

1-1-2000

The effects of ADHD child and parenting groups

Tonya Yvonne Gardner-Hernandez
University of Nevada, Las Vegas

Follow this and additional works at: <https://digitalscholarship.unlv.edu/rtds>

Repository Citation

Gardner-Hernandez, Tonya Yvonne, "The effects of ADHD child and parenting groups" (2000). *UNLV Retrospective Theses & Dissertations*. 1244.
<http://dx.doi.org/10.25669/s8wa-fk32>

This Thesis is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Thesis in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Thesis has been accepted for inclusion in UNLV Retrospective Theses & Dissertations by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact digitalscholarship@unlv.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI[®]

THE EFFECTS OF ADHD CHILD AND
PARENTING GROUPS

by

Tonya Yvonne Gardner

Bachelor of Arts
University of Nevada, Las Vegas
1999

A thesis submitted in partial fulfillment
of the requirements for the

Master of Social Work
Hank Greenspun School of Social Work
Greenspun College of Urban Affairs

School of Social Work
University of Nevada, Las Vegas
May 2001

UMI Number: 1405101

UMI[®]

UMI Microform 1405101

Copyright 2001 by Bell & Howell Information and Learning Company.

All rights reserved. This microform edition is protected against
unauthorized copying under Title 17, United States Code.

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

**Copyright by Tonya Yvonne Gardner 2001
All Rights Reserved**



Thesis Approval
The Graduate College
University of Nevada, Las Vegas

March 20, 2001

The Thesis prepared by

Tonya Gardner

Entitled

Evaluating the Effectiveness of an ADD/ADHA Child and Parents Groups

is approved in partial fulfillment of the requirements for the degree of

Masters of Social Work

Dr. Rapp-Taglietti
Examination Committee Chair

[Signature]
Dean of the Graduate College

[Signature]
Examination Committee Member

[Signature]
Examination Committee Member

[Signature]
Graduate College Faculty Representative

ABSTRACT

The Effects of ADHD Child and Parenting Groups

By

Tonya Yvonne Gardner

Dr. Lisa Rapp-Pagglieci, Examination Committee Chair
Assistant Professor, School of Social Work
University of Nevada, Las Vegas

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed childhood disorders in the United States. The symptomatic behaviors of ADHD often start as noncompliant behaviors, which can manifest themselves into increasingly inappropriate behaviors. If left untreated ADHD can become the catalyst for additional disruptive behavior disorders, as the child develops and begins to experience an increase in academic demands, family and peer rejection.

This study used a one-group pretest-posttest design that was implemented in four separate ADHD parent and child groups. There were 16 child participants and 9 parent participants. Three of the five hypotheses were accepted. The children's social skills were not improved in this study. There were several limitations to this study such as, control group issues, selection of measurements, comorbidity, generalization and sample size. This study helped to contribute to the literature by evaluating multi-modality interventions for ADHD children and their parents.

TABLE OF CONTENTS

ABSTRACT	iii
LIST OF TABLES	vii
ACKNOWLEDGMENTS	viii
CHAPTER 1 INTRODUCTION	1
Statement of the Problem	4
Purpose of the Study	4
Research Questions	4
Hypothesis	5
Scope and Significance	5
Limitations	6
CHAPTER 2 LITERATURE REVIEW	8
Overview of ADHD	8
Theories of Intervention in Relation to the Treatment of ADHD	11
Medication Management	11
Behavioral Management	14
Social Skills Training	17
Parent-Training	20
The use of Multidimensional-Modality Treatments for ADHD	23
CHAPTER 3 METHODOLOGY	26
Research Design	26
Variables and their Operationalization	27
Population, Sample and Sampling Technique	29
Child Participants	29
Parent Participants	30
Independent Variables	31
CHAPTER 4 INTERVENTION	33
The Child Groups	33
Modeling	34
Role-plays	34
Video Interaction	35
Homework	35
The Parent Groups	36
Handouts	36

Video Interaction.....	36
Role-Plays	37
Measurements	37
Child Measures	37
Parent Measures	38
Satisfaction Survey	39
CHAPTER 5 RESULTS	40
Child Outcomes	40
Parent Outcome.....	44
CHAPTER 6 DISCUSSION.....	48
Discussion of the Child Group Results	48
Measurement.....	48
Lack of Self-Awareness	49
Inattention	50
Correlation Comparisons	51
Satisfaction.....	52
Discussion the Parent Group Results	52
Limitations of the Study.....	53
Control Group	54
Selection of Measurements	54
Comorbidity	55
Generalization.....	56
Sample Size.....	57
CHAPTER 7 IMPLICATIONS FOR SOCIAL WORK.....	58
What Social Workers Need to Know	58
Ethical Considerations	60
CHAPTER 8 FUTURE RESEARCH.....	61
CHAPTER 9 CONCLUSION.....	64
APPENDIX A CONSENT FORMS	66
Consent For Child	67
Child Assent Form	68
Consent Form.....	69
APPENDIX B CHILD PARTICIPANT MEASURES.....	70
Child's Self-Observation Survey Adapted from the Student Skillsstreaming Checklist	71
Social Skill Homework Practice Sheet	78
APPENDIX C ADULT PARTICIPANT MEASURES	79
Home Situations Questionnaire-Revised	80

ADHD Parent Questionnaire	86
APPENDIX D SATISFACTION SURVEYS	91
Adult Satisfaction Survey	92
Child Satisfaction Survey	94
APPENDIX E HUMAN SUBJECTS APPROVAL LETTER.....	95
REFERENCES	97
VITA	105

LIST OF TABLES

Table 1	DSM-IV-TR Diagnosis.....	30
Table 2	Group Skills Taught – Each Session.....	32
Table 3	Number of times Social Skills were Practiced.....	41
Table 4	Improvement in Child Behaviors.....	41
Table 5	Helpfulness of Social Skills.....	42
Table 6	Social Skills Correlation Comparisons.....	43
Table 7	Pre- Posttests scores for Parent Participants.....	45

CHAPTER 1

INTRODUCTION

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed childhood disorders in the United States. ADHD accounts for 30% to 50% of all referrals made to mental health services for children (American Academy of Pediatrics, 2000; Biederman, et al., 1991; MTA Cooperative Group, 2000). Several studies have shown that 3% to 5% of all school-aged children have ADHD (DuPaul, McGeoy & Eckert, 1997; MTA Cooperative Group, 1999; Weinberg, 1999). Other studies have estimated that 4% to 12% of school-aged children are diagnosed with ADHD (American Academy of Pediatrics, 2000; Cantwell, 1996).

A study conducted by the American Academy of Pediatrics (2000) found that in the general population 9.2% of males and 2.9% of females demonstrate behaviors that are consistent with ADHD. Several studies have estimated the male to female ratio for ADHD ranging from as high as 9 to 1 and as low as 4 to 1 (Biederman, et al., 1991; Cantwell, 1996). Other studies have shown that boys are three times more likely to be diagnosed with ADHD than are girls (American Academy of Pediatrics, 2000; Barkley, 1998; Calhoun & Greenwell-Iorillo, 1998; Pelham, Wheeler & Chronis, 1998). The American Medical Association (1999) has estimated that in an average classroom of thirty children at least one child will have ADHD.

ADHD is a chronic disorder of childhood characterized by abnormally high levels of inattention, impulsivity and hyperactivity (American Psychiatric Association, 2000; Pelham & Waschbusch, 1999). Children with ADHD have substantial impairment in peer relationships, family relationships and academic functioning (Biederman, et al, 1995; Cantwell, 1996; Dumas, 1998; Landau, Milich, & Diener, 1998). With so many of American children diagnosed with this disorder, many families are constantly faced with trying to control and understand their child's ADHD behaviors.

Children with ADHD often do not appear to be listening to parental requests or simply forget to complete assigned tasks (Campbell, 2000). These children can be extremely impulsive and often want instant gratification. Their attention wanes often, which causes the child to become frustrated and angry. This can occur because they have to wait for something they desire or because they are denied a request. These symptoms often start to exhibit as noncompliant behaviors, which can manifest themselves as increasingly more and more inappropriate behaviors that often escalate as the child ages and reaches elementary school (Cantwell, 1996). The hyperactivity segment causes the child to be in a constant state of motion often increasing their misbehaviors. Due to these symptoms, parents often have difficulty managing their child's behaviors and what many parents consider "normal" discipline is often ineffective with ADHD children (Biederman, et al, 1995).

If left untreated ADHD can become the catalyst for additional disruptive behavior disorders that can start to develop, as the child grows older and begins to experience an increase in academic demands, family and peer rejection (Campbell, 2000; Cantwell, 1996; Samudra & Cantwell, 1999). As the ADHD child ages, comorbidity of ADHD

with internalizing disorders such as depression or anxiety and/or externalizing disorders such as Oppositional Defiant Disorder or Conduct Disorder increase greatly (Barkley, 1999; Biederman, et al., 1991). A study by Jensen, et al., (1997) showed approximately 93% of children with the diagnoses of ADHD had comorbid Conduct Disorder or Oppositional Defiant Disorder as well. While another study showed comorbidity for internalizing disorders such as Anxiety Disorder or Depressive Disorder at 50.8% of all children diagnosed with ADHD (Cipkala-Gaffin, 1998).

There has been a wide variety of treatments used for treating ADHD children. Some of them include individual therapy, restrictive or supplemental diets, allergy treatments, chiropractics, biofeedback, perceptual-motor training, treatment for inner ear problems (Pelham & Waschbusch, 1999), solution-focused therapy model (Dielman & Franklin, 1998), and language-theory therapy model (Yeschin, 2000). Currently, the primary focus for the treatment of ADHD is medication management, behavioral management, social skills training and parent training.

Studies have shown that multidimensional-modality treatments that combine medication management, behavioral management, social skills training and parent training are effective in treating children with ADHD (Dielman & Franklin, 1998; Landau, et al., 1998; MTA Cooperative Group, 1999; Richters, et al., 1995; Sheridan, Dee, Morgan, McCormick & Walker, 1996). This type of treatment combines psychosocial interventions such as social skills training and behavioral management strategies. It focuses on teaching/training parents, the school system and ADHD children how to effectively use these skills to help to control ADHD behaviors (Cantwell, 1994; Erk, 1997; Estrada & Pinsof, 1995; Landau, et al. 1998). Medication management when

combined with social skills training and behavioral management strategies are effective when included in the multidimensional-modality treatment strategies (Cantwell, 1995; MTA Cooperative Group, 1999).

Statement of the Problem

Treatment for ADHD is often one-sided focusing only on the parents parenting skills, medication management for the ADHD child or social skills training for the child. Few studies have been conducted that evaluate a multidimensional-modality treatment. This type of treatment focuses on the entire family. It teaches parenting skills to the parents, which aids them in controlling their child's behavior. It also teaches the ADHD children social skills, which helps the child to self-monitor his/her ADHD behaviors.

Purpose of the Study

This study will evaluate the effectiveness of a multidimensional-modality treatment for children diagnosed with ADHD and their parents who attended separate parent and child groups.

Research Questions

The following research questions were answered in this study. 1) Will the use of a multidimensional-modality treatment be effective in increasing the social skills of children with ADHD? 2) Will the use of a multidimensional-modality treatment be effective in increasing parental knowledge of ADHD? 3) Will a multidimensional-modality treatment be effective in increasing the parental perceptions of their ability to

effectively control their child's behavior in the home environment? 4) Will a multidimensional-modality treatment increase parenting skills that are needed when dealing with an ADHD child's symptomatic behaviors? 5) Will a multidimensional-modality treatment lower parental stresses that are associated with raising an ADHD child?

Hypothesis

1. The children will improve their social skills upon completion of their social skills group.
2. The parents' knowledge of ADHD will increase upon the completion of their parenting groups.
3. The parent's perception of their child's behavior in the home will improve upon completion of the groups.
4. The parents' parenting skills will improve upon the completion of their parenting groups.
5. The parents' stress levels will decrease upon the completion of their parenting groups.

Scope and Significance

This study will focus on the evaluation of the effectiveness of ADHD treatment groups. The ADHD treatment groups will consist of separate parent and children groups, which meet once a week for eight weeks, lasting for two hours each session.

The study is significant because the knowledge gained by using a pretest-posttest to evaluate the eight-week group sessions will help to establish the effectiveness of the sessions for the parents and their children. Knowing the effectiveness of the groups will help to improve the quality of future treatment groups for families who suffer from ADHD.

