CHILDHOOD LOSS AND AD/HD: PROGRAM IMPLICATIONS FOR EDUCATION ADMINISTRATORS

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Evidence-based practice and evidence-informed practice are not just buzzwords in education. It is essential that administrators encourage both the development and the application of new knowledge in the field. This study of 1755 elementary age children in Central Texas indicates a positive association between the experience of childhood loss and grief and a diagnosis of AD/HD. Implications of this information for administrators in education are explored, including the training of counselors and classroom teachers in grief interventions and accommodations for grief related attention problems in children.

Keywords: administration, research, loss, grief, attention deficit

As school administrators face shrinking budgets and increasing needs of students and families, the pressure to identify and implement best practices grows. Administrators in education are responsible for balancing numerous variables in educational systems. Accountability, fiscal responsibility, student graduation rates are all buzzwords of the day.

This article examines the use of research to identify new knowledge affecting both policy and practice in public schools. Specifically, the key to effective intervention with students is to remain current with research and best practice interventions. One area of challenge in schools is the growing incidence of AD/HD coupled with budgetary cuts leading to larger classroom sizes and higher student teacher ratios. This challenge affects school performance and graduation rates. The US Department of Education reported as long ago as 1997 that children with behavioral disorders and diagnoses are at much higher risk of dropping out of school, with a dropout rate almost twice as high as other students in special education classes (Dendy, 2006). Providing administrators and educators with research that identifies specific risk factors and suggests best practice interventions for behavior and mental health diagnosis gives them the tools to address the needs of these children.

The reauthorization of the Individuals with Disabilities Education Improvement Act (P.L. 108-446) in 2004 permitted states to discontinue the use of IQ achievement discrepancy in favor of Response to Intervention (RTI). RTI is an effort to intervene early with a strong focus on prevention and assessment before diagnosing children with learning disabilities or behavior disorders (Vaughn & Fuchs, 2003). If RTI deductively formulates a program that is effective for the student, then this study provides another layer for assessment. While RTI provides the basis for guidelines and implementation, new knowledge and best practices are underway or emerging that could have an impact on the prevention and identification of learning disabilities and behavior disorders. As a result, the findings of this research indicate the importance of assessing if a child has experienced loss and grief prior to the diagnosis.

THE PROBLEM AND THE RESEARCH

The literature suggested a tendency toward premature or overdiagnosis of AD/HD in children. The problem was the possibility of an unrecognized connection between loss and diagnosis of AD/HD in children that might result in misdiagnosis. Children sometimes display delayed response to grief or may have a prolonged response to a loss that

adults do not connect to problems of inattention and concentration in school. Walsh-Burke (2006) stated: "Grieving children can become afraid of going to school or have difficulty concentrating, may behave aggressively, become overly concerned about their own health, or withdraw from others" (p. 35). Grief counselors acknowledge that children who are grieving experience difficulties in concentration and attention in school (Smith & Pennells, 1995). Hooyman and Kramer (2006) suggested that children who experience traumatic loss, for example, might exhibit symptoms of Post Traumatic Stress Disorder (PTSD) including decreased concentration, often causing functional impairment. Consequently, parents and teachers may perceive children as having attention deficit disorder or other learning disabilities when they are actively grieving a major loss. It may be that a loss and grief create additional stress and distress in a child predisposed to attention deficit, which exacerbate the child's symptoms and bring them to the attention of adults in the child's life.

It is unclear, in these cases, whether grief or attention deficit disorder symptoms are primary and require intervention. An unnecessary or inappropriate diagnosis of AD/HD may follow a child throughout school with serious impact on the academic and social possibilities open to the child. This includes risk for early dropout. This is a significant problem for the child who lives with a diagnostic label that influences how teachers and others think about the child. Barkley (2006) identified the social stigma that children with a diagnosis of AD/HD can encounter, which includes being labeled "mentally disordered" (p. 93) and seen by teachers as a problem in the classroom. It is also a problem for parents and teachers who gear their responses to the child based on a diagnosis and misconceptions about that, rather than on the child's real experience. It is a problem for physicians and others who treat AD/HD medically as they manage the child's responses to medicine.

