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Margaret E. Gaskell
Parents' Perceptions of the Impact of
Teachers' Attitudes and Behaviors
on the Social-Emotional Functioning
of Children with ADHD/ADD

ABSTRACT

Attention Deficit Hyperactivity Disorder (ADHD/ADD) is the most common childhood psychiatric disorder, affecting attention, hyperactivity, and impulsivity, in 3 to 7 percent of school age children (American Psychiatric Association, 2000; Daley & Birchwood, 2010). ADHD/ADD can impact all aspects of life, in particularly school and social-emotional functioning (Mash & Barkley, 2006; Daley & Birchwood, 2010). Few studies have directly examined teachers' attitudes and behaviors related to teaching children with ADHD/ADD (Kos, Richdale, & Hay, 2006). The goal of this study was to explore the impact of teacher attitudes and behaviors on the social and emotional functioning of children with ADHD/ADD, by surveying parents of children with ADHD/ADD. Twenty-seven parents were surveyed, finding that 1) most parents felt teachers were either a little or somewhat knowledgeable of ADHD/ADD, 2) parents' perceived that teachers were either irritated with their child's behaviors which resulted the perception that teachers were unsupportive and blaming or that they were supportive and understanding that the child was not to blame, but still irritated, 3) parents viewed that children had decreased social functioning, but that 4) emotional functioning was not compromised as a result of teachers' attitudes or behaviors. Further research needs to be completed on the attitudes and behaviors of teachers towards students with ADHD/ADD and other diagnoses without doing so through only assessing teacher knowledge of the diagnoses.

**PARENTS' PERCEPTIONS OF THE IMPACT OF TEACHERS'
ATTITUDES AND BEHAVIORS ON THE SOCIAL-EMOTIONAL FUNCTIONING
OF CHILDREN WITH ADHD/ADD**

A project based on independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2011

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CHAPTER I

Introduction

Attention Deficit Hyperactivity Disorder and Attention Deficit Disorder (ADHD/ADD)

Attention Deficit Hyperactivity Disorder (ADHD/ADD) is the most common childhood psychiatric disorder, affecting attention, hyperactivity, and impulsivity, in 3 to 7 percent of school age children (American Psychiatric Association, 2000; Daley & Birchwood, 2010). Children with ADHD/ADD may exhibit delays in a variety of areas, including intelligence, motor coordination, executive functioning, and academic achievement, which can affect all aspects of life (Mash & Barkley, 2006; Daley & Birchwood, 2010). School in particular can be a challenge for children with ADHD/ADD, academically, socially, emotionally, and behaviorally.

Teachers' Attitudes and Behaviors

Few studies have directly examined teachers' attitudes and behaviors related to teaching children with ADHD/ADD, and those that do intend to address their behaviors and attitudes are assessing teachers' knowledge about ADHD/ADD, equating knowledge with attitudes (Kos, Richdale, & Hay, 2006). It is important to examine teachers' attitudes and behaviors because they may also impact the functioning of children with ADHD/ADD (Kos, Richdale, & hay, 2006; Sherman, Rasmussen, Baydala, 2008). Teachers' attitudes regarding ADHD/ADD might either help or hinder child with ADHD/ADD in regards to their social functioning, and emotional functioning. In the current research, I will address parents' perceptions of the association between of teachers' attitude and the social-emotional functioning of school age children with

Attention Deficit Hyperactivity Disorder. The results of this study may suggest areas in which social workers and other service providers can help students, their parents, and teachers to work together to promote healthy social-emotional skills and functioning.

Study Objectives

The goal of this study was to explore the impact of teacher attitudes on the social and emotional functioning of children with ADHD/ADD. Previous research has examined the impact as reported by adolescents (Moses, 2010), and has examined this issue from teachers' perspectives, and as a meta-analysis of the research on this impact, however has not examined these impacts from the perspective of the parents of children with ADHD/ADD. It is hoped that studying the association of teacher attitudes and students' social-emotional functioning will lead to a greater understanding for teachers, parents, and treatment providers. This greater understanding will lend itself to practice implications for teachers and for individuals who work with the teachers of students with ADHD/ADD, including social workers.

CHAPTER II

Literature Review

The purpose of this study was to explore the impact of teacher attitudes on the social and emotional functioning of children with ADHD/ADD. This review of the literature will address ADHD/ADD in child populations, common comorbid disorders, children at school, the impact of others, and the social-emotional functioning of children and the literature that exists on the impact of teachers' attitudes and behaviors on the social-emotional functioning of children with ADHD/ADD. By addressing the literature in these areas the foundation for the current research will be built.

ADHD in Children

ADHD is the most common childhood psychiatric disorder and is present in 3 to 7 percent of all school age children. It affects attention, hyperactivity, and impulsivity resulting in impairments in functioning in academic and social settings (American Psychiatric Association, 2000; Centers for Disease Control, 2010; Daley & Birchwood, 2010). A recent survey from the Center for Disease Control and Prevention indicated that there was an increase in parent reported diagnosis of ADHD in children ages 4 through 17, finding an increase from 7.8% prevalence in 2003 to 9.5% in 2007 (CDC, 2010). Although both male and female children both experience ADHD, there is a higher prevalence of ADHD in males than females. In addition, male children are more likely to be referred for diagnosis and treatment than girls. Although girls with ADHD

have similar impairments, boys experience greater intelligence deficits (Kerig & Wenar, 2006). Children with ADHD may present with difficulty with motor coordination, executive functioning such as planning and organization problems, deficits in self and emotional regulation, and difficult social interaction styles (Kerig & Wenar, 2006).

Comorbid Disorders

Comorbid disorders are common in children diagnosed with ADHD. They include the following: Oppositional Defiant Disorder, Conduct Disorder, anxiety and mood disorders, and learning difficulties. Within the clinical population of children with ADHD, it is estimated that between 20 and 30% of this population has a comorbid mood disorder (Kerig & Wenar, 2006). By the age of seven, 54-67% of clinically referred children with ADHD will also be diagnosed with Oppositional Defiant Disorder (ODD), and in middle childhood, between the ages of six and eleven, 20-50% will be diagnosed with Conduct Disorder (CD) (Fischer, Barkley, Smallish & Fletcher, 2004, in Kerig & Wenar, 2006). In the clinical population, ten to 40% of individuals with ADHD also have a diagnosed anxiety disorder (Tannock, 2000, in Kerig & Wenar). Learning disabilities are also a common diagnosis, with 19-26% qualifying for a diagnosis of a learning disability. Up to 80% of children with ADHD have learning difficulties that are significant enough to result in grade retention, resulting in a two-year grade difference between these children and their peers, an issue which is likely to effect a child's social-emotional functioning (Barkley, 2003).

Children at School

The transition to school is a period of change and adjustment in children's lives. The following section will address information and studies related to children with ADHD/ADD attending school. First, the issue of schools presenting new challenges in the form of increased

cognitive, social, and emotional stressors will be addressed. Second, the fact that teachers spend a great deal of time with their students will be reviewed, in the context of identifying symptoms of ADHD/ADD and making referrals for assessment. Third, this section will review information on teachers' knowledge of ADHD/ADD, and finally, the inclusion of parents in their children's education which may include creating behavioral plans for use within the classroom.

Demands at school increase observable ADHD/ADD symptoms.

Children with Attention Deficit Hyperactivity Disorder (ADHD) commonly have symptoms that manifest themselves during school hours, a time when cognitive, social, and emotional stressors on children are significantly increased. Because of subsequent problems, children with ADHD may require remedial or special education. They may experience poor grades, failed grades, failed classes, and may repeat grades. They may also experience disciplinary actions to include suspensions, or expulsions (Daley & Birchwood, 2010).

Academic difficulties and problems may also be experienced by children with ADHD due to this diagnosis having strong comorbidity with other diagnoses such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), anxiety, learning disabilities and Bipolar Disorder along with a potential for the child to have a decrease in cognitive ability (Daley & Birchwood, 2010). Due to these comorbid disorders, a child may be more likely to miss recess and other free times when he or she would be interacting with peers and gaining social emotional skills.

Teachers may be more likely to identify ADHD/ADD in children.

A shift in school curriculum, early in education, from a play-based education system to a skill acquisition based education system, the symptoms of ADHD, or cognitive development delays, may become more evident to a child's teacher early on in the child's education (Sherman, Rasmussen & Baydala, 2008; Sax & Kautz, 2003). Because symptoms of ADHD tend to

manifest themselves within the school setting, teachers are often the first to suggest a diagnosis of ADHD or a referral for treatment of symptoms (Sax & Kautz, 2003; Scuitto, Terjesen & Bender Frank, 2000). Although children with symptoms of ADHD may be referred for treatment and diagnosed with ADHD, some children with these symptoms may need a more developmentally appropriate or structured education environment. They may have other problems affecting their behavior such as a low IQ, anxiety, or psychosocial stressors such as family or peer difficulties (Sax & Kautz, 2003). Difficulties within the classroom and school environment have the potential to affect other areas of the child's life, such as relationships with family members, peers, and teachers (Moses, 2010).

Teachers' knowledge of ADHD/ADD.

There are few studies that examine the ADHD/ADD knowledge possessed by teachers. Currently only six articles between 1994 and 2005 have assessed teachers' knowledge of ADHD/ADD. Results are mixed regarding the amount of information known by teachers regarding ADHD/ADD (Kos, Richdale & Hay, 2006). Teachers who have expressed to parents that they have previous experience with children who have been diagnosed with ADHD/ADD are seen as being more knowledgeable about ADHD/ADD (Kos, Richdale, & Hay, 2006; Scuitto, Terjesen, & Bender Frank, 2000).

Research that has been done to assess teachers' knowledge of ADHD has determined that teachers may have misconceptions about ADHD/ADD. These myths and misconceptions were not directly addressed in this study; however, previous research has found that teachers believe that ADHD/ADD symptoms can be caused by a child's diet, that children can grow out of their symptoms, and that teachers are not knowledgeable about the side effects of stimulant medications used in the treatment of ADHD/ADD. Teachers are however knowledgeable

enough to identify symptoms of ADHD/ADD (Ohan, Cormier, Hepp, Visser, & Strain, 2008; Sciutto, Terjesen, & Bender Frank, 2000). Without adequate and correct information, teachers will not be able to accurately observe symptoms, provide referrals for assessment, provide information and support to parents, and most crucially, will not be able to properly provide support to children with ADHD/ADD within their classroom.

Research supports teachers including parents and providers in treatment plans.

Due to behavioral and academic difficulties that may occur in the context of ADHD or other diagnosis and stressors, it is paramount that school staff working with these students are a good fit and are able to support and tolerate the student and his/her behaviors (Sherman, Rasmussen, Baydala, 2008). Research has shown that teachers who try to prevent problematic behavior by including parents and treatment providers as part of the prevention plan achieve a greater measure of success in decreasing the negative or problematic behavior in the classroom environment (Sherman, Rasmussen, Baydala, 2008). Not having social supports can lead to negative outcomes throughout life for a youth with a mental health diagnosis, such as ADHD, whether those supports are at school, with peers, at home, or within the community (Moses, 2010).

