational psychologist may be included. In the case of ADHD, interviewees in this study advised

that Program Planning Teams consisted of the child's parent(s), classroom teacher, child (if old enough), guidance counsellor and possibly the special education teacher. The decision to include the special education teacher and the student is strictly determined by the individual school. When it is suspected that a child suffers from ADHD, the school's Program Planning Team may refer to an educational psychologist thus adding this person to the team. If ADHD is suspected, a report is usually written to a general practitioner or pediatrician for confirmation.

It is left to the discretion of the classroom teacher whether a child will be referred to another professional for further investigation of behaviours. Beyond the three referral routes, there is no policy direction on how to manage ADHD cases.

In the Essex sample, an ad hoc system also exists. Again, there is no clear direction at the departmental level beyond the existing referral routes.

The general British system is set up much differently from the Newfoundland system. There are two primary differences relevant to this discussion. Although educational psychologists in both Newfoundland and Britain have a number of schools in their catchment area which must be serviced, a formula exists in England which calculates the number of visits a school receives by an educational psychologist. This determination is based on student population. No such arrangement exists for educational psychologists with Newfoundland schools. The number of visits an educational psychologist makes is determined on a case by case basis. A second difference concerns the presence or lack of

guidance counsellors in both systems. No guidance counsellors, either part-time or full-time, are placed in English schools.

Again, there are three general routes that may be taken when a suspicion of ADHD exists with a child in Essex. In routes one and two, pediatrician/family doctor and pediatrician respectively, are in brackets because a referral may not be placed with these professionals. The three referral routes are:

- (1) Teacher/parent - Psychology and Assessment Service (PAS)- (pediatrician/family doctor)
- (2) School/parent- general practitioner- (pediatrician)
- (3) Teacher/parent- Child and Family Consultation Service

(1) Teacher/parent - Psychology and Assessment Service (PAS)-(pediatrician/family doctor)

A child may be referred to the PAS by the classroom teacher in conjunction with the parents. The PAS is comprised of educational psychologists who are responsible for a number of schools in a particular catchment area. The role of the educational psychologists is much more structured in the English system than in Newfoundland. If contacted by a school or parent, he/she conducts interviews, various assessment batteries and observations. The Essex Stages of Assessment determine procedure and timing. This can be very restrictive according to UKD. "They (psychologists) are tied to statutory

processes. A school may only have four or five visits in a year. The school may not wish to give up three of those visits so the educational psychologists can see one child."

(2) School/parent - general practitioner-(pediatrician)

Similar to the situation in Newfoundland, school personnel, in conjunction with parents, or parents independently, can contact a general practitioner when the presence of ADHD is suspected with a child. The service that is received is limited according to UKD. "Generally, medical doctors take a clinical history and perform a medical exam. There are no psychometric evaluations, tests for motor coordination, cognitive assessment or direct observation performed. The entire judgement is based entirely on the parents' narrative and possibly a letter from the school (UKD)." The school may not be notified of this referral.

(3) Teacher/parent - Child and Family Consultation Service

The Child and Family Consultation Service (CFCS) is a multi- disciplinary, community-based agency consisting of social workers, educational psychologists, clinical psychologists, psychiatrists, social workers, and community psychiatric nurses. A clinical history is taken and information is requested from the school at the initial presentation. CFCS is structured such that all referrals are discussed at a team meeting. The name of this child is then placed on a waiting list. It is up to the discretion of the professionals listed above which case they choose to treat. The type of treatment, dependent upon type of professional training, is determined haphazardly. CFCS is not the preference of the

educational psychologists interviewed because of the probability that a child will be seen by a psychiatrist. The British interviewees believe that ADHD is often misdiagnosed within this forum because most psychiatrists in England are schooled in psychoanalysis and, therefore, do not believe that ADHD exists. Even through this multidisciplinary route, therapy may be one-dimensional. If a child is treated by a pediatrician, a drug regime will probably be the only course of treatment.

With so many options available, it was not surprising that all psychologists found the referral process to be lacking in consistency and efficiency. "An absolutely cock-eyed system" is the way UKA described the British referral system. NF1 offered two explanations for children not being referred for assessment of ADHD. Firstly, there is no explicit school board policy of what you do with a child suspected of having the disorder. "There is no hard and fast rule for how to refer to outside agencies, to whom you refer and to whether in fact you should refer (NF1)." In not knowing what to do, school personnel become complacent and, as a result, children are being missed. Symptoms are not being identified as ADHD. Secondly, some teachers do not believe the disorder exists. They interpret poor behaviour as the result of poor parenting. They are not knowledgeable of the disorder and thus do not refer. It may be inferred from their inaction that some teachers are promoting poor behaviour in the classroom instead of discouraging it. They may not actively institute strategies for they may not know how or may not believe the tactics to be worthwhile. Adding to the chaos, NF3 believes that

some psychologists are not knowledgeable in the area of ADHD. "Definitions vary with some being looser than others." This response may be indicative of a problem in the professional training of educational psychologists. This problem is compounded for Newfoundland psychologists for they feel that the children's hospital, Charles A. Janeway, is not a preferred referral route because of the lengthy waiting time. There is, on average, a six to eight month waiting list. The Charles A. Janeway hospital is the only children's medical facility in the area.