Literature Review

Children experience significant losses, which affect them personally and interpersonally. Clinicians also diagnose children with problems with attention deficit in increasing numbers (Barkley, 2006; Stanford, 2008). An extensive literature review provided a comprehensive picture of children's loss and grief and of the experience of children with attention deficit. For purposes of this study, loss for children was defined as the death of a parent, grandparent or sibling; divorce of parents; deployment of parent or stepparent; other significant loss impacting the child, as defined by the parent/guardian to include incarceration of a parent.

While many authors wrote about the emotional impact of grief in the lives of children (Dyregrov, 2008; Hope & Hodge, 2006; Smith & Pennells, 1995; Walsh-Burke, 2006; Webb, 2002; Wolfelt, 1996), few wrote about the cognitive impact of loss on children. This left unanswered questions with respect to cognition and loss, i.e., the impact of loss on the thinking, learning, retention, and school performance of children. Some literature on children's loss and grief (Corr, 2000; Hooyman & Kramer, 2006; McCue, 1994; and Stevenson, 1995) included school difficulties, describing short attention span, difficulty concentrating, and difficulty learning new material as common experiences of bereaved children. While these are common diagnostic criteria of Attention Deficit Hyperactivity Disorder (AD/HD) and of other learning difficulties for children, there were few publications addressing the possible correlations between childhood loss and AD/HD or childhood loss and learning disabilities in children. There were even fewer publications addressing the implications those similar experiences might have for school and other programming for bereaved children.

There is increasing awareness reflected in the literature that children respond with grief to the losses that may come with a divorce, placement outside the home, or a move away from friends and/or family (Hooyman & Kramer, 2006). Sigle-Rushton, Hobcraft, and Kiernan (2005) reported that divorce, rather than death, is the leading cause of disruptions in families of children born after 1950. Further, they observed that children of divorce might experience as much pain and disadvantage as those who experience the death of a parent. Walter and McCoyd (2009) wrote about children as "the forgotten mourners when parents divorce" (p. 113). The authors further discussed the grief of children associated with the deployment of parents in the military, the ambiguous loss children experience when a parent returns with physical or brain injury, and with Post Traumatic Stress Disorder (PTSD). They stated that "The losses of attention, support, and nurture experienced by these siblings are likely to mirror some of the dynamics that may occur for children who lose military parents, either to death or to injury" (p. 114). Schipani (2007) noted that both

children and adults struggle with the ability to think clearly when under significant stress. The author introduced the notion that children's responses to stress and change, including the loss of an intact family, often result in difficulty in attention and learning. These issues of attention and concentration sound very much like attention deficit disorder.

AD/HD Prevalence

The issue of difficulty in sustaining attention in children has been the subject of research and writing since the early 1900s (Barkley, 2006). Added to this was literature explicating the proliferation of the diagnosis of AD/HD in the early and middle 2000s (Stanford, 2008). The U.S. Centers for Disease Control (Brown in Dendy, 2006) found the following: "about 7.8 percent of children aged 4 to 17 years are currently diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD). This means that most teachers are likely to have in every class they teach, on average, at least a couple of students with AD/HD" (p. 3). Rushton, Fant, and Clark reported that "ADHD is the most common childhood behavioral complaint presented to pediatricians and family physicians" (p. 23). Casat, Pearson, and Casat (2002) reported further that

> AD/HD is the most commonly diagnosed behavioral disturbance of childhood, affecting 3% to 5% of the general, nonreferred, school-aged population and representing more than 50% of referrals to clinics for mental health evaluations. This figure translates to approximately 2,000,000 children with handicapping impairment, making AD/HD a significant public health problem. (p. 263)

Dendy (2006) stated, "approximately one to three students in every classroom of thirty students has the disorder…a rate of up to 12%" (p. 10).

