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# Impact of "Attention Deficit Hyperactive Disorder" on Educational Placement and Service Delivery

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Impact of "Attention Deficit Hyperactive Disorder"

on Educational Placement and Service Delivery  
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BY

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Impact of "Attention Deficit  
Hyperactive Disorder"  
on Educational Placement  
and Service Delivery  
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## Abstract

Children with "Attention Deficit Hyperactive Disorder" face many changes within the school environment. Teachers strive to help these students meet those changes by providing for special learning and behavior needs. This study obtained teacher responses to examine demographic data, disability categories, placement, and educational treatment of children clinically diagnosed and/or suspected of having "Attention Deficit Hyperactive Disorders". Of the 76 teacher surveys returned, 107 students were reported to have or were suspected of having "Attention Deficit Hyperactive Disorder". Forty-five were identified as learning disabled, seven were considered behavior disordered, seven were receiving speech services, seven others were health impaired, three were diagnosed as educable mentally handicapped, one was diagnosed as trainable mentally handicapped, and nineteen had no disability category. This survey indicated the most common placement for students diagnosed or suspected of having "Attention Deficit Hyperactive Disorder" is the regular education classroom. Results indicated over 80% of the students clinically diagnosed with "Attention Deficit Hyperactive Disorder" were taking Ritalin as medication for "Attention Deficit Disorder" symptoms. The most frequently implemented behavior interventions utilized with students suspected or diagnosed with "Attention Deficit Disorder" included time-out, one-to-one instruction, behavior modification, special seating arrangement, and modified assignment.

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## Introduction

"Attention Deficit Hyperactive Disorder" is one of the most frequently diagnosed disorders of childhood; however, there is little known research about "Attention Deficit Hyperactivity" in a school setting. The question that is most often asked by many educators is how does one effectively treat and/or otherwise manage children who are generally diagnosed or labeled with the term "Attention Deficit Hyperactive Disorder". The purpose of this study is to examine disability categories, placement, and educational treatment of children both clinically diagnosed and children suspected of having "Attention Deficit Hyperactive Disorder" among a group of 155 teachers in three public school districts. In addition, the behavior modification approach and the medical treatment options will be presented to determine which method was most often used with students with "Attention Deficit Hyperactive Disorder" (A.D.H.D.) who were receiving special education services and students who were not receiving special education services. This study will address what types of placement options and/or service delivery are presently being utilized for students identified as "Attention Deficit Disorder". Moreover, it will consider the behavior modification and medical treatment most frequently used. Because the future of children diagnosed with "Attention Deficit Disorder" is strongly influenced by the awareness and effort of the classroom teacher, there is a need for teacher insight into acquiring the knowledge and skills of what "works".

Review of Literature

The term "Attention Deficit Disorder" (A.D.D.) has evolved from an array of former terminology: minimal brain damage, minimal brain dysfunction, hyperactivity, hyperkinesis, Werner-Strauss Syndrome, learning disability, impulse disorder, and post-encephalitic disorder (Goldberg, 1991; McBurnett, Lahey, Pfiffner, 1993). Though the problem is still most commonly called hyperactivity, in 1982, the American Psychiatric Association, in its Diagnostic and Statistical Manual (DSM III), changed the official designation to both "Attention Deficit Disorder Without Hyperactivity" and "Attention Deficit Hyperactive Disorder" (Brown, 1993; Goldberg, 1991; Kuncaitis, 1990).

