

PERCEPTIONS OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER  
AMONG MARSHALLESE TEACHERS AND PARENTS

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By  
Brenda M. Smith

Thesis Committee:

Marie Iding, Chairperson  
Rhonda Black  
Daniel Blaine

We certify that we have read this thesis and that, in our opinion, it is satisfactory in scope and quality as a thesis for the degree of Master of Education in Educational Psychology.

THESIS COMMITTEE

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Chairperson

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*Abstract*

Educators in Hawai'i are increasingly obligated, due to the socio-historical ties the United States has with Pacific entities such as the Republic of the Marshall Islands, to increase their cultural knowledge about these Micronesian immigrants. This qualitative examination of the perceptions of attention-deficit/hyperactivity disorder (ADHD) in the Marshall Islands aims to illuminate the *culture of family* in the Marshall Islands, adding to educators' collection of knowledge about Marshallese children and their families. Open-ended questions based on the American Psychological Association Diagnostic Statistical Manual IV (1994) were asked of 2 parents and 7 teachers during interviews in Majuro, Republic of the Marshall Islands.

Marshallese culture is collectivistic. Tight, crowded living quarters make for an intergenerational approach towards child-rearing. The parental role consists of encouraging children to "do good things," and to act harmoniously within one's home or community. When a child does not heed parental advice, or acts inappropriately, the parent feels shameful. Prevalent themes of pride and shame in the Marshallese culture were revealed during parent interviews. Some parents may hold the belief that ADHD-like behaviors are a result of bad parenting. Both of the parents were familiar with what are considered ADHD-type behaviors in the United States, but neither of the parents was familiar with the term attention/deficit-hyperactivity disorder.

Among the teachers, four had heard of ADHD, and three had not. However, all of the teachers were familiar with what are considered ADHD-type behaviors in the United States. Teachers attributed ADHD-like behaviors to both bad parenting and a physiologically based problem within the child. Though the perception of people with disabilities is improving in the Marshall Islands, behaviors representative of ADHD might be stigmatized. Shame was mentioned by teachers, relating to the frustration of not knowing how to handle children who exhibit ADHD-like behaviors in the classroom, and the likelihood that parents of children who exhibit ADHD-like behaviors, experience a sense of shame. Children who exhibit ADHD-like

behaviors are often placed in the “slow learner” category. Time and money constraints of the Ministry of Education might be reason for a broader categorization of children experiencing various disabilities in the Marshall Islands. Behaviors such as hyperactivity, impulsivity, and inattention might not be identified as ADHD in the Marshall Islands, but for the most part, children who exhibit these behaviors receive help under the category of “slow learners.”

Educators in Hawai`i should be aware of the understandings of ADHD-like behaviors among Marshallese families. Marshallese families should be coached through the process of assisting their child both in the home, and in the classroom. This study serves as an educational piece, to support educators in Hawai`i, as their interactions with Marshallese families will surely increase.

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## CHAPTER 1

*Introduction**Marshall Islands: A Greeting and a Message*

To greet someone in Marshallese, one would say “Yokwe yok.” The phrase breaks down into three pronouns: ‘eo’ is the object form of first person singular, ‘kwe’ is the absolute form of second person singular, and ‘eok’ is the object form of second person singular. Hart (1998) states, “In this affirmation, self as object (‘eo) is subordinated to the other as subject (‘kwe’) while also acknowledging a relationship to the other as object (‘eok’)” (p. 20). In reciprocal sense of connectivity, where the subject becomes the object and the object becomes the subject in the use of this phrase, the distinction between selves dissolves. As the phrase is also used to communicate “I love you” (Hart), the lesson in reflective warmth exchanged between two individuals in the Marshall Islands unfolds.

Scarce land and food resources, and volatility in the shadows of weather’s unpredictable will, have created a living environment that necessitates a sense of harmony between families and between individuals. Hart explains, “Within the closed ecological system of the atoll, survival was best served by co-merging personal and familiar identities in a communal consciousness committed to a collective effort to sustain the most amicable life possible” (Hart, 1998, p. 19). Diminishing reefs, rising ocean temperatures, and the erosion of shorelines, continue to threaten the sustainability of the Marshalls. Despite the odds, the Marshallese people have been able to maintain the thread of mutual respect for each other, and a sense of connectedness to each other through time, as echoed in the following passage:

An overabundance of what was desired or desirable, from breadfruit to beauty, was considered a fortuitous gift, not necessarily due to the actions of any individual or group, but deriving perhaps from intercession of magical or spiritual powers. Such gifts were to be shared with others. (Hart, p. 39)

Similarly, Hart describes how the “desired” and quite necessary food source was fish from the day’s catch. The Marshallese depended on the luck and skill of the fishermen. If the

fishermen were not so lucky one day, then the small catch would be portioned out very carefully to everyone in the village. However, if the fishermen came home with teeming boatloads of fish, a feast was to be had by all (Hart, 1998).

### *Marshall Islands*

For the purposes of this paper, teachers and parents of the Republic of the Marshall Islands (RMI) will be interviewed. Following World War II, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, and the Republic of Palau became what is known today as the Trust Territory of the Pacific Islands (TTPI) (Heine, 2002). The United States was obligated to help the entities prepare for self-government. New compacts were made though, as these entities began to seek out separate political status. The Compacts of Free Association with the United States, which were originally signed in 1986, allowed for unlimited immigration of Freely Associated States' residents, to live and work in any U.S. territory or state (Heine). The Compact was renewed in December 2003, and provides nearly \$3.5 billion over the next 20 years to RMI and the Federated States of Micronesia (Department of Interior, 2003). The Compact also provides \$600 million aid ("Compact Impact") to Hawai'i, Guam and the Commonwealth of the Northern Marianas to assist with the cost of migration and associated expenditures in education, health care and social services for people that have exercised the right to migrate under the Compact (Department of Interior, 2003).

### Section 124 of the Compact of Free Association states

The Government of the United States may assist or act on behalf of the Government of the Marshall Islands or the Federated States of Micronesia in the area of foreign affairs as may be requested and mutually agreed from time to time. (Government of the United States, Marshall Islands, and Federated States of Micronesia, 2003)

In return for national security benefits, residents of the nations are able to live and work in the United States without visas or green cards as "eligible non-citizens" (Heine, 2002). Therefore, many

Marshallese have accepted the United States' open-door policy, and have arrived on Hawai'i's doorstep in hopes of obtaining more fruitful employment and educational opportunities (Keesing, 2002).

Population in the Marshall Islands was listed at 50,840 (Republic of the Marshall Islands Office of Planning and Statistics, 1999), while 5,000 to 8,000 additional Marshallese resided mostly in Hawai'i, but also in other states including Arkansas, Oregon, California, Texas, and Oklahoma. Since the average annual income for a Marshallese household in 1999 was \$6,840, and the unemployment rate was 31% in 1999, there is a growing desire to seek out "better educational opportunities for the growing number of school-aged children and employment opportunities for families starting out" (Heine, 2002, p. 4).

### *Overview*

In this paper, I will discuss my experience with interviewing Marshallese special education teachers and parents regarding their perceptions of attention-deficit/hyperactivity disorder (ADHD). I became interested in ADHD as coursework in Education Psychology presented explanations for some of the questions I developed during a two-year stay in Japan. Several of the students, at one of the high schools where I taught, exhibited behaviors suggestive of ADHD. However, I always wondered why ADHD was never discussed among the teachers, especially in reference to children with ADHD-like behaviors.

Upon further exploration of the topic of prevalence and diagnosis of ADHD in other countries, I became curious about perceptions of ADHD, especially in developing nations. Since Hawai'i is the new home to many Marshallese families, and since the Republic of the Marshall Islands follows the Individuals with Disabilities Educational Act, the Marshall Islands became a point of curiosity for me. Therefore, I chose to take a look at Marshallese teachers' and parents' perceptions of ADHD.

Throughout the course of this paper, I will discuss my experience with interviewing Marshallese teachers and parents regarding their perceptions of attention-deficit/hyperactivity disorder. The remainder of this chapter will give a brief description of ADHD and how children with ADHD are accommodated in the United States. Though there has been an increase in enrollment of all Micronesian students in Department of Education schools in Hawai'i, the Marshallese group will be the focus of this study. Background information regarding the immigration of Marshallese families, and the subsequent

needs that Department of Education schools have developed as a result of the recent increase of Marshallese student enrollment, will then be explained. Subsequent chapters include (2) an overview of the current literature on the topic of ADHD, (3) an explanation of the study's methodology and interview process, (4) the findings of both teacher and parent interviews, and (5) a discussion of the findings, including limitations and areas for future study.

#### *Description of Attention-Deficit/Hyperactivity Disorder*

According to the American Academy of Pediatrics (AAP), attention-deficit/hyperactivity disorder hyperactivity disorder continues to be the most commonly diagnosed neurobehavioral disorder, and the most prevalent chronic health conditions affecting school-aged children (AAP, 2000), placing kids at risk for difficulties in school, poor relationships with peers and family members, and low self-esteem (AAP, 2000; Ademan, 2000; Barkley, 1998). Attention-deficit/hyperactivity disorder hyperactivity disorder (ADHD) is a condition characterized by three main symptoms -- inattentiveness and/or distractibility, impulsivity, and hyperactivity (Barkley, 1988; Barkley, 1989; Barkley, 2003; Braswell & Bloomquist 1991; Culatta, Thompkins & Werts, 2003; Mash & Barkley, 2003; Mastropieri & Scruggs, 2000; Neuwirth, 1999; Silver, 1992).

#### *Accommodations under IDEA or Section 504*

Children with ADHD can receive educational services under one of two laws, either the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973. IDEA is the federal law that regulates all special education services within the United States. In order for a child to be placed under the umbrella of provisions under IDEA, the child must meet specific eligibility criteria within one of the 12 categories: autism, communication disorders, deafness or blindness, hearing impairments, mental retardation, multiple disabilities, orthopedic impairments, other health impairments, serious learning disabilities, serious emotional disturbance, traumatic brain injury, and visual impairments. After a series of evaluations, an Individual Educational Plan (IEP) is created with the parents, educators, and any other outside consultants that the parents choose. This plan must be updated every year, and the child must be reevaluated every three years. Children who fall under IDEA criteria are eligible for special education services.

On March 12, 1999 the U.S. Department of Education amended IDEA so that the category “other health impaired” included ADD and AD/HD (Cohen, 2003). The new regulations read:

Other Health Impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that: 1) is due to chronic or acute health problems such as asthma, attention deficit disorder or attention-deficit/hyperactivity disorder hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and 2) adversely affects a child’s educational performance.” (Cohen, 2003, p. 2)

Thus, IDEA provides specific arrangements made for objectives, goals and plans of the educational program for the student within the least restrictive environment. Thus, whether or not the disorder is hindering the student’s ability to learn, determines whether or not the child will be accommodated for under either IDEA or Section 504. If the ADHD is not preventing the student from learning, and the child is not behind his same-age peers academically, he will not be eligible for IDEA. However, 504 accommodations should be made (Cohen, 2003; Culatta & Thompkins, 2003; Mastropieri & Scruggs, 2000).

Section 504, however, is a civil rights statute that covers all programs, both public and private, receiving federal funding. This statute requires that schools and places of employment do not discriminate against individuals with disabilities, and that appropriate accommodations be provided to any person with an identified physical or mental condition that substantially limits a major life activity. As learning is a major life activity, students exhibiting symptoms of ADHD for a period of a least six months, can be provided services under this statute if the conditions can be seen as those that are maladaptive, and that limit a student’s learning process (Culatta, Thompkins, & Werts, 2003). Students who meet the criteria under Section 504 typically exhibit medical difficulties, such as asthma, allergies, seizures, a heart condition, ADHD, and so forth. Thus, children who fall under the criteria for Section 504 are given services that are usually seen as less stigmatizing to the child’s family and peers, as students can receive specialized support that they need, without being placed in special education

classes. Some of the more common Section 504 accommodations are extended time for tests, a distraction free room or workspace, providing directions in written form, individualized homework assignments, and allowing the use of technological learning aides, (e.g. tape recorders, computers, multi-sensory manipulatives, etc.) (Blazer, 1999). Special accommodations, which may include specially designed instruction, must be provided to students within a regular classroom. Children who meet these criteria also have a plan for their educational accommodations created, however the frequency of review of the Section 504 plan is not mandated as with IDEA, and the parents are not required to be a part of the planning process (Cohen, 2003).

#### *Americans with Disabilities Act*

Another Civil Rights Act that teachers in public schools must comply with is the Americans with Disabilities Act (ADA). According to the Office of Civil Rights (2004),

The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. The mission of the Office for Civil Rights is to ensure equal access to education and to promote educational excellence throughout the nation through vigorous enforcement of civil rights. (Office of Civil Rights, 2004, ¶ 1).

#### *Felix Consent Decree*

Delays in identification and services for children with special needs prompted the Felix Consent Decree. In a 1993 civil case, the Plaintiffs, Jennifer Felix and her Mother Frankie Servietti-Coleman alleged that the State of Hawai'i did not adequately comply with the regulations of IDEA and Section 504 of the Rehabilitation Act. Children with mental health needs, or "qualified handicapped children", were "not receiving mental health services necessary to enable them to benefit from their education" (Hawai'i State Legislature, 2004, p. 1). Therefore, the Felix Consent Decree increased the

pressure on Department of Education (DOE) teachers and administrators to comply with IDEA and Section 504 to ensure equal service provision to any child with special needs. Since Marshallese children that might have ADHD might not be identified before they enter DOE schools in Hawai'i, a heightened level of awareness is called for among teachers to make sure that Marshallese children are receiving the services they might require, due to their mental health needs.

#### *No Child Left Behind*

The No Child Left Behind (NCLB) Act strives to have all children performing and achieving at grade level by 2014. Aiming towards intensely challenging academic standards, the Act also presents teachers and administrators with the responsibility of accountability. Teachers in every classroom are held accountable for the performance of every child, especially in subjects such as reading, science and math. Some goals NCLB aims to reach include:

- (1) Setting high expectations of all students, regardless of their race, ethnicity, family background, or disability, (2) Aiming to get all students doing grade-level work and encouraging them to reach still higher, (3) Helping to identify more accurately the students most in need of assistance, so schools can focus their efforts there. (NCLB Guide, 2003, pg. 2)
- 2) Considering the newly sculpted plan for overall improvement of both expectations and performance of all children, regardless of their ability or disability, NCLB pushes educators to actively ensure that each and every child meets their potential, and succeeds in doing so. (No Child Left Behind Guide, 2003)

#### *Marshall Islands Education and Special Education Program*

Public education is assured to all children ages 6 through 14 or completion of grade 8 in the Marshall Islands. There are 100 Elementary Schools (75 public and 25 private) for ages 6-14. For ages 15-18 there are 4 public high schools and 13 private high schools (Republic of the Marshall Islands Planning and Statistics Office, 2002). Students must pass the High School Admission Test in order to make it into a public high school. Competition for space is reflected in a limit of 500 students, which in 2003 meant that 41.1%, or 545 of 1,327 students who took the test were refused admission (RMI Planning and Statistics Office, 2002). One of the challenges faced by the Ministry of Education (MOE) is the difficulty in finding qualified teachers (Hosia, K., personnel communication April 14, 2004),

especially on the outer atolls. Teaching at these outer atolls is often a less appealing option for teachers from Majuro, the Republic's capital, due to the outer atolls' isolation and limited resources (Hosia, K., personnel communication, April 14, 2004). About half of the teachers in the Republic only have a high school diploma as their highest education qualification (RMI Planning and Statistics Office).