The findings from this study may add to the knowledge base for other professionals in the field. Should the results support the hypotheses it could help future professionals in the field to develop more effective treatment plans for families with children who have ADHD.

Limitations

There are a few limitations to this study. First, the study does not have a control group so there is the possibility of extraneous variables affecting the results. Without the use of a control group, it is not possible to accurately declare that the group sessions were the primary reason for a change in the ADHD symptomatic behaviors.

Second, obtaining a true diagnosis of ADHD is not a simple matter. A number of childhood disorders often display symptoms of ADHD and due to these symptoms, the child is diagnosed without any psychological testing to confirm or deny the ADHD diagnosis. ADHD is the most commonly diagnosed childhood disorder in America and as such, some professionals believe it is overly diagnosed (American Academy of Pediatrics, 2000; Cipkala-Gaffin, 1998; Eberstadt, 1999). The researcher tried to obtain recent testing such as psychological testing completed by either the school district or a psychologist to confirm the DSM-IV diagnosis of ADHD for all members of the

children's group. However, the researcher was unable to obtain this information for all of the members. Some of the participants had received the diagnosis of ADHD in the past and their parents were unable to obtain any testing materials to confirm the DSM-IV diagnosis.

Finally, the sample was not exclusively composed of clients with only ADHD. The DSM-IV indicates the primary difference between externalizing symptomatic behaviors such as ODD or CD and ADHD is that the externalizing behaviors focus primarily on aggressive and/or defiant behaviors whereas ADHD focuses on inattention and impulsiveness. 37.5% of the participants were not given a primary diagnosis of ADHD. They were given a primary diagnosis of another type of externalizing behavior such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and 31.3% were given a secondary diagnosis of ODD.

In this study, 62.6% of the participants were given a primary diagnosis of ADHD and 12.5% were given a secondary diagnosis of ADHD. Due to the comorbidity of the sample the results cannot fully support the effectiveness of the multi-modality treatment for ADHD. This lowers the reliability and generalization of the multi-modality treatment used in this study as an affective treatment of ADHD.

CHAPTER 2

LITERATURE REVIEW

Overview of ADHD

The impact of ADHD on our society is enormous in terms of the increase in family stress levels, financial costs, academic and social impacts, vocational activities and negative effects on the child's self-esteem (Spencer, Biederman, Wilens, Harding, O'Donnell & Griffin, 1996). There has been an increase over the past decade of children who have been diagnosed with ADHD (American Academy of Pediatrics, 2000; Cantwell, 1996; MTA Cooperative Group, 1999). Due to this increase, more and more families are suffering with an increase in financial strain and stress levels as a result of trying to deal with the ADHD symptomatic behaviors that are exhibited by their children (Biederman, et al., 1991; Pelham, et al., 1998).

In order for a child to be given the diagnosis of ADHD the child must be exhibiting the symptomatic behaviors in two distinct environments of the child's life i.e., the home environment and the school environment (American Academy of Pediatrics, 2000). The fact that the ADHD child demonstrates inappropriate behaviors in other areas of their life causes added pressure to the family system. The parents often do not know what to do to help their child to improve their behaviors and the child does not understand or is unable to decrease their behaviors even though they are aware of the

negative consequences associated with their behavior (Landau, et al., 1998; Landau & Moore, 1991; Saunders & Chambers, 1996; Twoey, 1997).

A child who has been diagnosed with ADHD suffers from family and peer rejection due to their ADHD symptomatic behaviors. They often lack the social skills that are necessary to notice the social cues that are given to them by their family and or peers (Maedgen & Carlson, 2000). As a result, the child often displays inappropriate and/or awkward behaviors in various situations and/or environments. As the child enters the school system, they also experience an increase in academic pressure (Kotkin, 1998). This disruption in the school system adds to the stresses experienced by the family system. Most classrooms in America have on average thirty children who are confined in a small area. It has been estimated that at least one child in that classroom will have ADHD (American Medical Association, 1999). Teachers very often do not have the time or are lacking in the necessary skills to deal effectively with the ADHD child's symptomatic behaviors (Kotkin, 1998). Parents are often faced with trying to maintain their child's behaviors in these dual environments, i.e., home and school. This can be a difficult task for any parent. For the parent of an ADHD child the task can feel extremely overwhelming and virtually impossible.

Due to his/her ADHD symptomatic behaviors, the child has difficulty concentrating while in the classroom. They very often exhibit off-task behaviors and an inability to complete assignments. Some studies have shown that a high level of high school dropouts had a diagnosis of ADHD (McMahon, 1994; Saunders & Chambers, 1996). The child with ADHD has a higher potential for substance abuse and/or criminal behaviors as he/she ages (Biederman, et al., 1991; McMahon, 1994). Comorbidity of

ADHD with other externalizing behaviors such as Oppositional Defiant Disorder and Conduct Disorders or internalizing behaviors such as high levels of anxiety or depression is very common for children who have not received treatment for ADHD (Biederman, et al., 1991; Hinshaw, 1992; Jensen, et al., 1997 and McMahon, 1994).

Most experts now regard ADHD as a chronic disorder like diabetes and/or asthma (American Academy of Pediatrics, 2000; MTA Cooperative Group, 1999). Children with ADHD need to learn how to control and maintain their own behavior and their family needs to make necessary life accommodations to optimize the family functioning when they have a child diagnosed with ADHD. Family systems need to make lifetime changes in order to control the symptoms of diabetes, just like family systems need to make lifetime changes in order to control the symptoms of ADHD.

Over the past thirty years, several treatments were used to treat ADHD. Today, four treatments are primarily used in the treatment of ADHD they are 1) Medication Management, 2) Behavioral Management, 3) Social Skills Training and 4) Parent-Training. A fifth multimodal option is currently being explored by several professionals in the field. As professionals learn more about ADHD and the effects it has on the entire family system and not just on the child, a multi-modality or multi-treatment approach appears more effective in dealing with the long term effects of ADHD (Dielman & Franklin, 1998; Landau, et al., 1998; MTA Cooperative Group, 1999; Richters, et al., 1995; Sheridan, et al., 1996). A multi-modality or multi-treatment approach would combine the use of the top four treatments of ADHD and has the potential to be more effective in dealing with the multiple systems that are affected by ADHD. There has been little research on this type of treatment approach to date.

Theories of Intervention in Relation to the Treatment of ADHD

Medication Management

Of all of the therapies developed to treat ADHD, a review of the literature shows that Medication management is the most researched and the most common type of treatment used (Cipkala-Gaffin, 1998; Eberstadt, 1999; Pelham, et al., 1998).

Methylphenidate, more commonly known as Ritalin, is the most popular stimulant medication that is used to control ADHD symptomatic behaviors (Buitelaar, Rutger, Gaag, Swaab-Barneveld & Kuiper, 1995; Eberstadt, 1999; Swanson, et al., 1993). The debate over the use of medication management to treat ADHD is huge and well beyond the scope of this paper. The literature is covered with studies showing the positive and negative results of stimulant medication.

There are several benefits for the use of stimulant medication. The most commonly reported benefit is the fact that it is a very inexpensive form of treatment (Buitelaar, et al., 1995; Eberstadt, 1999; Firestone, Crowe, Goodman & McGrath, 1986; Pelham, et al., 1998, Spencer et al., 1996). The use of stimulant medication can often suppress the ADHD symptomatic behaviors over different environments, such as school and home (Buitelaar, et al., 1995; Pelham, et al., 1998). ADHD children who are given stimulant medication are able to increase their abilities to correctly perceive communications, self-perceptions and situational cues from their social environment (Spencer et al., 1996). Their attention levels increase and in some cases aggression levels decrease (Eberstadt, 1999; MTA Cooperative Group, 1999; Swanson, 1993).

Another benefit is that stimulant medication is a quick solution to the chronic problem of ADHD. However, the positive effects are usually only temporary. It is important to note that several studies have indicated that the benefits received from stimulant medication are short-term and may not generalize to the child's abilities to control his or her own ADHD symptomatic behaviors without the use of the medication (Eberstadt, 1999; MTA Cooperative Group, 1999; Spencer, et al., 1996). Thus, the use of stimulant medication is not helpful for the child to develop any long-term solutions to aid them in controlling their chronic condition (Firestone et al., 1986; Pelham, et al., 1998; Swanson, et al., 1993).

Stimulant medications often have negative side effects for the child. "Rebounding effects" experienced by the child can be severe. The child's short-term attention span that has been heightened while the effects of the medication are working is suddenly pushed back down to the child's "normal" levels. This can often cause added stress for the child who does not understand why he or she is suddenly having difficulty concentrating. The child's levels of aggression will often increase due to the rebound effects (Eberstadt, 1999; Swanson et al., 1993). Ritalin can also cause a decrease in appetite and insomnia, which, is why many children on Ritalin are also prescribed a sedative to help them sleep (Eberstadt, 1999).

Although medication does help to control the ADHD symptomatic behaviors, it does not allow the child or the family to learn how to control these behaviors. Very often medication only works for a short amount of time (Pelham, et al., 1998, MTA Cooperative Group, 1999). As the ADHD behaviors start to reemerge, an increase in dosage often occurs in order to try to suppress the unwanted behaviors (Firestone, et al.,

1986; MTA Cooperative Group, 1999; Pelham, et al., 1998; Spencer, et al., 1996).

Several studies have shown that between 70% and 80% of children respond positively to stimulant medication. The remaining 20% to 30% of children have no response or an adverse response to the medication (Danforth, 1998; Firestone, et al., 1986; MTA Cooperative Group, 1999; Pelham & Waschbusch, 1999; Spencer, et al., 1996).

A study conducted by Pelham, et al. (1998) showed that a survey done for one New York County showed that the “vast majority” of ADHD children who had been given a prescription by their pediatrician for Ritalin only took the medication for one to two months. The study showed that the main reason for this was due to a lack of parental satisfaction with the side effects caused by Ritalin. Several studies have indicated positive short-term effect due to the use of stimulant medication (Buitelaar, et al., 1995; Spencer et al., 1996). However, other studies have shown that these short-term effects are only evident in “controlled studies” (Pelham, et al., 1998; Sheridan, et al., 1996). This indicates that the medication is not being used appropriately in “real-world situations”. This is also an indication that medication management should be combined with other treatment modalities in order to achieve the most effective results (Cipkala-Gaffin, 1998; Dielman & Franklin, 1998; Erk, 1997; MTA Cooperative Group, 1999; Pelham, et al., 1998; Sheridan, et al., 1996; Richters, et al., 1995).

Several studies have shown that when the ADHD child is medicated the relationship between the child and his/her parents does not improve (Biederman, et al., 1995; MTA Cooperation Group, 1999; Murphy & Barkley, 1994; Pelham & Waschbusch, 1999). Many times when medication management works and the ADHD behaviors are under control, the use of psychosocial and psycho-educational interventions

are not used (MTA Cooperative Group, 1999; Pelham & Waschbusch, 1999). It is believed that this could be one of the causes as to why parent/child relationships do not improve. In addition, it is thought that with the use of psychosocial interventions the dosage of Ritalin can be reduced while maintaining the behavioral levels that were found at higher doses (MTA Cooperative Group, 1999; Pelham, et al., 1998).

Children who receive strictly medication management for treatment of ADHD often suffer from peer rejection even though they are on medication and are able to control their impulsive behaviors. Some studies suggest that the medication lowers the ADHD child's self-esteem because the child believes they must have the medication in order to function normally (Greene, Biederman, Faraone, Ouellette, Penn & Griffin, 1996; MTA Cooperative Group, 1999; Landau & Moore, 1991). This could be one reason as to why peer rejection is often experienced by the ADHD children when they are on stimulant medications (Dumas, 1998; Landau, et al., 1998; Saunders & Chambers, 1996). These problems are a few of the most common reasons why experts in the field have tried to find alternative treatments for ADHD.

Behavioral Management

Behavioral management techniques are another common treatment for ADHD. Behavioral management therapy has been used in the treatment of ADHD for over twenty years (Pelham, et al., 1998). This treatment includes cognitive-behavioral therapy, direct contingency management, clinical behavioral therapy, and intensively packaged behavioral treatment therapy modalities (Pelham, et al. 1998).