ADHD/ADD and the Impact of Others: Stigma, Perceptions, and Attitudes

A common factor in negative outcomes is the presence of stigma within the youth's life, by family, peers, or school staff (Moses, 2010). Moses, found that children who experience stigma at school and are alienated from their teachers do not receive sufficient instruction in the classroom and are more likely to have a decreased interest in academics and less positive relationships within the school, with either staff or peers. Another finding by Moses demonstrated that students who experience stigma in one area of their life, from peers, family, or

school, are more likely to experience feelings of greater stigma in other areas (2010). It is evident that there is a lack of literature on the area of teachers' attitudes and behaviors towards children with ADHD/ADD. Previous studies claiming to assess teachers' attitudes regarding ADHD/ADD only end up examining teachers' knowledge of ADHD/ADD such as Jerome and Hustler, (1994), and Jerome, Washington, Laine, and Segal, (1998), are among a few articles that were intending to examine teachers' attitudes. These studies assume that teachers' knowledge of ADHD/ADD is related to their attitudes and behaviors within the classroom, without actually examining the attitudes and behaviors exhibited by teachers (Ohan, Cormier, Hepp, Visser & Strain, 2008).

Ohan, et. al., (2008) recognizing the lack of literature on the subject of teachers' attitudes, completed their own study and found that teachers' knowledge about ADHD did have a significant impact on the teachers' self-reported attitudes and behaviors, including behavior management skills, and perception that children with ADHD/ADD are harder to manage in the classroom. Although these studies of teacher knowledge and the impact on attitudes and behaviors of teacher are still important, more studies need to be conducted in the future on the attitudes and behaviors of teachers.

Social-Emotional Functioning of Children

In the middle childhood years, from approximately age six through 11 children are learning to master both their social and academic environments and their interest in peers and in mastering these environments increases. Children develop internal working models of self and others, develop sustained relationships with peers and adults, and are more able to utilize perspective-taking skills (Kerig & Wenar, 2006). Building relationships with peers and adults is an important part of a child's development, to include their social life, their social adjustment

and it requires skills that will be utilized throughout life. Positive peer relationships can enhance a child's social well being; increase their social status, their sense of belonging and inclusion, and their self-esteem (Heiman, 2005). Children with ADHD commonly display deficits in social interaction skills and may be perceived as annoying, intrusive, and insensitive to the needs of others. These deficits result in more negative interactions with others which, significantly increase the likelihood of rejection by their peers, result in difficulty establishing and maintaining relationships, and isolation from the social environment (DuPaul, Jitendra, Tresco, Vile Junod, Volpe & Lutz, 2006; Ek, Westerlund, Holmberg, & Fernell, 2008; Heiman, 2005; Kerig & Wenar, 2006). In an overview of social functioning and skills by Wehmeier, Schacht, and Barkley (2010), the authors discussed that children with ADHD have poorer social skills than their peers without ADHD. These include lacking friendships, participating in limited activities with friends, and 70% may have no close friends or relationships by third grade.

In a study by Heiman (2005) on the peer relationships of children with ADHD, compared to children without ADHD, these relationships were studied in 56 children, 39 with ADHD (31 boys, 8 girls) and 17 without ADHD (12 boys, 5 girls) between the ages of 5.5 and ten years old who attended school in a mainstream classroom. Using child, parent and teacher reports on the Friendship Quality Questionnaire (Heiman, 1995), and the Loneliness Questionnaire (Asher et al., 1990), it was determined that there was no significant difference between feelings of loneliness, activities done when lonely, and what children reported on how to make friends. The study further determined that parents and teachers of kids with ADHD perceived these children more lonely than their peers without ADHD, however there was no significant difference between the children's reports for both groups. Children's reports of number of friends was not significantly different between the ADHD and without ADHD groups, however there was a

significant difference discovered when analyzing the parent and teacher reports, with children without ADHD having more friends than those with ADHD. Although parents and teachers rated children similarly for some of the measure items, teachers reported that many children with ADHD were not invited to social activities by kids outside of school, and were also more likely than parents to rate the children in both groups as having less friends, and being more lonely.

Although this study by Heiman (2005) does make some distinction between parent reports and teacher reports and finds that teachers may view all children as being less socially involved and adjusted than parents do, teachers and parents may have a more negative and distorted view of the children, while children over estimate social acceptance through positive self-report biases. Heiman identified that future research should include assessments of children's social status, which reflects perceptions of others.

A child's social status can be determined by the way that their peers perceive them, which is called sociometric status. There are four distinct sociometric statuses, accepted, rejected, neglected and controversial (Kerig & Wenar, 2006). Accepted children can be described as intelligent, resourceful, dependable, sensitive, emotionally stable and cooperative. Rejected children are generally aggressive, distractible, unhappy, alienated by the group, and lack social skills needed to participate in their social environment. Neglected children are neither like nor disliked, and may be anxious and lack social skills needed to engage in their environment. Controversial children are perceived as both positive and negative, and may be troublemakers and the class clown, but have good interpersonal skills, and their charisma attracts and impresses other children (Kerig & Wenar, 2006).

Emotional functioning and competence does not develop on its own, it is connected with children's social experiences and relationships, such as those with parents and peers (Semrud-

Clikeman, & Schafer, 2000). Through these relationships, children learn about emotions, including understanding other's emotions, understanding their own emotions and how to regulate them (Semrud-Clikeman, & Schafer, 2000). Children with ADHD/ADD may experience difficulty in understanding and regulating emotion, which is deeply connected to their social experiences. Wehmeier, Schacht, and Barkley (2010), addressed the emotional functioning of children with ADHD, reporting that children with ADHD have poor self-regulation of emotions and experience excessive and intense emotions more frequently than their peers without ADHD. Children with ADHD also have poorer self-perception than their peers without ADHD including poorer self-esteem, and poorer ratings of competence, which can lead to other mental health diagnoses such as depressive disorders (DuPaul, Jitendra, Tresco, Vile Junod, Volpe, & Lutz, 2006; Ek, Westerlund, Holmberg, Fernell, 2008; Wehmeier, Schacht, & Barkley, 2010).

CHAPTER III

Methodology

The current study was designed to further the understanding of parents' perceptions of the association between teachers' attitudes and the social-emotional functioning of their third or fourth grade children with ADHD/ADD. By questioning parents directly, the survey provided parents an opportunity to explore their understanding of the impact of teachers' attitudes and behavior on the social-emotional functioning of their child, while allowing for analysis of the perceived impact of teachers' attitudes and behaviors on child functioning (See Appendix A). This research was conducted because children with ADHD/ADD commonly have deficits in social interaction skills, which may be perceived by teachers and peers as annoying, intrusive, and insensitive. The social interaction deficits experienced by these children may result in negative experiences with others. There may be increased likelihood of rejection by peers, more difficulty establishing and maintaining relationships, and isolation from the social environment (DuPaul, Jitendra, Tresco, Vile Junod, Volpe & Lutz, 2006; Ek, Westerlund, Holmberg, & Fernell, 2008; Heiman, 2005; Kerig & Wenar, 2006). Additionally, previous research has found that parents and teachers of children with ADHD/ADD perceived these children as lonelier than their peers, as having fewer friends, and as getting fewer outside of school invitations for social activities (DuPaul, Jitendra, Tresco, Vile Junod, Volpe & Lutz, 2006; Ek, Westerlund, Holmberg, & Fernell, 2008; Heiman, 2005; Kerig & Wenar, 2006).

Design

A descriptive, cross-sectional study was conducted to explore parents' perceptions of the impact teachers' attitudes have on social-emotional functioning of children with ADHD/ADD. The parents were surveyed about their own children. A mixed methods, online survey gathered data directly from parents. The online survey was created by this researcher, and included questions about demographics, co-morbid disorders, parents' perceptions of how the children's teacher viewed and treated them, and how the parents' felt about their children's social-emotional health, (see Appendix A). The survey was reviewed by this author's research advisor and the Smith College Human Subjects Review Committee for readability, relevance to the purpose of the study and ethical guidelines. No tests of reliability or validity were completed prior to the initiation of this study.

Sample

A non-probability sample of parents of both male and female children with ADHD or ADD was recruited for this study. A non-probability sample was selected due to limited time and resources along with no direct access to a population with the desired characteristics. Parents of both males and females were permitted to participate due to separating out gender related issues being beyond the scope of this thesis, even though there are gender differences within the population of children with ADHD/ADD and teachers' or others may react differently to students with ADHD/ADD based on the students' gender. Parents eligible to participate in the study were 1) able to read and write in English, and 2) parents of a child with a formal diagnosis of ADHD/ADD. The children were 1) in the third or fourth grade the current school year, 2) had been with the same teacher since the beginning of the 2010 school year, and 3) were receiving educational instruction in a regular, inclusive, classroom. In order to begin the online survey

participants were required to answer the above eligibility questions to ensure that they met eligibility criteria. Additional inclusion criteria were that the children may be either male or female, have comorbid disorders, and have an Individualized Education Plan (IEP) or other educational accommodations. Excluded from this study were parents who do not read or speak English, whose children who were not in the third or fourth grade, whose children receive their education in a special education classroom, and whose children have changed teachers since the beginning of the 2010 school year.

Recruitment

The sample for this study was recruited between April 1 and April 22, 2011, primarily through online groups and websites, including, Google Groups focusing on ADHD and Yahoo Groups such as ADD-ADHD-Parents, oddparents, ADHD_Children, children-with-adhd, adhdparentssupportgroup. Other support websites include the dailystrength.com support group “Parents of children with ADHD.” Additional recruiting was completed through advertisement to parents, using the social media website Facebook and through utilization of snowball sampling in which parents shared the survey link with other parents. Online recruiting was used to reach potential participants due to the access to the desired population through support groups, which did not require additional resources or time set aside to personally find or survey parents meeting the desired characteristics. Anonymous recruiting was important for this study to protect both parents and their children, and ensure that parents’ responses would not be tied to any identifiers that would result in the researcher or others being able to attach a particular person with particular results. It was hoped that such recruiting methods would yield 50 participants of diverse race, ethnicity, and socioeconomic status. A sample size of 50 parents is desired based

on an alpha level of 0.05 and an anticipated effect size (Cohen's d) of 0.8 indicating a large effect, and a desired statistical power level of 0.8 (Cone & Foster, 2010).