The Current Status Report (1990) from the Ministry of Education of the Republic of the Marshall Islands explains the need for special education services: "When the learning needs of a child with a physical, behavioral, or learning problem cannot be met adequately by the general school program, it is the responsibility of the Special Education Program to fulfill these needs." (Ministry of Education of the Republic of the Marshall Islands, 1990, p. 4). It also states that the Marshall Islands' Special Education Program philosophy is:

Disabled children have a right to self-improvement through education. This means that disabled children have the right to be recognized and to develop their potential, the right to independence and self-reliance to the fullest extent possible, the right to usefulness and acceptance by their families and community, the right to a wide range of experiences, and the right to the pursuit of happiness. (MOE of the RMI, 1990, p. 2)

Although the Marshall Islands follows Part B of IDEA in their educational system (Andrike & Muller, 1990; MOE of RMI, 1990), involving the incorporation of IEPs, and the implementation of educating a child in "the least restrictive environment," attention-deficit/hyperactivity disorder hyperactive disorder is not readily discussed or accommodated for (K. Hosia, personal communication, November 19, 2003).

#### *Ethnic Categories in Department of Education Schools*

Educators can begin to imagine the importance of this issue when considering the current climate of Hawai'i's schools. Ethnic categories in the Hawai'i Department of Education's School Status and Improvement Report (2002) include the following: Native American, Black, Chinese, Filipino, Hawaiian, Part-Hawaiian, Japanese, Korean, Portuguese, Hispanic, Samoan, White, Indo-Chinese, and All Others. Since there is no category specifically designating Micronesian, much less Marshallese, we might infer that for example, *some* of the 38.5% of "All Others" and *some* of the 46.3% of the "Limited English Proficiency" students at Palolo Elementary School are students from the Marshall Islands

(Hawai`i Department of Education, 2002). (Palolo Elementary School was chosen merely as an example because it had the highest percentage of both “All Others” and “Limited English Proficiency” students.) However, it is difficult to determine the exact ethnicity of these groups, as there are a number of ethnicities unaccounted for in the list, such as Tahitian, Tongan, Guamanian, and also immigrants from other Micronesian entities. Many students might have chosen this category because they are of mixed ancestry, and are otherwise unsure of what category they should mark.

#### *Increase of Marshallese in ESL Classes*

Evidence for the increase in immigration of Marshallese families can be found in recent records of the DOE’s English as a Second Language Learner (ESLL) program. Increases in the Hawai`i Department of Education’s ESLL Program show that, “13% of the state’s total English as a Second Language (ESLL) student population, or 1,671 students, come from the Freely Associated States (FAS): the Federated States of Micronesia (FSM—Chuuk, Kosrae, Pohnpei, and Yap), the Republic of the Marshall Islands (RMI), and the Republic of Palau (ROP)” (Heine, 2002 p. 1). In fact, Marshallese students are the fastest growing immigrant student population in Hawai`i's public schools (State of Hawai`i Board of Education, 2002). Doug Chong, an ESL specialist for McKinley Complex said that “About 20% or 1/5 of the ESL population in the State of Hawai`i are Micronesian...they are Chuukese, Marshallese, Pohnpeian, Kosraen, etc., and it is growing every day” (D. Chong, personal communication, February 21<sup>st</sup>, 2004).

The following information for school year 2001-2002, presents an even more complex issue that educators need to consider. Based on a three-year evaluation of the ESLL program (1997-1998, 1998-1999, and 1999-2000): the data showed that each year, the ESLL program served about 7.0 -8.0% of the student body statewide. Also:

- The top five ethnic groups among ESLL students statewide were Filipino, Samoan, Other, Chinese, and Korean.
- More than half of the ESLL students were found in Grades K-6.
- About 11% of the ESLL students statewide were also receiving services from the special education program.
- About 40% of the ESLL students were on the free or reduced lunch program.

(State of Hawai'i Board of Education, 2002)

For School Year 2001-2002:

- ESLL students comprised 8.5% of the total student population (13,173 ESLL students).
- The largest ethnic groups in ESLL were Filipino, Samoan, Micronesians, Chinese, and Hispanic (Mexican, South and Central Americans).
- The largest language groups in ESLL were Ilokano, Samoan, Tagalog, Marshallese, Cantonese, and Spanish.
- About 12% (1,570) of the ESLL students statewide were also receiving special education services. (State of Hawai'i Board of Education, 2002)

### *Marshallese Students*

Dr. Ramos, an Education Specialist in the Student Support Section of the DOE, suggests that ESLL program students are a diverse group of students. Especially concerning is their: prior educational experiences, exposure to English, learning styles, family literacy practices, socio-economic status, arrival conditions, and sense of selves (State of Hawai'i Board of Education, 2002). Dr. Ramos also illuminates the fact that school systems in the Marshall Islands differ from those of the United States. Presently, schools in the Republic of Marshall Islands are not implementing standards-based instruction or assessments. Difficulty acquiring teaching staff and instructional materials pose serious threats to the consistency of the educational environment in the Marshall Islands. Many Marshallese students do not attend school regularly because of the impact of poverty and the lack of transportation between the islands. Forty-two percent of the students have "F" grades in one or more of the core content subjects (State of Hawai'i Board of Education). The core content subjects for primary grades include math, science, Marshallese, English, and social studies and the core content subjects for secondary grades are math, science, social studies, language arts, and computer literacy (K. Hosia, personal communication, May 3, 2004).

Developing native language literacy (being able to read and write in Marshallese) is sometimes a problem for Marshallese parents and children. This might be a result of a typically oral-based culture, where in the past, there might have been less pressure to become literate (Hart, 1998). As a result, acquiring English literacy skills is a challenge for some Marshallese students, without having

the proper foundational knowledge of written Marshallese. Teenagers and youths who immigrate to Hawai'i usually have not passed the high school entrance exam in the Marshall Islands (State of Hawai'i Board of Education, 2002). Therefore Marshallese students enter the DOE schools at a disadvantage that many teachers might currently be unaware of.

#### *Malnourishment*

Malnourishment is also a problem for some Marshallese. Vitamin deficiency and malnutrition pose a threat to over one-third of Marshallese children below five years of age (Rowa, 2003). Malnourishment could lead to behaviors that differ from nourished children's behavior, and thus could be wrongly interpreted if teachers are not aware of this problem. Malnourishment might lead to problems with cognition and the learning process for students as well (Pollitt, Huang, & Jahari, 1999; Scott, Nonkin Avchen, & Holloman, 1999; Wachs, 1999). These things need to be considered as we welcome more and more Marshallese students into our communities and classrooms. For example, a child suffering from malnutrition could exhibit sluggishness both behaviorally and cognitively. Perhaps there is no immediate solution to this problem of possible malnourishment among Marshallese students. Simple awareness of the problem might positively influence the perspective through which teachers handle potential problems with a child that might not be getting enough of the right foods to eat.

#### *Cultural Differences in Appropriate Behaviors*

Differences in appropriate levels of activity in a classroom setting might account for the differences in prevalence rates of ADHD across national borders (Luk, Wing-Leung, Bacon-Shone & Lieh Mak, 1991; Luk, Wing-Leung & Lee, 1988). Understanding how different behaviors are perceived in different cultures is an enlightening process, especially when considering perceptions of ADHD. For example in Asian cultures where there are larger class sizes, and therefore more pressure to conform, one would think that lower prevalence rates of ADHD would be found. However, that is not always the case. Larger class size may actually increase the amount of disruptive behavior, as there are more students and thus more problems with keeping children on task (Locastro, 1989).

Mash and Barkley suggest "The deficit in behavioral inhibition arises principally from genetic neurodevelopmental origins rather than purely social ones, although its expression is certainly

influenced by social factors over development” (Mash & Barkley, 2003, p. 83). Perhaps differences in the development of behavioral disinhibition, which can lead to alteration in executive functions, become influenced by different social factors in other countries where there are different expectations, and acceptable forms of behavior (Mash & Barkley). This information suggests that possibly differences in one’s environment might impress upon an individual’s mind in ways that educators might not yet be aware of. We need to know more about the types of environments where these children are raised, disciplined, and educated before we can more effectively learn how to communicate and support these Marshallese children.

### *Purpose Statement*

As an extension of my personal quest to understand how ADHD is perceived in other countries, I chose to do this study. I have continuously been fascinated by the interplay between culture and disability during my experiences in Japan, and in my work and studies here in Hawai`i. Attention-deficit/hyperactivity disorder is one of the most intriguing points of controversy between educators, psychologists, and anthropologists. The same questions that researchers face regarding ADHD fascinated me as I read through the research on this topic before and during the preparation for this study. Questions such as (1) Does this disorder actually exist? (2) How is this disorder perceived in other cultures? (3) What do people in other cultures attribute symptoms of ADHD to?, drove the development of this study.

I chose the Marshallese because they, along with other Micronesian immigrants, are prevalent in our community and in our schools. I thought that this research could benefit some of the teachers in Hawai`i as they strive to understand their Marshallese students and families. In no way did I want to single out the Marshallese, and make it seem that they have more of a problem with what might be considered ADHD in the United States. My decision was influenced in part by reports that I had read on the growing presence of Marshallese in DOE schools (e.g. State of Hawai`i Board of Education, 2002). My decision was also based on a classmate’s presentation on the Marshallese, which happened to pique my curiosity a few semesters before. Originally I had planned on doing this study in Japan, but since I had already been there, and so had many other researchers, I chose another part of the world. This other

part of the world happened to be the Marshall Islands. Perhaps it was not just one thing that pointed me in that direction, but a mixture of many different signs that pointed me in the direction of the Marshall Islands.

My decision making process was ultimately influenced by a conversation that I had with Larry Zane in the Western Curriculum Coordination Center. I was referred to him in the early stages of the study. He encouraged me to apply for the grant offered through Project Waipuna. The people at Project Waipuna were looking for research that would enhance their attempts to better prepare educational personnel who serve LEP (Limited English Proficient) students (Project Waipuna, 2004). Since there was a need to more effectively interact with the large number of Marshallese students in Hawai`i, the people at Project Waipuna awarded me a grant to pursue this study. In attempting to learn more about how ADHD might be perceived within the Marshallese culture, I followed an interest of my own, while hoping to provide useful information about Marshallese culture, to educators in Hawai`i.

In striving towards a broader understanding of Marshallese students, this paper aims to illuminate merely one facet of Marshallese culture: understandings and perceptions of ADHD among Marshallese special education teachers and parents. It is important for teachers in Hawai`i to be aware of just how ADHD is perceived in the Marshall Islands, in the case of a child coming from RMI exhibits behaviors symptomatic of ADHD. That way, should the child be diagnosed with ADHD, the educator(s) will be aware that subsequent meetings in which the child's condition and educational plans are discussed with the child's family, might be the family's first encounter with the term "ADHD". Since ADHD might hinder a child's ability to learn, the situation should be addressed and managed in accordance with IDEA, Section 504, the Felix Consent Decree, and No Child Left Behind, and the Americans with Disabilities Act, with respect and with a certain degree of cultural knowledge and cultural sensitivity.

Hilda Heine stated it best in her statement,

For teachers and school administrators in Hawai`i and elsewhere with high concentrations of FAS students, this influx brings with it new challenges—unfamiliar languages, different value systems, and new cultures. Challenges faced by children from the FAS (Freely Associated States) region are attributed to poor English language abilities, lack of familiarity with school

system expectations, and a mismatch between their culture and the schools' culture. To the degree that these challenges can be positively alleviated, achievement levels will improve for these students. (Heine, 2002, p. 5)

### *Specific Research Objectives*

I hope to contribute to current knowledge regarding ADHD in other cultures. My time in the Marshall Islands was an opportunity for me to explore perceptions of ADHD. It was also a chance for me to make some connections with the people that I interviewed in order to perhaps build some relationships. From these short lived relationships that I made with teachers, parents, and students, I hope to share a little about the Marshallese culture to teachers here in Hawai'i who may not ever have the opportunity to see the Marshallese in their own environment. Specifically, my research objectives are as follows:

- a. To explore native Marshallese school teachers' perceptions of ADHD, or their perceptions of behaviors that might be considered to be representative of ADHD.
- b. To explore Marshallese parents' perceptions of ADHD, or their perceptions of behaviors that might be considered to be representative of ADHD.

### *Process and Findings*

In order to explore the research objectives, I traveled to Majuro, the capital of the Marshall Islands, to interview teachers and parents regarding their perceptions of ADHD. By conducting interviews, I planned to reach a clearer understanding of how perceptions of ADHD operate (or do not exist at all) within the minds of teachers and parents so as to work towards the construction of more effective channels of communication between Marshallese families and teachers in Hawai'i. The methodology, interview process and findings will be discussed in subsequent chapters.

## CHAPTER 2

*Literature Review**History of Attention-Deficit/Hyperactivity Disorder*

Attention deficit/hyperactivity disorder is not a new concept. Problems with inattention and excessive activity levels have been recorded as early as the late 19<sup>th</sup> century. \_ For example, the main character known for his hyperactive nature in the following poem by physician Heinrich Hoffman, was named ‘Fidgety Phil’.

“Phil, stop acting like a worm,  
 The table is no place to squirm.”  
 Thus speaks the father to his son,  
 Severely says it, not in fun.  
 Mother frowns and looks around  
 Although she doesn’t make a sound.  
 But, Philip will not take advise,  
 He’ll have his way at any price.  
 He turns,  
 And churns,  
 He wiggles  
 And jiggles  
 Here and there on the chair;  
 Phil, these twists I cannot bear. (Hoffman, 1863 in Silver, 1992, p. 3)

Since Hoffman’s poem, hyperactivity, impulsivity and inattention have been attributed to a variety of causes, and referred to in different ways. In the late 19<sup>th</sup> century, Theodule Ribot (1896) claimed that the ability to exhibit voluntary or sustained attention is the result of having received a good education. Therefore “sitting for extended period of times, while focusing on a specific task with full attention was a skill that humans had to learn, or acquire, according to Ribot (Ribot, 1896). George Still, a physician at King’s College Hospital, considered attention as the “essential phenomenon of will” (Still, 1868).

From 1917-1918, during the time of the encephalitis epidemic, inattention and hyperactivity were attributed to infections, birth trauma, head injury and toxin exposure (Mash & Barkley, 2003). A few decades later, the term “hyper-kinetic reaction to childhood” was used in the Diagnostic Statistical Manual-II (DSM-II) (American Psychiatric Association, 1968). In the DSM-III (APA, 1980), the distinction was made between ADD with hyperactivity, and ADD without hyperactivity. The most current edition of the Diagnostic Statistical Manual (DSM-IV) now defines two separate dimensions of the disorder: that of inattention, and the other of hyperactivity/impulsivity (Mash & Barkley, 2003).

### *Present Context*

Today, some people might even argue that ADHD does not exist, or that is a product of our ever-increasing pace of life (DeGrandpre, 1999; Goodenough, 2003). In fact, there is so much of a debate over whether or not this disorder exists, that Barkley and over 60 of his internationally based colleagues felt impelled to publish a letter announcing, with great conviction, that ADHD does in fact exist (Barkley, et al., 2002). In fact, they claim,

We cannot over emphasize the point that, as a matter of science, the notion that ADHD does not exist is simply wrong. All of the major medical associations and government health agencies recognize ADHD as a genuine disorder because the scientific evidence indicating it is so is overwhelming. (Barkley, et al., 2002).