Analysis of the responses given by the British psychologists shows that they also believe the referral process to be inconsistent and inefficient. UKD noted that some educational psychologists in the north of England do not assess ADHD at all because they define it as a medical problem. All interviewees referred to the ad hoc nature which determines if a school contacts the educational psychologists for a specific case. UKC voiced the concern of the educational psychologists in both Newfoundland and England when it was said "...sometimes they (students) appear with a diagnosis and we have no idea about them." For British psychologists, it is not only disbelieving teachers who hinder efficiency and consistency. The psychoanalytic psychiatrists at the CFCS are also a threat. "For the client, it is a lottery if a diagnosis of ADHD will be made. It is very hit and miss (UKC)." The need for collaboration was a common theme throughout all interviews. With regards to the referral process, Newfoundland and English psychologists wished for greater cooperation between various professionals who may be involved in a



child's case. Such professionals may include social workers, occupational therapists, physiotherapists and psychologists. "This is to ensure that the whole child is addressed as well as to prevent replication of services (NF2)." NF1 expressed a desire for more confidence within education. "We are the ones that collect the information, who know the kid. Medical involvement is needed only if all behavioural interventions have been exhausted. Then, and only then, should doctors be consulted to rule out other conditions and to prescribe medication." The medical profession is not needed for a diagnosis of ADHD according to NF1 and NF4. This comment is interesting because a medical professional was never required for the diagnosis of ADHD. Lack of formal procedures and inadequate training may account for the mistaken belief.

Newfoundland and British psychologists would like to see more streamlining and standardization with regards to referrals so that everyone is following the same procedure. According to NF1, this could never happen because there "...are too many different people with different personalities, different ways of dealing with things and too many people who want to refer everybody and some people who don't want to refer at all." More knowledge and research could be the answer according to UKC. This professional believes in joint training and joint assessments with such professionals as doctors, speech language pathologists and occupational therapists when needed.

### Assessment Process

Similar to the negative responses given in the referral patterns, seven of the eight psychologists responded negatively when questioned about the assessment process. The general consensus was that it is a 'hit and miss' affair (UKA)" because people have different knowledge of the disorder and comfort level (NF1)." NF3 sees a need for an agreed protocol that everyone understands and follows. This should increase consistency and efficiency of assessment and diagnosis. The education of teachers, counsellors, medical personnel and psychologists would greatly aid in the development of a standardized assessment procedure according to NF4.

The assessment of ADHD is seen by all psychologists as an exclusionary process. The assessment involves ruling out all possible explanations for the maladaptive behaviour in order to reach 'probable' conclusions. Yet no psychologists in this sample, either in conjunction with school personnel or independently, completed the comprehensive battery outlined by Rogers (1996) and Lerner & Lerner (1991).

Observation and teacher/parent checklists were the most popular tools in the assessment of ADHD by all psychologists, both in Newfoundland and England. This finding is in accordance with the conclusion drawn by Brown et al. (1994). In conjunction with the aforementioned tools, all Newfoundland psychologists requested visual and auditory batteries as well as a medical examination to investigate alternative causes of behaviour such as hypothyroidism or hyperthyroidism. UKC and NF4 believe all

educational psychologists use observation, attainment records and histories from school and parents. Neither discussed other possible testing tools. Individual psychologists completed additional testing such as the analysis of work samples (NF1); memory testing (NF3); and assessment of motor difficulties (NF2). Such variation in testing tools denotes lack of protocol, knowledge and training of educational psychologists.

Newfoundland professionals favour the quantification of behaviour and academic achievement. All four Newfoundland psychologists utilized intellectual and achievement testing as compared to only two British interviewees. For the latter group, the execution of cognitive testing was not necessarily standardized. Often, subtests and their contents were given in a non-specific order. On other occasions, some subtests were not given at all. Newfoundland psychologists complete such testing to determine the existence of a learning disability.

Cooper (personal communication, June 1997), in discussing the de-medicalisation of special education in Britain, stated that social and other environmental influences were considered pivotal in any investigation by a British educational psychologist. This declaration was reaffirmed by the findings of this study. The British psychologists favoured not only the tools of observation and checklists, but also utilized such instruments as family drawing, investigation of learning styles and determination of parenting issues to distinguish ADHD symptoms from other possible explanations.