Behavioral management techniques are used in two different facets for the treatment of ADHD. The first facet and the most commonly used form of behavioral

management places its focus on direct contingency management techniques. This form of behavioral management teaches the current caregiver i.e. the parent or the teacher, how to use behavioral management skills to maintain the ADHD child's symptomatic behaviors. The general theme used in this type of behavioral management therapy is teaching the current caregiver skills in behavioral modification, which include the use of positive and negative consequences for inappropriate and appropriate behaviors and the importance of consistency when implementing those consequences (Kazdin, Siegel & Bass, 1992; Pelham, et al., 1998). This approach focuses on controlling the ADHD symptomatic behaviors with the use of external consequences or cues.

The second facet focuses on helping the ADHD child to develop internal behavioral management techniques so they can learn how to control their own ADHD symptomatic behaviors (Kazdin, Siegel & Bass, 1992; Pelham, et al., 1998). Cognitive-behavioral treatment is used primarily with the ADHD child. With the use of cognitive-behavioral therapy, the ADHD child is taught behavioral management techniques such as the use of verbal self-instructions, problem-solving skills, self-monitoring skills, self-evaluation techniques, self-reinforcement techniques and cognitive modeling (Frazier & Merrell, 1997; Pelham, et al., 1998). The main goal of cognitive-behavioral therapy is to help the ADHD child become self-aware of their own ADHD symptomatic behaviors then teach them the skills that are necessary for them to control those behaviors. This type of behavioral management focuses primarily on teaching the ADHD child to respond to internal cues they may receive due to their own behaviors (Frazier & Merrell, 1997; Pelham, et al., 1998).

Most often behavioral modification is used in the first facet which includes teaching the ADHD child's current caregiver how to use behavioral modification and external reinforces to maintain their child's appropriate behaviors (Danforth, 1998; Kotkin, 1998; Pelham, et al., 1998). There are a few problems with the use of behavioral modification therapy when it is used in this way. First, many parents and teachers state they do not have the time to implement the behavioral modification program in their home or classroom environment (Danforth, 1998; Frazier & Merrell, 1997; Kotkin, 1998). This type of complaint is a major hurdle for direct contingency behavioral modification and must be overcome if the treatment is to be successful. It is thought that this flaw is due to a learning curve that is often experienced when the parent is taught a new way of dealing with their child's behaviors (Dielman & Franklin, 1998; Kotkin, 1998). The parent needs to stop and think about their disciplinary actions before they carry them out, this process requires an increased elevation in cognitive awareness when the parents are learning the necessary skills (Danforth, 1998; Estrada & Pinsof, 1995; Newby, et al., 1991).

Another major complaint regarding direct contingency behavioral modification is the use of positive consequences or rewards (Weinberg, 1999). Often parents intervene in their child's behavior when the child is engaged in a negative behavior and the parent implements a punishment for that behavior. Behavioral modification teaches the parent to focus on the positive behaviors and to reward their child for those behaviors (Danforth, 1998; Weinberg, 1999). Many parents feel they are "bribing" their child to behave and find it difficult to change their cognitive focus from the negative behaviors to the positive behaviors (Estrada & Pinsof, 1995; Pelham, et al., 1998).

Finally, this type of treatment does not have a positive impact on the domain of peer relationships for the ADHD child (Maedgen & Carlson, 2000; Merrell & Wolfe, 1998; Pelham, et al., 1998). In direct contingency behavioral modification, the ADHD child does not receive therapy per se; they receive external modification cues to correct their inappropriate behaviors. However, the ADHD child does not learn how to control their own behaviors or how to establish good peer relationships (Dumas, 1998).

Studies have shown that the use of cognitive-behavioral therapy is not an effective treatment for ADHD children because the child is often lacking in social skills (Evans, Axelrod & Sapia, 2000; Greene, et al., 1996; Pelham, et al., 1998). These studies suggest that behavioral therapy techniques could be more effective when they are combined with the multi-modality treatment packages which include the use of parent training for behavioral modification, cognitive-behavioral training for the child and social skills training (Frankel, Myatt, Cantwell & Feinberg, 1997; Pelham, et al., 1998).

Social Skills Training

Children with ADHD often suffer from a lack of social skills, and their peers frequently reject them due this deficit (Hepler, 1997; Landau & Moore, 1991; Landau, et al., 1998; San Miguel, Forness & Kavale, 1996; Saunders & Chambers, 1996). In fact, the lack of social skills in ADHD children is said to be a “hallmark” characteristic of the disorder (Dumas, 1998; Landau & Moore, 1991, Landau, et al., 1998). The effects of poor social skills do not go away as the person enters adolescences and finally adulthood. In order for a person to develop positive social skills as an adult, they need to practice, learn, implement and master the appropriate use of social skills as a child (Dumas, 1998; Landau, et al., 1998; San Miguel, et al., 1996).

Several studies have indicated that ADHD children who are exhibiting high levels of hyperactivity are rejected more often than are children who are being extremely aggressive (Landau & Moore, 1991, Landau, et al., 1998; Maedgen & Carlson, 2000; Sanders & Chambers, 1996). Children with ADHD, who have experienced rejection by their peers are unable to attribute the peer rejection to their hyperactive behaviors. This is due to a lack of self-monitoring skills that are often attributed to ADHD (Sanders & Chambers, 1996).

As the occurrence of peer rejection increases, the ADHD child can become angry or withdrawn and other inappropriate behaviors could start to develop. These behaviors often exhibit themselves as externalizing behaviors or internalizing behaviors. Studies have found that those who suffered from long term peer rejection as a child are at greater risk of dropping out of school, juvenile delinquency, addiction to drugs and alcohol, discharged from the military due to bad conduct, job termination and psychiatric hospitalization (Dumas, 1998, Landau & Moore, 1991, Landau, et al., 1998; Maedgen & Carlson, 2000). Social skills training can be used to counter the long-term negative effects that often develop due to prolonged social rejection (Dumas, 1998, Landau, et al., 1998, Landau & Moore, 1991; Merrell & Wolfe, 1998).

The lack of social skills could be one reason why children with ADHD often have comorbidity with other behavioral problems. A study by Jensen, et al., 1997 showed approximately 93% of children with the diagnoses of ADHD had externalizing comorbid behaviors such as Conduct Disorder or Oppositional Defiant Disorder. Another study showed comorbidity for internalizing behaviors such as Anxiety Disorder or Depressive Disorder at 50.8% of children diagnosed with ADHD (Cipkala-Gaffin, 1998). Although

the reasons for this prognosis are beyond the scope of this paper, some researchers believe that these behaviors develop due to a lack of social skills (Cipkala-Gaffin, 1998; Hepler, 1997; Landau, et al., 1998).

Due to the high levels of comorbidity of ADHD with other externalizing behaviors, it often becomes difficult to teach social skills to ADHD children because their externalizing behaviors diminish the therapeutic effects (Posavac, Sheridan & Posavac, 1999). To overcome this obstacle social skills training is often combined with behavioral modification therapy. This type of treatment is a form of multi-modality or multi-treatment because it uses two different types of treatments and combines them to create a better treatment package that is better suited for many ADHD children (Colton & Sheridan, 1998; Miranda & Presentacion, 2000; Posavac, et al., 1999).

Studies have indicated two types of social skill deficits that often affect ADHD children. The first is a lack of general social skills and the second is a lack of the performance of social skills (Dumas, 1998; Landau & Moore, 1991; Landau, et al., 1998; Maedgen & Carlson, 2000; Twoey, 1997). The ADHD child who is lacking in social skills does not know how to act in social settings or is unable to “pick up” the social cues that are given to them in various situations (Landau, et al, 1998; Maedgen & Carlson, 2000). These ADHD children have never learned how to use the appropriate social skills and are lacking in social skill knowledge.

The ADHD child who is lacking in the performance of social skills has learned the social skills that are necessary for various social settings, but they are lacking the “know how” to implement them (Landau, et al., 1998; Maedgen & Carlson, 2000). Teaching social skills to children with ADHD is an effective treatment that can be used to

improve both types of social skill deficits (DuPaul, et al., 1997; Hepler, 1997; Landau, et al., 1998; Maedgen & Carlson, 2000).

The teaching of social skills is often criticized for its inability to generalize into the ADHD child's every day life situations. Social skills are increased while in the "clinical setting" but are not generalized into the child's social environments (Frankel, et al., 1997; Posavac, et al., 1999). Studies have shown the major reason for this lack of generalization is due to the ADHD symptomatic behaviors (Frazier & Merrell, 1997; Posavac, et al., 1999). The ADHD child needs external cues given to them while they learn to implement the necessary social skill (Posavac, et al., 1999; Weinberg, 1999).

A multi-modality or multi-treatment approach that involves the parents in the training of the social skills is thought to be the answer to this criticism (Frankel, et al., 1997; Sheridan, et al., 1996; Weinberg, 1999). The parents could implement the necessary external cueing for their ADHD child. By involving the children's parents in the training of social skills, the children's generalization of the social skills into other environments including home, school and peer relationships may be enhanced (Dielman & Franklin, 1998; DuPaul, et al., 1997; Frankel, et al., 1997, MTA Cooperative Group, 1999; Posavac, et al., 1999; Weinberg, 1999).

Parent-Training

Parents often need parental training in order to educate themselves as to what ADHD actually is as well as on techniques that they can use to help control the ADHD behaviors more effectively (Erk, 1997; Murphy & Barkley, 1996; Newby, et al., 1991; Weinberg, 1999). A child diagnosed with ADHD often places significant behavioral management problems on their parents (Baldwin, et al., 1995; Erk, 1997; Estrada &

Pinsof, 1994; Frankel, et al., 1997; Newby, et al., 1991). Parents do not understand why their child's behavior is so difficult to control. They can become extremely frustrated and stress levels in the home can quickly escalate (Baldwin, et al., 1995; Estrada & Pinsof, 1995; Newby, et al., 1991).

Parental training can often help to decrease conflicts within the family and decrease the intensity of the anger and frustration often directed at the ADHD child by their parents (Baldwin, et al., 1995; Frankel, et al., 1997; Newby, et al., 1991). Parental training can be extremely helpful in increasing compliant behaviors of ADHD children as well as generalizing these behaviors to other social environments such as school or peer interaction (Danforth, 1998; Erk, 1997; Frankel, et al., 1997; Frankel, & Merrell, 1997; Frazier & Kenneth, 1997).

Several studies have indicated that the history of the family's dealings with ADHD behaviors or the family environment that has developed around the ADHD behaviors could be a catalyst for more intensive behavioral problems that are often displayed by the ADHD child (Biederman, et al., 1995; Estrada & Pinsof, 1995; Jenson, Green, Singh, Best & Ellis, 1998; Seidman, et al., 1995). These studies have indicated that after years of trying to deal with their child's ADHD symptomatic behaviors the parents' pattern of parenting, i.e. implementing consistent consequences is often extremely erratic (Danforth, 1998; Jenson, et al., 1998). This could be due to elevated stress levels of the parents who have been faced with years of trying to control their ADHD child's behaviors without the help of professional intervention (Baldwin, et al., 1995; Murphy & Barkley, 1996). Studies have indicated that in order for the ADHD symptomatic behaviors to decrease the family environment needs to be highly structured

with clear and precise consequences both positive and negative for behaviors. In addition parents need to be extremely consistent with their interventions in order to improve their child's behaviors across environments (Erk, 1997, Newby, et al., 1991; Weinberg, 1999).

Studies have shown that parental training has helped to increase the parent's self-esteem and decrease parental stress levels (Baldwin, et al., 1995; Erk, 1997; Estrada & Pinsof, 1995; Murphy & Barkley, 1996). Parents are dealing with their child on an hourly, daily, monthly and yearly basis therefore, parents have the most investment in helping their children to overcome their ADHD behaviors and have the best opportunity to alter those behaviors (Danforth, 1998; Estrada & Pinsof, 1995; Goisman & Zrebiec, 1996; Newby, et al., 1991; Weinberg, 1999). Due to the many problems that often affect the family system when dealing with an ADHD child's symptomatic behaviors parental training is an extremely important factor that must be included in the treatment of ADHD (Newby, et al., 1991; Weinberg, 1999).

Some studies have indicated that when parental treatment is the sole treatment for ADHD (i.e. no medication or social skills training) it does not decrease the child's ADHD behaviors (MTA Cooperative Group, 1999; Weinberg, 1999). When parental training was combined with medication management there was no real advantages found in decreasing the child's ADHD behaviors such as impulsivity or hyperactivity, however compliance behaviors were increased (MTA Cooperative Group, 1999).