Controversy surrounding the recent increase of diagnoses of ADHD fuels most of the debate among researchers and the media especially in regards to the safety and moral dilemma involved with prescribing young children psychoactive medications (AAP, 2000; Adams, Macy, Kocsis & Sullivan, 1984; Barkley, et. al., 2002; Green, Wong, Atkins, Taylor & Feinleib, 1999; Neuwirth, 1999; Schlozman & Schlozman, 2000). Some see the increase in pharmaceutical stimulant use among ADHD children, which actually calm the hyperactive child, as a panacea for

the problem, and some argue that medications actually deprive children of their natural tendency and need to take part in “rough and tumble play” (Panksepp, 1988, p. 91). Panksepp (1988) argues, “Increasingly, standardized educational expectations along with a growing intolerance of childhood playfulness may, in fact, be leading to more and more children being labeled with ADHD (Panksepp, p. 91), whereas others concur that the increase in diagnoses signifies the sharpening of our awareness towards the disorder as a very real, genetically based disorder (Barkley, 1998; Barkley, et. al., 2002; Mash & Barkley, 2003). In fact, Barkley and his colleagues boldly assert the existence of ADHD, especially in the statement, “There is no disagreement over whether or not ADHD exists...no more than there is over whether smoking causes cancer, for example, or whether a virus causes HIV/AIDS” (Barkley, et. al., 2002). The force of their statement is solidified by the support of the American Medical Association (AMA), the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychological Association, and the American Academy of Pediatrics (AAP) (Barkley, et. al., 2002).

#### *Etiology of ADHD*

The physiology of ADHD is slowly becoming clearer as more researchers conduct studies to determine the etiology of the disorder. Behavioral disinhibition cause problems in frontal lobe executive functions which include (a) working memory, (b) internalization of self-directed speech, (c) controlling emotions, and (d) reconstitution (or analysis and synthesis of new behaviors) which are increasingly believed to be the primary cause of symptoms typical of ADHD (Barkley, 1998; Lakoff, 2000; Mash & Barkley, 2003; Schlozman & Schlozman, 2000). Barkley suggests,

We are finding that ADHD is not a disorder of attention per se, as had long been assumed. Rather it arises as a developmental failure in the brain circuitry that underlies inhibition and self-control. This loss of self-control in turn impairs other important brain functions crucial for maintaining attention, including the ability to defer immediate rewards for later, greater gain. (Barkley, 1998, p. 67)

Whereas it was previously thought that these children were experiencing an overload of or an inability to filter out extraneous stimuli in their environment, currently, scientists are finding that the problem lies in poor behavioral inhibition, or the impulsive, physical reaction to such input (Barkley, 1998).

Differences in various brain structures have also been noted among researchers, which may explain the difficulties with executive functions that children with ADHD are known to experience (Barkley, 1998). Reduced size of children's right prefrontal cortex, and two basal ganglia, or the caudate nucleus and globus pallidus, can lead to difficulties with monitoring and editing one's activity within their environment, resisting distractions, developing an awareness of time, the ability to slow automatic responses, in order to allow more careful deliberation by the cortex, and to coordinate neurological input among various regions of the cortex (Barkley, 1998). The brain's natural ability to organize itself, and to plan for the future, and execute complicated tasks is thus compromised (Lakoff, 2000), as well as the ability to exercise hindsight and forethought (Mash & Barkley, 2003). Smaller areas of brain matter, less electrical activity, and slower metabolic rates in the brain have also been demonstrated in neuro-imaging studies for children with ADHD (Barkley, et. al., 2002).

Mutations of genes are thought to cause these differences in function and size of structures in the brain (AAP, 2000; Barkley, 1998; Barkley, et al., 2002; Mash & Barkley, 2003; Silver, 1992; Neuwirth, 1999). The traits characteristic of ADHD are routinely found to be genetic, and therefore inherited; in fact, genetic inheritability of the disorder is the most significant of all psychiatric disorders (Barkley, 1998). There are also non-genetic factors that can cause ADHD, though the factors account for only between 20 and 30 percent of ADHD cases among boys, and an even smaller percentage for girls. These include premature birth, maternal alcohol or tobacco use, exposure to high levels of lead in early childhood, brain injuries (Barkley, 1998; Mash & Barkley, 2003). It is also thought that environmental and psychological stress can lead to the development of attentional problems and hyperactivity (Schlozman & Schlozman, 2000).

### *Diagnosis*

There are several steps involved in diagnosing a child with ADHD. The American Academy of Pediatrics' Committee on Quality Improvement formed a committee, composed of neurologists, psychologists, child psychiatrists, developmentalists, educators, pediatricians and epidemiologists to derive a set of guidelines for physicians regarding the process of diagnosing a child who is suspected of having ADHD. The committee composed a set of six recommendations, which should guide physicians through the diagnostic process in their practices (AAP, 2000). The recommendations are as follows:

1. In a child 6 to 12 years old, who presents with problems with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems, primary care clinicians should initiate an evaluation for ADHD;
2. The diagnosis of ADHD requires that a child meet Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria (APA, 1994);
3. The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment;
4. The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and associated conditions;
5. Evaluation of the child with ADHD should include assessment for associated (coexisting) conditions;
6. Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD but may be used for the assessment of other coexisting conditions (AAP, 2000, p. 6).

The coexisting conditions mentioned in recommendation five, refers to: learning or language disorders, oppositional defiant disorder, conduct disorder, anxiety and/or depression (AAP, 2000). The physician determines the coexistence of these conditions through other diagnostic evaluations, which may include the use of the Diagnostic Statistical Manual for Primary Care (DSM-PC) (AAP, 2000). In recommendation six, the committee asserts that other diagnostic tests, such as screening for high lead levels or abnormal thyroid hormone levels, brain

imaging studies, or electroencephalography do not prove to be effective or reliable methods of diagnosing ADHD, though they may be used to determine some coexisting conditions such as learning disabilities or mental retardation (AAP, 2000). Some examples of the assessment tools that would be used as part of recommendations three and four of the AAP guidelines include the following: Conner's Parent Rating Scale, Conner's Teacher Rating Scale, and Barkley's School Situations Questionnaire. Other examples include: Child Behavior Checklist Parent (Parent and Teacher Form), and Devereaux Scales of Mental Disorders (AAP, 2000). Parents and teachers observe the child's behaviors at school, and in the home environment with the use of these scales and tests in order to help the physician reach a more sound diagnosis (AAP, 2000; Green, et al., 1999).

#### *Three Subtypes*

There are three subtypes of the disorder: (a) predominantly inattentive type (ADHD/I, meeting at least 6 of 9 inattention behaviors), (b) predominantly hyperactive-impulsive type (ADHD/HI, meeting at least 6 of 9 hyperactive-impulsive behaviors, or (c) a combination of these two together (ADHD/C meeting at least 12 of 18 behaviors in both the inattention and hyperactive-impulsive lists) (AAP, 2000; American Psychiatric Association, 1994; Braswell & Bloomquist, 1991; Culatta, Thompkins & Werts, 2003; Mash & Barkley, 2003, Mastropieri & Scruggs, 2000; Neuwirth, 1999; Silver, 1992).

#### *Prevalence Rates*

Prevalence rates of ADHD in the United States vary, opening a large arena for discussion among psychologists and anthropologists. When searching through literature on prevalence rates in school-aged children in the United States, the most consistent statistic found across the research was 3-5% (Barkley, 1988; Braswell & Bloomquist 1991; Culatta, Thompkins & Werts, 2003; Mash & Barkley, 2003; Mastropieri & Scruggs, 2000; Mash & Barkley, 2003; Neuwirth, 1999; Silver, 1992). The American Academy of Pediatrics report prevalence rates ranging from 4%-12% among the school-aged community, and 9.2% of the general population presenting behaviors consistent with ADHD (AAP, 2000). Alterations in the criteria for ADHD in the fourth edition of the DSM, which account for the possibility of predominantly inattentive type of the

disorder, has led to more females being diagnosed with the inattentive type (AAP, 2000), demonstrating that females might have been previously under-diagnosed.

Internationally, prevalence rates are just as varied. Barkley suggest that ADHD is a worldwide problem and that between 2 and 9.5 percent of all children worldwide are afflicted with the disorder (Barkley, 1998). However, comparing prevalence rates of ADHD in other countries is not an easy task, especially since different definitions of the disorder may exist in other cultures. Also, different cultures may employ different types and methods of identifying ADHD, therefore perhaps making comparison of results cross-culturally misleading or irrelevant (Mash and Barkley, 2003).

#### *Culture and ADHD*

Reasons why international prevalence rates of ADHD vary to such a great extent puzzle researchers today. Some researchers claim that changing syndrome criteria and variations in diagnostic methodology pose a threat to consistency of international statistics (Gingerich, Turnock, Litfin & Rosen, 1998). Others claim that diagnosticians from two different cultures might come to two very different sets of results when assessing prevalence rates of ADHD, leaving room for observer bias (Mann, et al., 1992) or simply non-uniform use of assessment instruments (Gingerich, et al., 1998). Differences in world-view, culture, and language between the evaluated and the evaluator are most likely the cause for observer bias and such widely varying results of prevalence studies (Brewis, Schmidt & Meyer, 2002; Jacobson, 2002; Lakoff, 2000; Mann, et al. 1992; Westermeyer, 1985).

Perceptions of this disorder vary across national borders, thus calling for a greater understanding of the cultural context in which the behaviors symptomatic of ADHD exist (Gingerich, et al., 1998). In a study by Langsdorf, Anderson, Waechter, Madrigal and Juarez (1979), the Conner's Teacher Rating Scale was used to examine teachers' perceptions of Mexican-American, African-American, and Caucasian children's behaviors. Black children were rated at significantly higher rates than Mexican-American children to be hyperactive, as expected based on the proportion of these ethnic groups in the rural elementary schools that were studied (Langsdorf, et al., 1979). The authors suggest that ethnicity and social class are factors

influencing these findings, as lower class black and Mexican-American children are less likely to have absorbed “the white middle-class values and attitudes characteristic of early childhood and primary level socialization patterns in American education” (Langsdorf et al., 1979, p.297). Thus these children are more likely, to exhibit behaviors that conflict with teachers’ expectations of what is socially acceptable (Langsdorf, et al., 1979). Teacher expectations can themselves be considered a product of their (teachers’) upbringing, educational history, and current living environment. Since this study was conducted in a rural school, the results are affected by the cultural lens through which teachers perceive children’s behavior.

Mann and his colleagues suggest that without accounting for the differences in world-view and perceptions of hyperactivity, cross-cultural comparisons cannot be made (Mann, et al., 1992). This is especially important when considering that characterizations of behaviors such as disruptive, hyperactive, or inattentive, are very much embedded in the culturally constructed fabric of acceptable forms of behavior in any given culture (Jacobson, 2002; Mann et al., 1992; Silver, 1992). For example, based on a study by Brewis and Schmidt (2003) on the identification of Mexican children’s psychiatric symptoms, hyperactivity is not included in the disorder’s description or name. ADHD is usually known as *deficit de atencion* among psychologists, educators and doctors (Brewis & Schmidt, 2003). Brewis and Schmidt noted, “In repeated conversations with Mexican professionals interested in children’s behavioral problems (psychologists, educators, doctors), hyperactivity was described as a very rare problem, almost always resulting from severe head trauma (Brewis & Schmidt, p. 387).” Variations in understandings of the disorder itself are important to examine, especially when considering the need to be more familiar with a child’s world-view, or the world-view of the social actors in a child’s environment. These social actors are the people who will decide whether or not a child would be identified or referred for ADHD, such as parents, teachers, or doctors.

Silver (1992) acknowledges the biologic and neurological basis of the disorder, but also claims that manifestation of the problems associated with ADHD depends on a number of social factors in that child’s environment, such as culturally acceptable levels of physical activity, loudness, attentiveness, and inappropriate behavior itself. In other words, biology does not

automatically ordain a behavior as “normal” or “abnormal,” social interpretation does (Jacobson, 2002). In studies done in Hong Kong by Luk, Wing-Leung, and Lee (1988), and by Luk, Wing-Leung, Bacon-Shone and Lieh-Mak (1991), using the Conner’s Teacher Rating Scale and the Preschool Behavior Checklist respectively, suggest that higher levels of hyperactivity, as perceived by teachers, could possibly be a result of higher expectations of conformity and discipline. Some authors go so far as to suggest we create categories in our society as a way of creating order in our lives (Douglas, 1966; Ingstad & Whyte, 1995; Jacobson, 2002; McDermott and Varenne, 1995). For example, in Hong Kong class sizes are usually larger than American class sizes, thus demanding more disciplined behavior. Thus, deviance from this expectation is more readily identified and reprimanded or corrected (Luk, et al., 1988; Luk, et al, 1991). Culture mandates specific understandings of each individual’s role, and subsequent reactions to these individuals.

It then becomes necessary then to examine how the biology of ADHD-type behaviors is intimately related with the individual’s social environment. Brewis and her colleagues, and Jacobson both agree that “inattention and hyperactivity... necessarily emerge from some combination of ecological, biological, and cultural factors” (Brewis, et al, in Jacobson, 2002, p. 285). The entire package (our behaviors) is not easily delineated; culture (the potter) molds the clay (our genes or biological makeup) that spins around on the potter’s wheel. Behavioral inhibition is also thought to be shaped by the social environment, which includes various amounts of structure and feedback (Gingerich, et al., 1998; Mash & Barkley, 2003). For example, a child’s ADHD-type behaviors might become more prevalent if there is little structure or consistency in his or her environment. Also, without proper feedback, the individual does not know that his or her behavior is inappropriate, and will continue to act as he or she normally would.

Much research has been done to demonstrate the effect of different variables in the child’s environment. According to Mash and Barkley (2003), children with ADHD do worse when

(a) the task is later in the day, (b) the task is more complex (c) when restraint is required (d) the child experiences lower levels of stimulation (e) more variable schedules of immediate consequences of the task are enforced, and (f) there are longer delay periods prior to reinforcement. (Mash & Barkley, 2003, p. 80)

These things will all change according to culturally constructed methods of instruction in the classroom, thus causing great variation in the types of behavior children in different cultures and countries will exhibit.

Despite the inherent controversy over how ADHD is perceived and the rates at which it is identified or merely how often behaviors are considered to be symptomatic of ADHD by parents or teachers, Brewis and Schmidt (2003) have demonstrated that ADHD associated behaviors, regardless of cultural context, are very common. Though interpretations of these behaviors may vary according to socially constructed roles of gender, appropriate levels of activity, or opportunities to interact with other children in the classroom settings, there still exists significant population differences in children's degrees of attentive or impulsive behaviors (Brewis & Schmidt, 2003).

### *Gender*

Gender also plays a very important role in understanding differences in the etiology and the cultural repercussions of ADHD. Barkley suggests that "Boys are at least three times as likely as girls to develop the disorder; indeed, some studies have found that boys with ADHD outnumber girls with the condition by nine to one, possibly because boys are genetically more prone to disorders of the nervous system" (Barkley, 1998, p. 67).