UKB discussed the apparent ineffectiveness of the assessment tools. "There is a

nasty tendency for ADHD to be a catching disease so you tend to get local outbreaks."

NF3 termed this phenomenon 'tissue box effect'. UKB expressed concern over the mistaken belief that a diagnosis will make the situation clearer and thus easier to treat.

"People want to move swiftly toward a diagnosis or an agreement. They don't necessarily think very carefully about how you might carry out an assessment at the time." NF3 and UKB again expressed concern with the diagnostic method utilized by medical personnel.

Educational psychologists say that doctors base judgements on parent narratives and a 15-minute behavioural observation. They said that the diagnosis of ADHD made by the general practitioner is based on extremely thin evidence.

Newfoundland and British psychologists differed when asked about the efficiency of the assessment for ADHD. Professionals in St. John's stated that the system is as efficient as it can be. NF2 said, "If we could come up with something better, I guess that we would have developed it by now." "I don't think there is an ADHD test. I think we have to learn to read our data and be very careful and cautious (NF3)." Newfoundland psychologists are satisfied with the tools available but understand that they are only valuable if interpreted correctly. British professionals on the other hand, believe the assessment of ADHD to be nonreliable and inconclusive.

All psychologists in both Newfoundland and England stressed the need for greater cooperation between the disciplines. "There should be easier and open channels of communications between any and all professions involved with the welfare of a child

(UKD)." A 'centralized multidisciplinary team' may be the answer according to UKD.

UKA stated that closer consultation with pediatricians, child neurologists and family therapists will greatly enhance the efficiency of ADHD assessment.

### Diagnosis

As educational psychologists working within their respective education systems, all interviewees report a positive collaborative working relationship existing with school personnel. There is easy access and a free exchange of ideas and information. However, this situation does not exist when one refers to outside agencies. Psychologists in both England and Newfoundland all emphasize the role of the doctor in the diagnosis. They feel that referrals must be made to this group of professionals so that a medical name can be applied to the constellation of behaviours. No such referral is needed to name the disorder according to official policy.

The psychologists complained about the lack of collaboration between doctors and schools. It is felt that a greater working relationship is needed. Some believe it is in the infancy stages. All realize that no one, including medical personnel, can work in isolation. "There should be other team members with their own expertise to really efficiently deal or address children's needs and identify difficulties that these children are having. We can come up with some options (NF2)." At present, according to NF1 "a medical professional is at the end of the line saying yay or nay. We together should say yay or nay. We should

be all on a level playing field." This concern was also expressed by British psychologists. UKB stated that there has traditionally been a lack of communication between health and education. Many in England and Newfoundland would like to see medical personnel act as consultant not as a diagnostician six to eight months after the school has referred. UKD would like ADHD to be seen by all professionals not as a medical problem nor a behavioural problem, but both.

All British interviewees use the DSM-IV as a guideline in the assessment of ADHD. Like Newfoundland psychologists, they see the classification as useful only in conjunction with other information. Four criticisms arose around the DSM-IV diagnostic criteria for ADHD. Firstly, the classification does not take into account such variables as family history which certainly affects a child's behaviour. The classification is limited and thus the investigation must be taken further (NF1). Secondly, the criteria is inclusive as opposed to exclusive. NF3 believes the present ADHD description allows for the inclusion of people who may be emotionally disordered and/or extremely intelligent (NF3). Thirdly, often professionals do not apply the criteria strictly. There is a subjective nature to the descriptors which provides opportunities for people to interpret symptoms to fit the criteria (NF3). Lastly, the exact nature of ADHD is a problem. Since there is no concrete medical testing to validate a diagnosis, there is an element of scapegoating according to UKB. This psychologist believes that the application of the ADHD 'label' is restrictive to the affected child because some members of society believe the ADHD child is unwilling,

not unable, to control his/her behaviour. The parents must have been very permissive.

### Summary

Educational psychologists in England and Newfoundland were interviewed to gauge their level of understanding of the disorder and to gain insight into the referral, assessment, and diagnostic procedures utilized within both educational systems.

The researcher found that all psychologists interviewed have a basic knowledge of the disorder. The DSM-IV criteria was known and utilized by all. Several interviewees voiced criticisms of the DSM-IV. The criticisms surround the noninclusion of such environmental variables as family history in the determination of ADHD, the exclusionary process inherent in the classification, the subjectivity of descriptors and the unknown nature of ADHD.

British psychologists appear to better understand the intricacies of the disorder for they discussed several existing controversies. Variations in the structure of the education system highlighted differences in the roles of professionals and the opportunities available for treatment.