Ethics and Safeguards

Confidentiality was maintained in a way consistent with federal regulations and the requirements of the social work profession. Before proceeding to the survey, participants were required to answer eligibility questions, and if the participant was determined eligible for the study, was followed by the informed consent letter at which time participants were asked to print a copy and express whether they agree or do not agree to participate in the study. Data and information was collected anonymously through the online survey, as IP address, computer location and participant's e-mail address will not be recorded. The research advisor had access to survey responses; however, no identifying information was available. Materials, including printed survey response summaries, will be kept in a locked file for 3 years, unless used for future research or publication at which point they will be destroyed. If data is needed for more than 3 years it will continue to remain in a secure locked file until no longer needed, at which time the data will be destroyed. Throughout this study, maintenance of data was secured and no confidential information was divulged.

Participation in the online survey was voluntary, and participants were able to refuse to answer questions or terminate participation at any time during the survey as long as the participant had not yet submitted the responses. To terminate participation in the survey, participants were instructed to close the webpage. Withdrawal of participation from the study after submission of responses was not possible due to anonymous nature of the study, as individual submissions were not able to be identified as computer location, IP address, or e-mail address of participants was not collected.

Data Collection and Procedures

Data was collected using a mixed methods survey developed for this study by this researcher. This study was hosted online by www.surveymonkey.com. The survey included, 1) eligibility questions, 2) informed consent letter, 3) demographic information, 4) questions about parents' perceptions of teachers' attitudes and behaviors, 5) parents' perceptions of their child's social-emotional functioning and 6) the association between teachers' attitudes and children's social-emotional functioning (Appendix A).

The first page of the survey contained a welcome screen directing participants to continue to the eligibility questions. Once these questions were completed and participants were found to qualify for the study, they were shown the informed consent letter. Those that did not qualify were directed to a thank you page containing resources on ADHD/ADD information and information on locating mental health services. Those parents who were determined eligible for the study were automatically directed to the informed consent letter (see Appendix D). Consent to participate was obtained by the participant reading the informed consent letter followed by checking the "I Agree" option on the survey website. Parents' were requested to print a copy for their records.

An example of quantitative questions regarding parents' perceptions of teachers' attitudes was "How do you think your child's teacher feels when your child interrupts or intrudes at inappropriate times (example: speaking out of turn or when others are speaking)" and "How do you think your child's teacher feels when your child loses focus easily or doesn't pay attention?" The final part of the survey, the qualitative question, further addressed the impact of teachers' attitudes and behaviors on children's social-emotional functioning by asking, "How do you think

your child's teachers' attitude affects your child's functioning?" Please see Appendix E for complete list of survey questions

Data Analysis

Data was collected from the completed surveys through Survey Monkey. None of the survey questions were required, and those individuals who fully completed the survey were included in analysis. Analysis of the mixed-method survey included descriptive statistics and qualitative thematic statistics. Descriptive statistics were used to summarize the characteristics of the sample and the responses to the survey questions, including means and percentages. A qualitative thematic analysis of open-ended question was completed to examine parents' understanding and examination of the association between teachers' attitudes and behaviors and children's social-emotional functioning.

Expected Findings

As found by Moses (2010), students who feel alienated from their teachers are less likely to get the educational support that they need to do well in school, and therefore are more likely to have a decreased interest in academics in general, fewer high quality relationships with peers and staff at school, and poorer mental health. The current research findings were expected to show from parent reports that there is an association between teacher attitudes and the social and emotional functioning of third and fourth graders with ADHD/ADD. Additionally, it is hypothesized that, per parent report, third and fourth graders with ADHD/ADD would have fewer positive interactions with staff, fewer positive peer interactions, and decreased feelings of self-esteem and competency, and seem less happy if their teachers have negative attitudes regarding ADHD related behaviors and difficulties.

With increased awareness of the association between teacher attitudes, and the social-emotional functioning of students with ADHD/ADD, social workers, parents, and teacher will become aware of the potential ill effects potentially harmful attitudes on children. With this knowledge recommendations can be made so that more positive impacts can be encouraged and taught, leading to better outcomes. By understanding these associations, social workers may be able to work more effectively with schools and parents on improving social-emotional functioning.

CHAPTER IV

Findings

This study explored parents' perceptions of 1) teachers' attitudes towards participants' children with ADHD/ADD and 2) and the social-emotional functioning of these 3rd and 4th grade children (with ADHD/ADD). Participants completed questions using an online survey regarding demographics, teacher ability, support, and understanding of child functioning, teachers' attitudes towards certain characteristics of ADHD/ADD behaviors, and the perceived social-emotional functioning of the participants' children. Twenty-seven participants completed the survey

The major findings in this research were that 1) most parents felt that their children's teacher had little or some knowledge of ADHD/ADD, 2) children tend to get different teachers at the beginning of third and fourth grade and do not stay with the same teacher for more than one year, 3) parents' perceived that overall teachers were irritated with their children's behavior in the classroom, which included the teacher being unsupportive by blaming the child for his or her behavior, or being supportive and understanding that the behavior may not be purposeful, 4) parents' viewed that their children had decreased social functioning, and finally 5) parents' perceived their children's emotional functioning to not be decreased.

Demographics

The following section reviews the demographic information of the parent participants, their children, and the teachers of the participants' children. Parent demographic information included age, gender, race/ethnicity, education level and socioeconomic status. Child demographics were collected on age, gender, race/ethnicity, and grade level. Teacher demographics will be addressed in a later section of this chapter.

Participant/parent demographics.

Participants were predominantly female, White, over 35 years old, Middle Class, and had completed some higher education. Of the 27 participants who completed the survey 92.6% were female (n=25), 92.6% of participants identified as White (n=25) and 81.5% were Middle Class (n=22). In the survey, participants were permitted to choose more than one race/ethnicity, causing the total percentage responding to the question to be higher than 100%. The age of participants was more equally distributed along a bell curve. The age range was between 25-55 years old, and most of the participants were between 36 and 50 years old, with an average age of 42. As part of the survey, parents were also asked about the highest level of education they had completed. All parents had completed high school or had received their GED. Most of the parents had gone on to attend higher education; this group was comprised of 25.9% who had completed some college (n=7), 40.7% who had completed either a two or four year degree program (n=11), and 25.9% of parents completed a graduate degree or postgraduate degree program (n=7). The demographic characteristics of the participants are illustrated in Table 1 below.

Table 1 Parent Demographics		
n=27	Frequency	Percentage
Age		
30 - 39	9	33.3%
40 - 49	16	59.3%
50 - 59	2	7.4%
Gender		
Male	2	7.4%
Female	25	92.6%
Race/Ethnicity ^a		
White	25	92.6%
Black, African American, Haitian	1	3.7%
Hispanic/Latino	1	3.7%
Prefer Not To Disclose	1	3.7%
Highest Level of Education Completed		
High School Diploma or GED	2	7.5%
Some College	7	25.9%
2 Year or 4 Year College	11	40.7%
Graduate School or Post Graduate Degree	7	25.9%
Socioeconomic Status		
Lower Class	3	11.1%
Middle Class	22	81.5%
Upper Class	2	7.4%

^a Participants permitted to choose all that apply; therefore, response is greater than number of participants

Participant report of child demographics.

Participants provided information about their children with ADHD/ADD. Out of the 27 children whom the parents described in the survey, 21 were male (77.8%). This ratio is similar to that found in the overall population of children with ADHD/ADD (American Psychiatric Association, 2000). Children of participants ranged in age from eight to ten, most were aged nine or ten, with 37% being nine years old (n=10), and 44.5% being 10 years old (n=12). To qualify for the survey children were required to either be in the third or fourth grade: the amount

of children representing each grade was nearly even, with 55.5% being in the third grade (n=15) and 44.4% being in the fourth grade (n=12). It is important to note that although there are more nine and ten year olds, there were more third graders than fourth graders in the sample. This may mean that children who exhibit symptoms of ADHD/ADD with or without comorbid disorders may start kindergarten at a later age than typically developing children due to potentially decreased school readiness. In addition, children with ADHD/ADD with or without comorbid disorders may have difficulty in school, lower grades and may be retained a grade early in their elementary school years. Overall, the race and ethnicity of the children varied more than that of their parents. Most children were identified as White (77.7%, n=21), similar to that of the parent demographics, however, other races and ethnicities were present. Child demographics are illustrated in Table 2.

Table 2 Child Demographics		
n=27	Frequency	Percentage
Age		
8	5	18.5%
9	10	37.0%
10	12	44.5%
Gender		
Male	21	77.8%
Female	6	22.2%
Race/Ethnicity ^a		
White	21	77.7%
Asian	2	7.4%
Black, African American, Haitian	3	11.1%
Hispanic or Latino	1	3.7%
Other:		
Asian Indian	1	3.7%
Prefer Not To Disclose	1	3.7%
Grade in School		
3 rd	15	55.5%
4 th	12	44.5%

^a Participants were permitted to choose all that apply; therefore, response is greater than number of participants

Diagnosis

This section reviews the responses received by parents about their child's ADHD/ADD diagnosis in addition to diagnosed comorbid disorders, and the prevalence in the same of these diagnosis as compared to the available literature. The reported prevalence of the diagnoses of ADHD/ADD and comorbid disorders in this sample was similar to the prevalence reported in the literature.

ADHD/ADD.

Upon examining information about the children and their diagnoses, it was found that most children were diagnosed with ADHD Combined Type (41.9%, n=13), followed by ADHD Predominantly Hyperactive-Impulsive Type (29%, n=9), and ADHD Predominantly Inattentive

Type (22.6%, n=7). Two parents (7.4%) reported being unsure of the subtype of their children's ADHD diagnoses. It may be that children with hyperactive behavior may be negatively perceived by teachers, which may also negatively impact teachers' attitudes and behaviors. Most of the children were diagnosed between ages five and nine with the mean age at diagnosis being at age seven. Most children were diagnosed by social workers, psychologists, or psychiatrists outside of the school (66.7%, n=18), with half as many children diagnosed by their Physician (33.3%, n=9). This may indicate many different factors such as, children not seeing their doctor often, doctors not being aware of the child's symptoms, or personnel at school suggesting that the child be assessed by a mental health professional among other factors. Most, parents (63.0%, n=17) reported that their children took medications to alleviate symptoms of ADHD/ADD at the time of the survey.

Comorbid disorders reported.

As part of the survey, participants provided information regarding any comorbid disorders with which their children were diagnosed. Approximately one third of the children did not have co-morbid disorders while two thirds were reported to have at least one comorbid disorder. Overall, 18 parents (66.7%) responded that their child had a comorbid disorder with a total of 25 comorbid disorders across the group, as parents were able to record more than one comorbid diagnosis. Nine parents recorded that their children had no comorbid disorder (33.3%). In breaking down the reported comorbid disorders, seven had an Anxiety Disorder (25.9%), six had Oppositional Defiant Disorder (22.2%), five had a Learning Disability (18.5%), and of the three remaining, one had Conduct Disorder (3.7%), one had Obsessive Compulsive Disorder (3.7%), and one had a Mood Disorder (3.7%). Parents also recorded their children as

having other comorbid diagnoses, such as High Functioning Autism (7.4%, n=2), Selective Mutism (3.7%, n=1), and Sensory Processing Disorder (3.7%, n=1).