For example, in Brewis, Schmidt and Meyer's study (2002), which examined how cultural models, or a child's gender specifically, influence the identification of psychiatric symptoms. They found girls were able to sit for longer periods of time, and they moved and fidgeted less than boys (Brewis, et al., 2002). Observations based on DSM-IV criteria by caregivers and homeroom teachers, and activity monitoring were evaluated. Boys were found to be more at risk of referral than girls, based on teacher reports, and girls are less likely to be

treated any differently by their teachers should they show signs of inattention or hyperactivity, even if boys are (Brewis, et al., 2002). Parents' observations and evaluations of activity showed no difference in regards to gender, however. Brewis and colleagues were expecting to find that the gender of the parents (the observers) might influence their evaluation of boys' and girls' behavior (Brewis, et al., 2002). This demonstrates the importance of social actors in the probability of referral of a child for ADHD, and that gender differences may play a role in the way behaviors are interpreted by specific social actors (Brewis, et al., 2002). This study leads us to examine how expectations of children's behaviors, based on their gender, vary in specific social settings.

Considering the aforementioned variables, especially the role of culture in the variance of prevalence rates and perceptions of ADHD, I examined the perceptions of ADHD among Marshallese teachers and parents. Interviews with Marshallese parents and teachers illuminated some of the beliefs and ideas about ADHD among the teachers and parents. The methodology and explanation of the findings from the interviews are discussed in subsequent chapters.

## CHAPTER 3

### *Methodology*

#### *Rationale for Instrumentation*

There were three points I wanted to keep in mind when developing the methodology for this study. The first point to consider was how to develop rapport with Marshallese people in a short amount of time. A qualitative approach seemed to be the best way to elicit information on personal beliefs regarding perceptions of ADHD, so that I could spend some time with each of the interviewees. Secondly, I wondered how to introduce ADHD while keeping the explanation of the disorder simple enough so as to not interfere with pre-existing understandings of ADHD. Therefore, the American Psychological Association's DSM-IV (1994) criteria for ADHD were used. Thirdly, I wanted to gather a large amount of information in a short amount of time. Open-ended questions during an interview seemed to be the most effective way to explore perceptions of ADHD.

In order to develop the interview format, I considered ways to examine participants' perceptions and understandings of ADHD. Two articles assisted me in the search for a conceptual basis for the interviews: 1) the American Academy of Pediatrics' Clinical Practice Guidelines (2000), and 2) Brewis and Schmidt's study of psychiatric symptoms among Mexican children (2003). The fourth edition of the Diagnostic Statistical Manual's (APA, 1994) criteria for diagnosis of attention-deficit/hyperactivity disorder was listed in the AAP Clinical Practice Guidelines (AAP, 2000), as one of the diagnostic tools to be used in the process of diagnosing a child with ADHD. In combination with an examination of the child's academic record, and reports from the child's teachers, parents or caregivers, the DSM-IV criteria assists physicians in their evaluation of a child presenting with ADHD symptoms.

Brewis and Schmidt (2003) utilized the DSM-IV criteria for ADHD in a study of Mexican children. Homeroom teachers were asked to rate children in their classes using the DSM-IV criteria in order to determine gender differences in perception of ADHD-type behaviors (Brewis & Schmidt). After reading this study, and seeing how the DSM-IV criteria was used, I felt that the DSM-IV criteria was the best "tool" for me to work with. I used the DSM-IV criteria

for ADHD as a base from which to develop questions to ask Marshallese teachers and parents, in a less structured interview setting, about their perceptions of ADHD.

I was unsure whether the participants were familiar with attention-deficit/hyperactivity disorder. Therefore, asking questions about the teachers' and parents' experiences with behaviors that might be considered ADHD, after having the participants read through the criteria for diagnosis, seemed to be the most effective way to achieve the study's goals. I wanted to elicit teachers' and parents' recollections of children's behaviors that might appear to be symptomatic of ADHD after a short introduction to the disorder. The DSM-IV provided the needed structure and explanation for me, and for the interviewees.

#### *Instrumentation*

The interview format was composed of two separate sets of questions, a set of 16 questions for the teachers, and a set of 14 questions for the parents (questions 1-4 were the same for both teachers and parents). I tried to think of appropriate questions to ask in order to explore teachers' and parents' perceptions of ADHD. Since parents might have less interaction with as broad a range of students as the teachers, I ended up with more questions to ask of the teachers. The parent format was given to parents, and the teacher format was given to teachers. On both the parent and teacher format, a short description of my study and rationale for my objectives was provided. The first four questions aimed to determine whether, and to what extent, the participant was familiar with ADHD. Following questions 1-4 were the criteria for ADHD diagnosis from the DSM-IV. Then, a short description of the three potential diagnosis types for ADHD was provided. The remainder of the interview format consisted of 8 questions for parents, and 12 questions for teachers.

#### *Initial Stages*

Qualitative research often involves what is known in sociological, educational and anthropological research as a gatekeeper (Pope & Mays, 2000). A gatekeeper is a person who is considered to be a part of, or "inside" the cultural group that a researcher is studying. This person

usually knows the language of the group, and the language of the researcher, and thus provides a means through which the researcher can communicate with other members of the group.

Gatekeepers are familiar with other members of the group, and are therefore more able to assist the researcher in gaining access into a culture, which would otherwise, without his or her assistance, be very difficult.

Throughout the initial planning stages of this project, several individuals played a significant role in steering me towards, who would eventually become, the gatekeeper for me. After explaining my research interests to a Chuukese classmate, I was directed to Hilde Heine. Hilda Heine, the former Director of the Pacific Comprehensive Regional Assisted States Education and the former President of the College of the Marshall Islands, and Secretary of Education for the Ministry of Education for the Republic of the Marshall Islands, is now a Pacific Resources for Education and Learning (PREL) Senior Scholar for Freely Associated States Education. Heine was very helpful in answering many of my questions, and then referred me to Mr. Kanchi Hosia for further information.

Mr. Hosia, the former Special Education Director, and Assistant Secretary for Curriculum and Instruction in the Ministry of Education in the Marshall Islands, currently works at the PREL office in Honolulu. He was offered a one-year residency as part of the Pacific Educator in Residence (PEIR) program. PEIRs work together with departments of education and institutions of higher education in the Pacific region to expand and develop the personal and professional skills of educators who work in the Pacific region. (Pacific Resources for Education and Learning, 2003)

As a member of the Pacific Region Educational Learning (Pacific REL) program, a five-year contract with the U.S. Department of Education, Mr. Hosia and the other professionals at PREL aim to improve student performance on early reading literacy in the Pacific Region by conducting education research and technical assistance to schools seeking to improve student performance in this area (Pacific Region Education and Learning, 2003). Since Mr. Hosia is a respected professional within the Special Education Department of the Ministry of Education in

Majuro, and is native to the Marshall Islands, he became the gatekeeper for me during the process of data collection.

### *Finding Participants*

Data collection occurred in February 2004, during my visit to Majuro, the capital of the Republic of the Marshall Islands. Since personal relationships and connections are highly valued in Micronesian cultures, including the Marshall Islands (Uehara & Flores, 2000), Mr. Hosia and I agreed that having him take care of the pre-departure correspondence would be the best way to proceed. Mr. Hosia and Ramona Albert, the Special Education Center supervisor, were very close with many teachers and parents of the children they worked with and so offered to “recruit” teachers and parents for the interviews. They arranged for the teachers to meet with me at the Special Education Center at Marshall Islands High School and at Rita Elementary School. They also arranged to have interpreters available, however since none of the participants felt that they needed an interpreter, the interviews were all conducted in English. Participation in the study was voluntary.

Finding teachers who had the time to participate in the study was perhaps an easier task than it would have been during a regular school week. Education Week was taking place during my stay, thus the school day ended at noon. Open-house festivities took place after classes, allowing a more flexible schedule for the teachers. Interviews were expected to last about 90 minutes.

The Marshall Islands Special Parents Association (MISPA) had their monthly meeting at the Special Education Center on the 19<sup>th</sup> of February. Though the meeting was supposed to commence at 5:00 p.m., it didn't start until 7:00 p.m., leaving time for potential parent interviews. While members of the association who had already arrived waited for those who were running late, I was able to solicit two parents who were willing to participate in the study before the meeting started.

### *Participants*

Seven teachers and two parents were interviewed. I had specified to Mr. Hosia and Ms. Albert that special education or regular education teachers would be acceptable for the study. All

of the teachers interviewed were special education teachers. Teachers' experience levels (number of years teaching) varied from one year to over twenty years. Teachers worked with deaf and blind (2), only deaf (1), slow learners (1), severely or multi-disabled (1), and in regular education classes, accompanying children in the special education program (2). Four of the teachers worked at an elementary school, and three of them worked at a high school. Teachers' academic backgrounds ranged from a high school diploma, to an Associates degree from the College of the Marshall Islands (CMI). Interviews with teachers lasted about 45-90 minutes, depending on how much each individual teacher expounded on his or her personal experiences and thoughts about children's behavior in the classroom.

One of the potential parent interviewees declined to take part in the study. She did not feel comfortable doing the interview because: (a) She did not feel confident with her level of English, even though she had a translator accompanying here, and (b) She did not feel that she knew enough about the interview content, even after I explained to her that she didn't need to know anything about attention-deficit hyperactivity disorder.

Two parents attending the MISPA meeting were interviewed, one was from Kwajelain, and the other was from Majuro. Both of them had several children. Each interview with the parents lasted around 30 minutes.

### *Interview Process*

The interview began with obtaining consent from the teacher or parent to participate in the study. A photo was taken of the participant, with his or her consent, to document our meeting as a sort of visual note for me, as well as for use in any future presentation of the study. Consent was obtained to audio-tape our conversation. A copy of the interview format was given to each participant at the beginning of each interview, after consent was obtained. Participants were encouraged to follow along as the I read aloud.

I took time to interject with questions every few minutes about whether or not the participant understood what was being said, and whether or not they had any questions. Questions 1 through 4 were asked of the participant after reading through the description of the study. Next, I explained the diagnostic criteria for attention-deficit/hyperactivity disorder that is found within

the DSM-IV, and how this criteria is used by physicians. I explained the three types of diagnoses, and then questions 5-12 (for the parents) and questions 5-16 (for the teachers) were asked.

A semi-structured interview, using open-ended questions, allowed for flexibility and organic growth and flow of conversation. Not all of the questions were asked in all situations, as some of the questions were made irrelevant by the interviewees' previous answers. Sometimes the interviewees answered more than one question with one answer, and so I would facilitate the conversation accordingly.

### *Data Analysis*

Interviews with the teachers and parents were transcribed. To help myself in locating portions of the transcripts during the writing of this paper, and for potential later use, the transcripts were numbered by line of the conversation. Each transcript was read at least two times before coding. Miles and Huberman (1994) suggested using a coding system by creating a "start list" of codes prior to fieldwork. The "start list" could come from a "...conceptual framework, a list of research question, hypotheses, problem areas, and/or key variables that the researcher brings to the study" (1994, p. 58). Originally, my "start list" came from my set of research questions. I planned on coding the findings by question number. In this case, all answers to question number 1 would be discussed together, and all answers to question 2 would be discussed together, etc. But, later, as per faculty guidance (Black, R., personal communication March 30, 2004; Yamauchi, personal communication, March 29, 2004) I switched to coding by theme.

For the parents, coding themes were: (a) family living situation, (b) parental role: encourage "doing good" and "listening" (c) frustration and discipline, (d) shame in two contexts, and the need for confidentiality, (e) parent communication with teachers or other professionals, (f) perceptions of ADHD, (g) familiarity with ADHD, (h) boy as an example of ADHD, (i) treatment of child with ADHD behaviors by peers.

Initial coding themes for the teachers' interviews became apparent after the first few readings of the transcripts, such as (a) topics dealing specifically with ADHD, (b) topics dealing with parents, (c) topics of disability and (d) topics of Marshallese children going to Hawai'i.

After another reading, I was able to create more specific sub-themes within these four broad themes that would shape the reporting of the results. A list of themes and sub-themes were created and labeled with what would become the code during the coding process, as per Miles and Huberman's suggestion (1994).

The sub-themes in the ADHD theme were: (a) familiarity with ADHD, (b) example of ADHD-like behaviors in specific children, (c) problematic behaviors, (d) strategies of ADHD behavior management, (e) peers' perceptions of children with potential ADHD behaviors, (f) importance of identification of ADHD, (g) perceptions of ADHD-like behaviors, (h) ADHD behaviors in teachers' classes, (i) emotions involved with dealing with ADHD-like behaviors, (j) failing (k) positive results of ADHD behavior management strategies, (l) teachers' educational training (m) teachers' workshop training (n) nutrition, and (o) advice or information about ADHD.

Sub-themes for the parent theme were: (a) perception of discipline, (b) parental involvement, (c) strategy of communicating with parents, and (d) parent strategies of managing ADHD-like behaviors.

Sub-themes for the disability theme were: (a) positive results of disability awareness, (b) perceptions of disability, (c) perspectives of teaching Special Education, (d) slow learners, (e) shame, (f) characteristics of students, (g) improvement of perceptions of disability, (h) teachers' life experience, (i) discipline, (j) IEP process.

Sub-themes for the theme regarding Marshallese children going to Hawai'i were: (a) perceptions of Marshallese children going to Hawai'i, (b) perceptions of Marshallese in Hawai'i, (c) IEPs for students bound for Hawai'i or already in Hawai'i.

This list grew and changed during the coding process, as sub-themes were subsumed into under sub-themes, and themes themselves were combined and condensed. Some of the material, especially regarding Marshallese children going to Hawai'i was left out, as it did not completely fall within the scope of this paper. However, I feel that some of the information from those sub-themes might be very useful in a subsequent paper or a follow-up workshop for educators in Hawai'i. The final list of sub-themes was chosen for the reporting of findings for the

teachers: (a) interviewees' educational training and experience, (b) characteristics of interviewees' students, (c) familiarity with ADHD, (d) training with ADHD, (e) perceptions of ADHD, (f) nature versus nurture, (g) activity levels in Marshallese classrooms, (h) constraints: money and time, (i) status and stigma, (j) slow learners, (k) most problematic behavior, (l) presence of ADHD in your class, (m) examples of ADHD-like behaviors, (n) strategies used when dealing with ADHD (o) perceptions of children exhibiting ADHD-like behaviors by their peers, (p) teachers' emotions involved in dealing with children exhibiting ADHD-like behaviors, (q) importance of identifying ADHD, (r) need for advice regarding how to manage children with ADHD, (s) nutrition, (t) parental involvement, (u) shame, (v) improvement in the perception of disabilities in the Marshall Islands. To improve consistency, transcripts were read at least twice before coding, and then several times while coding.

## CHAPTER 4

*Findings from Interviews with Parents**Background Information*

Two parents were interviewed using a set of open-ended questions (Appendix A and B), which were developed based on the diagnostic criteria for ADHD in the DSM-IV (1994). The parent questions differed slightly from the teacher questions. Their accounts provide the reader with an introduction to what I will deem the *culture of family* within the Marshallese society. In order to brief the reader on Marshallese family culture, and to set the stage for understandings of ADHD, sections regarding family living situations, parental roles, issues of discipline, shame and parental communication with teachers precede more focal sections of the study dealing with familiarity with ADHD and the perceptions of ADHD. The names of all the interviewees have been changed to protect their identities. The word “interviewer” is used, referring to myself, the author of this paper.