In both systems, there are three referral routes that can be chosen. The route comprised of the school/parent and medical personnel is similar in both areas. Both Newfoundland and British psychologists believe that the referral processes in their respective countries are ad hoc with no structure or procedure. The procedure for referral

is determined by the experience of each school's personnel and the relationship which exists between the school and the psychologist. Although both education systems are set up very differently, the operation of both is very similar. The referral process is considered by all to be both inconsistent and inefficient. There is no protocol specifying the roles of individual professionals, criteria determining when a referral is warranted and to whom a referral is sent, if this action is deemed necessary. Differences are seen when one studies the outside agencies who may assess for ADHD such as the CFCS.

The assessment of ADHD was described by all as exclusionary and a hit and miss affair. The assessment batteries used by both Newfoundland and British psychologists are similar with some individuals completing more comprehensive assessments than others. The most popular tools are observation and parent/teacher checklists. No psychologist in this sample reported completing the comprehensive assessment battery outlined in the literature review. The decision as to appropriate assessment tools is left to the knowledge and experience of the individual psychologist. The assessment of ADHD is seen to be both inconsistent and inefficient. Although British and Newfoundland psychologists use the DSM-IV criteria, it was found that British professionals investigate each case more extensively, conducting a greater number of interviews and environmental investigations instead of standardized achievement and intelligence testing. The latter assessment tools are favoured by Newfoundland interviewees. All psychologists expressed concerns over the limited amount of time and the few, if any, assessment procedures carried out by



medical personnel. It is for this reason that they believe a diagnosis of ADHD made by certain doctors is based on very flimsy evidence. Newfoundland psychologists believe that the assessment tools presently in use are adequate. British psychologists, on the other hand, feel that the batteries are nonreliable and inconclusive.

In discussions concerning the referral, assessment and diagnostic processes, all psychologists expressed their wishes for change. Common themes surrounded the need for education, agreed protocol and the creation of a multidisciplinary team to handle all cases of ADHD. There is a great need for continuing education in the area of ADHD. This research discovered inconsistencies by both groups of psychologists in their assessment of ADHD. The variation in assessment tools used by interviewees supports the recommendations of increased education initiatives and the creation of agreed protocol. At present, ADHD is solely a medical diagnosis completed by a physician. Although this is not policy, educational psychologists refer cases of suspected ADHD to doctors. It is speculated that they believe doctors are more knowledgeable of the disorder or they may not wish to have the responsibility of diagnosing. More education is needed in the area of ADHD for all professionals. With increased training, educational psychologists will gain confidence in their professional abilities and thus refer less to medical personnel.

All psychologists interviewed wished for greater collaboration between disciplines. Collaboration should only be needed for cases where behaviour problems are severe. The

purpose of the collaborative effort should be to investigate the negative behaviours, not to produce a diagnosis. Greater importance needs to be placed on the exhibiting behaviours. In order for collaboration to be effective, all participating professionals must be knowledgeable of the subject area. Again, greater education initiatives are needed.

In educating the public and professional groups, the understanding of ADHD must be viewed as an evolving concept (British Psychological Society, 1996). This initiative will, hopefully, help to destroy myths and unfounded speculation concerning the disorder, and lead to answers to the many existing questions.

#### Limitations of Study

The primary purpose of an internship is to provide the graduate student with an opportunity to gain clinical experience. Secondary importance is placed on the value of conducting research in the clinical setting in which the internship was carried out. The clinical setting chosen by this intern had relatively few subjects available for this study during the three month placement. The low numbers of subjects participating in this study indicates that caution must be used when interpreting results.

#### Implications of Findings

The referral, assessment, and diagnosis of one of the most prevalent childhood disorders is greatly lacking in protocol and coordination of services among professionals.

As a result, ADHD is being over and under referred and incorrectly assessed. Greater education initiatives are needed so that behaviours, not the disorder, are investigated. Education for all professionals will thus lead to more accurate diagnosis of the disorder. Then, and only then, will prevalence rates be a true indication of the numbers of children suffering with ADHD.

A standard protocol for referring those children suspected of having ADHD should be incorporated provincially by the Department of Education. This would ensure consistency and efficiency in the referral process. Currently, there is no formal policy which outlines procedures and professional roles concerning the referral, assessment and diagnosis of ADHD. At present, teachers, guidance counsellors, and psychologists institute their own procedures based upon experience, knowledge and relationships with other professionals. Very individualized and tentative criteria determine if a child is referred for an assessment. A pupil in one school may be seen by a guidance counsellor, educational psychologist, and medical personnel whereas in another school this same child may be perceived as a problem child, with no referral being made for assessment of behaviour. In some cases the ADHD label is being applied before a comprehensive assessment and collaborative diagnosis are made. One interviewee warned against becoming rule bound in the referral process. Even though this warning is realistic, an agreed protocol is a necessity. Children are being under and overreferred for assessment.