The incidence of AD/HD has grown steadily the past few years and "the rate of medication administration with children with AD/HD has increased as much as 600% over a ten-year period" (Dendy, 2006, p. 33). Evans, Morrill, and Parente (2010) suggested that the rising rates of AD/HD create the question of misdiagnosis of AD/HD. Elder (2010) suggested that as many as one million children with AD/HD may be misdiagnosed. Stanford (2008) attributed the increase in diagnosis of AD/HD in the United States to three issues including increased anxiety in children resulting directly from social stressors including divorce and absentee parents.

The intent of this study, then, was to examine the incidence of AD/HD in children who experienced loss and who have been diagnosed with AD/HD. For purposes of this study, ADD and AD/HD are identified as the same diagnosis with the understanding that children diagnosed with AD/HD also experience hyperactivity as part of the syndrome. The two diagnostic categories ADD and ADHD, often identified as AD/HD, have been used through the years, sometimes interchangeably, but always with the same characteristics except the presence or absence of hyperactivity. The current literature identified both categories as Attention-Deficit/Hyperactivity Disorder (DSM-IV-TR, 2000).

The Method

The central research question in this study was: What is the relationship between the experience of loss and a diagnosis of symptoms of AD/HD in elementary school-aged children? Additional questions included examining the role of parents and teachers in referring children for assessment of AD/HD, the role of physicians in making the diagnosis of AD/HD, and the use of testing in the diagnostic process. The researcher developed a survey instrument and vetted it through the faculty at a local college of education and statistics consultant.

The population and sample. The school setting is frequently the place where children demonstrate difficulties with attention and concentration. Most children diagnosed with AD/HD are diagnosed while in elementary school. This study took place, then, in a school district with emphasis on the elementary school population. The researchers chose a Central Texas school district located within 20 miles of a large military base. Children affiliated with military families experience loss through death, divorce, and deployment at higher rates than children in the general public did, particularly in times of war (Karney & Crown, 2007; Weins & Boss, 2006).

The researchers distributed three thousand surveys to children in grades one through six in six elementary schools in

the district. Additionally, the researchers mailed 500 surveys to families of elementary school children who lived on the Central Texas military base. These five hundred households represented children affiliated with the military but in a nearby school district from the primary school district. This increased the data pool and avoided duplication of response. Six hundred forty-five parents and guardians of children completed the surveys with information about the children in the household and returned them for analysis. The return rate for each of the six elementary schools ranged from 19-29 percent, while the return rate from the mailed surveys was only five percent. The vast majority (97.1%) of the surveys were completed by a parent of the child/ren. While one of the variables in the survey was loss and grief, more than 97 percent of the children represented in the survey retained at least one biological parent who was present to complete the survey.

Descriptive and data analysis. The sex of each child represented in the survey was almost equally distributed. Females represented 49.6 percent of the returned survey cases; males represented 47.4 percent of the returned survey cases with the remaining four percent missing data. Almost 25% or one in four children in the sample were in kindergarten or preschool, i.e. younger than 5. Since very few children are diagnosed with AD/HD before age 5, the AD/HD rates found in the study would largely be from 75% of the study sample. Fifty-seven percent of the children represented in the sample were in grades one through five, the grades surveyed. The largest clusters of children were in the second grade, 222 (13.3%), first grade, 217 (13%), followed by the third grade with 204 (12.2%). Almost 30 percent of this sample of children had connections to military service and more than half of those children (300) had experienced at least one deployment of a military family member. Children in this sample ranged in age from 1-19 with a mean age of 8.44 years (*SD=3.73*). One hundred eighty one children (10.2%) were diagnosed with AD/HD. Seven hundred thirty five losses were noted in the sample. Children who were reported to have had a loss experienced a range of one to six losses (*M=1.84, SD=.98333*).