Even though an interpreter was available for both of the interviews, both of the parents insisted there was no need for one. While Collin exercised a strong command of the English language, Ben’s understanding of English was not as strong. Though Ben was not as confident with his English ability, he thought that he didn't need an interpreter, and so we tried our best to communicate our ideas to each other. There were a few instances where he asked for clarification, but for the most part, I felt that Ben was comprehending most of what was being said.

*Family Living Situation*

One way to examine the *culture of family* among the Marshallese is to take a look at the actual home environment in which children grow, interact and learn. Looking at family’s living situations in the Marshall Islands illuminates facets of their culture such as family dynamics, attitudes towards child-rearing, and descriptions of parental roles. The first parent interviewed, Collin, has a grandchild with a physical disability. Collin explained to me that extended families live all together in one house.

Collin: So in our community, most of the kind of families stay together, brothers and sisters, and sometimes the parents, with the grandkids, and the brother and sisters and their kids. Some houses have up to 30 people in one house.

Interviewer: ...Are the houses bigger? How big are the houses?

Collin: Some houses are about 24 by 30, but like I said, close to 20-30 people in the house.

Interviewer: How many rooms do you have?

Collin: Probably 3, maybe brothers and sisters of the parents and the kids, they all stay in the living room....It is very different from your culture, we like to stick together (Collin, Text Units 26-40).

Many family members live in one house, therefore one would imagine that child-rearing is a task dispersed among siblings, cousins, aunts, uncles and grandparents. When asked if this was true, he agreed (Collin, Text Units 49-50). And, not only does Collin explain the proximal closeness of intergenerational family members, he clearly pinpoints the sense of cohesion among family members, in his statement, “we like to stick together” (Collin, Text Unit 40).

*Parental Role: Encourage “Doing Good” and “Listening”*

The parental role of enforcing or encouraging the child to “do good,” or to “do nice things,” or to “do a good thing” were common themes that came up in conversation with Ben, the second parent interviewed. Two elements made themselves clear in examining the data further. From what I was able to gather from Ben’s responses, he believed the parent must do all that he or she can to encourage positive, socially appropriate behavior, which is characterized by “doing good,” and “doing good things”. He also felt the child must respect his or her parents enough to “listen” to them earnestly. On many occasions, the act of listening was mentioned as a fundamental responsibility of the child within the family context. When this doesn’t happen, parents become angry, as reflected in Ben’s comment, “Sometimes when we talk to our children, they don’t want to hear what we are telling them to do...and then they just run out and play, and we get mad” (Ben, Text Units 22-25). When asked which of the ADHD behaviors would cause

the most problem in the home for a parent or caregiver, Collin answered, “I would say inattention, because they don’t really listen when we try to help them out” (Collin, Text Units 127-128). The same frustration that Ben felt when his children didn’t listen was similar to Collin’s comment about the importance of attention.

Ben’s response to the question regarding the most problematic behavior in the home was as follows.

Interviewer: In your opinion, out of these ADHD symptoms, which one would be the most noticeable for the parent, for you in the home? Would it be hyperactivity, or excessive talking, or inattention, not being able to focus, which would be the biggest problem?

Ben: What does it mean?

Interviewer: Which would make you the most upset? Or frustrated?

Ben: Upset? Feeling not so good, about...?

Interviewer: If a child was running around everywhere, would that be frustrating for you?

Ben: Yeah, (soft laughter)

My use of the phrase “running around everywhere” was a very poor attempt at translating ADHD into terms that Ben would understand. I was trying to convey the idea of hyperactivity by the phrase “running around everywhere,” but the poor word choice was a product of my uneasiness and sense of worry that arose as Ben did not understand the interviewer’s English. Therefore, this comment cannot be interpreted as uniquely Ben’s, and the validity of his positive response is very much compromised by my use of the phrase “running around everywhere”, as this is a deficient description of *one* (hyperactivity) of the many possible symptoms possibly representative of ADHD.

When Ben was asked how he would react (would he be concerned or worried?) if he noticed some of these behaviors in one of his own children, Ben commented, “Yes, if they don’t do the good thing, we get mad” (Ben, Text Unit 50). He also said that if one of his children exhibited some of these symptoms that he would try to “talk to him, try to correct him, [he would] say “don’t do that”, “do that thing”, “do this.” You have to do something really nice” (Ben, Text

Unit 52-53). It was my understanding that he was really trying to convey the importance of “doing nice things” in his vision of this hypothetical situation. Again, the desire for his child to “do good” was emphasized in the response to my question,

Interviewer: Would you rather have help, like maybe some advice from teachers or something, about how to handle your child better at home? Would that be helpful, or would you feel ashamed, or embarrassed?

Ben: Well, I might not say anything, but . . .with the child, what to do . . .do the good thing, if I don’t advise them, and let them do bad, they have nothing but bad to do, that is the time I will agree (Ben, Text Units 54-60).

We can see that not until Ben felt he had reached a ‘brick wall’ in his effectiveness, would he have been willing to accept “advice” from others. His ineffective advising would leave him with no other alternative, than to accept the advice of teachers or other professionals. This question seemed to have made Ben uncomfortable, as he reacted to this statement with body language that signified to me sadness. His disposition when he answered this question was different than his disposition throughout the other parts of the interview. I assumed that this would not have been an easy alternative for Ben to have pursued.

### *Frustration and Discipline*

As mentioned before, when children don’t listen, Ben told me that he gets “mad.” As the child’s behaviors deviate from the parents’ expectations of how the child *should* act (meaning listening to the parents’ directions, commands or advice about what to do or what not to do), parents get angry, and they get frustrated. This frustration can lead to the use of physical discipline, as mentioned by both of the parents during the interview. I posed a hypothetical situation where a child repeatedly had problems in school with hyperactivity or inattentiveness, or impulsivity, and the child just could not seem to get “better.” Even after numerous ill-fated attempts to “talk” to the child about the problems, and to enforce the need to behave nicely, the child just would not seem to “listen.” Collin responded with the following:

Collin: It’s really hard, because you say “don’t,” and they touch that, and “don’t touch that thing,” but they do whatever you tell them not to do. And sometimes you lose your

temper, and you try to beat them, which is not nice. But I see parents do that, sometime I try to take my part, and try to talk them out of it, I don't have any patience for that. I feel sad, I feel bad when I just look at them.

Interviewer: Ok, so do you think those parents, I mean, I think you have pinpointed that they feel frustrated.

Collin: Yeah, frustrated, that's the word.

Interviewer: And do you think they might feel sad, or ashamed?

Collin: Yeah, they ashamed, and when you try to talk to them, then they feel bad, and they feel sad, and ashamed because they have lost their temper. And they're frustrated and tried hitting their children (Collin, Text Unit 79-90).

I continued the conversation by asking if Collin thought this was common in Marshallese culture, to spank or hit your children, and he said, "Yes" (Collin, Text Unit 92). Though Collin didn't admit to resorting to this type of behavior, he let me know that it is common practice. In fact, Collin doesn't agree with this practice and actually tries to dissuade people from hitting their children.

#### *Shame in Two Contexts, and the Need for Confidentiality*

Shame is another interesting topic that came up in two different contexts in the discussions with parents. Shame in regards to parents' regret for having lost their temper, was mentioned in the comment above by Collin. The second topic of shame was centered on the shame of having a child with disability. Collin was explaining the uneasiness some parents experience with having a disabled child, and their resultant absence at the Special Parent Organization meetings.

Some, like some of the parents, they don't want to get involved in the Special Parents Organization. They don't accept that their children [sic] is in these a, is having a disability. They don't want to accept that. Some they are ashamed. (Collin, Text Unit 96-100).

One of the most touching examples of the intense sense of respect and love parents have for their children was communicated to me in a delicate moment of the conversation. When Collin was posed with another hypothetical situation, that of his own child exhibiting at least 6 of the ADHD symptoms, for a period of at least 6 months, he shared the following:

Personally, if I was ashamed of the children, then I really don't care about the child, but since I really care about them, I would really try to participate with the teachers or professionals to try to help them to help him or her out. (Collin, Text Unit 134-136)

Collin followed this comment with a response to my question of "What would be the most appropriate way for a teacher or other professional to approach you and your family about this type of problem" (Collin, Text Units 137-139)? Collin replied, "I would like them to talk to me, instead of share with other teachers, and other people about it, at least, one to one...about how to help the child or the family of the child" (Collin, Text Units 140-143). The desire to keep things private with a potential case of ADHD might parallel the uneasiness of other parents with a disabled child, of which Collin spoke. The desire of Ben to want his children to do "good" things, in conjunction with Collin's statement about the desire for confidentiality reflects a possible level of pride that might be involved with childrearing in the Marshallese culture.

#### *Parent Communication with Teachers or Other Professionals*

The difference in these two parents' answers to the question of whether they would like to receive advice from teachers or other professionals, regarding their ill-fated attempts to correct their child's behaviors (which were explained to be symptomatic of ADHD) were interesting. Ben's response was, "Well, I wouldn't be happy, and I need to chat to the you know, I need the teacher to make counsel to the child and..." (Ben, Text Units 125-128). I added in, "And to make suggestions?" and Ben answered, "Yeah, and to try to counsel" (Ben, Text Units 127-128). I asked Ben if he thought he might feel sad, and Ben replied, "Yes" (Ben, Text Unit 130). At this point in the conversation, Ben became quiet, and his head lowered, with what I would say, a state of defeat, or sadness, or helplessness as described earlier in these sections. His body language prompted me, to use the word "sad," as I was merely interpreting Ben's physical behavior. That

he mentioned the words “counsel,” which was similar to “advise,” and “talk to,” on several occasions was also revealing. It seemed that Ben was under the impression that he would be able to “talk” a child out of this problem, and if he couldn’t do it, then the teacher might be able to “talk” and “counsel” him out of the problem. There was a lack of words implying a specific “action” in Ben’s speech that makes me wonder about his understanding of the origins of the disorder.

Furthermore, when asked about the most appropriate way for teachers and professionals to approach Ben and his family, he replied, “Well, if they ask me to let them take care of the child, and give him more advice, I would be happy” (Ben, Text Units 136-137). This separation between teachers and professionals, and Ben’s efforts to help the child is unique to Ben.

Collin, on the other hand responded to the same types of question with this insightful thought.

Collin: Sure, I would listen to them, because they know, they probably know more than I about treating a child with these kinds of problems, they have knowledge and training, what they can do with these children, but me I don’t have, maybe I can take some knowledge from them. They can explain (Collin, Text Unit 147-150).

### *Perceptions of ADHD*

I asked Ben how he felt when he saw children with these problems (symptoms of ADHD). Ben shared with me, “I feel sorry and sad, but we are doing, we can do more better” (Ben, Text Unit 66). The fact that Ben said “we can do more better” prompted me to ask Ben about his understandings of the origin of ADHD, as it seemed he still understood the disorder to be representative of bad parenting. The following conversation occurred.

Interviewer: So, do you think that if a child was having these problems, do you think it is because of how they were raised, or something in their mind?

Ben: Maybe from how they were raised, and then something happened in their...(silence).

Ben: "Yeah, sometimes when we see some kid that always makes a bad thing, we ask hey, that kid, what their family doing? We ask the history of the family, they always complaining, and they quibble with people, and that is why that kid, these kids act like their family, because they raised him badly. They don't teach him, and you know..."

Interviewer: So maybe it's more of a discipline issue.

Ben: Yeah, discipline, yeah. Many kids have seen in the school, or anyplace. I see them.

Interviewer: Ok, so some of these problems could be because the way a child is raised?

Ben: um hum, yes.

Interviewer: But it could also be things in their mind.

Ben: Yes. (Ben, Text Units 67-84)

The question of whether Ben thought ADHD behaviors were a product of either "how a child was raised," or merely something "in the mind" was not how it was explained to Ben. The phrase "in the mind" was the phrase Ben used in repeating his understanding of the disorder to me when ADHD was explained to him in the beginning of the interview.

Though the opening question in the previous excerpt may have seemed very leading I used Ben's language so that I could gather more information about his understandings of the disorder. So much of what Ben was saying made me think that he thought ADHD was a result of bad parenting. I was trying to respect his answers and understand them for what they were, plain and simply, without trying to change his understandings of the disorder.

From what was expressed in the interviews, these two parents assumed a heavy measure of responsibility in terms of how a child acts in public, and how that child will be perceived in the community. This portion of the conversation was emphasized by Ben's final statement of the interview, "...well, I don't know, but I can see that this is a really important question. And everybody get problems with these" (Ben, Text Unit 140-141). The fact that everybody might have these problems made me wonder how well Ben had understood my explanation of the disorder.

*Familiarity with ADHD*

For question (1) “Before today, had you heard about ADHD/ADD?,” both parents answered “No.” Therefore, the following questions were omitted from the interview: (2) “If yes, what do you know about the disorder?”, (3) “From whom did you hear about the disorder?”, and (4) “What does Attention Deficit Hyperactivity Disorder mean to you?” or “Please explain your understandings of ADHD”.

In response to question 5, which asked whether the parents felt there were students in the family or community who exhibited any ADHD-like behaviors, as listed in the DSM-IV criteria that was read to the parents, Collin answered by stating,

Collin: Yeah, I think we have quite a few

Interviewer: Yeah? Ok, what sort of behaviors have you noticed before?

Collin: The hyperactivity and impulsivity. I know there is a little boy, that, he is my neighbor.

Interviewer: Oh really, he has some of these problems?

Collin: Yeah.

Collin’s example of a boy, who might demonstrate problems with hyperactivity or impulsivity, fits nicely with the amount of research on this topic. Since boys are more prone to disorders of the nervous system, they are more likely than girls to develop ADHD (Barkley, 1998). Ben used the word “him” whenever I asked him to entertain a hypothetical child with symptoms typical of ADHD. I am not sure if this is because Ben only has male children, or if he was speaking from his own experiences in which boys were the primary exhibitors of behaviors which sounded like ADHD.

When I asked if he thought these behaviors would cause any trouble between the child with ADHD-like symptoms and his or her peers, Ben said “No” (Ben, Text Units 45-46). Ben commented “It’s you know, no different. They don’t fight”(Ben, Text Unit 44). Collin however, suggested, “To tell you the truth, a lot of kids doesn’t want to play with him” (Collin, Text Unit

19). Perhaps in some situations, children with ADHD-like behaviors are less “fun” to “play” with, due to their difficulties with social situations.

#### *Summary of Findings from Interviews with Parents*

Overall, findings from the interviews with parents provided background information regarding the Marshallese culture. Parents’ answers to my questions revealed a strong sense of connectedness among family members, or a collectivistic culture. The living situation in the Marshall Islands consists of 20-30 family members living in one house. These tight living quarters create an intergenerational approach towards child-rearing. Parents shared with me the importance of encouraging their children to “do good” and to “do nice things” for others in the family, or in the community. A child must listen to their parent’s advice regarding how to “do good things.” When the child does not listen to the parents, parents often feel shameful, and might use physical discipline. Should a child exhibit ADHD-type behaviors, parents might feel uncomfortable receiving advice from an outside party regarding how to deal with their child more effectively. Though parents say that they have not heard of ADHD, both of the parents were familiar with ADHD-type behaviors.