In addition, the quality of the relationship between the parent and their child did not improved when parental training was the only treatment used (Estrada & Pinsof, 1995; MTA Cooperative Group, 1999). The need to combine social skills training with parental training and medication management appears to be a key factor for treating

ADHD (Cipkala-Gaffin, 1998; Danforth, 1998; Dielman & Franklin, 1998; Erk, 1997; Frankel, et al., 1997; MTA Cooperative Group, 1999; Landau, et al., 1998; Sheridan, Dee, Morgan, McCormick & Walker, 1996).

The use of Multidimensional-Modality Treatments for ADHD

A multidimensional approach appears to be an effective treatment for ADHD (Cipkala-Gaffin, 1998; Erk, 1997; Kotkin, 1998; MTA Cooperative Group, 1999; Landau, et al., 1998). As demonstrated previously in this literature review ADHD has a profound effect on several systems such as the family system, educational system, legal system, social system as well as many others. Treatments that focus exclusively on an individual such as the child, the parents or the school do not take into account the full impact of the problem of ADHD.

The multidimensional-modality treatment gives a wide variety of treatment models that can be combined to provide the most effective management strategies for ADHD (DuPaul, et al., 1997; Erk, 1997; Kotkin, 1998; MTA Cooperative Group, 1999; Sheridan, et al., 1996). A multidimensional-modality treatment also uses the knowledge of many proven treatments for ADHD and allows the therapist to combine these treatments as needed to more effectively develop a treatment plan that can target salient behaviors and/or problem areas that are being experienced in these systems (DuPaul, et al., 1997; Kotkin, 1998).

A review of the literature shows very little existing data on the effectiveness of multidimensional treatment for ADHD (Cipkala-Gaffin, 1998; Erk, 1997; Landau, et al., 1998; MTA Cooperative Group, 1999). Some studies have been conducted which

examine the combination of medication management, parental training, which includes behavioral therapies, and social skills training. These studies have found that when medication management is the only source of treatment given for the ADHD child a higher dose of medication is needed to maintain appropriate behavioral levels (Erk, 1997; MTA Cooperative Group, 1999; Sheridan, et al., 1996). When medication management was combined with parent training and social skills training a smaller dosage of medication can be used to achieve the same effects (Erk, 1997; MTA Cooperative Group, 1999; Sheridan, et al., 1996).

The MTA Cooperative Group (1999) conducted a study that showed that multidimensional treatment was more helpful in reducing ADHD symptomatic behavior than just behavioral treatment alone. The same study also showed that when behavioral management was combined with social skills training and parental training ADHD symptomatic behaviors were maintained successfully in more than three-quarters of the participants. In addition, a study conducted by Sheridan, et al (1996) which implemented separate parent skills training sessions and child social skills training sessions found that the children were able to generalize the social skills learned to different environments. This study also found that in addition to training parents how to control their child's ADHD behaviors by including parents in the treatment the parents were able to help their child to improve their social aspects as well in other environments as well.

Studies have also shown that multidimensional treatment offered greater benefits for oppositional/aggressive behaviors, internalizing symptoms, peer interactions and parent-child relationships (Cipkala-Gaffin, 1998; Dielman & Franklin, 1998; DuPaul, et al., 1997; Erk, 1997; Kotkin, 1998; Landau, et al., 1998; MTA Cooperative Group, 1999).

Further studies evaluating the effectiveness of different multidimensional treatments should be conducted to determine the most effective combination of treatments for ADHD. This paper will evaluate the effectiveness of one multidimensional treatment program for parents and children with ADHD.

CHAPTER 3

METHODOLOGY

Research Design

The research design for this study was a one-group pretest-posttest design conducted at Human Behavior Institute in Las Vegas, NV. The impracticality of creating a control group was the main factor for the selection of this research design.

The use of a control group often raises ethical considerations of withholding treatment from clients. Very often researchers can overcome this dilemma by using clients on a waiting list as a control group. In this study when the researcher received a referral for the ADHD group, the researcher placed the participant into one of four ongoing ADHD groups. All four ADHD groups used the same agenda for each individual group session, which assured the practice of the same social skills for each consecutive group session. Due to revolving admissions into the ADHD groups there was no waiting list developed during this study.

Variables and their Operationalization

ADHD Child Participant:

For this study a person between the ages of 8 to 11 years of age who had been diagnosed with Attention-Deficit/Hyperactivity Disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition:

A. Either (1) or (2):

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

Inattention

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

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

Hyperactivity

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

Impulsivity

- (g) Often blurts out answers before questions have been

completed

(h) Often has difficulty awaiting turn

(i) Often interrupts or intrudes on others (e.g., butts into conversations or games).

- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g., at school (or work) and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Parent Participants:	A person(s) who has legal guardianship of the ADHD child.
Parenting Skills:	The behavior used by parents to correct their child's behaviors.
Parent Training:	Teaching of behavioral management techniques, which included established principles of social learning theory. Training included specific reference to communications skills, consequences, time-out, discipline and token economy.
Parental Knowledge of ADHD:	A general understanding of ADHD behaviors normally displayed by an ADHD child. ADHD knowledge also included understanding of behavioral management techniques and medication management used to help control ADHD behaviors.
Social Skills:	The use of socially appropriate behavior and/or decisions in social situations.
Socially Appropriate Behavior:	The ability to accurately identify and implement the correct social skill needed in various situations, this includes correct interpretation of social information and/or cues from other people and correctly using any social feedback to perform the appropriate verbal and/or nonverbal response in different social situations.
Social Skills Training:	Teaching/training socially appropriate behaviors.

Population, Sample and Sampling Technique

The population of this study consisted of all of the children referred to HBI due to their child's symptomatic ADHD behaviors or due to other behavioral problems. The referrals to HBI came from several sources such as, the parents, the child's pediatrician, the Clark County School District or the family's insurance carrier. Participants received a referral to the ADHD groups based on the clinical determination of the family's therapist. The convenience sample consisted of a total of 16 children participants and 9 parent participants.

Child Participants

There were sixteen child participants in this study eleven were boys and five were girls. The participants ranged in age from 9 to 13 (Mean age = 10.5). Seven of the participants were Caucasian, four were African American, two were multiracial and three were Hispanic. Ten of the participants lived only with their biological mother, one lived with his biological father and stepmother, three lived with their maternal grandmother, one lived with his adopted parents and one lived with his paternal aunt. All of the child participants were currently enrolled in public schools in Clark County.

Six of the child participants had a primary DSM-IV-TR diagnosis code of Oppositional Defiant Disorder (ODD). Ten of the child participants were diagnosed with ADHD according to the DSM-IV-TR of those ten, three were diagnosed with the predominantly inattentive subtype of ADHD, and three were diagnosed with the predominantly combined typed of ADHD. The remaining four child participants were diagnosed with ADHD with no subtype being specified. Nine of the child participants were given no secondary DSM-IV-TR diagnosis code. Five had a second diagnosis of

ODD and two had a second diagnosis of ADHD. This means that 75% of the child participants were given either a primary or a secondary DSM-IV-TR diagnosis of ADHD and 69% of the child participants were given either a primary or a secondary diagnosis of ODD (see Table 1). Given the high rates of comorbidity of ADHD with other externalizing behaviors the child participants appear to be a representation of the population of children diagnosed with ADHD.

Table 1

<u>DSM-IV-TR Diagnosis</u>								
Diagnosis	ADHD Inattentive Type		ADHD Combined Type		ADHD		ODD	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Primary	3	18.8	3	18.8	4	25.0	6	37.5
Secondary					2	12.5	5	31.3
Totals					12	75.0	11	69.0

Parent Participants

There were nine parent participants in the study. The parent participants included the primary care provider for the child. If there were two primary care providers in the home the couple was asked to choose one to answer both pre- and post-tests. All of the questionnaires were answered by the female caregiver. Six of the parent participants were mothers; one was a stepmother, one grandmother and one aunt. Seven of the

participants were Caucasian and two were Hispanic. The ages of the parent participants were reported as one under the age of 21, two between the ages of 21 and 30, four between the ages of 31 to 40, one between the ages of 41 to 50 and one over age 50. Two of the parents reported having only one child in the home, four reported having two additional children in the home and three reported having three additional children in the home. All of the parents reported that they had never been diagnosed with ADHD. Four of the participants reported having a high school degree and five of the participants reported having some college. No additional specific demographic data was collected on the parent participants.

Independent Variables

Separate parent and child groups served as the source of independent variables in this study. The parent and child groups were conducted at Human Behavioral Institute (HBI) in Las Vegas, Nevada. The parents and children attended separate group sessions in different group rooms at HBI. The groups met once a week for eight consecutive weeks, with each session lasting two hours.

The parent groups were skill-based parenting groups, in that the parents were given information about parenting their ADHD child and were taught how to set up a structured behavioral plan in the home environment. The behavioral plan included the use of positive and negative consequences. The child groups were social skills training groups. The child groups were also taught self-esteem building skills during their group sessions by using interactive videos, role-playing and modeling. Table 2 shows the skills covered in each weekly child and parent group sessions.

Table 2

<u>Group Skills Taught</u>		
Sessions	Child Groups	Parent Groups
1	Following Instructions	Behavior Characteristics
2	Accepting “No” for the answer	Family Effectiveness Strategies
3	Talking With Others	Communication and Discipline
4	Introducing Yourself	Effective Behavior Shaping Techniques
5	Disagreeing Appropriately	Classroom and Homework Strategies/Management
6	Accepting Criticism or a Consequence	Understanding Special Education Law
7	Showing Sensitivity to Others	Development of Behavioral Plan
8	Showing Respect	Treatment Options and Modalities

CHAPTER 4

INTERVENTION

The Child Groups

The children's groups were conducted by one LCSW, one LSW and one MSW student. The LCSW conducted visual observations of the child participants and maintained process notes for the group sessions. The LCSW also provided clinical observations of targeted behaviors for the child participants and maintained clinical contact with the parents. The LCSW also provided weekly supervision to the LSW and the MSW student.

The LSW and the MSW student conducted the group sessions. The LSW presented the group material and the MSW student implemented positive reinforcement for appropriate behaviors and negative reinforcement for inappropriate behaviors. The objectives of the child groups included teaching the children the steps necessary to comprehend the social skills being taught, increasing self-monitoring behaviors, increasing self-esteem of the child participants, increasing on task behavior, decreasing aggressive behavior and increasing peer skills.

Each group session included a review of the group rules and a review of the positive and negative consequences used in the group. A definition of social skills was given as well as an explanation of why social skills were important. The homework was

reviewed and an introduction and discussion of the new social skill was given. The leaders then modeled the new social skill for the group and the children were then asked to role-play the new social skill, feedback was given by the group leaders and the children's peers. The reinforcement of positive behaviors, i.e., returned previous sessions' homework, the use of appropriate peer skills, role-playing, following the group rules and group participation was continuously given throughout the group session.

Modeling

Modeling by the group leaders was used in the group in the following way. Once the social skill had been taught the group leaders would model the social skill incorrectly and ask the group members to identify what the group leaders had done wrong. Next, the group leaders would model the skill correctly and ask the group members to identify the steps that were used by the group leaders the group leaders accepted the feedback given by the group members.

Role-plays

Role-plays were conducted in the following ways. First, the group leaders would role-play with each member of the group and would give feedback to each child participant after their role-play. The child would be asked to role-play the social skill again until the social skill was used correctly. After each member of the group had role-played with one of the group leaders, the group leaders would then ask the children to volunteer to role-play the social skill with each other. The group members were given positive reinforcement for volunteering, which insured that every member of the group would volunteer to role-play the social skill with one of their peers. The volunteers were then given feedback by their peers and the group leaders. Every member of the group

had the opportunity to role-play the social skill at least once during the group session.

The role-plays would continue until every member of the group had performed the social skill correctly. Performing the social skill correctly was measured by the child's ability to correctly implement the social skill.

Video Interaction

Part of the children's group session included building the child's self-esteem.

This was done with the use of an interactive video called "Free The Horses". The video helped to develop the child participants abilities to problem solve and self-monitor their own behaviors.

Homework

Weekly homework assignments were given to each child. The assignments included writing in their self-monitoring journal and practice of the social skills learned during the group session at home. The assignment given to the child to be completed in their self-monitoring journal was centered on the video interaction lessons that were learned during the group session. For example the child would be asked to write about how the way they think has an affect on the way they feel and that has an affect on what they do.