These findings are within the range of percentages established through previous research that depending on the comorbid disorder, 20% to 80% of children with ADHD/ADD have a comorbid disorder (Fischer, Barkley, Smallish & Fletcher, 2004, in Kerig & Wenar, 2006; Kerig & Wenar, 2006; Tannock, 2000, in Kerig & Wenar). Children who experience other symptoms or difficulties related to additional disorders may in turn experience additional difficulties at school. These additional symptoms or difficulties may affect the child's teacher by changing the teachers' attitude in turn affects the functioning of these children. Table 3 illustrates information regarding ADHD/ADD and comorbid disorders that respondents provided through this study.

n=27	Frequency	Percentage
ADHD/ADD Type		
ADHD Combined Type	11	40.7%
ADHD Predominantly Inattentive Type	6	22.2%
ADHD Predominantly Hyperactive-Impulsive Type	8	29.6%
ADHD Unsure of Type	2	7.4%
Comorbid Diagnosis		
Anxiety Disorder	7	25.9%
Oppositional Defiant Disorder	6	22.2%
Learning Disability	5	18.5%
Conduct Disorder	1	3.7%
Obsessive Compulsive Disorder	1	3.7%
Mood Disorder	1	3.7%
Other:		
High Functioning autism	2	7.4%
Selective Mutism	1	3.7%
Sensory Processing Disorder	1	3.7%
No Comorbid Diagnosis	9	33.3%
Medication Prescribed and Taken		
Yes	17	63.0%
No	10	37.0%

Participants' Perceptions of Teachers

The majority of the teachers described in the study were female, White, and older than 30 years old. Twenty-four of the teachers were female (88.9%), and three were male (11.1%). Parents described most teachers as being between 31 and 40 years old (40.7%, n=11), followed by 41-50 (22.2%, n=6) and over 50 (22.2%, n=6) and the fewest teachers were under the age of 30 (14.7%). The race and ethnicity of the teachers was less diverse than that of the parents and children, with 26 teachers being described as White (96.3%), and one described as biracial, White and Black (3.7%). These demographics may influence teachers' attitudes and behavior toward students. For example, an older teacher may be more experienced and have more knowledge and patience.

As almost all of the teachers were described as White, and the children they were teaching were of a more diverse racially and ethnically the teachers may have had attitudes related to the diversity of their students. Although the impact of race on teachers' attitudes is important to study and understand, it is beyond the scope of this thesis. Table 4 shows information respondents provided about their child's teacher.

Table 4 Teacher Demographics		
n=27	Frequency	Percentage
Gender		
Female	24	88.9%
Male	3	11.1%
Age		
Under 30	4	14.8
31 - 40	11	40.7%
41 - 50	6	22.2%
Over 50	6	22.2%
Race/Ethnicity^a		
White	27	100%
Black, African American, Haitian	1	3.7%

^a Participants were permitted to choose all that apply; therefore, response is greater than number of participants

Parents' perceptions of teacher classroom preparedness regarding ADHD/ADD.

Overall parents reported teachers were not that knowledgeable about ADHD/ADD and most teachers did not receive extra classroom assistance. When rating how knowledgeable parents perceived teachers to be regarding ADHD/ADD, More than half of the parents (66.6%, n=18) felt that their child's teacher had a little or some knowledge about the disorder, and 14.8% of parents felt that their child's teacher was either very knowledgeable (n=4), with an equal percentage feeling that their child's teacher was not knowledgeable (14.8%, n=4) and one parent reported being unsure of the level of ADHD/ADD knowledge of their child's teacher. It is notable the number of parents who felt that their child's teacher was not knowledgeable about ADHD/ADD. The impact of teacher knowledge on teacher attitudes will be discussed further in the next chapter. Participants were asked if their child's teacher received in class assistance or services during the school day. Overall, a little over half (51.9%, n=14) responded that the teacher did not have in class assistance, and 10 (37.0%) responded that the teacher did have in

class assistance, and three parents (11.1%) were unsure if their child’s teacher received in class assistance during the day. It is important to know about assistance in the classroom because this extra support may lead to teachers being more patient and helpful with the children who require extra attention. Table 5 below shows information provided by respondents on their perceptions of teachers’ knowledge and preparedness.

Parents were also asked to report how long their children had known the teacher, 77.8% (n=21) of respondents reported that their child had only known his or her teacher this school year. Only one child knew his or her teacher the previous year, and four children knew their teacher before the previous school year. Parents responded that four children knew their teacher prior to the current school year. When a teacher has known his or her students longer than the current school year, the teacher may be more understanding of the child’s individual needs and how to best support and help that child. Greater understanding of individual needs and ways to support a child may result in teachers having a more positive attitude about that child and ADHD/ADD. Table 5 depicts participants’ responses about their perceptions of teachers’ knowledge, in class assistance, etc..

Table 5
Perceptions of Teacher Knowledge,
Classroom Assistance and Preparedness re:
ADHD/ ADD

n=27	Frequency	Percentage
Perceived Level of ADHD/ADD Knowledge		
Very Knowledgeable	4	14.8%
Somewhat or A Little Knowledgeable	18	66.6%
Not Knowledgeable	4	14.8%
Unsure of Knowledge	1	3.7%
Receives in Class Assistance		
Yes	10	37.0%
No	14	51.9%
Unsure	3	11.1%

Parents' Perceptions of Teacher Response to Child Behavior

A focus of this study was to examine parents' perceptions of how their child's teacher responds when the child exhibits certain specific behaviors related to the symptoms of ADHD/ADD because how teacher responds is likely to affect the social and emotional functioning of child. The behaviors exemplified are 1) hyperactive impulsive behavior, 2) difficulty focusing and maintaining focus, and 3) difficulty with organization. For this series of questions parents were asked to think about how their children's teachers would respond to certain classroom behaviors. Across all questions in this series, there were 189 total responses. More than half of parents perceived that teachers were irritated with their children's behaviors (55.0%, n=104). Children who perceive that their teacher is responding negatively to them may experience decreased social and emotional functioning.

Overall, parents responded more that they thought that teachers were irritated and blamed the child, feeling that they were doing it on purpose (30.0%, n=58), which is the most negative response indicating that teachers may have low knowledge an understanding of ADHD/ADD and are not helpful or supportive in the class. Parents responded 46 times (24.3%), that they thought that teachers were irritated but helpful, feeling that the child's behavior might not be on purpose, which might indicated a moderate level of understanding of ADHD/ADD and helpfulness or support in the classroom. The teacher being happy to accept the challenge and feeling that the child's behavior was not on purpose exemplified a positive response by teachers, and parents responded 40 times (21.2%) that they thought this is how their child's teacher felt. Parents responded 10 times (15.9%) that they were unsure of how their child's teacher responded to the children's behavior. Table 6 below shows the total responses per category across questions for

this section. See Appendix E for further data on parents' perceptions of teachers' response to child behavior.

Table 6
Parents' Perceptions of Teacher Response to Child Behavior

n=189	Frequency	Percentage
Irritated and blames, child is doing it on purpose	58	30.0%
Irritated but helps, behavior might not be on purpose	46	24.3%
Happy to accept the challenge, behavior is not on purpose	40	21.2%
Unsure	10	5.3%
Behavior does not apply to my child	30	15.9%
Did not respond	5	2.6%

Parents' Perceptions of Child's Social-Emotional Functioning

The main focus of this research was of the impact of teachers' attitudes and behaviors on the social and emotional functioning of children with ADHD/ADD. Social and emotional skills continue to develop during a child's middle childhood years, however children with ADHD/ADD may have decreased or less advanced social and emotional functioning than that of their peers without ADHD/ADD due to various factors, including teacher influence. The following sections briefly reviews the literature on social and emotional functioning respectively, the findings regarding social and emotional functioning of children with ADHD/ADD in this study.

Social functioning.

One of the final series of questions asked to parents participating in this survey was in regards to the social functioning of their children. Previous research by Heiman (2005), found that children with ADHD were more lonely than their peers without ADHD, their parents and teachers perceived that the children with ADHD had less friends than children without ADHD

and the teachers reported that children with ADHD were not invited to as many social events as their peers without ADHD. In an overview of social functioning and skills by Wehmeier, Schacht, and Barkley (2010), the authors discussed that children with ADHD have poorer social skills than their peers without ADHD, including lacking friendships, participating in limited activities with friends, and that 70% may have no close friends by third grade.

Similar to previous studies, the current study found, when asking about social functioning, about three quarters of parents reported that their child had few friends (74.1%, n=20), and were invited to few events by classmates (77.8%, n=21). More than half of parents reported that their child does not develop and maintain friends easily (55.6%, n=15), and that their child was not bullied (51.8%, n=14). However, more than a quarter of parents reported that their child does develop and maintain friends easily (37.0%, n=10) and that their child was bullied (33.3%, n=6). Notably, two parents were unsure if their child developed and maintained friends easily (7.4%), and seven parents were unsure if their child was bullied, representing about a quarter of responses (25.9%). Frequencies and percentages of responses to social functioning questions are reported below in Table 7.

Emotional functioning.

Wehmeier, Schacht, and Barkley (2010), also addressed the emotional functioning of children with ADHD. These authors addressed that children with ADHD have poor self-regulation of emotions and experience excessive and intense emotions more frequently than their peers without ADHD. In addition, Wehmeier, Schacht, and Barkley (2010), reviewed that children with ADHD have poorer self-perception than their peers without ADHD including poorer self-esteem, and poorer ratings of competence, which can lead to other mental health diagnoses such as depressive disorders.

In contrast to published literature on emotional functioning of children with ADHD the current study found overall that parents perceived that their child were doing better emotionally than has been expressed in the literature. Parents were asked a series of questions regarding the emotional functioning of their children in the final section of the survey. Questions in this section inquired about the children's feelings of competency, self-esteem, and mood. Most parents reported that their children felt somewhat competent, either had somewhat positive self-esteem or somewhat negative self-esteem, were somewhat happy which parents viewed as the same as their peers. More than half of all parents reported that they thought that their child felt somewhat competent (63.0%, n=17), and only one parent reported perceiving that their child felt very incompetent (3.7%). More than one third of parents perceived that their children felt either somewhat positive (37.0%, n=10) or somewhat negative in regards to their self-esteem (37.0%, n=10). However, it is interesting that only three parents reported that they thought their child was ambivalent about his or her self-esteem (11.1%), and only two parents reported for each of the extremes that they thought that their child felt either very positive or very negative about him or herself (7.4% each).

In regards to child's perceived mood a Little less than half of parents reported that they thought that their child was somewhat happy (44.5%, n=12) with more than half of parents reporting they thought their children's mood was about the same as other children (51.9%, n=14), and somewhat less than half thought that their child was less happy or more sad than other children (40.7%, n=11). Only two parents reported that they thought that their child was happier than other children (7.4%). See Table 7 for parents' responses to this set of questions.