The assessment of ADHD is a somewhat similar story. Neither psychologists nor

medical personnel perform comprehensive assessments. Again, there is no protocol describing necessary testing tools and professional roles. Based upon the comments made by the psychologists interviewed, a standard assessment protocol must be incorporated for children are being incorrectly assessed. This protocol should be completed by teachers, parents, guidance counsellors, doctors and psychologists to ensure an accurate and thorough assessment.

ADHD is a medical diagnosis implying a neurological dysfunction. With such a classification, educational psychologists feel that the value placed on their work which considers both the child's problems and the learning environment is secondary to the word of the doctor. All psychologists in this study wished to redefine the role of the doctor in the diagnosis. It is felt that this professional provides verification for what has already been investigated and determined. If there is no official policy requiring a referral to medical personnel, why are referrals being made? Do psychologists wish to pass on the responsibility for diagnosing ADHD to another person? Do they feel competent to make such a diagnosis? Or are there more practical reasons such as getting a jump start on the waiting lists to see pediatricians before it is even determined if drug therapy is to be an option? One can only speculate. Whatever the reason(s), educational psychologists must become more involved in the diagnosis of ADHD. They, along with school personnel, know the child and his/her behaviour. A doctor should consult on Program Planning Teams and, if drug therapy is required, prescribe and monitor medication. More education

is needed, however, for both education and health personnel before ADHD can be properly assessed and diagnosed.

Another facet of the ADHD discussion which arose during research for the paper and interviews conducted with educational psychologists in Newfoundland and England concerns the negative connotations that are applied to the label ADHD. The benefits and drawbacks of labelling emotional and behavioral difficulties have been debated in the literature. In categorizing difficulties, Cooper (1996) says that a focus is placed on deficiencies and deficits instead of strengths. This leads to exclusion from normal activities and thus serves a self-fulfilling prophecy. The Special Education Policy manual devised by the provincial Department of Education, Division of Student Support Services (1992) does not promote the use of labelling by any personnel under their jurisdiction. It is stated in Policy 3.A.5: "Labels should not be applied to any student, regardless of his/her exceptionality. Labels of exceptionality should only be used as administratively necessary for the allocation of staff and funds by the Department of Education."

Arguments for the use of labelling emotional and behavioral difficulties are outlined, however, in the newly released Student Support Services Transitional Policy and Guidelines Policy 1.A.1, also devised by the provincial Department of Education, Division of Support Services (1998).

Provincial definitions and eligibility criteria provide a framework. Based on comprehensive assessment, labels describe individuals as belonging to a group or category. Labels allow access to knowledge or better understanding of the category or group's needs. In addition, labelling or categorizing allows a common language by advocacy groups, educators and parents. Utilization of categories or labels must be carefully monitored in order to avoid inaccurate estimations of students' capabilities, stereotyping or stigmatizing.

There are positive connotations for people who deal with ADHD children on a daily basis. The ADHD label lets the child, parent and teacher "off the hook". The child cannot be blamed for bad behaviour; parents for poor parenting and teachers for inadequate behaviour management skills.

The stated arguments for the use of labelling are not compelling in the case of ADHD according to Goodman & Poillion (1992). The ADHD label has limited value because of the uncertain nature of the disorder. Communication, planning and decision making among educators, therefore, should not be based on any presumed knowledge.

Cooper (1996), states that ADHD should be viewed as a bio-psycho-social entity with links to medicine, mental health, psychology and education. The results of this report indicate that educational psychologists feel there is a need for a greater collaborative working relationship between disciplines so that the interests of the whole child are addressed: physical, emotional and educational. They realize that each profession has an important but separate role. These functions must be coordinated, however, to determine if a child's poor behaviour is psychiatric, developmental, psychological or educational. It is the proposition of Maras, Redmayne, Hall, Braithwaite & Prior (1997) that the school

psychologist is in an advantageous position to bring together all disciplines to jointly diagnose and treat a child both properly and thoroughly. A comprehensive, collaborative assessment protocol involving parents, doctors, schools and psychologists will lead to beneficial partnerships. Not only will each group learn from each other, they will come to value each profession. These are the findings of several research studies conducted in England (Evans, G., Fuller, Heller, Morgado, Salisbury, & Salisbury, 1997; Keen, Olurin-Lynch, & Venables, 1997; Power, Atkins, Osborne, & Blum, 1994; Connor et al., 1997). Psychologists can assess attention and behaviour problems, consult with teachers regarding behavioral and educational strategies and coordinate the therapy regime.