The Chapter of Attention Deficit Disorder (CH.A.D.D.), a national parent support group, effectively lobbied in Washington D.C., prompting Congress to investigate how children with "A.D.D./A.D.H.D." symptoms or characteristics were being serviced in schools. After reviewing information from schools, teachers, and parents, a joint memo was issued by the United States Department of Education and the Office of Civil Rights on September 16, 1991. Specifically, the memo stated:

After giving consideration to making A.D.H.D. a separate special education category, the Department of Education took the position that A.D.H.D. did not need to be added as a separate disability category. Children which are diagnosed as having A.D.D. are eligible for special

education under Part B of the Individuals with Disabilities Education Act, if they satisfy the criteria applicable to other disability categories. That is, if a child diagnosed with A.D.D. meets Learning Disability (L.D.) or Educational Disability (E.D.) criteria, they are eligible to receive those services. Those children diagnosed as A.D.H.D. who are not eligible under Part B for special education because they do not meet criteria for special programs, but fall within the definition of "handicapped person" under Section 504 of the Rehabilitation Act of 1973, are eligible to receive services in the regular education setting (Goldberg, 1991, p. 59).

"Attention Deficit Disorder" is a syndrome which is characterized by serious and persistent difficulties in three specific areas: (a) attention span, (b) impulse control, and (c) hyperactivity (sometimes) (Berry, 1994; Fowler, 1991; Javorsky, 1993; Parker, 1992). "A.D.D." is a chronic disorder which can begin in infancy and extend through adulthood, while having negative effects on a child's life at home, school, and within his/her community. Furthermore, it is conservatively estimated that three to five percent of our school age population is affected by "A.D.D." (Fowler, 1991; Goldberg, 1991).

Fowler (1992), Goldberg (1991), Linkenhoker (1988), Parker (1992), and Parker, Storm, Petti, Anthony (1991) assert that according to the criteria in the "Diagnostic and Statistical Manual" (DSM III-R), a child can be diagnosed as having "A.D.D."

if he/she displays at least eight of the following fourteen signs for a period of at least six consecutive months (onset before the age of seven):

1. Fidgeting, squirming, or complaining
2. Difficulty staying seated
3. Extreme distractability
4. Difficulty taking turns while in a group
5. Blurting out an answer
6. Chronically leaving projects and chores unfinished
7. Trouble sustaining attention in tasks or games
8. Flitting from one unfinished activity to another
9. Inability to play quietly
10. Incessant talking
11. Butting into other peoples' work or play
12. Appearing not to listen when spoken to
13. Constantly losing things
14. Unthinkingly taking foolish risks (Fowler, 1991; Goldberg, 1991; Linkenhoker, 1988; Parker, 1991)

Students who have exhibited characteristics mentioned above for longer than six months may be at risk for having an attention deficit disorder. However, this designation should be made only after ruling out other factors related to medical, emotional, or environmental variables which could cause similar symptoms (Berry, 1994; Mandelkorn, 1993).

Goldstein and Ingersoll (1992) state that the issue on treatment for children with "Attention Deficit Hyperactive

Disorder" has certainly been explored. They found several treatment alternatives for children that are diagnosed with "A.D.H.D.". Given the fact that other alternative treatments are utilized, it is important to establish that the medical treatment approach and nonmedical treatment (behavioral) options are the primary techniques that are being utilized for children diagnosed with attention deficit disorders (Brown, 1993; Mandelkorn, 1993; and Parker et al., 1991).

According to Goldberg (1991) Linkenhoker (1988) and Parker (1992), the DSM III-R manual emphasizes that, when attention deficits and hyperactivity occur together, as they so often do, both conditions need to be diagnosed and treated.

Children with attention problems need more frequent, immediate, consistent, and tangible feedback (Gordon, Thomason, Cooper, & Ivers, 1991; Shelton & Crosswaite, 1992). It seems that having a periodic report card is generally insufficient for a child with "A.D.H.D." symptoms. Behavior interventions focus the attention on the positive behaviors of the child. Subsequently, they are encouraged through a very rich system of feedback. Just knowing the child is inattentive, impulsive, or hyperactive, unfortunately, does not really provide enough information about the various behaviors the child exhibits and what to do about them (Goldberg, 1991; Goldstein & Ingersoll, 1992; Gordon et al., 1991; Johnson, 1989).

Accordingly, behavior theory suggests that behaviors are preceded by antecedents and followed by consequences; antecedents

which set the stage for behavior to occur. Consequences resulting from the behaviors provide either the reward or the punishment, with rewards increasing the likelihood of positive behaviors recurring (Swanson, Kotkin, Pfiffner, & McBurnett, 1992).