#### *Findings from Interviews with Teachers*

##### *Interviewees’ Educational Training and Experience*

Seven special education teachers were interviewed. Five of the seven teachers held an Associate of Science degree in Education from the College of the Marshall Islands (CMI), which is a two year program. One of the interviewees attended a community college in Portland, Oregon, and graduated with an Associate of Science degree in Education as well. I was not aware of this until the very end of the interview. Although the goal was to speak with teachers trained only in the Marshall Islands, I found it appropriate to keep this teacher’s responses in the study, as he had very insightful answers, especially since he had never heard of ADHD, even after having been educated in the United States. One teacher had become certified to use American Sign Language in Kwajalein, the U.S. military base in the Marshall Islands. She is the only certified American Sign Language interpreter on Majuro. Another teacher had not attended any

college; his highest level of education was his high-school diploma. Years of teaching experience ranged from one year to over twenty years.

#### *Characteristics of Interviewees' Students*

Interviewed teachers worked with all types of children. Some of the students were considered "slow learners" (these children have problems with reading, writing, speaking, or behavioral problems, which we will see later might be behaviors typical of ADHD) and some have multiple disabilities. In the class with students with multiple disabilities, three students are split among three teachers. Some of the students in this class are deaf, or blind, and some have other physical disabilities. Another class consisted of ten students, six were deaf, and four were slow learners. These ten were divided between two teachers.

Some of the students had just returned to school after an extended absence following preschool. These students were two or three grades behind their expected reading level, and thus are labeled "slow learners." Some of the teachers were in the classroom with the same students all day, whereas other teachers accompany students who are included in some regular classes throughout the day, such as computer, sewing, cooking, carpentry or carving classes. Students' grade levels (of the interviewed teachers) ranged from kindergarten to 12<sup>th</sup> grade.

#### *Familiarity with ADHD*

Out of the seven Special Education teachers interviewed, four had heard of ADHD, and three had not. Two of the interviewees had been given a description of the disorder by their supervisor, in order to prepare them for the interview, unbeknownst to me. Of those two, one had heard of ADHD before and one had not.

#### *Training with ADHD*

When speaking to the interviewees about their previous exposure to ADHD seemingly inconsistent results appear. Whereas some (4) teachers claimed they had been told about ADHD through workshops given to all Special Education teachers in the Marshall Islands, not all of the Special Education teachers knew about the disorder (3). One of the teachers talked about visiting the island of Hawai'i and Guam for workshops, and another teacher claimed,

I heard it from a workshop. There was once a Special Ed. workshop and they came out with this. There were two [workshops], every summer, last maybe two or three years ago, and last summer, there was one lady from the University of Guam, she came to do a workshop with all the Special Ed teachers. (Rhea, Text Units 36-42)

One teacher recollected some of the content of a workshop she had attended. She told me that they had learned about “The behavior of the child, and what we’re going do about it, and the teacher, how to detect it” (Jenny, Text Units 13-14). Another teacher claimed, “That’s one of our problems, we haven’t trained for like, behavior, to handle these kinds of problems” (Gil, Text Units 194-195).

### *Perceptions of ADHD*

After listening to the teachers' comments, I posed the question, “It sounds like ADHD is not something known about here in the Marshall Islands, is that so?” Four of the teachers agreed with this statement. In fact, Jenny tells me,

Yes, you are right. Only some teachers know. Probably regular ed [teachers], they don’t. Some teachers just don’t care, they just ignore it, and you know, they think that it’s just not their problem. Sometimes they might say, “Ok, we will give them to Special Ed because they will know about the problem.” They just give them to us, yeah. We have many, many problems. (Jenny, Text Units 364-371)

When Gil and I were going over the criteria for the diagnosis of ADHD, Gil confidently assured me that these behaviors were present in both the regular education classes and special education classes (Gil, Text Units 41-44). While I was reading the DSM-IV criteria for ADHD, Gil asserted, “Um, this is clearly stated, all the problems that we have with our students” (Gil, Text Unit 97). To further clarify, I asked Gil, “So in order for a child to be diagnosed, they have to meet six of the criteria in one of these categories for a period of six or more months. Do you think that your answer still holds?” Gil answered, “Yes” (Gil, Text Units 111-112).

Differences among perceptions of the disability between Special Education teachers take place in an environment textured by many variables. Some of these variables will be explained in the following sections: opinions regarding the etiology of the disorder (Nature versus

Nurture), levels of activity in any given classroom, which may vary by teacher and/or students (Activity Levels in Marshallese Classrooms), and financial and temporal constraints (Constraints: Money and Time).

#### *Nature versus Nurture*

In Rhea's interview, when speaking in more general terms, she claimed that mostly it is the responsibility of the family to discipline the child in order to eliminate the possibility that the child will exhibit behavioral problems.

I believe that maybe um, this kind of problem is, I think it started from when the child, because I believe everybody is born with behavior, a kind of behavior, different kinds of behaviors, like when the child is being born, and then it's the family's responsibility to teach him or discipline him, from the time he... for whenever he starts to grow up. (Rhea, Text Units 12-16)

However, when Rhea was talking about a specific student of hers, she stated that sometimes there is a biological basis for a child's behavior, but that the way the behaviors manifest depends on the way in which the child is raised. Regarding one of her students who had problems with hyperactivity, inattention, impulsivity and memory:

Interviewer: Do you think his problem is mostly like how his life is at home, how he has been raised, or do you think that it's something in the wiring in his brain? Which do you think?

Rhea: I think maybe sometimes it's from his home and from his brain. (Rhea, Text Units 229-231)

#### *Activity Levels in Marshallese Classrooms*

I became curious about what might be considered acceptable levels of behavior after visiting five different classrooms, each with widely varying degrees of activity. Some of the classes' students were very well behaved, students were in their seats doing individual work, but other classes were very active. There was one class where the teacher was trying to conduct a lesson in English about health, and the students were moving around freely, talking among

themselves, listening only sporadically to what the teacher was saying. I asked Gil if it is acceptable for children to get up out of their seats, and Gil replied,

No, it's not. We do follow all the regulations with high school policies. So we take that up to attendance, their behavior, their uniforms... and they do know all about these rules and regulations. (Gil, Text Units 246-252)

*Constraints: Money and Time*

Since Rhea stated that she was familiar with ADHD, I asked the question, "Have you ever heard of a child having an IEP because they had been identified as having ADHD?" Rhea answered, "No, I haven't" (Rhea, Text Units 419-420). (I should have specified to Rhea that in the United States, a child would only receive services under IDEA if ADHD was causing the child to experience academic difficulties, causing him to fall behind his same-age peers.)

According to Lynn, a possible explanation for the reason why ADHD has not been readily identified or discussed might be due to financial restraints within the Ministry of Education (MOE), and therefore the financial and time constraints of individual teachers. Added expenses incurred when visiting a parent, taxes the personal resources of individual teachers.

Interviewer: So currently ADHD is not really discussed it sounds like....

Lynn: It should be, but you know, I think the problem is money, not having the money to do another thing outside their job. Like we might have a Special Ed person go to their home, to talk to the parents, something like that, but we don't have enough money for that.

Interviewer: I see, does it cost money to have an IEP meeting?

Lynn: Well, you know, I have to take a taxi because I don't have a car, it costs money to take a taxi, and you know if I take a taxi, I might stand there for thirty minutes, waiting for a taxi.

Interviewer: So it's a big time commitment, too and you're busy already with your students...

Lynn: Yeah, and I already have students here. (Lynn, Text Units 74-89)

### *Status and Stigma*

Two statements from one of the teachers regarding her student pointed towards the potential negative perception associated with the disorder. While discussing a student who is related to a very well known person in the community, this teacher was reluctant to put a label on the child's condition. Though I was unsure if her avoidance of labeling the child was typical of Marshallese culture, or unique to the student's situation, her comments warranted close consideration for the purposes of this study. She described this child's behavior in the following excerpt, "He can sit still for like 5 minutes, and then, pew-pew, he is all over the place" (Rhea, Text Unit 185). She also noted that whenever he hears someone talking outside, "He just stands up, opens the window, and even though they are not talking to him, he says, 'Hey what are you doing?'" (Rhea, Text Units 254-256). On two occasions during our interview, I asked if Rhea thought this child might have ADHD and she deflected the question. The first time, instead of answering the question, she explained to me that this boy is a relative of the aforementioned figurehead in Majuro (Rhea, Text Units 203-205). The second time, she started to explain some other aspect of his behavior, involving his tendency to kick other children when he doesn't get his way (Rhea, Text Units 238-245).

### *Slow Learners*

The category "slow learners" came up in conversation with several of the teachers. Children who are placed under the "slow learner" category, are given an IEP, and put into special education classes. These could be children who have missed out on the first few years of school, and are now are trying to catch up. They might be children with reading, writing, or speaking abilities, or they might be children who are considered to be hyperactive, impulsive, or inattentive. These children may have learning disabilities, or they may have other emotional problems. Lynn states,

They [slow learners] are regular children, but the problem is that they are too slow. The problem is that they didn't go to school when they should have been going to school. They were attending Head Start, the school, and when they come to school maybe 10 or 11 years, they decide to come back, and I give them a test that show where they are,

that shows that they should be in the 7<sup>th</sup> grade or in the 8<sup>th</sup> grade, but it shows that they are really low level, maybe at the first grade level...It's difficult because I start from the beginning, I show them how to write A, the letter, when they are 7, 8, 9. (Lynn, Text Units 38-55)

These children are already so far behind when they start, that they are at a huge disadvantage from the beginning of their educational experience.

Rhea explained to the interviewer about children in the "slow learners" category, are "those are the multi-group, they have two or more than two disabilities...like learning disabilities, and those hyperactive disorders" (Rhea, Text Units 415-417).

Gil explained IEP process in regards to "slow learners."

Gil: What we do is we follow their IEP. Their capabilities... from that, we give them, according to their level of understanding, in reading, or math.

Interviewer: Ok, so has there ever been a child that was given an IEP just because you might think that they might have ADHD. Has a student ever been identified as having this disorder? That you know of?..

Gil: We hardly identify them as ADHD. But we place them under "slow learners." (Gil, Text Units 199-204)

Gil explained that the term "slow learners" encompasses hyperactive children. He reminded me that the use of the word "disorder" is less often used, instead they used the term "slow learner". Gil continues, "And this is the term that we have been using with most of the programs we have in the Marshall Islands. We don't call them "disorder", or "hyperactive". We call them "slow learners" (Gil, Text Units 207-208).

Gil: They don't have problems in any activities that they do, but the only thing is reading, writing and spelling. But when you ask them to do something, they do, but their attention and their behavior, is what makes them, like if you if you give them a task they can maybe participate maybe for only 3-4 minutes, and then they are lost,

Interviewer: So, maybe because they have a problem with attention, they don't really read or write very well.

Gil: Yeah, yeah. (Gil, Text Units 211-219)

Gil's comment clued me in, in terms of how ADHD-like behaviors are managed within the Special Education system in the Marshall Islands. Children who exhibit ADHD-like behaviors are usually placed in the "slow learner" category.

#### *Most Problematic Behavior*

When asked which of the behaviors from the DSM-IV criteria was most problematic, I was hoping that the teachers would mention some of the specific behaviors listed under the three categories hyperactivity, impulsivity, and inattention. Instead of mentioning behaviors such as "often fails to give close attention to details or makes careless mistakes in school work," "often has difficulty organizing tasks or activities," or "often fidgets with hands or feet or squirms in seat," teachers chose the broader categories, either hyperactivity, inattention, or impulsivity. Helen and Jenny both claimed that hyperactivity and inattention would be the worst problems in the classroom, while Serena and Lynn claimed hyperactivity to be the biggest obstacle for instruction. Curt said it would be inattention, and Rhea named hyperactivity and impulsivity to be the most troublesome behaviors.

#### *Presence of ADHD in Your Class*

When asked whether, after having read through the DSM-IV symptoms, the teachers believed they might have children in their class who exhibit some of the behaviors, seven of the teachers responded with a "Yes."

#### *Examples of ADHD-like Behavior*

Many teachers offered example behaviors that exemplified to them, what might be ADHD symptoms during our interviews. By describing some of the examples shared during the interview, I am trying to present to the reader how some of these teachers viewed students in their classes in light of our conversation of ADHD. Specific questions asked were meant to find out exactly what teachers might think ADHD looked like in their classes.

Some of the examples of behaviors that were considered to be ADHD by the teachers after having read the DSM-IV criteria were behaviors that might be associated with some aspects of the disorder, while others might be attributed to other emotional or behavioral problems. Some

of the behaviors listed included: stealing from other children, lying, interrupting the teacher, or inability to sit still for extended periods of time. There were also more positive behaviors mentioned, balancing the negative aspects of a child's behavior. Two of those more positive behaviors were above average displays of creativity, and an above average reading ability.

Helen described one of her troubled students,

What do you call a student with this kind of behavior? He comes to school, and steals all those, steals away things from the other students, like their things, and give to other students, and then he always tell a lie. He never tells us anything. He has a problem. Do you know how many times my principal talked to him? Maybe, if I remember, 5 times.

He goes from one classes, take their belongings, and takes things to the other class.

(Helen, Text Units 120-126)

Helen explained how she had tried talking to the parents of this child at least three times, but that the parents don't even know how to handle the child's behaviors. Even the parents said, "I don't know what else to do" (Helen, Text Unit 119). Unfortunately, I am far from being skilled enough be certain what exactly this particular child is experiencing.

While I was interviewing Selena, asking about the worst problem that she faces as a teacher with children who might portray symptoms of ADHD, a student of hers walked in, interrupting her mid-sentence. Just as she was saying, "The worst problem that I face is that when..." (Selena, Text Unit 132). Right at this point in our conversation, the student walked in. There was much discussion in Marshallese, and Selena became suddenly distressed. She was upset that the student would not leave despite her pleas for him to leave us alone. I offered to stop the interview, or to continue on somewhere else, or to continue on where we were talking, with the student present, as long as the student remained quiet. She repeatedly apologized to me, in between her firm, yet controlled attempts to make the student understand the inappropriateness of his unannounced entrance into the room. Selena continued, "That is the kind of problem we have, that boy. I don't know...I feel that his mind always runs through" (Selena, Text Units 136-137).

Another teacher talked about a student of hers from the Philippines who was an exceptional reader, but yet still he struggled with behavior problems and was unable to sit still. Selena claimed, “He is six years [old] but he reads like a high school student” (Selena, Text Unit 22-23). This student had trouble with sitting still, and therefore, “He cannot attend a regular school because he has some problems with behavior. He can’t sit still so he needs a teacher to be with him all the time” (Selena, Text Units 28-32).

Rhea spoke of a child who expresses himself primarily through drawings. This child was discussed earlier in the paper (section on Status and Stigma) with regards to his unruly behavior patterns and the complexity of his situation as he is a relative of a well-known businessman in Majuro. When he is creating art, Rhea says he is the most productive, and well behaved. She explains,

He has lots of energy, he really likes fishing, that’s one thing, he really likes fishing, whenever he came to school, he always have story that they went to the small island, and they fished. And I said, oh can you draw what you did last weekend, and he started to draw fish and boat and ski, and I say what is that? He says that’s the boat that we went on. (Rhea, Text Units 221-226)

Gil sums up the situation best when he comments about the children in the school's special education programs. He claims, “Most of our students are having the same problems that are listed on this disorder. It happens mostly with their work, and their attention, and their behavior in class. There are a couple of students here, “that they act really hyper, they shout, and they cannot sit still” (Gil, Text Units 236-237).