Table 7
Social-Emotional Functioning of Participants' Children

n=27	Frequency	Percentage
Social Functioning		
How many friends does your child have?		
Many	2	7.4%
Few	20	74.1%
None	5	18.5%
Unsure	0	0%
Does your child get invited to events by classmates?		
Many	2	7.4%
Few	21	77.8%
None	4	14.8%
Does your child develop and maintain friends easily?		
Yes	10	37.0%
No	15	55.6%
Unsure	2	7.4%
Is your child bullied?		
Yes	6	33.3%
No	14	51.8%
Unsure	7	25.9%
Emotional Functioning		
Does your child feel competent?		
Very Competent	3	11.1%
Somewhat Competent	17	63.0%
Neither Competent or Incompetent: neutral	3	11.1%
Somewhat Incompetent	3	11.1%
Very Incompetent	1	3.7%
How does your child feel about himself or herself?		
Very Positive	2	7.4%
Somewhat Positive	10	37.0%
Neither positive or negative: ambivalent	3	11.1%
Somewhat Negative	10	37.0%
Very Negative	2	7.4%
Unsure	0	0.0%
In the past month, how does your child appear to feel?		
Very Happy	4	14.8%
Somewhat Happy	12	44.5%
Neither Happy or Sad: neutral	5	18.5%
Somewhat Sad	4	14.8%
Very Sad	2	7.4%
Unsure	0	0%
Child's Mood Compared to Other Children		
More Happy	2	7.4%
About the Same	14	51.9%
Less Happy or More Sad	11	40.7%
Unsure	0	0%

Qualitative Responses: Impact of teacher attitudes and behavior on child functioning.

As a final question, parents were asked to respond to the following question. How do you think your child's teacher's attitude affects your child's functioning? The responses were coded into either being a negative or positive perception of the impact of teacher attitudes and behavior on the social-emotional functioning of the participants' children. Overall, responses were nearly even with 13 participants (48.1%) responding that they thought that their child's teacher exhibited positive attitudes or behaviors towards their child, and 14 responded (51.9%), that they thought their child's teacher exhibited negative attitudes or behaviors. The responses were coded into like categories for both negative and positive responses.

Impact of teachers' negative attitudes and behaviors.

Parents responded that they thought that teachers were blaming, not helpful and thought that the child's behavior was on purpose, that the teacher was not understanding and willing to be flexible, in addition to the teacher having negative views about the outcome and not liking their student. Generally when parents responded that these attitudes and behaviors were present the child exhibited behavioral difficulties, impaired social dynamics with peers and their teacher poorer self-perception including self-esteem and competence, and depressed mood. One parent responded,

My child's teacher says his behavior is "purposeful." She says she has experience with ADHD kids but I find her very inflexible and unreceptive to my suggestions. My child has to work harder in this class because she doesn't spend much time with him.

Another parent wrote,

My child's teacher says that he "pushes his buttons" and they argue and have frequent conflicts. I think this has been disastrous for my child. On the one hand, my child seems determined to not let the teacher dominate him. On the other hand, he feels like a loser who can never succeed in the classroom. I feel the

teacher's attitude towards my child has made the peer social dynamics very difficult as well. The teacher has acknowledged he does not get along with my child or see him as "educable" in a general education system (this is an alternative public school). He has said, in front of my child, that he feels "extremely negative and pessimistic" about the possibility of any of this improving.

Impact of teachers' positive attitudes and behaviors.

Overall, parents' responses were coded into categories that exemplified their perceptions that teachers were helpful, supportive, and understanding, were positive, had personal experience with ADHD/ADD and thought that the teachers and their children were of good fit. Parents reported that positive attitudes and behaviors led to their children working well with peers in groups, reaching their academic potential, having positive behavior in the classroom, having positive self-perceptions including positive self-esteem and feelings of competency along with liking school. One parent wrote,

Teacher recognizes his strengths and focuses on them – which has helped my child continue to be intellectually curious and feel competent. She was also very supportive of my son's use of assistive technology, which has helped him immeasurably.

Another responded,

My son's teacher is really a gem. We have had several teachers that did 'label' my son and is a [sic] problem child. Most of them were older teachers... My son loves that she is fair and makes a point to praise him and encourage him but she also makes sure to hold him accountable for his actions.

Although parents responded that they thought the teachers' negative attitudes and behaviors impacted their children negative, and teachers' positive attitudes and behaviors impacted their children positively, this was found in the qualitative responses, but not in the quantitative responses, with the quantitative responses indicating that parents did not perceived their children to have poorer social and emotional functioning.

CHAPTER V

Discussion

Attention Deficit Hyperactivity Disorder (ADHD) is the most common childhood psychiatric disorder, affecting attention, hyperactivity, and impulsivity in three to seven percent of school age children (American Psychiatric Association, 2000; Daley & Birchwood, 2010). Children with ADHD/ADD may exhibit delays in various areas including intelligence, motor coordination, executive functioning, and academic achievement which can result in school being especially challenging (Daley & Birchwood, 2010; Mash & Barkley, 2006). Children who exhibit difficult behaviors, have poor social interaction skills or emotional regulation skills in the classroom may experience difficult relationships with their teacher and classmates, rejection by them and isolation from them which, can result in decreased social and emotional functioning of these children (Heiman, 2005; Kerig & Wenar, 2006; Moses, 2010; Sherman, Rasmussen & Baydala, 2008; Whemeier, Schacht & Barkley, 2010)

Previous research has examined the perspectives of teachers and/or parents on the social and emotional functioning of children with ADHD/ADD and has examined children's self-perceptions, however previous research on parents' perceptions of the impact of teachers' attitudes on children with ADHD/ADD was not able to be located in databases (EBSCO, PsychINFO). Due to the lack of this perspective represented in the published research, a descriptive, cross-sectional study was conducted to explore parents' perceptions of the impact teachers' attitudes and behaviors have on the social-emotional functioning of children with

ADHD/ADD. The primary goal of this study was to examine the impact of teachers' attitudes and behaviors on the social-emotional functioning of third and fourth grade children with ADHD/ADD from their parents' perspective. Major findings, limitations and implications for social work clinical practice will be addressed in the following pages.

Major Findings

The results of the study were that, 1) most parents felt that their child's teacher had little or some knowledge of ADHD/ADD, 2) children tend to get different teachers at the beginning of third and fourth grade and do not stay with the same teacher for more than one year, 3) parents' perceived that overall teachers were irritated with their child's behavior in the classroom, which included the teacher being unsupportive by blaming the child for his or her behavior, or being supportive and understanding that the behavior may not be purposeful, 4) parents' viewed that their children had decreased social functioning hallmarked by having few friends, being invited to few social events by peers, not developing or maintaining friends easily, and finally 5) parents' perceived their children's emotional functioning to not be decreased, which included perceiving that their children felt somewhat competent, having either somewhat positive or somewhat negative self esteem, and being somewhat happy which parents perceived to be similar to the mood of their children's peers.

Teachers have little knowledge of ADHD/ADD.

A major finding in this study was that most parents perceived teachers to have little or some knowledge about ADHD/ADD. Teachers are viewed as valuable sources of information related to the diagnosis of children because most children are in school many hours each day and teachers observe many different activities throughout each day, from in class behavior, social interactions, and interactions during play times. Teachers are also likely to see behaviors related

to a diagnosis of ADHD/ADD because of the cognitive and behavioral demands that are inherent in school (Kos, Richdale, & Hay, 2006; Scituito, Terjesen, & Bender Frank, 2000). However, teachers without adequate knowledge of ADHD/ADD are not able to provide appropriate support to their students who present with a diagnosis of ADHD/ADD (Kos, Richdale, & Hay, 2006; Scituito, Terjesen, & Bender Frank, 2000).

There are few studies that examine the ADHD/ADD knowledge possessed by teachers, and only six articles between 1994 and 2005 assessed teachers knowledge of ADHD/ADD; however, results are mixed regarding the proportion of information known by teachers regarding ADHD/ADD (Kos, Richdale & Hay, 2006). Teachers who have expressed to parents that they have previous experience with children who have been diagnosed with ADHD/ADD may be seen by parents as being more knowledgeable. Teacher experience with ADHD/ADD has been found to be linked with ADHD/ADD knowledge (Kos, Richdale, & Hay, 2006; Scuitto, Terjesen, & Bender Frank, 2000).

It is important that teachers have adequate knowledge regarding ADHD/ADD due to the cognitive and behavioral demands of the classroom which may make ADHD/ADD symptoms more evident to teachers (Kos, Richdale, & Hay, 2006; Scituito, Terjesen, & Bender Frank, 2000). Without adequate and correct information, teachers will not be able to accurately observe symptoms, provide referrals for assessment, provide information and support to parents, and most crucially, will not be able to provide adequate support to children with ADHD/ADD within their classroom.

Children change teachers, on average, every year.

Another interesting finding of this study was that the children in this study changed teachers, on average, every year. Children who are able to keep the same teacher each year may

benefit from positive teacher-child relationships which can foster social interactions, academic success, and positive school adjustment (Jerome, Hamre, & Pianta, 2009; Thijs, Koomen, & van der Leij, 2008). Within schools, positive relationships with teachers act as a protective factor due to positive relationships being characterized by helpful, compassionate, and supportive attitudes and behaviors that are evident in teachers who are invested in their students, however, when teachers have negative relationships with students it is viewed as a risk factor for that student due to the negative attitude and behaviors that may be exhibited by that teacher (Murray-Harvey, & Sleep, 2007; Thijs, Koomen, & van der Leij, 2008). Even when children change teachers every year, which is a normal experience for children, having past and current positive relationships with teachers remains important in academic, social and emotional functioning (Jerome, Hamre, & Pianta, 2009). Due to the many risk factors, academic, social, emotional and behavior difficulties already experienced by students with ADHD/ADD having a different teacher each year may cause increased difficulties, especially if the student and teacher do not have a good relationship. It is hoped that students with ADHD/ADD are able to form positive relationships with their teachers each year so that their pre-existing difficulties are not further exacerbated by negative teacher attitudes and behaviors.

Teachers are irritated with children's behavior in the classroom.

Overall, it was found that when children with ADHD/ADD exhibited difficult behaviors in the classroom or required extra assistance during the school day their teachers responded negatively including feeling irritated and blaming the children for their behaviors, not understanding that the behaviors may not have been purposeful. In research by Moses, (2010), it was found that children who experience stigma at school and are alienated from their teachers do not receive sufficient instruction in the classroom and are more likely to have decreased interest

in academics and less positive relationships with peers and other staff within the school. Little research has been done on teachers' attitudes and behaviors towards children, especially those with ADHD/ADD symptoms or other behavioral disorders. The studies that have been done on attitudes focus on knowledge as the basis for teachers' attitudes and behaviors (Ohan, Cormier, Hepp, Visser & Strain, 2008). Ohan et. al., (2008), found that the knowledge that teachers had about the ADHD/ADD diagnosis allowed them to understand what behavior management skills they could utilize, but also when teachers were more knowledgeable about ADHD they reported the perception that children with ADHD/ADD were harder to manage in the classroom and felt less prepared. Although a small number of studies directly address the attitudes and behaviors of teachers' related to ADHD/ADD or other behavioral disorders, it is important to acknowledge that teachers have different levels of education, have different experiences, and some may be more prepared or willing to work with children who have ADHD/ADD than others and may do so in a positive, supportive, compassionate way that positively impacts the children's functioning.