One hundred fifteen children diagnosed with AD/HD in this study were age five or older. Of the 131 children with AD/HD for whom ages were provided, 77.2% of the children were diagnosed between the ages of five and nine. Fewer than 23% of children diagnosed with AD/HD were outside this age range. Only 10.8 percent of children diagnosed with AD/HD were older than nine years of age. This is particularly important because, logically, children are more likely to experience loss and grief the older they are. The 131 children in this study who were diagnosed with AD/HD, and whose age at diagnosis was provided, were a young population.

The variables loss and grief in children and diagnosis of AD/HD are each nominal or categorical variables. The best distribution and analysis then for comparisons of the two nominal variables in this study was cross tabulation with chi-square analysis. When an association was present and statistically significant in the findings, the next data analyses performed was a logistic regression. According to Peng and So (2002), analyzing dichotomous variables for not only association but also prediction is best done with a binary logistic regression. This particular analysis provides an odds ratio addressing probability of one variable "showing up" when the other is present, i.e. the ability to predict the odds of a second variable being present when the first variable is present. In this study, logistic regression was performed to determine the predictability of a diagnosis of AD/HD when loss/grief was present in the child's experience including the impact on multiple losses.

Research Findings

The central question in this study is whether or not there is an association between the experience of childhood loss and grief and a diagnosis of AD/HD. The review of literature supports the possibility of an association, as difficulties with attention and concentration are frequent components of grief in children (Doka, 2000; Grollman, 1995; and Hooyman & Kramer, 2006). Problems with attention and concentration are central symptoms in the diagnosis of AD/HD (Barkley, 2006; Beidermann & Perrin, 1996). A chi square crosstabulation of the variables loss and diagnosis of AD/HD in this sample of 1,755 cases reveals a significant association between the variables.

In looking at the actual numbers in the crosstabulation, the expected count of children with no loss who were diagnosed with AD/HD was 84.8 children. The actual count was only 55, almost 30 fewer than expected, diagnosed with AD/HD who had not experienced any identified loss. If the frequencies obtained in the sample were substantially

the same as the expected ones, we would conclude there is no association between the variables loss and AD/HD.

The cells for those who have been diagnosed with AD/HD and who have experienced loss reveal a similar pattern. There was a difference of 30 between the expected count of children with AD/HD to have experienced loss (96.2) and the actual count (126). Again, when the expected and observed frequencies are different, we are seeing "statistical dependence, more effect of one variable on the other" (Kendrick, 2005, p. 356). This suggests that there is an association between childhood loss and grief and a diagnosis of AD/HD. Chi square analysis of the statistical significance of these count differences reveals the Pearson chi-square significance of .000 (χ^2=21.94; p<.05). The significance standard for this study is .05, i.e. a 95% confidence interval that the results of the study are not simply due to chance. This statistic indicates that with one degree of freedom, there is less than one chance in ten thousand that the association between childhood loss and grief and a diagnosis of AD/HD in this sample is due to chance. There was, in this sample, a significant relationship between the experience of loss and a diagnosis of symptoms of AD/HD in elementary school-aged children.

Logistic regression was conducted to examine whether or not the association between loss and grief in children's experience increases the odds of a response on the survey instrument that the child has been diagnosed with AD/HD. The results suggested that loss did not, of itself, increase the odds of a child's diagnosis of AD/HD. However, multiple losses might (B (1) =1.259; p=.015). The B in this case is regression coefficients. From this we get predicted probabilities of AD/HD for particular values of the factors. Expected B, the regression coefficient, was .231, exponentiated. This is the odds ratio. Therefore, as number of losses increases by 1, a person is about 1.26 times more likely to have AD/HD. Essentially, this means that with each successive loss experienced by a child in this sample, they were 26% more likely to be diagnosed with AD/HD. The odds ratio was compared to 1 to see how much more likely. The confidence interval indicated that the odds ratio was anywhere from 1.05 to 1.52. Therefore, the true effect of losses on AD/HD could be between 5% and 52%. What is clear is that multiple losses increase significantly the risk of diagnosis with AD/HD with each successive loss. Beyond that, even simple or singular loss is positively associated with a diagnosis of AD/HD. The important question then becomes what we do with that information.