#### *Strategies Used When Dealing with ADHD*

The teachers had many different strategies to deal with difficult behaviors in children that might possibly be diagnosed with ADHD. Some of the strategies employed by the different teachers included finding things that interest the student, and rewarding him or her with that thing after he or she can pay attention or sit still for five minutes. Another strategy involved playing music when the child gets angry. Two teachers mentioned keeping the student as busy as possible

so that he or she is always working. One teacher reported that she would try to contact the parents to invite them in for a meeting to discuss their child's behavior.

Since every day is different, and each child is different, when I asked Lynn if he had any other behavior management strategies, he replied: "Well, it just depends you know, there are a few days that I decided something else, just depending on the problem they have" (Lynn, Text Units 69-73). One of Lynn's strategies involves the following: "For the one I said that he can walk anytime he wants to" (Lynn, Text Unit 26). Lynn lets his hyperactive student walk around the room whenever he feels the need to get up and move around, thus eliminating the need to stay seated for an entire class. He even said that he tries "to do some modeling" (Lynn, Text Units 33-35). He tries to explain to his students what they are to do, and tries to make sure that they understand the directions before they get started on any activity.

Rhea employed modeling in her classroom as a strategy to help her with children struggling with behavioral challenges. Rhea tells how she tries to use the negative behavior of one child to deter future episodes of the same behavior in either the same child, or in other children in the class.

Yeah, sometimes when we do something that is new, like something that is new for the other students, right away we just stop him. That's when we try to stop it. And then I try to explain why it's not better to do that. I try to explain it to their classmates. (Rhea, Text Units 132-136)

Rhea claimed this was a successful way of quickly extinguishing a behavior.

Another very successful tactic employed by Rhea involved creating a more positive alternative to the negative situation. Rather than reprimanding the child, Rhea planted a very alluring, positive idea within the mind of the child who was misbehaving.

There was one time he was playing around this chair, like running around, and I said, "[Student's name], do you want to have that kind of chair?" And he said "Yes", "Well you have to do your class work, and so when you can grow up will become a teacher, and you can have that kind of chair." "Oh", he says "Emmon\*, that's cool!" "I'd like

to have that kind of chair!” (Rhea, Text Units 195-201) (\*Emmon is Marshallese for that’s good, it’s cool, or it’s fine)

The last example that was mentioned by Jenny shows the importance of collaboration between teachers. Rhea asked Jenny for advice about what to do with a child who had been having problems with hyperactivity.

Like for [Student’s name], the first time he came here, Jenny and I we just talked, and we thought, “What do you think we can do, so that we can help him while he is hyperactive?” And we talk and I say, “Can we separate him from the others?” “Ok, let’s just work and see if it can work out.” (Rhea, Text Units 283-286)

And so, the teachers decided to separate the student, and give him his own space, so that he does not distract the other students. His desk sat apart from the other students, though he was still able to interact with the other students during group activities.

#### *Perceptions of Children Exhibiting ADHD Behaviors By Their Peers*

Results from question 6 varied widely. The way children who exhibit ADHD-like behaviors are treated by their peers ranged from, (a) mutual respect and no difference in behavior, to (b) being teased, (c) getting beaten-up and punched, or (d) having personal items stolen. While one teacher claimed, “They are having a different concept of these children” (Serena, Text Unit 60), another teacher claimed, “They don’t tease them any more” (Gil, Text Unit 132), and that they are even “quite accepting” (Gil, Text Unit 245) of children experiencing problems with hyperactivity, impulsivity, or inattention.

#### *Teachers' Emotions Involved in Dealing with ADHD behaviors*

Some of the emotions teachers reported as having experienced upon working with children with behaviors that might be suggestive of ADHD include feelings of (a) sadness, (b) frustration, or (c) that the teacher has failed his or her student(s). One teacher stated her desire to further her education in order to help her understand her students and to help her students more effectively. She said, “I feel like I want to go to learn more...so I can come back and help the, help my students” (Serena, Text Units 63-64). Another teacher sympathizes with other teachers and students in the classroom who might be disturbed by her student’s behavior.

Sometimes I'm kind of frustrated because other students, other teachers are working, so I am trying to calm him down so he can behave like the others, are having their works, and he is just running around and around. I think, "please stop!" (Rhea, Text Units 122-127)

Gil offered his opinions regarding how he felt when he first started working with Special Education students, after already having been a regular education teacher for seven years.

Interviewer: Ok, let's talk about how you feel about these kids. How do you feel when these behaviors happen? Like if a student is hyperactive, or inattentive...

Gil: You know when I first start working with these students I feel like [I want] to quit right away. But things change, from the help of God. (Gil, Text Units 174-175)

Gil turned to his spiritual strength to help him get through the challenges of teaching and working with these children. The interviewer asked if Gil's feelings had changed about being a Special Education teacher, and he said "Yes" (Gil, Text Units 169-170). Now, Gil says that he enjoys working with these children.

Jenny claimed, on the other hand, that she has had so much practice with these kinds of behaviors, that she feels comfortable with the way in which she handles situations. She explained to the interviewer her experience:

Jenny: I feel like um, when I went home, the first day I saw that, um, I was surprised a little bit, but well, I can do that. And I go home and do my lesson plans, and come back the next day and say that's the thing I would have done.

Interviewer: If the same thing happened?

Jenny: Uh huh, and I handled it perfectly well. (Jenny, Text Units 330-336)

### *Importance of Identifying ADHD*

When asked if the teachers thought it is important to identify children as having ADHD, all of them responded with a "Yes". Jenny's answer provided some reasoning for her positive answer in the following:

Yes, yes, so that we can try to eradicate the behavior, get rid of the behavior as soon as possible, before the child is going up to the upper levels, and getting older, and then there is nothing we can do about it. (Jenny, Text Units 382-385)

Since some of the teachers talked about the difficulties with reading and writing in children that might have problems symptomatic of ADHD, the interviewer found the following statement interesting.

Interviewer: I guess why I'm asking that is, um do you think it would be important to identify these kids as having ADHD so we can help them, like for example, with their reading and writing,

Gil: Yes (Gil, Text Units 263-266).

#### *Need for Advice Regarding How to Manage Children with ADHD?*

All of the teachers, when asked, reported that they would like to receive further information regarding the disorder, the etiology of the disorder, and how to handle these children in their classrooms, and how to approach their parents so that the children's behavior can improve at home, too.

#### *Nutrition*

One of the themes that I found important was the mention of nutrition, or lack thereof, among some of the students. Two of the teachers gave explicit examples of how nutrition might come into play in the classroom.

Jenny: Some of them, sometimes maybe they don't eat breakfast, they don't get enough to eat.

Interviewer: So they don't have enough energy.

Jenny: Yeah

Interviewer: So what would you do in that situation?

Jenny: Ask them if they ate anything, and they say "no", and I take them to the store, and buy them something to eat. So next, the student come back to the classroom.

Interviewer: And maybe then they were more attentive?

Jenny: Yes (Jenny, Text Units 35-43)

Another example was brought up by another teacher regarding too much of the wrong kinds of foods. Jenny explained that the parents,

When they [the kids] cry, they give them their chocolate, and they just...and they just say here ok... they like to calm them down with that, and then they say, ok, they're calm now (Jenny, Text Units 53-55).

Giving kids chocolate in order to make them be quiet, or to behave more appropriately could actually be making their behavior worse. In a sense, instead of alleviating the problem, chocolate could produce the reverse of what the parents assumedly want.

### *Parental Involvement*

Upon discussing behaviors, which might be deemed ADHD, several teachers brought up the importance of parental involvement. Since no official system is currently employed to bring a child who might have ADHD behaviors under the IEP for that sole purpose, teachers rely on cooperation from the parents to form an alliance to help the child behave more appropriately in the classroom. Different teachers reported different experiences with parent involvement and parent communication. While Helen lamented the fact that she does not see some of the parents from the beginning of the school year until the end of the school year (Helen, Text Units 108-109), Gil said that it was his general opinion that parents want to get involved (Gil, Text Units 308-309), and that parent involvement has been rising over the last few years (Gil, Text Units 139-140). Serena mentioned that she has to go visit the parents herself sometimes, in order to see them (Serena, Text Units 72-73) and that sometimes she sends a letter home (Serena, Text Units, 105-108). Helen tried to send notes home to the child's family (Helen, Text Units 40-41), and Selena said that she sometimes calls the parents (Serena, Text Unit 64).

An interesting insight into parental involvement and its role in the management of ADHD-like behaviors in the Marshall Islands was made apparent by a comment by Gil. Gil looked ahead on the questionnaire to number 13, which asked, "How should teachers help a child

who might be identified as having ADHD?" Gil explains about the process that occurs when a child is misbehaving.

See for number 13, what we would do most of the time, if the student is misbehaving, we do call the parents. We have a form like AC6, we write a consent form to parents to have them come in, so that we can discuss with them, and this is what we mostly do with most of the students that are misbehaving. We follow up with their parents, we sit with them, talk to them...And it seems to work, because sometimes the students, you know, they start improving at once. That's the only kind of treatment we have (Gil, Text Units 270-276).

When the interviewer asked how effective that was, Gil replied, "Most students, they change, I think it's all part of the custom to discipline" (Gil, Text Units 279-281). This statement shows how parents are expected to discipline the child, in order to control his or her behavior in the classroom.

However, a problem surfaced in light of the need and desire of teachers to want to communicate with parents by sending a letter home. Serena explained how one of her children's parents failed to come to meetings that Serena repeatedly invited her to with countless letters. The mother told Serena, when Serena finally made a trip to the child's house, "I failed to come to the meeting because I don't know how to read" (Serena, Text Units 107-108). The fact that this mother didn't know how to read could be a huge obstacle for attempts to get this parent involved through written communication.

### *Shame*

One of the things that might prevent parents from returning calls or letters, or to come into meetings with the teachers might involve shame. Shame is something that was mentioned by a few of the teachers in relation to having a child with any sort of behavioral problem. Serena expanded on the topic,

I think one of the problems that we have in the Marshall Islands, with the parents, some they are kind of ashamed of their kids, they don't want people to see [their kids],

because they are ashamed. And then they don't want to talk about it too much (Serena, Text Units 88-95).

*Improvement in the Perception of Disabilities in the Marshall Islands*

Mention of shame should come hand-in-hand with the topic of improvement in the perception of disabilities in the Marshall Islands. There are still a few kids who tease other kids about having a disability, according to Serena's comment, "yes, some do [make fun of kids with disabilities], they call them names, when they see people like that walking around (Serena, Text Units 122)." However, the general sentiment towards people with disabilities continues to improve. Helen, Rhea, Gil, and Lynn all mentioned that support for Special Education programs has increased, support of the community for certain activities such as Disability Awareness Week, and the general attitude of other students and people in the community towards people with disabilities has improved tremendously. Before the change, which took place maybe in the early 90s, Gil commented about the parents in regards to the IEP meetings, "they were afraid to refer their kids to the program, but now every month, all parents are coming" (Gil, Text Units 134-140). I asked Gil about how disability issues became more widely known about in the community, and he answered:

Gil: From the awareness programs that we have been doing. We do have Disability Awareness Week.

Interviewer: What does that involve?

Gil: Just informal activities. It's like Education Week, we have a parade, and floats, and parents come together, and now the community, is getting involved, and parents taking part in all the activities (Gil, Text Units 153-158).

Lynn also mentioned the increased communication with parents during the IEP meeting as one of the reasons that maybe the morale of parents has risen in regards to their children with disabilities. Lynn stated, "Yeah, well they are attending the meetings, and by just you know, we are during our IEP meeting, we explain everything to them, are talking to them about their due process, their rights" (Lynn, Text Units 149-151).

*Summary of Results from Interviews with Teachers*

Out of seven special education teachers, four had heard about ADHD, and three had not. The four that had heard about ADHD said that ADHD is not well known or discussed in the Marshall Islands. Some of the variables influencing the perceptions of ADHD among the teachers included a) nature versus nurture, b) status and stigma, c) shame, and d) time and money constraints.

In terms of nature versus nurture, some of the teachers felt that ADHD-type behaviors are a result of bad parenting. Some of the teachers' comments hinted toward the importance of status of certain children, and the associated stigma that might occur as a result of being labeled as ADHD. Shame was also a topic brought up by teachers when discussing ADHD-like behaviors. Teachers felt shameful when they had a child in their class who might have been exhibiting ADHD-like behaviors. The teachers also referred to the shame that parents might experience as a result of teachers reaching out to the parents in hopes of increasing communication about the student exhibiting ADHD-like behaviors. Time and money restraints might be one way to explain why ADHD is not readily known about, or covered under the current special education program in schools in the Marshall Islands. However, children that do exhibit ADHD-like behaviors fall into the category of "slow learners." Children that might be considered as ADHD in the United States are not identified as "hyperactive" or "disabled" in the Marshall Islands, they are called "slow learners." All teachers wanted further advice on how to manage children who exhibit ADHD-like symptoms.

## CHAPTER 5

*Summary of Findings and Discussion**Summary of Results for Parents*

Since ADHD is not a disorder that is recognized, or is not worked into the system to warrant an Individual Educational Plan, I didn't think it would be possible to find a parent with a child with ADHD. Perhaps I could have asked around to find a parent who had a child with ADHD-like symptoms, and speculated that the child actually might have what we consider in the United States "ADHD", but given the limited time constraint of a ten-day trip to the Marshall Islands, it wasn't really feasible.

Since neither of the parents knew what ADHD was, one could say that most of the questions were hypothetical. Subsequently, there is not an abundant supply of what the parents thought of ADHD, and how the parents thought about the disorder itself. The whole process with parents was much less structured than interviews with the teachers as I was trying to think on the spot to get the most relevant information from them in a short amount of time. Since neither of them had heard of ADHD, I was really trying to seek out how they might have viewed behaviors symptomatic of ADHD in their children, or in other children in the community. ("How parents might have viewed behaviors symptomatic of ADHD in... other children in the community" was added in spontaneously during the interview.)

Overall, the two parents interviewed did not know about attention-deficit/hyperactivity disorder. Interviews with parents provided more background information regarding the *culture of family* among Marshallese. A strong element of collectivism pervaded the interviews with Ben and Collin during which, it was explained that extended families live together, child-rearing is an intergenerational task, and children are encouraged to "do good" and to "listen" to one's parents. When children don't listen to the parents, or misbehave, parents feel shameful. Parents also feel shameful when their children exhibit ADHD-like behaviors. Though the use of physical discipline was mentioned, a very gentle, yet prominent element of quiet pride pervaded the conversations.

I sensed the desire for children to grow into responsible, well-behaved young adults, among the parents interviewed. Parents try to encourage their children to make good decisions about how they choose to conduct themselves. With the hypothetical situation in which a parent's child might display symptoms of ADHD, the parents would try to correct the situation on their own, by advising and talking to the child. However, if the strategy was not successful, then the parents would agree to accept some advice or intervention from teachers or other professionals.

Both parents had children, but I assumed that neither had a child with ADHD, as neither of them mentioned that their own children exhibited ADHD-like symptoms. However, this could be a result of social desirability, I will never know for sure. Both parents, however, were able to give examples of what they thought ADHD might look like, after having read through the criteria for ADHD. Both parents referred to boys when asked to give examples of ADHD behavior that they think they might have noticed in their community.