Children with ADHD/ADD had decreased social functioning.

The results regarding the decreased social functioning of students with ADHD/ADD were consistent with previous studies, including that children with ADHD/ADD have poorer social skills than their peers without ADHD/ADD including having fewer friendships, and engage in fewer activities with peers outside of school, and are more lonely than their peers without ADHD/ADD (DuPaul, Jitendra, Tresco, Vile Junod, Volpe & Lutz, 2006; Ek, Westerlund, Holmberg, & Fernell, 2008; Heiman, 2005; Kerig & Wenar, 2006; Wehmeier, Schacht & Barkley, 2010). Building relationships with both peers and adults is a crucial part of children's development, which affects their social skills throughout the rest of their lives

(Heiman, 2005). Positive peer relationships during childhood enhance social well being including increased social status, sense of belonging and increased self-esteem (Heiman, 2005). Unfortunately, many children with ADHD/ADD may be seen as annoying, intrusive and insensitive to the needs of others which are often the result of deficits in social skills which can result in rejection by peers, difficulty establishing and maintaining friendships, and social isolation (DuPaul, Jitendra, Tresco, Vile Junod, Volpe & Lutz, 2006; Ek, Westerlund, Holmberg, & Fernell, 2008; Heiman, 2005; Kerig & Wenar, 2006; Wehmeier, Schacht & Barkley, 2010).

The finding that children with ADHD/ADD have decreased social functioning in relation to their peers without ADHD/ADD was not addressed in relationship to teachers' attitudes and behaviors, however, when children have poor social skills it may be more difficult for them to appropriately relate to peers and engage in social interactions. When teachers respond negatively to students with ADHD/ADD, it may influence their views of themselves negatively, increasing their social isolation and withdrawal among other potential effects.

Children with ADHD/ADD did not have decreased emotional functioning.

Contrary to previous research (DuPaul, Jitendra, Tresco, Vile Junod, Volpe, & Lutz, 2006; Ek, Westerlund, Holmberg, Fernell, 2008; Semrud-Clikeman, & Schafer, 2000; Wehmeier, Schacht, & Barkley, 2010), the findings regarding emotional functioning in this study were not similar to the findings in these previous studies in which children were found to have poorer self-regulation of their emotions, and poorer self-perception such as poor self-esteem and poorer competence in comparison to their peers without ADHD/ADD. The current research found that, overall, parents perceived that their children did not have markedly poor feelings of competence, self-esteem, or that their mood was overall worse than that of their children's peers without ADHD/ADD. Previous research makes a connection between positive peer relationships

and positive self-esteem. Although children in this study were perceived by their parents to have few friendships and difficulty establishing and maintaining friendships, it may be that the few friendships that the children had were positive which led to positive emotional functioning, including competence, self-esteem, and overall mood.

Additional Findings: The Impact of Comorbid Disorders

Comorbid disorders are common with the diagnosis of ADHD/ADD and commonly include Oppositional Defiant Disorder, Conduct Disorder, anxiety and mood disorders, and learning difficulties. Approximately 20% to 30% of individuals with ADHD/ADD have a comorbid disorder (Kerig & Wenar, 2006), however other research shows great variability in rates of comorbid disorders in this population ranging anywhere from 20% to 80% depending on the comorbid disorder (Barkley, 2003; Fischer, Barkley, Smallish & Fletcher, 2004, in Kerig & Wenar, 2006; Kerig & Wenar, 2006; Tannock, 2000, in Kerig & Wenar). Previous research has shown that up to 80% of children with ADHD/ADD have significant learning disabilities that impact academic performance resulting in grade retention, which likely impacts the social and emotional functioning of children with ADHD/ADD (Barkley, 2003; Kerig & Wenar 2006). In the current study 18 parents responded that their child had at least one comorbid disorder, which was 66.7% of participants' children, 25 total comorbid disorders were recorded meaning that most child had either one or two comorbid disorders. Due to the addition of other diagnoses to ADHD/ADD, children may experience increased difficulties in the classroom, which may result in negative attention from the teacher and classmates, and decreased time interacting with peers and gaining social-emotional skills.

Limitations

Several limitations to this study require attention and discussion. First, the current study examined the impact of teachers' attitudes and behaviors and the social-emotional functioning of third and fourth grade children with ADHD/ADD. Unfortunately, the sample for the study was small resulting from participant attrition during the survey, which produced unusable data for this study. Because less than 50 participants provided usable data, correlations could not be run due to the limited statistical power caused when a study has less than 50 participants. Additionally, the small number of participants does not allow the study to be generalized past the study sample of White, female, middle class, college educated, parents.

Second, the current study was based on a survey hosted on the internet. This method for doing the research has the opportunity for creating a bias, as not all individuals who would have been eligible for the survey may have had access to the survey. This limitation may have impacted the demographics in the current study, which also limits the generalizability of the findings.

Third, the validity of this study was compromised due to study design, including using a mixed methods, cross-sectional study in which there was no control group or variables that were able to be manipulated in addition to having potential third variables, or confounds present, that were unable to be controlled for. The measure used in this study was not a standardized measure, but was self-developed for the purpose of the study, and no tests for validity or reliability of the measure were completed prior to the study. Although the measure was created for the purpose of this study, the variables were operationalized based on previous research and literature regarding symptoms of ADHD/ADD, and common measures of child social-emotional functioning.

Recommendations for Future Research

In doing research on the impact of teachers' attitudes and behaviors it was found that there are few studies examining the impact of teachers' attitudes and behaviors on their students, specifically, those children with ADHD/ADD. Unfortunately, the previous studies have primarily examined teachers' attitudes and behaviors related to ADHD/ADD by seeking information about teachers' knowledge of ADHD/ADD. Future research should examine other ways to investigate teachers' attitudes and behaviors, in addition to assessing the impact of their level of knowledge about particular diagnosis. For future research, it might be important to utilize a standardized measure to examine both teachers' attitudes and the social-emotional functioning of children.

In the future, it might be useful to replicate the current study but with a sufficiently large sample to run correlations in order to assess the association between teachers' attitudes and behaviors and the social-emotional functioning of students with ADHD/ADD. Additionally, if this study were to be replicated it might be important to ask parents how severe they perceive their child's ADHD/ADD to be, as severity of the symptoms and behaviors related to ADHD/ADD might also impact the teachers' attitudes and behaviors, which then might result in greater impacts on the social-emotional functioning of those children.

Implications for Clinical Practice

The current study addressed the impact that teachers' attitudes and behaviors had on the social-emotional functioning of children with ADHD/ADD. Schools are institutions in which social workers may be present and already working with students who experience negative behaviors or attitudes of teachers, and with teachers who are experiencing challenges with students who have ADHD/ADD in their classroom. School social workers have a unique role as

they provide not only guidance and support to students within the school, but they also provide guidance and support for teachers, staff, and administrators within the school. Several implications for clinical work with this child population emerged from the findings of the current study.

First, social workers might make themselves available to teachers for support if the teachers are experiencing difficulty supporting children with ADHD/ADD, other diagnoses, or challenging behavior. Challenges for teachers may include not knowing interventions that could be used in the classroom, how to best help a particular student, or having a poor teacher-student relationship. Helping teachers with understanding the behaviors and useful interventions can benefit all students in the classroom.

Second, social workers could provide services within the school to provide education and information on ADHD/ADD and other common diagnosis, including what the symptoms are, the behaviors that may manifest, and interventions that can be successfully utilized within the classroom to benefit all students. The school based education for teachers may consist of leading or coordinating an in-service training about common childhood diagnosis, symptoms, and interventions, providing information sheets on the diagnosis that are common, useful interventions that can be implemented with an individual child or the whole class, and how to implement them. However, social workers can also meet with teachers in groups or individually regarding the information that they need to assist their students in reaching their academic potential.

Third, social workers might also work with students individually or in groups who have been impacted by teachers' attitudes and behaviors, especially attitudes and behaviors that are negative. Social workers could facilitate self-perception improvement groups with a focus on

confidence and self-esteem building work, social skills building, and emotional regulation skills improvement, such as increasing successful use of coping skills, with students individually or in groups. Fourth, social workers might also work with the families of these children, when possible, to provide support, referrals to mental health professionals if needed or requested, and information on how to continue to bolster the children's self-perception, social skills, and emotional regulation skills at home.

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: American Psychiatric Association.
- Barkley, R. A., (2003). Issues in the diagnosis of attention-deficit/hyperactivity disorder in children. *Brain & Development*, 25, p. 77 – 83.
- Centers for Disease Control and Prevention (CDC). (Nov. 12, 2010). Increasing prevalence of parent-reported Attention-Deficit/Hyperactivity Disorder among children --- United States, 2003 and 2007. *Morbidity and Mortality Weekly Report*, 59(22), p. 1439 – 1443. Accessed at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5944a3.htm?s_cid=mm5944a3_w>.
- Cone, J. D. & Foster, S. L. (2010). *Dissertations and thesis from start to finish: Psychology and related fields*. Washington, DC: American Psychiatric Association.
- Daley, D., & Birchwood, J. (2010). ADHD and academic performance: Why does ADHD impact on academic performance and what can be done to support ADHD children in the classroom? *Child: Care, Health, and Development*, 36(4), 445 – 454.
- DuPaul, G. J., Jitendra, A. K., Tresco, K. E., Vile Junod, R. E., Volpe, R. J., & Lutz, J. G. (2006). Children with Attention Deficit Hyperactivity Disorder: Are there gender differences in school functioning? *School Psychology Review*, 35(2), p. 292 – 308.
- Ek, U., Westerlund, J., Holmberg, K., & Fernell, E. (2008). Self-esteem in children with attention and/or learning deficits: The importance of gender. *Acta Paediatrica*, 97, p. 1125 – 1130.
- Heiman, T. (2005). An examination of peer relationships of children with and without Attention Deficit Hyperactivity Disorder. *School Psychology International*, 26(3), 330 – 339.
- Jerome, E. M., Hamre, B. K., & Pianta, R. C. (2009). Teacher-child relationships from kindergarten to sixth grade: Early childhood predictors of teacher perceived conflict and closeness. *Social Development*, 18(4), p. 915 – 945.
- Kerig, P., & Wenar, C. (2006). *Developmental Psychopathology*. (5th Ed.). New York: McGraw Hill.
- Kos, J. M., Richdale, A. L., & Hay, D. A. (2006). Children with Attention Deficit Hyperactivity Disorder and their teachers: A review of the literature. *International Journal of Disability, Development and Education*, 53(2), p. 147 – 160.