The social skill homework sheet was used to monitor the child's usage of the social skill learned during their group session. The child was instructed to use the social skill during the following week at home with their parents. The child gave the social skill homework sheet to their parents and discussed the social skill with them. The parents would then indicate how many times the child used the skill, how much of an improvement the social skill made on the child's behavior and how helpful the social skill

was for improving their child's behavior. The parents were then asked to sign the social skill homework sheet and the child then returned the social skill homework sheet at the next group meeting.

The Parent Groups

The parent groups were conducted by a certified behavioral specialist. During each session the group leader guided a discussion of the weekly skills. The parent participants would interact in the group by giving examples of their child's behaviors and give examples of how the skill being taught could be used in their own situation. The objectives of the parenting groups were to teach the parents the development and foundation for behavior management and family treatment, increase the parents education of ADHD symptomatic behaviors and interventions, decrease the parental stress levels that are often associated when dealing with an ADHD child and to increase the parents parenting skills.

Handouts

Weekly handouts were given to each parent at the start of every group session. The handouts provided information for parent review and direction for the group discussion during the group session. Parents were provided with weekly homework assignments that related to the development of the skill that was taught during the group session.

Video Interaction

The group leader used various videos regarding ADHD and the use of behavioral management techniques. The videos were used to help demonstrate the implementation

of the skills that were learned during the group sessions and to help support information that was being taught within the parent group sessions.

Role-Plays

The parent group also used role-playing to demonstrate the main points of the lesson being presented during the group session. The role-plays also helped the parents to practice the skill being taught during the group session. Feedback was given to the parents from other parents and the group leader regarding the proper implementation of the parenting skill and alternative parenting techniques that could have been used to reduce the child's inappropriate behavior.

Measurements

Before the collection of any data, all participants involved in the study signed consent forms, which explained in detail any risks involved by participating in the study. The consent forms also explained to the participants that participation in the study was voluntary and confidential (see Appendix A).

Child Measures

The children completed the Student Skillsstreaming Checklist (SSC) developed by McGinnis & Goldstein (1997) to establish their social skills level (see Appendix B – pg 71). The SSC was adapted for this study and included 31 questions which were answered on a 5 point Likert-Scale where a one equaled never and a five equaled always. The SSC was given to the child participants before attending the first group session and again during the child participants last group session. The SSC took approximately 30 minutes to complete. It included five subscales, following instructions, peer skills, self-

monitoring skills and expressing feelings appropriately skills. The children's generalization of the social skills to the home environment was measured by social skills homework practice sheets that were developed by the researcher (see Appendix B - pg 78).

Parent Measures

The parents measured their child's behaviors in the home by completing the Home Situations Questionnaire (HSQ) developed by Barkley, (1990). This scale was modified for this study by changing the format of the HSQ to include a Likert-type scale ranging from never to always. Parents were asked sixteen questions regarding their child's behavior in the home. The HSQ was given to the parents before their first group session and again at their last group session. It took approximately 15 minutes to complete the HSQ scale (see Appendix C – pg 80).

The researcher developed a survey in order to obtain demographic information, parental skills, parental knowledge of ADHD and the stress levels felt by the parents. The parents answered eight questions regarding demographic information for themselves and their child. The parents knowledge of ADHD was asked in three questions, one that measured the parents general understanding of ADHD, one question asked about the parents' understanding of medication and the last question measured the parents' understanding of behavior management approaches used to treat ADHD.

The parents' stress levels were obtained by asking two questions. One asked about the parents' stress level in raising an ADHD child. The second question asked about the level of stress the parent felt due to their child's behavioral problems. Finally, the parents were asked to evaluate their parenting skills by answering eight questions

regarding their current parenting style and patterns for dealing with their ADHD child. All of these questions were combined into one questionnaire, which took approximately 10 minutes to complete (see Appendix C – pg 86).

Satisfaction Survey

All of the participants, parents and children completed satisfaction surveys during the very last group session this survey was developed by the researcher. The satisfaction survey took approximately 5 to 10 minutes to complete. The parental satisfaction survey contained six questions that asked about the parent's feelings of satisfaction, helpfulness and relevance of the parenting groups. The parents' responses were recorded on a five-point Likert scale ranging from not important to extremely important (see Appendix D – pg 92).

The children were given a four-question satisfaction survey that measured the child participants' feelings of importance, helpfulness and satisfaction of the child groups. The children's responses were recorded on a five-point Likert scale ranging from not important to extremely important (see Appendix D – pg 94).

CHAPTER 5

RESULTS

Child Outcomes

The Student Skillsstreaming Checklist (SSC) was adapted for this study to include the social skills that would be administered during the group sessions and exclude the social skills that would not be covered during the eight group sessions. The SSC was administered during the first 20 minutes of the first group session and again at the last 20 minutes of the final group session. A paired t-test showed no significant increase between the pre-test and the post-test ($t = -.06$, $df = 15$, $p = .953$). The mean score for the pre-test was 3.46 with a standard deviation of .6 and the mean score for the post-test was 3.47 with a standard deviation of .62.

The generalization of the social skills to the home environment was measured by homework practice sheets of the social skill that was taught during the group session. The parent indicated the number of times the social skill was practiced (see Table 3); they also rated their child's improvement of behavior (see Table 4) and the helpfulness of the social skill (see Table 5).

Table 3

<u>Number of times Social Skills were Practiced</u>		
<u>Variable</u>	<u>Freq</u>	<u>Percentage</u>
1-2 Times	21	17.5
3-4 Times	48	40.3
5-6 Times	27	22.7
7 or more Times	11	9.2
Missing Information	12	9.7

Table 4

<u>Improvement in Child Behaviors</u>		
<u>Variable</u>	<u>Freq</u>	<u>Percentage</u>
No Improvement	1	.8
Little Improvement	23	19.3
Average Improvement	47	39.5
Great Improvement	30	25.2
Extreme Improvement	7	5.9
Missing Information	11	8.6

Table 5

<u>Variable</u>	<u>Helpfulness of Social Skill</u>	
	<u>Freq</u>	<u>Percentage</u>
Not Helpful	1	.8
Somewhat Helpful	14	11.8
Helpful	44	37
Very Helpful	41	34.5
Extremely Helpful	8	6.7
Missing Information	11	8.6

Correlations were calculated to evaluate if there was a correlation between the amount of times the social skill was practiced and the parent's perception of improvement and helpfulness of the child's ability to correctly implement the use of the social skill. No correlation was found between the number of times the skill was practiced and the improvement of the child's behaviors ($r = .085$, $p = .193$). There was a significant correlation between the number of times a skill was practiced and the helpfulness of the skill ($r = .203$, $p = .018$). A correlation was found between the parent's perception of the helpfulness of the skill and the parent's perception of the improvement on their child's behavior ($r = .545$, $p = .000$). There was a correlation found between the parent's perception of improvement in their child's behavior and the type of social skill that was taught ($r = .204$, $p = .017$). There was a correlation found between the parent's perception of helpfulness of the social skill and the type of social skill that was taught ($r = 2.44$, $p = .005$). Table 6 below shows the correlations and their levels of significance.

Table 6

Social Skills Correlation Comparisons

<u>Comparison</u>	<u>Pearson Correlation</u>	<u>Significances</u>
1. # Times practiced X Improvement	.085	.193
2. # Times practiced X Helpfulness	.203	.018*
3. Helpfulness X Improvement	.545	.000**
4. Type of Social Skill X Improvement	.204	.017*
5. Type of Social Skill X Helpfulness	.244	.005**

Note. * $p < .05$. ** $p < .01$.

The child participants' satisfaction survey indicated high levels of satisfaction from the child participants. The mean scores of the survey indicated that the child participants perceived the importance of the group as very important with a mean score of 4.04. They found the group was helpful to very helpful in changing their behavior as indicated with a mean score of 3.68. The child participants perceived the training of the social skills to be very helpful in their home environment, mean score of 4. The over all satisfaction of the child participants was rated as very satisfied with a mean score of 3.92. Figure 1 below displays a graph of the results of the satisfaction survey.

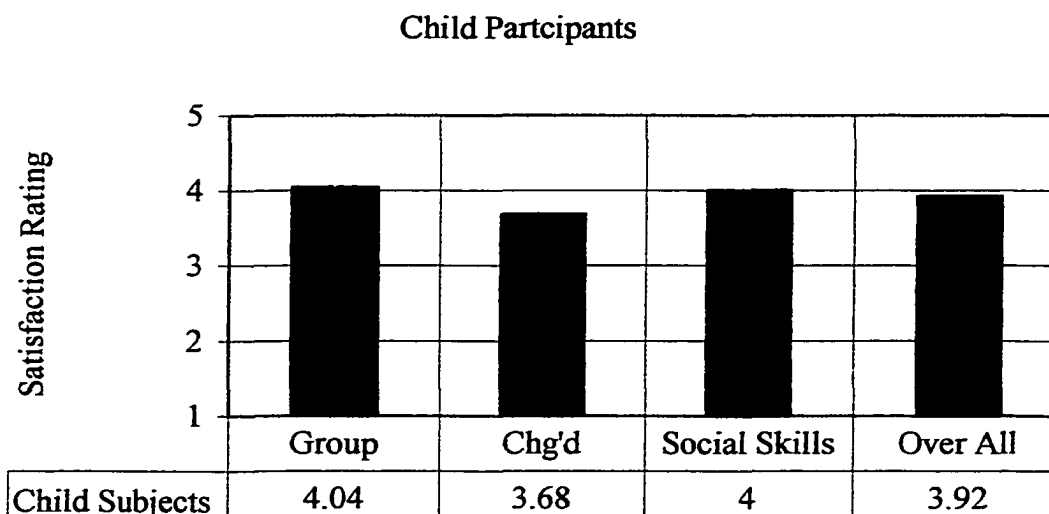


Figure 1. Satisfaction ratings of child participants

Parent Outcomes

Parental outcomes were measured by distributing the Home Situations Questionnaire (HSQ) and a measure developed by the researcher to measure parental stress levels, knowledge of ADHD and parenting skills. These measures were completed by the parents during the first 30 minutes of their first group session and again in the last thirty minutes of their last group session.

The paired t-test for parenting skills did show a significant change in parenting skills ($t = -6.96$, $df = 8$, $p = .000$). The analysis of the data indicated a mean of 3.02 and a standard deviation of .26 for the parenting skills pre-test and a mean of 3.94 with a standard deviation of .31 for the parenting skills post-test (see Table 7).

The paired t-test for knowledge of ADHD did not indicate a significant change in the knowledge of ADHD ($t = -.713$, $df = 8$, $p = .496$). The mean for parental knowledge

of ADHD before the group sessions was 2.74 with a standard deviation of .74 and the mean for parental knowledge of ADHD after the group sessions was 2.94 with a standard deviation of .17(see Table 7).

The paired t-test for stress levels did indicate a significant change in stress levels ($t = 5.5$, $df = 8$, $p = .001$). The mean for parental stress levels prior to the group sessions was 3.72 with a standard deviation of .44. The mean for parental stress levels after completion of the group sessions was 3.11 with a standard deviation of .42 (see Table 7).

The pre-test and post-test of the HSQ were analyzed by using a paired t-test. The HSQ was used to measure the parents' perception of their child's behavior in the home. The paired t-test did show significance for the HSQ with the mean of the pre-test being 2.7 and the mean of the post-test being 2.3 ($t = -3.119$, $df = 8$, $p = .014$). The standard deviation for the pre-test was .38 and the standard deviation of the post-test was .29 (see Table 7). This does indicate an increase in the parent's perception of their child's behavior in the home.

Table 7

<u>Pre- Posttest Scores for Parent Participants</u>						
<u>Measure</u>	<u>Pretests</u>		<u>Posttests</u>		<u>Paired t Analysis</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>P</u>	<u>T</u>
Parental Skills	3.02	.26	3.94	.31	.000**	-6.96
ADHD Knowledge	2.74	.74	2.94	.17	.496	-.713
Stress Levels	3.72	.44	3.11	.42	.001**	5.5
HSQ	2.7	.38	2.3	.29	.014*	3.12

Note. * $p < .05$. ** $p < .01$.
N = 9

Satisfaction levels were measured during the last group session. This survey measured the over all satisfaction of the parent participants and their perception of the different elements of the parent group sessions. The parent participants rated the relevance of the information presented in the groups as very to extremely relevant with a mean of 4.32. The parents perceived the group's helpfulness in increasing their ability to control their child's behaviors as very to extremely helpful with a mean of 4.44. The survey also measured if the parents' expectations of the groups had been met. The parents indicated that the group had met their expectations with a mean rating of 4.24. The parents also perceive the helpfulness of the groups in changing the parent's behaviors for dealing with their ADHD child as very to extremely helpful with a mean score of 4.32. Finally, the parents indicated an improvement of their child's behaviors upon completion of the groups with a mean score rating of 4.16, indicating the groups were very to extremely helpful in changing their child's behaviors. The parent participants indicated an over all satisfaction level with the ADHD group sessions as very to extremely satisfied with a mean rating of 4.33 (see Figure 2).