Gordon et al. (1991) and Greene (1992) state that teachers are encouraged to have clear simple classroom rules for behaviors which are posted and reviewed frequently. Other techniques found in research include self-monitoring and self-reinforcing, writing contracts, providing immediate, frequent feedback to students, using visual or auditory cues as reminders, controlling proximity, and giving students choices of activities (Brown, 1993; Gordon et al., 1991; Greene, 1992).

An example of a simple management technique would be "good slips", which are given to all students in the class to reinforce desired behavior. According to Javorsky (1993), more complex strategies could include a cost-response system, point system, or daily progress notes; all should be used concurrently with similar parental reward systems at home.

Another commonly used therapy involves training the parents in behavior modification and child management skills. This can reduce the child's misbehavior substantially, but, like medical therapy, cannot eliminate it completely. Such training offers parents a set of skills to effectively manage disruptive behavior, thereby helping them cope with the distressing aspects of their child's symptoms (Blackman, Westervelt, & Stevenson,

1991; Gordon et al., 1991).

Gordon et al. (1991) and Rosenberg, Wilson, and Legenhausen (1989) suggested behavior techniques for assessing hyperactivity of preschool children. They can be conceptualized as falling into four major domains: (a) direct observation, (b) rating scales, (c) acometers, and (d) structured interviews.

To begin with, direct observation techniques are used to assess children who exhibit hyperactivity. Furthermore, the easiest and most successful of these techniques, according to Rosenberg et al. (1989) and Shelton and Crosswaite (1992), is frequency or event recording. An observer can assess this behavior by counting the number of hyperactive incidences during a set interval of time. Additionally, numerous rating scales have been developed to measure the intensity of the hyperactivity in children. Rating scales typically consist of a list of items which describe a child's behaviors or personality variables and a means by which parents, teachers, or significant others rate the items. Too, acometers, or activity meters are often utilized. This device measures activity levels and records the child's frequency of movement. Finally, structured interviews, with both a relevant family member and the child suspected of being hyperactive, are conducted. Specific purposes are noted for these interviews: (a) to gather data, (b) to get information about the problem behavior, (c) to ascertain the stimuli associated with the problem behavior, (d) to determine the approaches which have been attempted previously, and (e)

to identify contingencies that can be utilized (Blackman et al., 1991; Rosenberg et al., 1991).

Assessment can be most successful if the subject of the observation is cooperative and responsive. An accepted view expressed by Blackman et al. (1991), Linkenhoker (1988), and Rosenberg et al. (1989) states that children with "A.D.H.D." respond well to rewards and structure. In fact, the child does best in an organized environment where rules and expectations are clear and consistent, and when consequences for meeting the demands of a given situation are set forth ahead of time and delivered immediately (Linkenhoker, 1988; Shelton et al., 1992).

After assessment techniques have been utilized, three guidelines for behavior management are considered successful. One popular use of behavior modification involves the use of chips or stickers earned for appropriate behavior. Additionally, a response cost may be implemented, whereby tokens are withdrawn for inappropriate behavior. Furthermore, many behavior modification programs include punishment for inappropriate behavior; "time out", for example, is sometimes an effective punishment technique which involves sending a child who has caused problems to a predetermined location for a limited amount of time (Gordon et al., 1991; Parker, Storm, Petti, & Anthony, 1991; Swanson et al., 1992).

Gordon et al. (1991), Greene (1992), and Parker et al. (1991) determined that teachers have applied behavior

modification principles in classrooms for many years. They further elicit these principles assume that teachers can increase, decrease, or eliminate specific behaviors of their students by manipulating responses which follow those behaviors. Teachers have the potential for enormous impact - both positive and negative, on learning, behavior, self-esteem, and general psychological status of all children. However, according to Greene (1992), this potential for positive and negative impact may be even more critical for students identified as having "Attention Deficit Disorder".