IMPLICATIONS AND APPLICATION

The basic philosophy of an administrator is important to the climate of the school. If the principal believes everyone is responsible for student learning, the administrative prerequisite is to implement the professional activities that help to support teachers, related services personnel, and paraprofessionals in creating the conditions that support student learning (Elias, et al., 2003). What is the administrators' role in RTI? The administrator establishes a climate where the standard is intervene early, use problem-solving methods to make decisions, use research-based interventions, monitor student progress to inform instruction, and use data to make decisions. The administrator establishes an environment to serve students based not on a particular label, program, or place, but on the services that flow to and from students based on the effect it has on the student learning. The administrator is the cheerleader for the team of teachers, related services personnel, and paraprofessionals for transforming current practices in order to create the conditions that support student learning (Leithwood & Poplin, 1992).

Implications for Working with Teachers

The teacher is the first layer of early identification and intervention (Fry, Ketteridge, & Marshall, (1999). As a result, the implications for the number and type of children identified, the kinds of educational services provided, and who delivers them, starts with the classroom teacher. As the classroom teacher delivers instruction, monitors each student's response to the instruction, evaluates performance against expectations, and assesses the learner's need, a collection of data establishes the degree at which the student learned (Olson & Hergenhahn, 2009). In addition, the classroom teacher observes student behavior during this process. If the student experiences difficulty learning, the teacher intervenes. Intervention is uncomplicated if the teacher has established a good rapport with the students' parents or guardians, campus administrator, and related services personnel. The parent-teacher conference is very important when trying to ascertain the source of the difficulty experienced by the student. The teacher needs to ask probing questions, such as *Have you noticed your child behaving differently?* or leading questions, such us *Has there*

been a recent death in the family? (Fitzgerald, 2000) If indeed there has been a death in the family, the teacher can approach intervention with the student in a number of ways:

- Allow for extended time on homework or assignments by establishing a due date with the student;
- utilize collaborative assignments to provide a means for socialization;
- provide personal time with the child during recess or conference period; and
- maintain ongoing communication with the parent/guardian regarding the progress being made by the student. (Davidson & Doka, 1999)

Implications for Working with Parents

Worden (1982) and Rando (1998) wrote extensively on grief responses, which included physical, social, emotional, and cognitive responses in grief. Both authors implied that issues of inattention, short attention span, and difficulty learning new material apply to all ages of bereaved. It is important administrators remember the parents of grieving children are likely grieving as well. Children are nested in family relationships. The death or divorce of a parent means the surviving or remaining parent has experienced the loss of spouse (Rando, 1998). This may well mean the surviving or remaining parent has difficulties with attention and concentration while the parent is trying to support the child through the loss. The parent may well turn to the teacher, counselor, or administrator for assistance when the child experiences changes in school performance and achievement (Smith & Pennells, 1995). Additionally, teachers may well respond to changes in a child's school performance by asking parents to intervene with their child/ren.

The beginning place, when working with grieving parents, is for teachers and administrators to hear and respond to the needs and experiences of parents (Webb, 2002). This conversation may be the first awareness of the teacher or school personnel the child has experienced a loss. It will not happen if school personnel do not ask the questions about what has changed in the family, what is different for the student, and what the parents and children are dealing with together. School personnel may

- help parents with the awareness that there is a cognitive component to grief, which both they and their children may be dealing;
- encourage parents to model self-care and grief management including making referrals to bereavement counselors, grief groups, and/or relevant reading (Wolfelt, 1996);
- contract with parents to advocate for their children both at school and in social venues for grief support and for adjustments around attention challenges;
- encourage parents to talk with teachers and collaborate on strategies for helping students secure and retain the information they need to be successful in the classroom;
- schedule regular contacts and/or meetings with parents to monitor the students' progress through the grief experience and progress in the classroom;
- remind parents and teachers that children re-visit and re-experience losses like the death of a parent at each new developmental stage (Aldridge & Goldman, 2007); and
- provide for parents written information about attention and concentration difficulties that typically occur with grieving children and specific direction about how to manage them. This information should include the following:
    - Manage difficulty with multiple audio instructions given at the same time by providing instructions in written bullet points on a list.