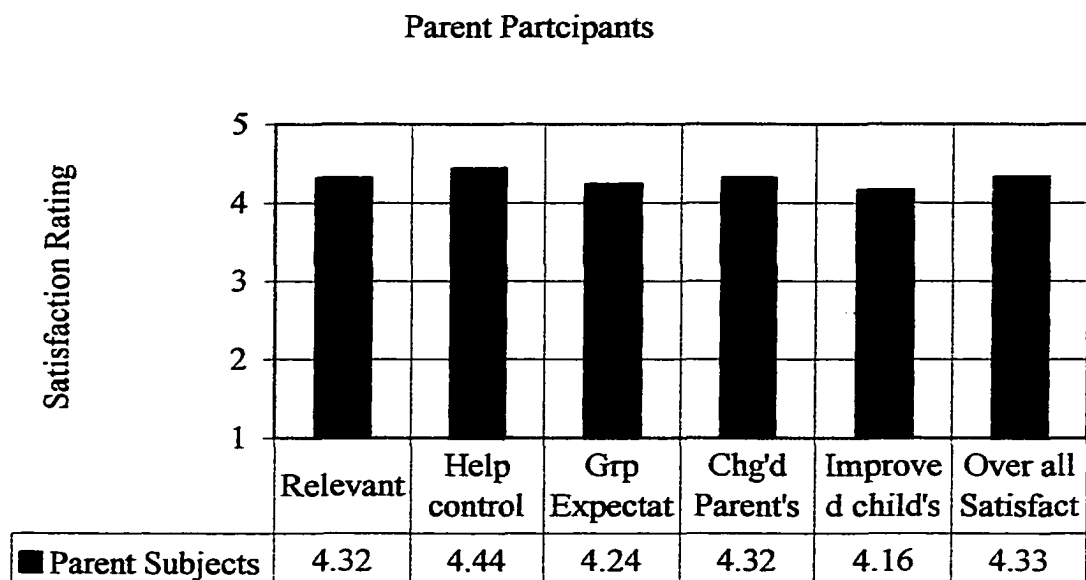


Figure 2. Satisfaction Ratings of Parent Participants

CHAPTER 6

DISCUSSION

Discussion of the Child Group Results

The hypothesis of improving the child's social skills was not supported in this study. It should be noted that other studies have also failed to find clinical improvement in the ADHD child's social skills (Sheridan, et al., 1996; Weinberg, 1999). These studies gave two reasons for this outcome 1) sample size (Sheridan, et al., 1996) and 2) the child's inability to effectively assess their social skills (Weinberg, 1999). In this study it is thought that the inability to support the hypotheses could be due to several reasons, 1) the type of measurement that was used 2) children's lack of self-awareness of their own behaviors, 3) the child subjects lack of attention to appropriately answer the survey questions and 4) the small sample size.

Measurement

The SSC was modified for this study and the modification of the measurement could have lowered its reliability. In addition, the researcher was unable to locate empirical evidence of the validity of the measurement to accurately identify the lack of, or improvement of the child participants' social skills. This flaw in the measurement could be an indication of why no change was found in the pre- and posttests.

The parents did indicate a perceived improvement of the child's social skills in the home environment, which was indicated by the parents on the social skills homework practice sheets. This is an indication that the social skills were possibly being learned and generalized to the home environment. The parents also indicated that the social skills were helpful to their child's behaviors. However, because no pre-test measurements were taken it is impossible to say that the child groups were the cause of the parents perceived improvement in their child's social skill. The parents might have perceived the improvement simply because their child was in the group i.e. Hawthorn effect, or they could have answered the social skills homework practice sheet in such a way that they believed was pleasing to the group leaders i.e. social desirability.

Lack of Self-Awareness

As indicated in the literature review a common element of ADHD is a lack of self-awareness of problem behaviors. One indication of this lack of self-awareness could be indicated by the large amount of "5s" meaning "I always do that" answers from the child participants. A hallmark symptom of ADHD is the inability to notice social cues. This inability is what causes the ADHD child to suffer from peer rejection. They are unaware of how their lack of social skills is contributing to this rejection or even that they are lacking in social skills.

The ADHD child believes that there is nothing wrong with their abilities to properly perform social skills. This is best illustrated by an example of a conversation between one of the child participants and the researcher. At the start of one of the first group sessions, the researcher was giving the group directions for answering the SSC survey. The instructions were repeated five times to the same child who was unable to

maintain his attention level long enough to fully hear the directions. When the child finally heard the instructions he graded himself a five meaning I always do that to the question, “I listen to someone who is talking to me”. This is an example of an ADHD child’s inappropriate attention level as well as a lack of self-awareness

The SSC may not have been successful in properly measuring the child’s current social skills due to the child’s own subjectivity of their ADHD symptoms. The lack of self-awareness of the ADHD child’s own behaviors could have greatly swayed the results of the study. The SSC measurement may not have been sensitive enough to successfully evaluate this phenomenon.

Inattention

Another reason for not showing an improvement in social skills upon the completion of the ADHD group could also be due to the ADHD child’s attention level. Tasks that are perceived as being boring, tedious or mundane are quickly excused by the ADHD child. They quickly change their focus to something more fun and exciting. The development of the measurement by the researcher may have increased the likelihood of the ADHD child’s lack of attention. This could have affected the results of the measurement and caused it to be invalid. The SSC was modified from its original format, which had over 130 questions to just 31 questions. The researcher chose the questions based on the social skills that would be taught in the eight group sessions. The researcher placed only three questions on each page, believing that this would help to maintain the child’s attention level. The reverse effect could have occurred instead. That is the child may have noticed how “big” the survey appeared due to the number of pages and decided not to truly read and answer the questions.

Correlation Comparisons

The correlations that were found in this study were weak. A correlation ranges from zero meaning no correlation to plus or minus one mean perfectly correlated. The closer the correlation comes to a one the better the correlation is between the two items.

The highest level of correlation was found between the helpfulness of the social skill and the improvement of the child's behavior although the correlation would still not be considered highly correlated. Highly correlated items would have numbers of .6 or higher. The correlation found between helpfulness and improvement was .545. However, considering the low number of participants in this study, finding this correlation could be significant for the development of future treatment interventions.

Knowing this correlation could help in the future development of the type of social skills that are selected for treatment interventions. The type of social skills that were taught for example following instruction, accepting "no" for the answer or introducing yourself had a significant correlation with the parent's perception of the improvement of their child's behavior. The type of social skill being taught had a higher level of significant correlation with the parents' perception of the helpfulness of the social skill. The parents' perception of the helpfulness of the social skill had a higher level of significant correlation with the parents' perception of their child's improvement of their behavior and showed the highest actual correlated number.

This could be interpreted to mean that if a parent does not perceive the social skill being taught as being helpful for their child then they may not place as much emphasis on practicing the social skill with their child in the home environment thus the parent would not perceive an improvement in their child's behavior. Further indication of this could be

found in the fact that no correlation was found between the number of times the social skill was practiced and an improvement in the child's behavior.

Satisfaction

The children did indicate a high level of satisfaction with the group sessions. They also indicated that the groups were helpful in changing their behaviors and that learning social skills were important. These measures show that the children enjoyed the group sessions and that they felt they were helpful in improving their social skills and in changing their behaviors.

Discussion of the Parent Group Results

Three of the four hypotheses regarding the parenting groups were supported. The parent's parenting skills increased, the stress levels of the parents decreased and the parents' perception of their child's behavior in the home increased. The parental knowledge of ADHD did not increase therefore this hypothesis was not supported. The parents did show a high level of satisfaction with the parenting groups.

This study indicated that parents benefited from their parenting groups in three ways. First, the parents showed a significant improvement in their parenting skills for dealing with their ADHD child. The intervention appears to be successful in teaching parents a more effective way of dealing with their ADHD child's symptomatic behaviors. The difference between the pre- and post-test means indicate almost one full point (.92) difference from the beginning of treatment. This would indicate that the parenting groups were successful in improving the parenting skills of the parent participants.

Second, parents indicated an improvement in their child's behavior in the home environment. The mean measurements of the HSQ indicate .04 points of improvement in the child's behaviors. This small difference between the pre- and post-test mean could be due to the low sample size. It is important to note that the amount of change in the standard deviation indicates a closer range of ratings in the post-test. This can be interpreted to mean that the groups did appear to help the child's behaviors in the home environment. However, this fluctuation could also be attributed to the small sample size or it could indicate gravitation towards the mean.

Finally, parents indicated a reduction in their stress levels. This indicates that the parenting groups were successful in having a significant effect on the reduction of the stress that is associated with raising an ADHD child. Treatment approaches that are designed to alleviate the ADHD symptoms have a profound effect on the entire family system and elevating parental stress could be part of this effect. Stress measures were taken by asking two questions to the parents. It is possible that a more sensitive measurement could produce findings that are more robust and possibly more valid

Limitations of the Study

As demonstrated in the literature review the development of a multi-modality treatment package that can more effectively deal with the various problems faced by ADHD families is a unique intervention. There are several limitations to this study they are, control group issues, selection of measurements, comorbidity, generalization and sample size.

Control Group

The lack of a control group in this study questions the validity of the results. Several ethical issues arise when developing interventions for human beings. The use of a control group is one such issue. It would have been ideal to initiate a control group so that the effects of this multi-modality treatment for ADHD could have been more efficiently analyzed. However, the ethical issues of withholding treatment and the potential damaging effects that this could cause far out way the benefits of the use of a control group. This is a common limitation in human behavioral studies. The use of pre- and post-tests do help a little with this limitation, however without the use of a control group there is no way to accurately determine if the behaviors changed due to the treatment or due to other extraneous variables. Due to this limitation, the results of this study should be taken within that context.

Selection of Measurements

The researcher had several problems with the selection and use of the measurements in this study. Multi-modality treatments are a new and developing concept, therefore the researcher had problems finding measurements that could effectively measure this treatment modality. The measurements that were selected needed to be modified to accommodate for this phenomenon. Unfortunately, adapting the measurements created questions regarding the validity and reliability of the results obtained by those measurements.

In addition, the researcher was unable to find reliable measurements for some of the variables being measured and had to create the measurements to accommodate for this problem. This also lowered the validity and reliability of the study. There were also

financial restraints on the researcher which caused the researcher to “make do” with what was more cost effective.

Another problem with the measurements was the collection of the post-test measures. Although the researcher was able to obtain the pre-tests for almost all of the participants entering the groups, it became extremely difficult to obtain the post-tests. Problems occurred due to time limitations of the group sessions, refusal by the parents to complete the post-test and clients failing to attend the final group session. An informal survey by the researcher revealed that the parents felt the survey was too long and did not want to answer the sixteen questions. The researcher believes that this was in fact a flaw in the design of the survey and not the actual length of the survey. When the surveys were developed, three questions were placed on each page. This gave the perception that the surveys were much longer than they actually were. If the surveys had been, only a page long it is hypothesized that more parents might have answered the post-test.

Comorbidity

As indicated in the literature review comorbidity of ADHD with other externalizing and internalizing disorders is very common for children diagnosed with ADHD. In this study, several of the child participants had been given a dual diagnosis or were diagnosed solely with an externalizing behavior such as Oppositional Defiant Disorder (ODD). None of the child participants was diagnosed with internalizing behaviors such as anxiety disorder.

Unfortunately, there is no way to know if the intervention was affected by a dual diagnosis. The fact that most of the child participants were experiencing comorbidity could be an indication that they were exhibiting severe behavioral problems possibly

worse than behavioral problems that are characteristic of ADHD when it is the sole diagnosis.

For example, some of the main characteristics of ODD include hostile behaviors toward authority figures, arguing, loss of temper, being angry and being spiteful. Whereas the characteristics of ADHD are inattention, impulsivity and hyperactivity. The primary focus of the child groups were the teaching of Social Skills, which are often lacking for children with ADHD. The researcher did not conduct a literature review to determine if the same type of treatment could be warranted in treating ODD. Therefore, the diagnosis of ODD could have affected the results of the study.