Researchers (Cowart, 1988; Gadow, 1992; Javorsky, 1993; Lacetti, 1987; Mandelkorn, 1993; Parker, 1992; Viadero, 1987) contend that Ritalin, the most commonly used medication in treating "A.D.H.D.", has been prescribed for many years with very favorable results and minimal side-effects. Other psychostimulant medications, such as Cylert and Dexadrine (Cowart, 1988; Gordon, 1992; Mandelkorn, 1993), and antidepressant medications, such as Trofranil and Norpramine, have also been proven successful in treating the disorder (Gordon, 1992; Parker, 1992; Mandelkorn, 1993). However, all of these medications carry with them the chance of some side-effects; side-effects may include appetite loss, sleep difficulties, and/or lethargy in the classroom (Gordon, 1992; Linkenhoker, 1988; Mandelkorn, 1993; Swanson et al., 1993). Consequently, each medication, its characteristics, effects, and side-effects, should be reviewed and discussed by the parents

and the child's physician before any form of treatment is determined.

To better understand how medication influences social interactions, one group of researchers ventured into the lunchroom where it became possible to study nearly every type of behavior known to children (Gadow, 1992). In this study, Ritalin reduced the level of verbal aggression in children diagnosed with "Attention Deficit Hyperactive Disorder" and increased their amount of successful social interaction. Similarly, other studies concluded that medication appeared to decrease negative interaction without interfering with "good" social behaviors (Gadow, 1992; Mandelkorn, 1993; Parker, 1991).

The issue of treatment for children with "Attention Deficit Hyperactive Disorder" has certainly been explored (Brown, 1993; Goldstein & Ingersoll, 1992; Gordon et al., 1991; Javorsky, 1993; McBurnett et al., 1993; Reid et al., 1994). Nevertheless, most teachers feel ill-equipped to deal with these students (Reid, Maag, Vasa, & Wright, 1994). Moreover, despite the fact that most students diagnosed with "Attention Deficit Disorders" are served in the mainstreamed setting, little information is available detailing how prepared general education teachers are to work effectively with these students. This information is important since the classroom teacher is viewed as the major factor in the success of any student, and particularly in the success of those with "Attention Deficit Hyperactive Disorder" (Gordon, 1991; Greene, 1992; Javorsky, 1993; Reid et al., 1994).

Statement of the Problem

This study is designed to determine that there is a pattern among intervention strategies or techniques used with students diagnosed with "A.D.H.D.". Intervention strategies refers to the nonmedical treatment approach, such as behavior modification and/or consultation. These techniques refer to the medical treatment options available to students who are medically diagnosed with "A.D.H.D.".

Little is known about the type of services students with "A.D.H.D." are receiving in the schools, the extent to which these students are identified under existing handicapping categories, nor the type of educational placement recommended. Therefore, to gain a realistic assessment of the impact of "A.D.H.D." on educational placement and service delivery, it is imperative that we examine the phenomenology of "A.D.H.D." in the schools. The ability of the general classroom teacher to meet the needs of students with "A.D.H.D." has yet to be addressed by researchers. Thus, a very real need exists to provide general education classroom teachers with both knowledge of "A.D.H.D." and a repertoire of techniques to deal with the problems students with "A.D.H.D." may experience in the general classroom environment.

## Method

Design

This study was developed using a survey design. Its focus is the impact of "Attention Deficit Disorder" on educational placement and service delivery. This study does not attempt to define and describe individual programs nor treatment options. Rather, this study utilizes the responses of a sample of educators specific to intervention techniques and their effectiveness. The survey also assesses teacher knowledge and intervention strategies used with students diagnosed and/or suspected by the teacher as demonstrating characteristics of "Attention Deficit Hyperactive Disorder".

Subjects

The sample consisted of 155 K-8 teachers currently teaching in three rural school districts. Data was collected from nine elementary/middle schools in rural southeastern Illinois. Rural communities with populations of less than 10,000 were chosen for this study. A survey was given to seventeen teachers in each of seven schools and eighteen teachers in each of two schools, for a total of 155 surveys.