Knowledge, as well as professional equality, are important ingredients in the new team-approach framework. Everyone needs to gain a greater understanding on the subject of ADHD. This coordinated effort, spearheaded by the educational psychologist, could place a greater emphasis upon behavioural interventions instead of a medical diagnosis. This would reduce the waiting time to see pediatricians for children who actually need to be assessed for drug therapy. Fewer children would be referred to medical personnel. The following multidisciplinary team approach has been adapted from a more comprehensive model undertaken in North Somerset Unitary Authority. (For more information, consult Evans et al., 1997)

A multidisciplinary team approach may be structured as follows:

#### Pre-Referral Procedure

1. Teacher who suspects a child in his/her classroom to have ADHD, completes observations. ABC reporting forms (Antecedent/Behaviour/Consequences) should be completed. Parents are notified by the classroom teacher of action and asked about home behaviour.
2. The child is screened by the school nurse for possible visual and auditory problems.
3. A meeting is held with special education teacher and classroom teacher to discuss findings and institute possible behavioural strategies. It is considered very important to utilize the expertise and services of the special education teacher, especially in the pre-referral stage. At present, the role of the special education teacher appears to be limited for they are not being called upon for consultations.
4. A follow-up meeting is held to determine success of strategies. The classroom teacher and special education teacher would compare the ABC reports of behaviour to determine degree of change. If strategies are deemed to be of little or no impact, a referral is made to the guidance counsellor.

#### Referral and Assessment Procedures

1. Guidance counsellor completes structured classroom observations, intelligence and achievement testing. A referral is made to the educational psychologist.



2. The educational psychologist, after receiving a referral from the guidance counsellor, invites the parents, classroom teacher and special education teacher to a meeting. Classroom observation reports from teachers and assessment results from the guidance counsellor are reviewed. Teacher rating scale is completed. The parents are asked to complete a behaviour rating scale and to record behaviours at home. The educational psychologist obtains a complete clinical history from the parents. Teacher and parent interviews are also completed.
3. At this time, parents may be asked to take the child to the family doctor. A complete physical is to be requested along with coordination and motor ability assessment.
4. The educational psychologist visits the school to complete a psychometric evaluation. Included in this visit would be an analysis of available attainment testing, collection of work samples, and classroom observations. A discussion of behaviour modification strategies with the class teacher should end the visit.
5. The educational psychologist collects all information to form the basis of a report. The psychologist, after an analysis of the data, then decides if the information should be forwarded to a doctor for further investigation. This decision is made in conjunction with the parents.

For this scenario to be effective, proper education must be conducted with parents, teachers, psychologists and doctors. Adequate and workable solutions are possible in the referral, assessment, diagnosis and treatment of ADHD if, and only if, everyone involved

is knowledgeable about the disorder and is clear on the objective of the working relationship, the child's welfare.

In the best interest of the child, both medicine and education, along with psychology, must work together. Education and medicine can complement each other as professed by Cooper (1996). Connor et al. (1997) advise, however, that education should devise its own terminology. They suggest the term "children with attentional difficulties with or without over-activity and impulsivity" should replace ADHD in the field of education. With such wording, the researchers say the child's needs and difficulties will be emphasized without the negative connotations of stigmatization and ostracism. This shift away from medicine will not only lead to more importance placed upon the educational and psychological disciplines but will also lead to less categorization/labelling and fewer referrals beyond the classroom. Will this change in terminology really make a difference? Will children who suffer the symptoms of behavioural disorders be better off? Society, not terminology, should change. The general public must become more accepting and tolerant of individual differences, disabilities, and disorders. The symptoms/behaviours and needs of the child can then be addressed.

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## APPENDICES



## Appendix A

### DSM-IV Description for Attention Deficit

### Hyperactivity Disorder

## Attention Deficit Hyperactivity Disorder

### AMERICAN DESCRIPTION

#### **Diagnostic Criteria**

##### A. Either (1) or (2):

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

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

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

##### *Hyperactivity*

- a. often fidgets with hands or feet or squirms in seat
- b. often leaves seat in classroom or in other situations in which remaining seated is expected
- c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- d. often has difficulty playing or engaging in leisure activities quietly
- e. is often "on the go" or often acts as if "driven by a motor"
- f. often talks excessively

*Impulsivity*

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

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

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

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

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

**Specify Type:**

- **Attention-Deficit/Hyperactivity Disorder, Combined Type:** if both Criteria A1 and A2 are met for the past 6 months
- **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:** if Criterion A1 is met but Criterion A2 is not met for the past 6 months
- **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:** if Criterion A2 is met but Criterion A1 is not met for the past 6 months

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

**Associated Features**

- Learning Problem
- Hyperactivity

**Differential Diagnosis**

Age-appropriate behaviours in active children; Mental Retardation; understimulating environments; oppositional behaviour; another mental disorder; Pervasive Developmental Disorder; Psychotic Disorder; Other Substance-Related Disorder Not Otherwise Specified.