- Mash, E. J., & Barkley, R. A. (Eds.). (2006). *Treatment of childhood disorders*. (3rd Ed.). New York: Guilford Press
- Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine*, 70, 985-993.
- Murray-Harvey, R., & Slee, P. T. (2007). Supportive and stressful relationships with teachers, peers and family and their influence on students' social/emotional and academic experience of school. *Australian Journal of Guidance & Counseling*, 17(2), p. 126 – 147.
- Ohan, J. L., Cormier, N., Hepp, S. L., Visser, T. A. W., & Strain, M. C. (2008). Does knowledge about Attention-Deficit/Hyperactivity Disorder impact teachers' reported behaviors and perceptions? *School Psychology Quarterly*, 23(3), p. 436 – 449.
- Sax, L., & Kautz, K. J. (2003). Who first suggests the diagnosis of Attention-Deficit/Hyperactivity Disorder? *Annals of Family Medicine*, 1(3), 171-174.
- Sciutto, M. J., Terjesen, M. D., & Bender Frank, A. S. (2000). Teachers' knowledge and misperceptions of Attention-Deficit/Hyperactivity Disorder. *Psychology in the Schools*, 37(2), 115-122.
- Semrud-Clikeman, M., & Schafer, V. (2000). Social and emotional competence in children with ADHD and/or Learning Disabilities. *Journal of Psychotherapy in Independent Practice*, 1(4), p. 3 – 19.
- Sherman, J., Rasmussen, C., & Baydala, L. (2008). The impact of teacher factors on achievement and behavioural outcomes of children with Attention Deficit Hyperactivity Disorder (ADHD): A review of the literature. *Educational Research*, 50(4), 347-360.
- Thijs, J. T., Koomen, H. M., & van der Leij, A. (2008). Teacher-child relationships and pedagogical practices: Considering the teacher's perspective. *School Psychology Review*, 37(2), p. 244 – 260.
- Wehmeier, P. M., Schacht, A., & Barkley, R. A. (2010). Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life. *Journal of Adolescent Health*, 46, 209 – 217.

Appendix A

Survey

Welcome! Thank you for your interest in participating in this survey. Please answer the following questions to determine eligibility.

*1. Does your child have a formal diagnosis of Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder, that was diagnosed by a physician, psychiatrist or other mental health clinician (social worker, psychologist etc.)?

- Yes
- No

* 2. Is your child a 3rd or 4th grade student?

- Yes
- No

*3. Does your child attend class in a regular/inclusive classroom?

- Yes
- No

*4. Has your child had the same teacher all this school year?

- Yes
- No

PLEASE CAREFULLY READ THIS INFORMED CONSENT DOCUMENT. IF YOU AGREE TO PARTICIPATE, PLEASE PRINT A COPY FOR YOUR RECORDS AND PROCEED TO THE SURVEY QUESTIONS.

THANK YOU

Dear Parent,

My name is Meg Gaskell, and I am a graduate student at Smith College School for Social Work. I am conducting a mixed methods survey of parents to further understand parents' perceptions of the association between teachers' attitudes and the social and emotional functioning of 3rd and 4th grade children with ADHD/ADD. The intention of this research is to further study the perceived impact teachers have on the social and emotional functioning of children with ADHD/ADD.

I am conducting this research for my thesis as part of the requirements for the Master of Social Work degree at Smith College School for Social work and future presentations and publications. Participation in this research will include providing information about yourself, your child, and your child's teacher and answering a survey. All together, this survey should take approximately 30 minutes to complete. The survey consists of multiple choice questions and one open ended question asking about how you think your child is doing socially and emotionally and the association between your child's teacher's attitudes and how your child is doing socially and emotionally.

The information you provide in the survey will be collected anonymously as e-mail address, computer location or IP address will not be collected or requested. Confidentiality will be maintained consistent with federal regulations and the requirements of the social work profession. My research advisor will have access to survey responses; however, no identifying information will be available. Materials, including survey responses will be kept in a locked file for 3 years, unless used for future research or publication, at which point they will be destroyed.

Participation in this project is voluntary and you may refuse to answer any question or end your participation at any point up to submitting your survey responses. To end the survey early close the survey window or click the "exit survey" link. Withdrawal after submission of your responses will not be possible due to the anonymous nature of the study as individual responses will not be identifiable.

By participating in this study you will have the opportunity to share your understanding of your child's teacher's attitudes and how your child is doing socially and emotionally. By reflecting on your the interactions between your child and your child's teacher and the impact of those interactions, you may gain a greater understanding of how your child is doing both socially and emotionally, and what your child needs in the school setting to best suit his or her needs.

If you have questions or concerns about your rights or this study please do not hesitate to call me at (603) 504-4633, e-mail me at ADHDthesis@gmail.com or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Thank you for your time,

Meg Gaskell

PLEASE PRINT A COPY OF THIS INFORMED CONSENT LETTER FOR YOUR RECORDS, BY SELECTING THE "PRINT" ICON OR OPTION IN YOUR INTERNET BROWSER.

*5. BY CHECKING "I AGREE" BELOW, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY DESCRIBED. IF YOU HAVE QUESTIONS ABOUT THE STUDY PLEASE CONTACT THE RESEARCHER MEG GASKELL BY TELEPHONE (603) 504-4533 OR E-MAIL ADHDthesis@gmail.com

- I Agree to participate
- I do not wish to participate

Demographic Information – Parent

Please answer the following questions about yourself

6. What is your current age?

7. Please indicate your gender

- Male
- Female
- Prefer not to disclose

8. Please indicate your race/ethnicity (select all that apply)

- White
- Native American, or Alaska Native
- Asian
- Black, African American, or Haitian
- Native Hawaiian or other Pacific Islander
- Hispanic or Latino
- Prefer not to disclose
- Other: Please Specify _____

9. What is the highest level of education you have completed?

- Less than high school
- Some high school
- High school diploma or GED
- Some college
- 2 year college
- 4 year college degree
- Graduate school
- Post graduate degree
- Prefer not to disclose

10. With which socioeconomic class do you identify?

- Lower class
- Middle class
- Upper class
- Prefer not to disclose

Demographic Information - Child

11. What is your child's current age?

12. Please indicate your child's gender

- Male
- Female
- Prefer not to disclose

13. Please indicate your child's race/ethnicity (select all that apply)

- White
- Native American, or Alaska Native
- Asian
- Black, African American, or Haitian
- Native Hawaiian or other Pacific Islander
- Hispanic or Latino
- Prefer not to disclose
- Other: Please Specify _____

14. What grade is your child currently in?

- 3rd
- 4th
- Other

15. What type of ADHD/ADD is your child diagnosed with?

- ADHD combined type
- ADHD predominantly inattentive type
- ADHD predominantly hyperactive-impulsive type
- ADHD unsure of type
- ADD unsure of type

16. How old was your child when he or she was diagnosed with ADHD/ADD?

17. Who first gave your child the diagnosis of ADHD/ADD?

- Physician or Doctor
- School mental health clinician (social worker, psychologist etc.)
- Other mental health clinician (social worker, psychologist, psychiatrist etc.)
- Other (please specify) _____

18. Does your child have an Individualized Education Plan (IEP) or 504 plan?
- IEP
 - 504 Plan
 - No
 - Unsure
19. Does your child receive services during the school day?
- Yes: Pull-out services or assistance (child is taken out of the classroom to receive services)
 - Yes: In classroom services or assistance
 - Yes: Both pull-out services and in classroom services
 - No
 - Unsure
20. Does your child take any medications for symptoms of ADHD/ADD?
- No
 - Yes
21. Does your child have any other mental health diagnoses? (Select all that apply)
- Anxiety
 - Oppositional Defiant Disorder (ODD)
 - Conduct Disorder (CD)
 - Obsessive Compulsive Disorder (OCD)
 - Learning Disability
 - Mood Disorder
 - None
 - Other (please specify) _____

Demographic Information - Teacher

22. What is the gender of your child's teacher?
- Male
 - Female
23. What is the approximate age of your child's teacher?
- Under 30
 - 31 – 40
 - 41 – 50
 - Over 50

24. Please indicate the race/ethnicity of your child's teacher (select all that apply)

- White
- Native American, or Alaska Native
- Asian
- Black, African American, or Haitian
- Native Hawaiian or other Pacific Islander
- Hispanic or Latino
- Prefer not to disclose
- Other: Please Specify _____

25. How long has your child known his or her teacher?

- Just this school year
- Since last school year
- Before last school year (please indicate number of years in a whole number) _____

26. Do you think your child's teacher is knowledgeable about ADHD/ADD?

- Yes, very knowledgeable
- Yes, somewhat knowledgeable
- Yes, a little knowledgeable
- Not knowledgeable
- Unsure

27. Does your child's teacher receive services or assistance in their classroom? (example: extra teacher, classroom aid, paraprofessional, etc.)

- Yes
- No
- Unsure

Parents' Perceptions of Teachers' Attitudes

Disruptive/Hyperactive Behavior

28. How do you think your child's teacher feels when your child interrupts or intrudes at inappropriate times? (examples: speaking out of turn, when others are speaking etc.)

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

29. How do you think your child's teacher feels when your child leaves his or her seat at times when remaining seated is expected?

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

30. How do you think your child's teacher feels when your child is uncooperative, defiant, angry or hostile?

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

Distractibility/Inattention

31. How do you think your child's teacher feels when your child requires redirection multiple times in a short time span? (example: teacher must verbally redirect your child or show your child to the desired/expected activity)

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

32. How do you think your child's teacher feels when your child loses focus easily or doesn't pay attention?

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

Organization and Planning

33. How do you think your child's teacher feels when he or she must help your child clean, organize or find things in his or her desk, folders or backpack?

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

34. How do you think your child's teacher feels when he or she must spend extra time with your child during transition times and activities?

- Irritated and blames the child, feels that he or she is doing it on purpose
- Irritated but helps, your child may or may not be doing it on purpose
- Happy to accept the challenge and feels that your child isn't doing it on purpose
- Unsure
- This behavior does not apply to my child

Parents' Perceptions of Child's Social and Emotional Functioning

Social Functioning

35. Does your child have close friends?

- Many
- Few
- None
- Unsure

36. Does your child get invited to events by classmates such as birthday parties, sleepovers, play days etc.?

- Many
- Few
- None

36. Does your child get invited to events by classmates such as birthday parties, sleepovers, play days etc.?

- Many
- Few
- None

36. Does your child get invited to events by classmates such as birthday parties, sleepovers, play days etc.?

- Many
- Few
- None

Emotional Functioning

39. Overall, does your child feel competent in what they do?

- Very competent
- Somewhat competent
- Neither competent or incompetent; neutral
- Somewhat incompetent
- Very incompetent
- Unsure

40. Overall, how does your child feel about himself or herself?

- Very positive
- Somewhat positive
- Neither positive or negative; ambivalent
- Somewhat negative
- Very negative
- Unsure

41. Overall in the past month how does your child appear to feel?

- Very happy
- Somewhat happy
- Neither happy or sad; neutral
- Somewhat sad
- Very sad
- Unsure

42. Compared to other children, how does your child seem overall?

- More happy
- About the same
- Less happy or more sad
- Unsure

43. Do you think your child's teacher likes your child?

- Yes
- No
- Unsure

44. Do you think your child likes his or her teacher?

- Yes
- No
- Unsure

45. Please think about your child's teacher's attitude... and take a minute to respond fully to the following question:

How do you think your child's teachers' attitude affects your child's functioning?