Overall, 80 of the 155 surveys were returned. However, four of the surveys were invalid because they were either not completed correctly, or they were completed inappropriately by persons not presently teaching in a K-8 setting. As a result, the usable number of returned surveys was 76 of 155, or 49%. Tables 1 and 2 show the grade level and ethnic status,

respectively, of the teachers reporting and of the students reported. The return rates indicate that the highest return was from the K-2 group and the 3-5 group, respectively.

Additionally, of the 76 useable teacher surveys returned correctly, 21 teachers (27.6%) had 1-5 years experience, 16 teachers (21.0%) reported 6-10 years experience, 9 teachers (11.8%) had 11-15 years experience, 12 teachers (15.7%) had 16-20 years experience, and 14 teachers (18.4%) reported 20 or more years experience. The largest return rate, 27.6%, was from teachers with five or less years experience.

#### Instrumentation

A ten-item survey was developed based on an extensive review of the literature and state guidelines indicated under Section 504. (See Appendix A for survey.) Survey items 1-5 sought information pertaining to medical diagnoses, medications, behavior interventions, and effective methods. Five items (6-10) sought demographic information from both regular and special education teachers concerning student grade level, disability category, placement, and ethnicity. Additionally, Item #10 sought information pertaining to the years of experience of the teacher.

#### Procedures

The regular education teachers and special education teachers were asked to respond to each item on the survey and to complete one survey for each child diagnosed or suspected of having "Attention Deficit Hyperactive Disorder". Each survey

Table 1

Return Rates

	Total Returned	Completed Correctly	Completed Incorrectly
Total	80/155 51.6%	76/155 49.0%	4/155 2.6%
Group K-2	30/51 58.8%	30/51 58.8%	0/51 0%
Group 3-5	33/68 48.5%	31/68 45.5%	2/68 2.9%
Group 6-8	15/36 41.6%	13/36 36.1%	2/36 5.6%

Table 2

Ethnic Status

Ethnicity of Students	Number of Students Reported	Percentages
Caucasian	78	72.8%
Native American	13	12.1%
Hispanic	1	0.9%
Asian/Pacific Islander	0	0.0%
African American	2	1.8%
(No Response	13	12.1%)

was pre-coded to determine the number of surveys completed by each teacher. A pre-coded survey and an accompanying letter were sent to nine schools in three districts (see Appendix B for cover letter). Upon completion, the teachers were asked to return the surveys to a return box in the main office of their building by a stated date. A follow-up survey was not conducted.

## Survey Results

There were 91 students represented by the responses to: How many students do you have in your classroom medically diagnosed with "Attention Deficit Hyperactive Disorder"? Results indicate that 46 students (50.5%) were not medically diagnosed as having "Attention Deficit Hyperactive Disorder". Teachers responses indicated that 41 students (45.0%) were medically diagnosed as having "Attention Deficit Hyperactive Disorder". Four teachers (4.0%) reported no response, while five teachers (5.4%) reported it was unknown whether the child in their class was medically diagnosed as having "Attention Deficit Hyperactive Disorder". Of the 76 teachers surveyed, when asked if they suspected a child in their classroom of having "Attention Deficit Hyperactive Disorder", 57 teachers (75.0%) answered yes, 13 teachers (17.1%) answered no, and 6 teachers (7.8%) gave no response.

Teachers were asked to indicate if they used behavior interventions to improve behavior (Question #7): 74 teachers (97.3%) reported they did, and 2 teachers (2.6%) reported they did not. Thirty-two teachers (42.1%) reported that behavior interventions were effective, 19 teachers (25%) reported that behavior interventions were not effective, and 25 teachers (13.1%) had no response. Teachers were also asked what interventions were utilized to improve behaviors. Behavior modification, time-out, one-to-one instruction, seating arrangement and modified assignment format were interventions

most frequently used. (Refer to Table 3 for a list of complete results for behavior interventions.)