Appendix B

DSM-IV diagnostic criteria for Conduct Disorder  
and Oppositional Defiant Disorder

**DSM-IV Criteria for Conduct Disorder (CD)**

1. Has stolen without confrontation on more than one occasion (including forgery)
2. Has run away from home overnight at least twice while living in a parental or surrogate home (or once without returning)
3. Often lies (other than to avoid physical or sexual abuse)
4. Has deliberately engaged in fire setting
5. Is often truant from school (for older person, absent from work)
6. Has broken into someone else's house, building or car
7. Has deliberately destroyed other's property (other than by fire setting)
8. Has been physically cruel to animals
9. Has forced someone into sexual activity with him or her
10. Has used a weapon in more than one fight
11. Often initiates physical fights
12. Has stolen with confrontation, e.g., mugging, purse-snatching, extortion, armed robbery
13. Has been physically cruel to people

At least three of the above should be present for a minimum of six months.

**DSM-IV Criteria for Oppositional Defiant Disorder (ODD)**

1. Often loses temper
2. Often argues with adults
3. Often actively defies or refuses adults' requests or rules, e.g., refuses to do chores at home
4. Often deliberately does things which annoy other people, e.g., grabs other children's hats
5. Often blames others for his/her mistakes
6. Is often touchy or easily annoyed by others
7. Is often angry and resentful
8. Is often spiteful and vindictive
9. Often swears or uses obscene language

At least five of the above nine behaviours should be present more than is usual for peer group.

Appendix C  
ICD-10 criteria for Hyperkinetic Disorder



International Classification of Diseases  
10th Edition-World Health Organisation 1992 (ICD-10)

**Criteria For Hyperkinetic Disorder**

- A. Demonstrate abnormality of attention and activity at HOME, for the age and development level of the child, as evidenced by at least three of the following attention problems:
1. short duration of spontaneous activities
  2. often leaving play activities unfinished
  3. over-frequent changes between activities
  4. undue lack of persistence at tasks set by adults
  5. unduly high distractibility during study, e.g., homework or reading assignment
- and by at least two of the following activity problems:
6. continuous motor restlessness (running, jumping etc.)
  7. markedly excessive fidgeting and wriggling during spontaneous activities
  8. markedly excessive activity in situations expecting relative stillness, e.g., mealtimes, travel, visiting, church
  9. difficulty in remaining seated when required
- B. Demonstrate abnormality of attention and activity at SCHOOL or NURSERY (if applicable), for the age and developmental level of the child, as evidenced by at least two of the following attention problems:
1. undue lack of persistence at tasks
  2. unduly high distractibility, e.g., often orientating towards extrinsic stimuli
  3. over frequent changes between activities when choice is allowed
  4. excessively short duration of play activities
- and by at least two of the following activity problems:
5. continuous and excessive motor restlessness (running, jumping etc.) at school
  6. markedly excessive fidgeting and wriggling in structured situations
  7. excessive levels of off-task activity during tasks
  8. unduly often out of seat when required to be sitting

- C. Directly observed abnormality of attention or activity. This must be excessive for the child's age and developmental level. The evidence may be any of the following:
  - 1. direct observation of the criteria in A or B above, i.e. not solely the report of parent and/or teacher
  - 2. observation of abnormal levels of motor activity, or off-task behaviour, or lack of persistence
  - 3. significant impairment of performance on psychometric tests of attention
- D. Does not meet criteria for pervasive developmental disorder, mania, depressive or anxiety
- E. Onset before the AGE OF 6 YEARS
- F. Duration of AT LEAST 6 MONTHS
- G. IQ of above 50

Note: The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention and restlessness that are pervasive across situations and persistent over time, that can be demonstrated by direct observation, and that are not caused by other disorders such as autism or effective disorders. Eventually, assessment instruments should develop to the point where it is possible to take a quantitative cut-off score on reliable, valid and standardised measures of hyperactive behaviour in the home and classroom, corresponding to the 95th percentile on both measures. Such criteria would then replace A and B above.