(For example: Your child's teacher is helpful and your child feels good about him or herself and does well socially; your child's teacher blames your child and your child feels like he or she is a "bad kid" and no one likes him or her)

Thank you for participating in this survey.

Please contact me at ADHDthesis@gmail.com if you have any questions.

PLEASE PRINT THE FOLLOWING RESOURCES FOR YOUR RECORDS AND USE BY CHOOSING THE "PRINT" OPTION IN YOUR INTERNET BROWSER

FOR MORE INFORMATION ON ADHD OR ADD PLEASE VISIT THE FOLLOWING TRUSTED WEBSITES:

1. Children and Adults with Attention Deficit/Hyperactivity Disorder
www.chadd.org

2. National Resource Center on AD/HD
www.help4adhd.org

3. Centers for Disease Control and Prevention
www.cdc.gov/ncbddd/adhd/

4. American Academy of Pediatrics
www.aap.org/healthtopics/adhd.cfm

IF YOU ARE INTERESTED IN LOCATING MENTAL HEALTH SERVICES IN YOUR AREA FOR YOUR CHILD OR FAMILY PLEASE USE THE FOLLOWING TRUSTED RESOURCES:

1. Call your child or family's primary care physician or clinic.

2. To find a social worker:
<http://www.helppro.com/nasw/basicsearch.aspx>
or
<http://www.helpstartshere.org/find-a-social-worker>

3. To find other services and resources including mental health clinicians call 2-1-1 to access available services in your state and local area (2-1-1 is a service of your local United Way)

Please pass on the following link to others who may be interested in participating or who can pass it on. Thank You!

<https://www.surveymonkey.com/s/ADHDsurvey>

Appendix B

Smith College School for Social Work HSR Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 28, 2011

Margaret Gaskell

Dear Meg,

Your revisions have been reviewed and they are fine. One thing remains to be done. Please put the boilerplate at the end of your Consent letter in bold caps. We are at this point happy to give final approval to your study with the understanding that you will make the above correction and send the corrected page to Laurie Wyman.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mollie Sherry, Research Advisor

Appendix C

Recruitment Letter

Hello,

My name is Meg Gaskell and I am a graduate student at Smith College School for Social Work currently doing research for my master's thesis. I am looking for parents of children with Attention Deficit/Hyperactivity Disorder (ADHD or ADD) in the 3rd or 4th grades to participate in an online survey examining parents' perceptions of associations between teachers' attitudes and how their child with ADHD/ADD is doing socially and emotionally. If you are a parent of a child in the 3rd or 4th grade with ADHD or ADD your participation in this survey is greatly appreciated. If you know of other parents or individuals who work with parents and/or children please pass along this information.

Participating in this research is entirely voluntary, anonymous and confidential and will take approximately 30 minutes to complete. You may skip any question and can end your participation at any time during the survey, however, due to the anonymous nature of this survey, withdrawal from the study after submitting the completed survey will not be possible.

Thank you in advance for your contribution to this study. Please send this e-mail, or information and link to other parents or individuals who work with parents or children that you may know. Posting this survey on related online groups would also be appreciated. Please contact me at ADHDthesis@gmail.com if you have any questions.

To participate in this survey please click on the following link to open the survey in your web browser <https://www.surveymonkey.com/s/ADHDsurvey>

Thank you for your time,

Meg Gaskell

Appendix D

Informed Consent Letter

Dear Parent,

My name is Meg Gaskell, and I am a graduate student at Smith College School for Social Work. I am conducting a mixed methods survey of parents to further understand parents' perceptions of the association between teachers' attitudes and the social and emotional functioning of 3rd and 4th grade children with ADHD/ADD. The intention of this research is to further study the perceived impact teachers have on the social and emotional functioning of children with ADHD/ADD.

I am conducting this research for my thesis as part of the requirements for the Master of Social Work degree at Smith College School for Social work and future presentations and publications. Participation in this research will include providing information about yourself, your child, and your child's teacher and answering a survey. All together, this survey should take approximately 30 minutes to complete. The survey consists of multiple choice questions and one open ended question asking about how you think your child is doing socially and emotionally and the association between your child's teacher's attitudes and how your child is doing socially and emotionally.

The information you provide in the survey will be collected anonymously as e-mail address, computer location or IP address will not be collected or requested. Confidentiality will be maintained consistent with federal regulations and the requirements of the social work profession. My research advisor will have access to survey responses; however, no identifying information will be available. Materials, including survey responses will be kept in a locked file for 3 years, unless used for future research or publication, at which point they will be destroyed.

Participation in this project is voluntary and you may refuse to answer any question or end your participation at any point up to submitting your survey responses. To end the survey early, close the survey window or click the "exit survey" link. Withdrawal after submission of your responses will not be possible due to the anonymous nature of the study as individual responses will not be identifiable.

By participating in this study, you will have the opportunity to share your understanding of your child's teacher's attitudes and how your child is doing socially and emotionally. By reflecting on your the interactions between your child and your child's teacher and the impact of those interactions, you may gain a greater understanding of how your child is doing both socially and emotionally, and what your child needs in the school setting to best suit his or her needs.

If you have questions or concerns about your rights or this study please do not hesitate to call me at [REDACTED], e-mail me at ADHDthesis@gmail.com or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Thank you for your time,

Meg Gaskell

By checking “I Agree” below, you are indicating that you have read and understand the information above and that you agree to participate in the study described. If you have questions about the study please contact the researcher Meg Gaskell by telephone (603) 504-4633 or e-mail ADHDthesis@gmail.com

- I Agree to participate

- I do not wish to participate (exits survey)

Appendix E

Parents' Perceptions of Teachers' Response to Child Behavior

n=27	Frequency	Percentage
How do you think your child's teacher feels when your child interrupts or intrudes at inappropriate times?		
Irritated and blames, child is doing it on purpose	8	29.6%
Irritated but helps, behavior might not be on purpose	7	25.9%
Happy to accept the challenge, behavior is not on purpose	6	22.2%
Unsure	0	0%
Behavior does not apply to my child	6	22.2%
How do you think your child's teacher feels when your child leaves his or her seat at times when remaining seated is expected?		
Irritated and blames, child is doing it on purpose	8	29.6%
Irritated but helps, behavior might not be on purpose	5	18.5%
Happy to accept the challenge, behavior is not on purpose	6	22.2%
Unsure	0	0%
Behavior does not apply to my child	7	25.9%
Did not respond	1	3.7%
How do you think your child's teacher feels when your child is uncooperative, defiant, angry or hostile?		
Irritated and blames, child is doing it on purpose	9	33.3%
Irritated but helps, behavior might not be on purpose	7	25.9%
Happy to accept the challenge, behavior is not on purpose	3	11.1%
Unsure	0	0%
Behavior does not apply to my child	8	29.6%
How do you think your child's teacher feels when your child requires redirection multiple times in a short time span?		
Irritated and blames, child is doing it on purpose	10	37.0%
Irritated but helps, behavior might not be on purpose	6	22.2%
Happy to accept the challenge, behavior is not on purpose	7	25.9%
Unsure	3	11.1%
Behavior does not apply to my child	1	3.7%
How do you think your child's teacher feels when your child loses focus easily or doesn't pay attention?		
Irritated and blames, child is doing it on purpose	7	25.9%
Irritated but helps, behavior might not be on purpose	7	25.9%
Happy to accept the challenge, behavior is not on purpose	9	33.3%
Unsure	2	7.4%
Behavior does not apply to my child	0	0%

Did not respond	2	7.4%
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How do you think your child’s teacher feels when he or she must help your child clean, organize or find things in his or her desk, folders or backpack?

Irritated and blames, child is doing it on purpose	7	25.9%
Irritated but helps, behavior might not be on purpose	9	33.3%
Happy to accept the challenge, behavior is not on purpose	3	11.1%
Unsure	2	7.4%
Behavior does not apply to my child	6	33.3%

How do you think your child’s teacher feels when he or she must spend extra time with your child during transition times and activities?

Irritated and blames, child is doing it on purpose	9	33.3%
Irritated but helps, behavior might not be on purpose	5	18.5%
Happy to accept the challenge, behavior is not on purpose	6	33.3%
Unsure	3	11.1%
Behavior does not apply to my child	2	7.4%
Did not respond	2	7.4%

Appendix F

Parent's Perceptions of the Impact of Teachers' ADHD/ADD Knowledge

	Frequency (%)
Very Knowledgeable	
Irritated and blames, child is doing it on purpose	0
Irritated but helps, behavior might not be on purpose	4 (14.3%)
Happy to accept the challenge, behavior is not on purpose	16 (57.1%)
Unsure	2 (7.1%)
Behavior does not apply to my child	5 (17.9%)
No Response	1 (3.6%)
Total Responses	28
Somewhat Knowledgeable (n=49)	
Irritated and blames, child is doing it on purpose	7 (14.3%)
Irritated but helps, behavior might not be on purpose	12 (24.5%)
Happy to accept the challenge, behavior is not on purpose	14 (18.6%)
Unsure	3 (6.1%)
Behavior does not apply to my child	11 (22.4%)
No Response	2 (4.1%)
Total Responses	49
A Little Knowledgeable	
Irritated and blames, child is doing it on purpose	36 (46.8%)
Irritated but helps, behavior might not be on purpose	21 (27.3%)
Happy to accept the challenge, behavior is not on purpose	9 (11.7%)
Unsure	2 (2.6%)
Behavior does not apply to my child	7 (9.1%)
No Response	2 (2.6%)
Total Responses	77
Not Knowledgeable	
Irritated and blames, child is doing it on purpose	15 (53.6%)
Irritated but helps, behavior might not be on purpose	3 (10.7%)
Happy to accept the challenge, behavior is not on purpose	1 (3.6%)
Unsure	3 (10.7%)
Behavior does not apply to my child	6 (21.4%)
No Response	0
Total Responses	28
Unsure of Knowledge	
Irritated and blames, child is doing it on purpose	0
Irritated but helps, behavior might not be on purpose	6 (85.7%)
Happy to accept the challenge, behavior is not on purpose	0
Unsure	0
Behavior does not apply to my child	1 (14.3%)
No Response	0
Total Responses	7