Teachers were asked to indicate whether students diagnosed with "Attention Deficit Hyperactive Disorder" had been prescribed medication (Item #4). Responses indicated 76.3% of the teachers surveyed said students diagnosed as having "Attention Deficit Hyperactive Disorder" were on medication, and 14.4% of the teachers surveyed indicated that their students were not receiving medication. The teachers indicated that the students were prescribed Methylphenidate (Ritalin) most frequently (89.6%). Pemoline (Cylert), was prescribed 6.8% of the time. Of the teachers surveyed, 5.2% indicated that they were unsure if their students were on medication. Additionally, 2.6% noted that the parents had refused medication after it had been prescribed.

Also, teachers were asked if they noticed a difference in the student's behavior once medication was used (Item #5). Responses concerning variations in behavior once medication was used matched the number of students reported as being on medication (76.3%). A large number of those (65.7%) reported a difference in behavior once medication was used and 10.5% noticed no variation in behavior once medication was administered. The most frequently noted comments were that the child was more focused, had a better attention span, could sit and concentrate, and/or had an improved performance level. Some additional comments included that behaviors sometimes

Table 3

Behavior Interventions

Intervention	* Number of Students Reported	Percentages
Behavior modification	43	56.5%
One-to-one instruction	54	71.0%
Modified assignment format	28	36.8%
Shortened assignments	40	52.6%
Peer tutoring	20	26.3%
Consultation	38	50.0%
Time-out	41	53.9%
Special seating	63	82.8%
Frequent breaks	25	32.8%

\* Most teachers utilized more than one intervention.

worsened after medication was removed, student's behavior sometimes became more subdued, and work often became sporadic. Ultimately, teachers listed these positive attributes of behavior once the child received medication: better relations with peers, less inappropriate talking during class time, greater ability to stay on task, reduced distractability, better comprehension, controlled behavior, greater attention given to directions, improved thinking skills, and an overall calmness.

The majority of the students identified from this survey as having or suspected of having "Attention Deficit Hyperactive Disorder" were identified as having Learning Disabilities (42%). The second highest category was students having no disability label at all (17.8%). The third highest categories were behavior disorders, speech, and other handicaps (each at 6.5%). Table 4 summarizes these results.

Table 5 shows placement information for 107 students which were reported by 76 teachers. Only a small portion were either full or part-time self-contained (7.5%). The majority of the students were in a general education classroom (64.4%) with 28% receiving resource services. (See Table 5.)

Table 4

Disability Categories

Disability	Number of Students Reported	Percentages
Behavior Disordered	7	6.5%
Learning Disabled	45	42.0%
Educable Mentally Handicapped	3	2.8%
Trainable Mentally Handicapped	1	0.9%
Speech Impaired	7	6.5%
Orthopedically Handicapped	0	0.0%
No disability	19	17.8%
Other health impaired	7	6.5%
No answer	18	16.8%

Table 5

Placement Options

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Placement	Number of Students Reported	Percentages
General Education Class	69	64.4%
General Education Class with Resource	30	28.0%
Part-time Self-contained	5	4.7%
Full-time Self-contained	3	2.8%

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## Discussion

A survey was developed based on a review of literature pertaining to treatment, placement, and service delivery of students identified or suspected of having "Attention Deficit Hyperactive Disorder". This survey was completed by Illinois educators in three school districts, in an attempt to gather information regarding the impact of "Attention Deficit Hyperactive Disorder" on educational placement and service delivery. Additional focus was placed on the behavior modification approach and on the medical treatment approach. The responses from the survey were descriptively summarized, relative to placement options, intervention strategies, and medication most frequently prescribed.

There were more teachers responding who were K-2 teachers and 3-5 teachers than 6-8 teachers. This is supported by previous research that indicates diagnosis of "Attention Deficit Hyperactive Disorder" peaks about third grade level and then declines (Reid et al., 1994).