- Obtain lecture notes from school by asking teachers for written lecture notes the child can read and review at home.
- Address difficulty with doing homework with a study area identified in the house with organized materials and minimal distractions.
- Address the challenge of getting assignments back to the school with a parent/child checklist in the backpack; and if necessary, for young children a signed assignment sheet from teacher to parent to teacher (Dendy, 2006).

Implications for Working with Physicians

While the diagnosis of AD/HD is a psychiatric diagnosis, family physicians frequently make it in response to concerns raised by parents and teachers (Barkley, 2006; Dendy, 2006). There is also no industry standard for diagnostic testing required to substantiate or verify the diagnosis (DSM IVTR, 2000). Faraone, Sergeant, Gillberg, and Biederman (2003) found that clinicians make most diagnoses based on teacher or parent reports, expressing the concern that "prevalence based on symptom assessment alone is likely to be overestimated" (p. 109). The behaviors of inattention, difficulty in concentration, and difficulty with learning new material occur along a continuum with no clear demarcation of when the behaviors rise to the level of an attention deficit disorder diagnosis. In fact, according to the AD/HDA website, there must be sufficient behavioral disturbance to create a handicap in at least two locations in order to distinguish attention deficit from normal stress and distractibility occurring in modern society. According to the Children and Adults Attention/Hyperactivity Deficit Disorder (CHAD/HD) Educator's Manual (2006), "Virtually all individuals suffer some impairment in these functions sometimes…. the extent to which these symptoms impair life functions, for example socially, academically, or occupationally, must be considered for a diagnosis" (p. 8).

One area of real concern in the literature is the method for diagnosis. Rushton, Rant, and Clark (2004) reported a problem of utilization of practice guidelines among pediatricians and primary care physicians in the diagnosis and treatment of AD/HD. They report that there are evidence-based guidelines established by the American Academy of Child and Adolescent Psychiatry. In Rushton, Rant, and Clark's 2004 study of 1208 physicians (60% response rate), the authors found that while most physicians are aware of the guidelines, only one in four adhered to all four diagnostic components. Lanham (2006) studied physicians in 34 primary care physician programs with respect to diagnosis and AD/HD. Half of the programs were civilian physicians and half were military physicians. The responses from 235 physicians indicated serious challenges around diagnosis of AD/HD: "Only 22 % of physicians are familiar with published ADHD guidelines" (p. 803). Few physicians screen for AD/HD at periodic visits. Instead, physicians respond to parent or teacher referral (Barkley, 2006). A majority of physicians use a child's behavior in the office and a child's response to stimulant medication in diagnosing ADHD.

Consequently, the information from teachers to both parents and physicians can be critical in assessment and diagnosis. The implications are strong: the school has a responsibility to encourage parents to communicate with physicians and to communicate directly with the physician, with the parent's permission, of course. Recommendations for counselors, teachers, and administrators working with children who have experienced a loss and are demonstrating behaviors more typically suggesting a diagnosis of AD/HD include the following:

- Request the parent provide the physician with the details of the loss, i.e. the date, relationship, circumstances, child's response, and current interventions.
- Provide specific written information for physicians including the child's behavior and school performance prior to and since the loss.
- Offer consultation and collaboration on planning and intervention with the physician, parent, and child.
- Follow-up on physician recommendations in the classroom with respect to medications, adjustments, and accommodations.