#### *Summary of Results for Teachers*

Four of the teachers had heard of ADHD, and three of them had not heard of ADHD. Some of the teachers had heard about ADHD through training workshops. All of the teachers however, were able to give examples of what they thought ADHD might look like, after having read through the criteria for ADHD. Symptoms of hyperactivity, impulsivity and inattention were all provided by the teachers as possible ADHD behaviors

Though ADHD is not identified in the Marshall Islands, children with behaviors thought to be symptomatic by the teachers are identified and placed under the "slow learner" category in their Special Education programs. As "slow learners," these children receive the services they need in order to succeed in school.

The various reasons teachers offered as to why hyperactive, impulsive, or inattentive behavior is not defined as a specific disorder, that we in the United States call ADHD are, time and money constraints, status and stigma, and the fact that these children are accommodated for under the category of "slow learners". Children that might have problems with hyperactivity or impulsivity, or inattention are not called "hyperactive" or "kids with a disorder." They are considered to be "slow learners." I am inferring that "slow learners" receive the academic

enrichment that the Ministry of Education and Marshallese teachers see fit for these children in order for them to do better in school.

Some of the emotions mentioned by teachers in regards to working with children who might have ADHD reflected those of parents, and include notions of shame, sadness, and a willingness to learn more to help these children.

#### *Discussion*

Overall, elements of shame and frustration resulting from a child who doesn't "listen," or "do good things," affects both parents and teachers alike. Since hyperactive, impulsive, or inattentive behaviors are not identified as ADHD in the Marshall Islands, parents and perhaps some of the teachers seem to attribute behaviors symptomatic of ADHD to poor parenting. Parents and teachers hinted towards the desire for children to fit harmoniously into the community, and to not stick out. Behaviors that might appear to be ADHD seemed to threaten the parents attempt to instill this sense of collectivism in their children.

The teachers, it sounded, were at the point of transition in their understandings of ADHD. There was a difference between some of the older teachers' perceptions and the younger teachers' perceptions of behaviors such as hyperactivity, inattention and impulsivity. Maybe some of the older teachers were feeling the same way as the parents, that behaviors typical of ADHD could be the result of bad parenting. However, most of the younger teachers were more aware that these behaviors can be the result of a biologically based disorder. Either way, every teacher mentioned a sense of pride in his or her students. Each of them, after discussion of children who might be exhibiting ADHD-type behaviors, mentioned that they are improving. I imagine this might be due to social desirability; the teachers wanted me have a positive image of his or her students. Perhaps the way in which they presented their culture to me was a representation of their cultural pride. And, perhaps presentation of their students' behavior might be representative of their pride as teachers. The teachers really seemed to want me to leave the interview with a positive memory of the interview. And it worked! I felt the positive momentum in these teachers' eyes, smiles and voices.

When I was in the process of conducting the interviews, the idea that behaviors which in the U.S. are representative of ADHD were not readily identified as ADHD, worried me. However, after reading through the materials and thinking about the large degree of compassion and care that was evident in these teachers' approach towards teaching, I realized that they do their best with the resources that they have. The kids are getting identified as needed, under the "slow learner" category, and getting help with their academics. Perhaps information would be helpful for the Marshallese teachers though, in terms of how to better manage children with ADHD behaviors.

The objective of this study was to explore perceptions of ADHD among teachers and parents. Perceptions of the disorder were varied. Parents do not know about ADHD, and some teachers do know about it. Behaviors representative of ADHD in children in the Marshall Islands probably exist with the same proportion, or the same degree of frequency as in the United States. Teachers deal with these behaviors in the best way they know how.

While some of the examples of what teachers and parents considered to be ADHD, some of the cases sounded like a different type of behavioral problem, or perhaps a co-morbid condition. This is not surprising considering almost one-third of children with ADHD also have at least one co-morbid condition, including oppositional defiant disorder, conduct disorder, depressive disorder, anxiety disorder or multiple co-morbidities (Agency for Health Care Policy and Research, 1999). Teachers might have noticed something like conduct disorder, or anxiety disorder, and referred to it as ADHD in the context of these interviews. This is another area in which the Marshallese might benefit from more information, in order to become more familiar with, children with co-morbid conditions.

In terms of Marshallese children coming to Hawai'i, teachers in DOE schools should be aware that ADHD is not readily known about in RMI. Teachers in Hawai'i should know that children with ADHD-type behaviors are often placed in what the Marshallese call "slow learner." If a child without an IEP does exhibit ADHD symptoms, educators should proceed with care and sensitivity towards this new term for new families. If a child with an IEP exhibits ADHD

behaviors in Hawai`i, then the teachers and professionals in the DOE schools should be aware of the term “slow learner,” if they aren’t already. Furthermore, the fact that though the child might have preexisting conditions, ADHD might not have been discussed prior to the move.

### *Limitations of the Study*

Since the number of teachers and parents interviewed for the study was very small, generalizability of the results is very limited. Also, generalizability of the results for teachers is limited because the teachers who participated in the study may not represent the entire group of special education teachers in the Marshall Islands. And the two parents interviewed might not represent the entire group of parents in the Marshall Islands. In fact, the results should only be considered an exploratory study of these 7 individual teachers, and 2 parents.

Another possible limitation was the location where five of the teacher interviews took place. The interviews for Helen, Serena, Curt, Jenny and Gil took place in the Special Education office, where their supervisor and other teachers were working. The conversations could possibly have been heard by anyone working in the building, including their supervisor, and so might have influenced what the interviewers said. Again, the issue of social desirability becomes an issue. Perhaps the teachers felt pressed to answer my questions in a certain way. This might have had significant impact on my findings.

Other limitations of the study revolve around the use of DSM-IV criteria. Perhaps introducing the criteria for ADHD explained in the DSM-IV influenced how the participants answered my questions. Perhaps the participants felt obligated to admit that they had experienced ADHD-like symptoms or behaviors in children in their classrooms because they wanted me to be confident that they were “good teachers.”

Perhaps presenting the DSM-IV criteria so early in the interview was not the most appropriate way to gather the interviewees’ genuine perceptions of the disorder. One teacher even asked me if ADHD was common problem among Marshallese in Hawai`i, after listening to the introduction of the study (Appendix A). This made me worry that by merely introducing the

topic of ADHD in the way that I did, I might have made the participants feel that they *should* have a *problem* with these types of behavior.

By introducing the disorder early in the interview, I feel that social desirability became a veil through which the participants might have answered my questions. The participants might have felt that since I used the DSM-IV criteria that they must also think about ADHD in the same way that Americans do, as prescribed by the criteria. Perhaps they felt pressured to see ADHD-like behaviors as a problem that must be diagnosed and treated, or accommodated for in the classroom should the child experience scholastic difficulties as a result of having the disorder.

Should I have the opportunity to do this study over again, I would probably not offer the DSM-IV criteria at all. Or, I might leave the presentation of the DSM-IV criteria until the very end of the interview, so as to not contaminate the authenticity of their answers. Another way of handling some of these issues might be to split participants into two groups. I would introduce the DSM-IV criteria to one group only, and then compare the answers of the participants with respect to the issue of social desirability. It would be interesting to see if the answers would differ between the two groups.

Although an interpreter was available for all of the interviews, none of the teachers or parents opted to use one. Therefore, all of the interviews were conducted in English. Some of the responses may have varied if interviews were conducted in Marshallese. Validity of responses could also have been influenced by what they thought I wanted to hear regarding ADHD. Their answers may have been simplified in order to deal with the struggle of conducting a conversation in their non-native language. I tried to hear exactly what was said during the interview and transcription process. However, as with any qualitative study, there were inherent risks. I might have interpreted the interviewees' responses according to my own perception of the situations and circumstances.

### *Future Directions*

One interesting thing to examine would be to find out if physicians identify and treat ADHD at all in the Marshall Islands. How the medical community perceives a disorder such as ADHD would greatly influence the perceptions of the disorder among teachers and parents. This would be important to know in the case that a child presents with symptoms of ADHD, a teacher and the child's family might have a better idea of where to go for help for the child. This way, issues of treatment, counseling for the child and for the family, and discussions about ways the family can help provide more structure in the child's life would be helpful. Discussing these issues with a physician might ease some of the stress that is often brought upon by this disorder, in a safe and effective way.

Educators in Hawai'i need to help families know about their rights regarding ADHD should their child exhibit symptoms. Especially since we now know that children that exhibit ADHD-type behaviors are not identified as having ADHD, I hope that educators are sensitive to the differences in the use of the identifying term "ADHD," and the differences in perception of ADHD-like behaviors so that teachers and other professionals can work together to assist the family of the child with care. This need for cultural sensitivity goes not only for ADHD, but for other challenges that a Marshallese child may have as well, and for the well-being of the Marshallese child in general. Workshops about Marshallese culture might benefit DOE teachers and the community in Hawai'i. This research provides a much needed contribution in that direction.

## APPENDIX A

*Format for Interviews with Marshallese Teachers**Introduction*

I would like to talk to you today regarding your understanding of Attention Deficit Hyperactivity Disorder. In the United States, we use the term Attention Deficit Hyperactivity Disorder to describe children who have difficulties with hyperactivity and impulsivity, inattentiveness, or a mixture of both.

As you probably know, there are many Marshallese people who have relocated to the islands of Hawai`i. Therefore educators in Hawai`i need to know more about Marshallese culture so that they can help those students more effectively in school. By talking to you today, I am trying to better understand a little more about your culture, and specifically, about your understandings of Attention Deficit/Hyperactivity Disorder. Educators in Hawai`i should be aware of your understandings of this disorder so that we may more effectively teach children from the Marshall Islands, and interact with the families of those children in a more responsive manner. Should a child from the Marshall Islands exhibit ADHD-like symptoms, we hope to assist the child in any way possible under laws (IDEA or Section 504) that provide for special services and accommodations in the United States. Healthy relationships between the American educators and Marshallese families in Hawai`i would encourage the types of positive, integrated environments in which the student could thrive. By talking with me today, you are initiating the enrichment of the quality of those relationships.

*Initial Questions*

1. Before today, had you heard about ADHD/ADD?
2. If yes, what do you know about the disorder?
3. From whom did you hear about the disorder?
4. What does Attention Deficit/Hyperactivity Disorder mean to you? (Please explain your understandings of ADHD)

*Introduction to DSM-IV criteria*

I will now introduce to you the Diagnostic Statistical Manual (IV) criteria for diagnosis of Attention-Deficit/Hyperactivity Disorder (APA, 1994). Please read through the following symptoms with me. If you have any questions at any point, please feel free to ask.

(1) Symptoms of Inattention

The individual:

- (a) often fails to give close attention to details or makes careless mistakes in school work, 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
- (e) often has difficulty organizing task or activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
- (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

(2A) Symptoms of Hyperactivity

The individual:

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in the classroom in other situations in which remaining seat is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or acts as if “driven by a motor”
- (f) often talks excessively

(2B) Symptoms of Impulsivity

The individual:

- (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 conversation or games)

*Review of three main potential diagnoses: 1) inattentiveness, 2A) hyperactivity, 2B) impulsivity.*

If six or more of the following behaviors have persisted for 6 or more months

in (1) and (2A) or (2B): Attention-Deficit/Hyperactivity Disorder, Combined type

in (1), but not in (2A) or (2B): Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type

in (2A) or (2B), but not (1): Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

*Remainder of Interview Questions*

Now that we have read through these questions, I would like to ask you a few more questions.

5. After having read through these symptoms, do you feel that there are students in your class or classes that exhibit any of the following behaviors?
6. If yes, are those children treated any differently by their peers?
7. Which behaviors have you experienced in your class?
8. How do you feel when these behaviors occur?
9. What do you do when these behaviors occur?
10. In your opinion, which behavior would be the most noticeable, for a teacher in the classroom?
11. In your opinion, which behavior would be the most noticeable, for the student, in the classroom?
12. Do you believe that it is important for a child to be identified as having ADHD?
13. How should teachers help a child who might be identified as having ADHD?
14. Can you give me an example of a student who was identified as having ADHD?
15. What happened?
16. What kind of help or assistance was available for this child?

## APPENDIX B

*Format for Interviews with Marshallese Parents**Introduction*

I would like to talk to you today regarding your understanding of Attention Deficit Hyperactivity Disorder. In the United States, we use the term Attention Deficit Hyperactivity Disorder to describe children who have difficulties with hyperactivity and impulsivity, inattentiveness, or a mixture of both.

As you probably know, there are many Marshallese people who have relocated to the islands of Hawai`i. Therefore educators in Hawai`i need to know more about Marshallese culture so that they can help those students more effectively in school. By talking to you today, I am trying to better understand a little more about your culture, and specifically, about your understandings of Attention Deficit/Hyperactivity Disorder. Educators in Hawai`i should be aware of your understandings of this disorder so that we may more effectively teach children from the Marshall Islands, and interact with the families of those children in a more responsive manner. Should a child from the Marshall Islands exhibit ADHD-like symptoms, we hope to assist the child in any way possible under laws (IDEA or Section 504) that provide for special services and accommodations in the United States. Healthy relationships between the American educators and Marshallese families in Hawai`i would encourage the types of positive, integrated environments in which the student could thrive. By talking with me today, you are initiating the enrichment of the quality of those relationships.

*Initial Questions*

5. Before today, had you heard about ADHD/ADD?
6. If yes, what do you know about the disorder?
7. From whom did you hear about the disorder?
8. What does Attention Deficit/Hyperactivity Disorder mean to you? (Please explain your understandings of ADHD)

*Introduction to DSM-IV criteria*

I will now introduce to you the Diagnostic Statistical Manual (IV) criteria for diagnosis of Attention-Deficit/Hyperactivity Disorder (APA, 1994). Please read through the following symptoms with me. If you have any questions at any point, please feel free to ask.

(1) Symptoms of Inattention

The individual:

- (a) often fails to give close attention to details or makes careless mistakes in school work, 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
- (e) often has difficulty organizing task or activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
- (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

(2A) Symptoms of Hyperactivity

The individual:

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in the classroom in other situations in which remaining seat is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or acts as if “driven by a motor”
- (f) often talks excessively

(2B) Symptoms of Impulsivity

The individual:

- (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 conversation or games)

*Review of three main potential diagnoses: 1) inattentiveness, 2A) hyperactivity, 2B) impulsivity.*

If six or more of the following behaviors have persisted for 6 or more months

in (1) and (2A) or (2B): Attention-Deficit/Hyperactivity Disorder, Combined type

in (1), but not in (2A) or (2B): Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type

in (2A) or (2B), but not (1): Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

*Remainder of Interview Questions*

Now that we have read through these questions, I would like to ask you a few more questions.

9. After having read through these symptoms, do you feel that there is a child in your family that exhibits any of the following behaviors?
10. If yes, is that child treated any differently by their siblings or friends?
11. For the specified child, which behaviors have you observed?
12. How do you feel when these behaviors occur?
13. What do you do when these behaviors occur?
- 9a. What would you do if you noticed some of these behaviors?
14. In your opinion, which behavior, would be the most noticeable for a parent or caregiver in the home?
15. How would you feel if your child exhibited a combination of 6 of these symptoms for a period of at least 6 months, and a teacher or other professional wanted to talk to you about your child?
16. What would be the most appropriate way for a teacher or other professional to approach you and your family about this type of problem?

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