Generalization

The measures that were used to determine generalization of social skills into the home environment were determined by what the parent reported on the social skills homework practice sheets. The parents rated their child's improvement, helpfulness and amount of times the social skill was practiced and returned the homework page to the group every session.

The problem of trying to determine the generalization of the social skills in this way is the lack of a pre-test. There was no way of knowing the pre-intervention level of the perceived usage of the social skills in the home environment before the family began the group sessions.

The ratings given on the homework sheets were an objective measure given by the parents of their child's behaviors. The lack of a baseline measurement limits the reliability of the measurement because the parents could have answered the questions in a way that they thought the group leaders wanted and not how their child actually behaved

in the home. Therefore, there was no way of knowing if the skills actually generalized to the home environment or the school environment. In addition, the fact that the measures did not indicate an improvement in the child's social skills also indicates a lack of support for generalization.

However, the parent's perception of the improvement of their child's social skills does have some validity. The perception of generalization is extremely important for successful treatment. The parental perception of improvement in their child's behaviors could have a potentially positive impact on the parent/child relationship. The strongest correlation was found between the parents' perception of the helpfulness of the social skill and the improvement of the child's behavior in the home. This could be an indication of generalization because the parents perceived the social skills to be improving their child's behaviors.

The intervention was brief, lasting only eight weeks. Follow-up sessions should be conducted to determine if the intervention was working after a significant amount of time. If follow-up measures were conducted, they could better determine the validity of the results and help to support generalization.

Sample Size

The size of the sample in this study was extremely small. The fact that significance was found in some of the hypotheses and not found in others in this study needs to be considered under that milieu. An increase in sample size could have produced very different results. Replication of the study could help to further prove or disprove the use of multi-modality treatments of ADHD.

CHAPTER 7

IMPLICATIONS FOR SOCIAL WORK

What Social Workers Need to Know

The problem of ADHD is multifaceted and has an impact on several systems and environments (i.e. the individual, the family, the home, the school and the community). Using the systems approach to develop treatment modalities for ADHD is an area where social workers are best suited. Social workers are trained to focus on the micro, the mezzo and the macro systems that are affected by a problem. Using the systems approach to find solutions to problems is the key element for the successful development of a treatment for ADHD.

ADHD not only has an effect on the individual child but also on every system involved with the ADHD child. Treatments that focus on only one aspect of the problem do not help the child in all aspects of their lives. Social workers can see all of the affected areas and develop, implement and advocate for more successful treatments of ADHD in all of these system.

The very fact that ADHD is the leading psychological diagnosis for school aged children, and the fact that it has a strong negative impact across environments, places the social worker as one of the key figures in the development of treatments for ADHD.

Multi-modality treatments can be implemented in different environments. Social workers have the advantage of being firmly established in the systems that are affected by ADHD. Therefore, social workers are best suited to develop and implement treatments for ADHD across these systems. Social workers can take their treatment on “the road” and implement it in a systems approach that has been proven the most beneficial for the treatment of ADHD.

Social workers often avoid research-based practice. The reasons for this are vast, however it is the belief of this social worker that by avoiding research-based practice fellow social workers are selling themselves short. Proving the treatments for ADHD to be effective is one of our duties as a social worker. This social worker sees it as our ethical responsibility to our clients as well as to the development of the social work profession.

In order to gain respect as a profession from other disciplines such as medical or the educational system social workers need to empirically prove the treatments that are being developed for ADHD as effective. By conducting empirical research, social workers can add to the knowledge base of the treatment of ADHD. By doing this, other professions will be able to understand why a systems approach is so important when treating ADHD. The more social workers contribute to the literature base by providing solid empirical research, the more social workers will be seen as professionals and not as friendly volunteers. Our clients benefit from this as well, because by testing our treatment social workers will know if what they are doing is beneficial to the client.

Ethical Considerations

The child who has been labeled as ADHD could possibly use this label as a type of self-fulfilling prophecy and begin to believe that they are supposed to behave in a negative fashion. The parent could also use the label as a way of dismissing behaviors that the child may be exhibiting or lowering their expectations of their child. Parents could also blame themselves for their child's misbehaviors.

It is important that group leaders remind the children and their parents that they are not "bad" because they are attending the group sessions. The ADHD child may feel singled out in the family as the problem child and may experience teasing and/or jealousy from his/her siblings who are not attending the group sessions. The siblings may feel that the ADHD child is receiving special attention due to his or her inappropriate behaviors. This can be overcome by group leaders advising the parents of this potential problem so they can prevent this.

As social workers, it is extremely important that we are aware of the possible ethical considerations that are involved when conducting research so we can try to eliminate or at least reduce any possible negative effects. Advocating for the participant is an extremely important part of overcoming the possible negative effects of treatment research. It is also our duty as social workers to always remember that the research participants are not just subjects, they are real families trying deal with everyday life problems and as such are not pawns that can be manipulated at our will in order to achieve the goals of our research.

CHAPTER 8

FUTURE RESEARCH

The need for future research in multi-modality treatments for ADHD needs to be conducted. This research project has brought about several indications of areas where future research could be conducted. The limitations to this study were important and those limitations need to be eliminated or reduced in order to obtain more reliable research results in the future.

First, better measures need to be obtained to determine the effectiveness of the treatment modalities. Since the conclusion of this paper, the researcher has found the Social Skills Rating Scale (SSRS) that can be used across several environments such as home and school. The SSRS is rated by the child, the parent and the teacher and is useful for determining the current levels of the child's social skills. The use of this proven and valid measure could be helpful in conducting future research to better determine the effectiveness of the intervention. It would also be extremely helpful to determine the generalization of the social skills learned during the group sessions to other environments.

The parent groups would also benefit from measurements that are more valid and reliable. An example of such a measurement could be the Children's Behavioral Rating Scale and the Connors Parent Rating Scale. If these measures were used in a pretest-posttest fashion, they could indicate a more accurate measure of the effectiveness of the

treatment modality. These scales can also be completed by the child's teacher. The use of teacher measurements would be extremely helpful in determining the intervention's successful generalization to other environments. Generalization is important in the treatment of ADHD because ADHD symptomatic behaviors do have a strong affect on multiple environments for the family.

Second, the implementation of a single subject design (SSD) with ratings made by the child and the parents could be helpful in determining the effectiveness of the group sessions. This type of research design is useful in that the participants are used as their own control group via the baseline measures that are collected before the start of intervention.

The SSD also implements follow-up data after termination of the group sessions. The follow-up data would be helpful in determining the long-term effectiveness of the treatment modality. A sound SSD research design would contact the family at least three times after termination, usually one month, three months and six months to gather the follow-up data. When using SSD follow-up measures are necessary in order to more accurately measure the successfulness of the intervention. The follow-up phase of SSD would help the social worker to better evaluate the effectiveness of the intervention for the families upon completion of the group sessions and would allow the social worker to initiate booster sessions for the families if the follow up measures indicated that it was necessary.

The measures collected by each parent and child participant would be statistically aggregated to determine the effectiveness of the group sessions. Thus, the SSD measures would be repeated time and time again as each group member completed their group

sessions which would allow for a larger number of participants to be statistically measured for significances and could thus better determine the effectiveness of the intervention.

One problem with implementing an SSD research design is the subjectivity of the ratings by the rater. Should an SSD be implemented it is also important to further support the results found by the SSD with additional proven measurements or standard scales such as the Children's Behavioral Checklist or the Conners Parent Rating Scale. These measures could be used as a pre-and post-test in order to help support the results that would be found in the SSD, thus further increasing the validity of the study.

Third, because comorbidity is so common with ADHD future studies should consider this and include this variable in the development of the treatment modality of ADHD. In other words, the treatments that are being developed and measured should include the issue of comorbidity of ADHD with other disorders. This research could indicate that different sub-types of comorbidity with ADHD need to have different treatment types in order to be the most effective treatment.

Finally, because ADHD affects different social environments of the family system (i.e., the school environment) it is recommended that future research focus on the generalization of the treatment to the school environment. One way that generalization could be included would be by involving teachers in the training of social skills and behavioral modification modalities. Since ADHD is a chronic condition, it would be beneficial for the ADHD child if his or her teacher had access to the same treatment options. This could be helpful in increasing the effectiveness of the treatment of ADHD not only in the home environment but in the school environment as well.

CHAPTER 9

CONCLUSION

The information that was gathered in this study helps to increase the literature for the treatment of ADHD. The negative effects that ADHD has on the family system have been shown to have negative implications to the child that often displays itself via comorbidity of other disorders as well as additional problems for the family system. The fact that so many children in the United States have been diagnosed with ADHD shows the importance of finding valid treatments.

The results of the study are promising in that the parents' parenting skills, stress levels in dealing with their child and their perception of their child's behavior all improved upon completion of the group sessions. As social workers, we are trained to examine the environmental factors that often contribute to or are a significant cause of problem behaviors. Since ADHD is a global problem, it is necessary for social workers to use their skills in the development of multi-modality treatments that can focus on several environments.

This study tried to focus on the effects of ADHD to the family system and develop a method of treatment that would be congruent in treating ADHD in this environment. As social workers, we can develop future treatment modalities that can include an expansion of this type of intervention. This study helped to contribute to the

literature bases for developing and implementing multi-modality interventions for children with ADHD and to increase the parenting skills of their parents.

APPENDIX A

CONSENT FORMS

Consent for Child

My name is Tonya Gardner and I am a graduate student in the School of Social Work at the University of Nevada, Las Vegas. Human Behavior Institute (HBI) and I are conducting a study to determine the effectiveness of these ADHD child's groups.

I would like to ask your permission for your child to participate in the study. Your child will be given a questionnaire at the beginning and the end of their sessions. The questionnaire should take approximately 15 minutes for them to complete. The questionnaire your child answers will be kept completely confidential. This study is completely voluntary and your child does not have to participate in the study if you or your child chooses no to. Participation in this study will have no effect on your child's treatment at HBI. You or your child may withdraw from this study at any time.

The risks to your child for completing this questionnaire are minimal. Unfortunately, we are unable to provide any compensation for your child's participation. If you have any questions regarding this questionnaire or this study, you may contact me by calling the Department of Social Work at the University of Nevada, Las Vegas at 895-1037. If you have any questions about the rights of research participants, please contact the Office of Sponsored Programs at 895-1357.

Thank you very much for your cooperation and assistance.

Tonya Gardner

Parent's Signature

Child's Name

Child Assent Form

My name is Tonya Gardner and I am a graduate student in the School of Social Work at the University of Nevada, Las Vegas. Human Behavior Institute (HBI) and I are conducting a study to determine the helpfulness of this group.

I would like to ask you to take part in the study. We will ask you some questions at the very first session and again at the very last session. It will take approximately 15 minutes for you to complete it. Your answers will be kept completely confidential, which means only HBI and myself will view your questionnaire. There are no right or wrong answers so please answer each of the questions as honestly as you can. This study is completely voluntary and you do not have to do it if you choose not to. You may stop answering the questions at any time.

The risks to you for completing this questionnaire are minimal. When you have finished, I will give you a reward for answering the questionnaire honestly and accurately. Please feel free to ask me if you have any questions about this questionnaire.

Thank you very much for your cooperation and assistance.

Tonya Gardner

Your Signature

Consent Form

My name is Tonya Gardner and I am a graduate student in the School of Social Work at the University of Nevada, Las Vegas. Human Behavior Institute (HBI) and I are conducting a study to determine the effectiveness of these ADHD parent and child groups.

I would like to ask you to participate in the study. To do so, you need only to complete this attached questionnaire. It will take approximately 15 minutes of your time. This questionnaire will be kept completely confidential, which means no one outside of HBI and myself will view your questionnaire. There are no right or wrong answers so please answer each of the questions as honestly as you can. You will be given the same questionnaire at the end of the ADHD parenting sessions. It is important that the same person who completes the first questionnaire also completes the second questionnaire given at the end of the sessions. This study is completely voluntary and you do not have to participate if you chose not to. You may withdraw from this study at any time. Participation in this study will have no effect on your treatment at HBI.

The risks to you for completing this questionnaire are minimal. Unfortunately, we are unable to provide you with any compensation for your participation. If you have any questions regarding this questionnaire of this study, you may contact me by calling the Department of Social Work at the University of Nevada, Las Vegas at 895-1037. If you have any questions about the rights of research participants, please contact the Office of Sponsored Programs at 895-1357.