Implementing Change

This study is an important beginning to addressing the issue of attention and concentration in students who experience loss and grief. At least in this sample of 1,755 children in Central Texas, there is a clear association between the experience of loss and grief and a diagnosis of AD/HD. That is not to imply, however, that childhood loss and grief causes AD/HD. It is more likely that the cognitive impact of grief on children looks a lot like the symptoms of AD/HD and may lead to misdiagnosis of the psychiatric illness. It may also be that grief exacerbates the symptoms of AD/HD enough in a child whose behavior has been just below the magical attention threshold that they are now brought to the attention of teacher and/or parent, and this leads to a referral.

When administrators take the new information provided by research and use it to guide interventions with constituents, including children, their parents, and others, it is essential to do so with intentionality. The new information must be disseminated to teaching and counseling staff with discussion around application. Implementing change includes considering all levels of a system that are impacted by the change. In this case, that includes the counselors, teachers, coaches, and sponsors of extra-curricular activities who interface with the child. Respect for privacy and confidentiality means attending to release of information and care in information being distributed to those who have a need to know.

Implications for parents and physicians, as well as teachers and administrators, suggest the need for intentional communication and multi-disciplinary responsibility. Coordinating the flow of information and communication creates additional work and time requirements. Teachers must have time built into the workday for communication with counselors, parents, and physicians. In this case, communication with and coordination with the school nurse around medical administration might be a factor as well.

Evaluating Results

The use of new research and new findings implies, as well, the need to continue to research and investigate the appropriateness, impact, and outcomes of the interventions. Administrators may well want to engage in research that examines the performance outcomes of students who have experienced loss and grief and receive the interventions and attention recommended here. Additionally, it is important to track the time required to provide behavioral interventions for students with grief and loss and the time required to communicate with parents and physicians. The implementation of change comes with the responsibility to assess the effectiveness of the change and to develop additional knowledge about best practices. Beyond that, the dissemination of those results is essential for the growth and development of the profession.

SUMMARY AND CONCLUSIONS

The most exciting research is not the research that answers all questions but the research that leads us to better and best practices with those we serve and the research that raises additional important questions. In this study, the researchers examined a question the literature suggests, but which had not been examined previously. In a sample of 1,755 children in public elementary school in Central Texas, there was a significant association between the experience of childhood loss and grief and a diagnosis of Attention Deficit-Hyperactivity Disorder. In fact, multiple losses were suggestive of increased risk of the diagnosis by as much as 26% with each successive loss. What is promising about this research is the possibility of change in educational systems that could result in stronger interventions and better outcomes with children experiencing attention and concentration problems. At least in this sample, children who experienced loss and grief were more likely to be diagnosed with AD/HD. Some of the misdiagnosis and overdiagnosis of AD/HD in current society may be attributed to this phenomenon. In any case, understanding the possibilities is the beginning of assessment that leads to appropriate treatment of children. Administrators are in a position to make organizational change that applies this new information and results in children being accurately assessed and appropriately diagnosed and treated.

The primary recommendation out of this study is the realization that there are other possibilities for a student to

respond with symptoms often associated with AD/HD. Further, parents of a child who experiences loss and grief through death, divorce, deployment or other separation may realize that attention problems might be part of the child's response. This means not deciding easily or quickly on the psychiatric diagnosis of AD/HD. When teachers of children who experience loss are aware of the loss and of the possibility of attention and concentration challenges, they can assist the children through the challenges successfully rather than beginning with a physician referral for AD/HD. The AD/HD literature suggests there are accommodations for poor concentration and attention, including hand written notes and more time for assignments and tests. Parents and teachers are in a position to make these adjustments for students responding to loss in their lives. This might include the development of strategies for children with temporary concentration problems as well as school programming to meet bereavement needs.

Intentionally responding to this knowledge, implementing these strategies, and tracking the progress of the organizational change is the work of the administrator. The challenge is adding to an already large load the responsibility to both read and respond to current knowledge and trends. The reward is the opportunity to make principled, embodied change that affects the lives of students and their families. May we rise to the challenge and reap the rewards.

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