## Appendix D

Letters of Consent for Educational Psychologists  
in St. John's, Newfoundland and Essex, England

**LETTER-ST. JOHN'S, NF**

Educational Psychologist  
Avalon East School Board Office  
St. John's, NF

Ms. Colleen Hickey  
Memorial University of Newfoundland  
St. John's, NF

Dear

Please consider this request to interview you as one (1) of four (4) Educational Psychologists in the St. John's area. The research I am conducting is of a qualitative nature and concerns the topic of Attention Deficit Disorder. A comparative analysis of the nature, referral, assessment and diagnostic practices of Educational Psychologists in St. John's, Newfoundland and Essex, England will be undertaken. The information collected through interviews will form the research component of an internship report required for the fulfilment of a Masters degree in Educational Psychology. The complete interview time will be 45-60 minutes.

Each interviewee will be assigned a number as to ensure anonymity. To expedite future analysis, I am requesting permission to audiotape the interview. Any and all identifying information, ie. teachers, schools, parents, students, colleagues, will be omitted. Once transcription of the tapes has been completed, all tapes will be destroyed. You are under no obligation to participate, and can withdraw your support at any time. Copies of the final report will be made available to you, the other interviewees and the local school board.

Interviews with Educational Psychologists in Essex, England were conducted in June/July, 1997. If you have any questions or concerns, please contact me at (709) 596-6110. If you would like to speak to a resource person at the university who is aware of this research, please contact Dr. Elizabeth Strong. Thank-you for consideration of my request.

Sincerely,

Colleen Hickey

---

I \_\_\_\_\_ do hereby agree to be interviewed and audiotaped by Colleen Hickey in research concerning Attention Deficit Hyperactivity Disorder. I understand that participation is voluntary and that I may withdraw my approval at any time. All information collected is confidential with no identifying information included in the final report.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**LETTER-ESSEX**

Educational Psychologist  
Psychology and Assessment Service  
Essex, England

Ms. Colleen Hickey  
Memorial University of Newfoundland, Harlow Campus  
Cabot House, Old Harlow  
Essex, England

Dear

Please consider this request to interview you as one (1) of four (4) Educational Psychologists in the Essex area. The research I am conducting is of a qualitative nature and concerns the topic of Attention Deficit Disorder. A comparative analysis of the nature, referral, assessment and diagnostic practices of Educational Psychologists in St. John's, Newfoundland and Essex, England will be undertaken. The information collected through interviews will form the research component of an internship report required for the fulfilment of a Masters degree in Educational Psychology. The complete interview will be 45-60 minutes.

Each interviewee will be assigned a number to ensure anonymity. To expedite future analysis, I am requesting permission to audiotape the interview. Any and all identifying information, ie. teachers, schools, parents, students, colleagues, will be omitted. Once transcription of the tapes has been completed, all tapes will be destroyed. You are under no obligation to participate, and can withdraw your support at any time. Copies of the final report will be made available to you, the other interviewees and the Local Education Authority.

Interviews with Educational Psychologists in Newfoundland will be conducted in December, 1997. If you have any questions or concerns, please contact me at (01279)439 266. If you would like to speak to a resource person at the university who is aware of this research, please contact Dr. Elizabeth Strong. Thank-you for consideration of my request. Sincerely

Colleen Hickey

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I \_\_\_\_\_ do hereby agree to be interviewed and audiotaped by Colleen Hickey in research concerning Attention Deficit Hyperactivity Disorder. I understand that participation is voluntary and that I may withdraw my approval at any time. All information is confidential with no identifying information included in the final report.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix E

Semi-structured Interview Questions



**General Category**

1. What term do you use when discussing disorders of attention and/or hyperactivity?
2. How do you define the disorder? What characteristic features must be included in this definition?
3. Who do you believe first notices problems with a child suffering from this disorder: parent/caregiver or teacher?
4. What are the characteristic behaviours or factors one looks for in deciding if problems of attention and/or hyperactivity exist with a particular child?

**Referral Process**

1. If a suspicion exists with either the parent/caregiver or teacher that a problem with attention and/or hyperactivity may exist, how does the referral process work? Who is involved? What are their roles and responsibilities?
2. Do you believe this process is consistent among other school authorities or boards? Why or why not?
3. Do you believe the process you have just described is efficient? Why or why not?
4. What changes, if any, would you like to see in the future?

**Assessment Process**

1. Please describe the assessment process employed as it pertains to problems of attention and/or hyperactivity? Who is involved? What are their roles and responsibilities?
2. What tools/procedures are utilized in this process? Please describe both formal and informal tools?
3. Do you believe this process is consistent among other school authorities or boards? Why or why not?
4. Do you believe the process you have just described is efficient? Why or why not?
5. What changes, if any, would you like to see in the future?

**Diagnosis**

1. Does the team approach exist for the diagnosis of attention and/or hyperactivity problems? Who makes the final diagnosis?
2. Do you see any problems existing with the current classification system that you now use?