Forty-two percent of the students diagnosed or suspected as having "Attention Deficit Hyperactive Disorder" were identified as also falling within the Learning Disabilities category. This was expected because the overlap between Learning Disabilities and Attention Deficit Hyperactive Disorder has been well documented, according to Reid et al. (1994). The highest reported placement option was the General Education classroom. There was also a high incidence of placement in

in the General Education classroom with resource support. This could be due to the inclusionary trend in education.

In this study, nearly half (50.5%) the students identified as having "Attention Deficit Hyperactive Disorder" were medically diagnosed, and almost 90% of those students on medication were taking Ritalin. According to Mandelkorn (1993), Ritalin is one of the best and most dependable medications for treatment of "Attention Deficit Hyperactive Disorder" symptoms.

The number of students reported as being on medication was 58. As reported, there was a noticeable difference in behavior for 50 (86.2%) of those students once they were on medication. The most frequent comments regarding student improvement once on medication was that students seemed more focused on activities and improved their work performance.

Teachers responses regarding behavior interventions revealed that a special seating arrangement was the intervention most frequently used (82.8%). Too, one-to-one instruction was a favored choice, with 71% of the teachers surveyed agreeing that it was effective in improving behavior.

This study shows that many interventions are tried, and the reported frequency of intervention use was consistent across all groups with the exception of special seating, an intervention used more frequently with students in the general education setting. These results indicate a possible need to examine the intervention or accommodation practices utilized in general education settings.

## Implications for Further Research

The results of this survey point to a possible need to either expand or reframe the current focus on "Attention Deficit Hyperactive Disorder" in the schools. This study indicated that classroom teachers are often facing students diagnosed as or suspected of having "Attention Deficit Hyperactive Disorder" in a regular education setting. Thus, a need to examine or revise the focus by increasing the awareness or knowledge of what works with most students is certainly necessary. An additional need exists to consider which variables, if any, consistently impact upon identification, placement, treatment, and service delivery of students identified as having "Attention Deficit Hyperactive Disorder". Furthermore, teacher response indicated that a possible need exists to better develop intervention strategies for use by the classroom teacher, since the majority of the students identified as or suspected of having "Attention Deficit Hyperactive Disorder" are in a regular education placement.

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8. Student: PLACEMENT  
General Education Classroom \_\_\_\_\_  
General Education Classroom Plus Resource \_\_\_\_\_  
Part-Time Self-Contained Class \_\_\_\_\_  
Full-Time Self-Contained Class \_\_\_\_\_

9. Student: ETHNICITY  
Caucasian \_\_\_\_\_ Native American \_\_\_\_\_  
American \_\_\_\_\_ Asian/Pacific Island \_\_\_\_\_  
Hispanic \_\_\_\_\_ African \_\_\_\_\_ Other \_\_\_\_\_

10. Teacher: YEARS EXPERIENCE  
Circle:  
(1-5)      (6-10)      (11-15)      (16-20)      (21+)

Appendix B

May 16, 1995

Dear Fellow Teacher,

I am completing my masters degree at Eastern Illinois University in Special Education Supervisory. As partial fulfillment of my requirements for a masters degree, I am completing a thesis related to Attention Deficit Hyperactive Disorder. One of the components of my research is a questionnaire regarding medical and behavior interventions and placement options of students identified as having Attention Deficit Hyperactive Disorder and for students suspected of having Attention Deficit Hyperactive Disorder.

Your response to the attached survey will help me to evaluate teacher knowledge and service delivery of students with Attention Deficit Hyperactive Disorder. This survey is intended to be an easy and effective means of getting your input. Results will be contained within my thesis. If you are interested in more information, please contact me at Central School after September 1, 1995. (The thesis will be completed at the end of August, 1995.)

Your comments are invited, and your willingness to complete this survey is very much appreciated. Your responses will not be shared individually but will be treated as group percentages. Please complete this survey and return it to the main office in your building by May 26, 1995. A mailbox will be available for your responses in the main office of your building.

Your response counts! As a token of my appreciation, I am enclosing an ink pen for your help. Thank you in advance for your input.

Sincerely,

Marsha L. Groves