Thank you very much for your cooperation and assistance.

Tonya Gardner

Adult Participant Signature

APPENDIX B

CHILD PARTICIPANT MEASURES

Child's Self-Observation Survey
Adapted from the Student Skillsstreaming Checklist

Name: _____ Date: _____ Age: _____

Instructions: Based on your own observations in various situations, rate your use of the following skills. Please mark an "X" in the box next to the answer that most explains how often you do that statement. Only mark ONE answer for each statement. Remember there are no right or wrong answers. This questionnaire is completely confidential, which means only HBI and I will see your answers.

1. I listen to someone who is talking to me.

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

2. I ask questions when I want to know something.

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

3. I say thank you when someone does something nice for me.

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

4. I tell other people when I like them.

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

5. I tell other people when I like something they have done.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
6. I ask for help when I am having difficulty doing something.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
7. I explain to people clearly how to do a task.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
8. I follow instructions from other people quickly and correctly.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
9. I apologize to others when I have done something wrong.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always

10. I am aware of the feelings I have at different times.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

11. The way I feel has an effect on the way I behave.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

12. I let others know what I am feeling.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

13. I tell others how I am feeling without hurting their feelings.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

14. I try to understand how other people are feeling.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

15. I get angry when someone else is angry.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

16. I know what makes me afraid.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

17. When I am faced with a big project that I find difficult to do, I give up because it is just too hard.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

18. I say nice things about myself when I have done a good job on something.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

19. When I am told to do something, I do it right away and let the person I am doing it for know when I am done.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

20. I understand when I need to ask permission to do something.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
21. I help others when they need help.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
22. When I disagree about something, I am able to explain my side without getting upset.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
23. When I ask one of my parents to do something and they tell me “no”, I will argue with them to get my way.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always
24. I make complaints I have about others in a way that will not hurt feelings.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Often
 - ☐ Always

25. I get upset when someone makes a complaint about me.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

26. I get embarrassed when I have made a mistake.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

27. I let someone know when I feel a person is being treated unfairly.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

28. If I know something I am about to do is wrong. I do it anyway so I can impress my friends.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

29. If I make a mistake, I try to figure out why I made it.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

30. I get upset when someone accuses me of doing something.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

31. I pay full attention to whatever I am working on.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Social Skill Homework Practice Sheet

Dear Parents:

Your child has been practicing the social skill of _____. Please help your child to develop this important skill by helping them to learn the steps for this skill. Watch your child during the week and try to notice them using this skill then write below whom your child was using this skill with. Your child should return their completed homework assignment at our next group meeting.

Example of how Social Skill was used? _____

Steps for Social Skill (Name of Social Skill) _____:

Step 1) _____
 Step 2) _____
 Step 3) _____
 Step 4) _____

Child's Name: _____ Date: _____

Did your child use the social skill during the week? ☐ Yes ☐ No

If yes, approximately how many times? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+

If no, did your child have the opportunity to use this skill? ☐ Yes ☐ No

Please rate any improvement you have noticed in your child's behavior for using this social skill.

- ☐ No Improvement
- ☐ Little Improvement
- ☐ Average Improvement
- ☐ Great Improvement
- ☐ Extreme Improvement
- ☐ Did not practice this skill

Please rate the helpfulness of this social skill.

- ☐ Not Helpful
- ☐ Somewhat helpful
- ☐ Helpful
- ☐ Very Helpful
- ☐ Extremely Helpful
- ☐ Did not practice this skill

Parent's Signature: _____

Child's Signature: _____

APPENDIX C

ADULT PARTICIPANT MEASURES

Adapted from
The Home Situations Questionnaire – Revised

Name of child: _____ Date: _____

Name of person completing this form: _____

Please rate your child in the following areas. Please remember there are no right or wrong answers. If you would to comment on any of the behaviors listed please feel free to do so in the space provided.

1. My child has a problem playing alone.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

2. My child has problems with other children.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

3. My child has attention difficulties during mealtimes.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

4. My child has difficulties getting dressed.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

5. My child has difficulties concentrating when watching television.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

6. My child misbehaves when visitors are in our home.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

7. My child misbehaves when visiting in someone else's home.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

8. My child has behavioral difficulties when attending church or Sunday school.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

9. Is your child's behavior difficult to control when in public places, for example in supermarkets, restaurants or stores?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

10. My child completes his/her chores at home.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

11. My child can maintain his/her attention when speaking to others.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

12. My child has difficulties concentrating while in the car.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

13. My child displays inappropriate behaviors when his/her father is home.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

14. My child displays inappropriate behaviors when his/her mother is home.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

15. My child has difficulty completing his/her homework.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always
- ☐ Not Applicable

Comments: _____

16. Are there any behaviors that are not listed in this survey that you consider a problem in you home?

- ☐ Yes
- ☐ No

If yes, please identify the problem behavior(s) below:

ADHD Parent Questionnaire

Name of Child: _____

Date: _____

Name of Person Completing this form: _____

Please check the best answer to each of the following questions. Remember there are no right or wrong answers. Please answer the questions regarding the child that is currently enrolled in the ADHD children's group.

1. What is your relationship to this child?

- ☐ Mother
- ☐ Father
- ☐ Step-Mother
- ☐ Step-Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Legal Guardian
- ☐ Other: _____

2. What is your gender?

- ☐ Male
- ☐ Female

3. What is your age?

- ☐ Under 21 years
- ☐ 21 to 30 years
- ☐ 31 to 40 years
- ☐ 41 to 50 years
- ☐ More than 50 years

4. What is your race?

- ☐ Hispanic/Latino (a)
- ☐ Black
- ☐ Caucasian
- ☐ Asian
- ☐ American Indian
- ☐ Bi or multiracial
- ☐ Other: _____

5. What is the race of your child?

- ☐ Hispanic/Latino (a)
- ☐ Black
- ☐ Caucasian
- ☐ Asian
- ☐ American Indian
- ☐ Bi or multiracial
- ☐ Other: _____

6. How many children are living in your home?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four
- ☐ More than four
- ☐ Other: _____

7. Have you ever been diagnosed with ADHD?

- ☐ Yes
- ☐ No

8. Please indicate the last year of school completed:

- ☐ Some High School
- ☐ High School
- ☐ Some College
- ☐ Bachelors
- ☐ Masters
- ☐ Other: _____

9. My general understanding and knowledge of ADHD is:

- ☐ No knowledge
- ☐ Little knowledge
- ☐ Average knowledge
- ☐ Very knowledgeable
- ☐ Extremely knowledgeable

10. My understanding of medication used to treat ADHD is:
- ☐ No knowledge
 - ☐ Little knowledge
 - ☐ Average knowledge
 - ☐ Very knowledgeable
 - ☐ Extremely knowledgeable
11. My understanding of parenting and behavior management approaches used to treat ADHD is:
- ☐ No knowledge
 - ☐ Little knowledge
 - ☐ Average knowledge
 - ☐ Very knowledgeable
 - ☐ Extremely knowledgeable
12. My level of stress and frustration in raising an ADHD child is:
- ☐ No stress
 - ☐ Little stress
 - ☐ Average stress
 - ☐ Very stressful
 - ☐ Extremely stressful
13. My ADHD youngster's behavioral problems are:
- ☐ No stress
 - ☐ Little stress
 - ☐ Average stress
 - ☐ Very stressful
 - ☐ Extremely stressful
14. I tend to scream and yell when my child misbehaves.
- ☐ Never
 - ☐ Rarely
 - ☐ Sometimes
 - ☐ Most of the time
 - ☐ Always

15. I deny my child's requests before hearing them out.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

16. I focus mainly on things my child does wrong.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

17. I give in to my child's whining or pleading.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

18. The adults in my house disagree in front of my child about discipline if we feel differently from one other.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

19. When my child is misbehaving, I have to spank him/her in order to correct their behavior.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

20. I tend to use positive rewards when my child does a job correctly.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

21. I take it personally when my child misbehaves.

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Most of the time
- ☐ Always

Thank you for your answers this concludes this questionnaire.

APPENDIX D

SATISFACTION SURVEYS

Satisfaction Survey for Parent Groups

The following questionnaire is used to rate the quality of the ADHD parent group sessions. This questionnaire is completely confidential and anonymous, so please do NOT write your name on this form. Please rate the quality of the ADHD group sessions.

1. Overall, how relevant was the material given in these sessions?
 - ☐ Not relevant
 - ☐ A little relevant
 - ☐ Relevant
 - ☐ Very relevant
 - ☐ Extremely relevant
2. How helpful were these sessions in providing you with ways to control the behaviors of you ADHD child?
 - ☐ Not helpful
 - ☐ A little helpful
 - ☐ Helpful
 - ☐ Very Helpful
 - ☐ Extremely Helpful
3. Were your expectations of this group satisfied?
 - ☐ Not satisfied
 - ☐ A little satisfied
 - ☐ Satisfied
 - ☐ Very satisfied
 - ☐ Extremely satisfied
4. How helpful were these sessions in changing your behavior toward your child?
 - ☐ Not helpful
 - ☐ A little helpful
 - ☐ Helpful
 - ☐ Very Helpful
 - ☐ Extremely Helpful

5. How helpful were the group sessions in improving your child's behavior?

- ☐ Not helpful
- ☐ A little helpful
- ☐ Helpful
- ☐ Very helpful
- ☐ Extremely helpful

6. How would you rate your overall satisfaction with the group sessions?

- ☐ Not satisfied
- ☐ A little satisfied
- ☐ Satisfied
- ☐ Very satisfied
- ☐ Extremely satisfied

Satisfaction Survey for Child Groups

The following questionnaire is used so that we can improve the group sessions that you just completed. We want to keep your identity a secret so DO NOT write your name on this paper. There is no right or wrong answers – just be truthful when you answer the questions.

1. Overall, how important did you find the information given in these group sessions?

- ☐ Not important
- ☐ A little important
- ☐ Important
- ☐ Very Important
- ☐ Extremely Important

2. How helpful were these sessions in changing your behavior? ?

- ☐ Not helpful
- ☐ A little helpful
- ☐ Helpful
- ☐ Very Helpful
- ☐ Extremely Helpful

3. Did you find the social skills helpful to you at home? ?

- ☐ Not helpful
- ☐ A little helpful
- ☐ Helpful
- ☐ Very helpful
- ☐ Extremely helpful

4. Overall, how satisfied were you with these group sessions? ?

- ☐ Not satisfied
- ☐ A little satisfied
- ☐ Satisfied
- ☐ Very satisfied
- ☐ Extremely satisfied

APPENDIX E

HUMAN SUBJECTS APPROVAL LETTER



DATE: July 6, 2000

TO: Tonya Gardner
Social Work
M/S 5032

FROM: *for* Dr. Fred Preston *K. Preston*
Chair, Social/Behavioral Committee
of the Institutional Review Board

RE: Status of Human Subject Protocol Entitled:
"Group Sessions for Parents and their ADHD Children – Teaching Social Skills"

OSP # 386s0600-046

This memorandum is official notification that the Social/Behavioral Committee of the Institutional Review Board has approved the protocol for the project listed above. This approval is for a period of one year from the date of this notification, and work on the project may proceed.

Should the use of human subjects described in this protocol continue beyond a year from the date of this notification, it will be necessary to request an extension.

If you have any questions or require any assistance, please contact the Office of Sponsored Programs at 895-1357.

cc: OSP file

Office of Sponsored Programs
4505 Maryland Parkway • Box 451037 • Las Vegas, Nevada 89154-1037
(702) 895-1357 • FAX (702) 895-4242

REFERENCES

American Academy of Pediatrics. (2000). Clinical practice guideline: Diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics, 105 (5), 1158-1170.

American Psychiatric Association (2000). American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC.

Baldwin, K., Brown, R. T., & Milan, M. A. (1995). Predictors of stress in caregivers of attention deficit hyperactivity disordered children. The American Journal of Family Therapy, 23 (2), 149-160.

Barkley, R. A. (1998). Attention-deficit hyperactivity disorder. Scientific American, 279 (3), 66-72.

Biederman, J., Milberger, S., Faraone, S. V., Kiely, K., Guiole, J., Mick, E., Ablon, S., Warburton, R. & Reed, E. (1995). Family-environment risk factors for attention-deficit hyperactivity disorder. Archives of General Psychiatry, 52, 464-470.

Biederman, J., Newcorn, J., & Sprich, S., (1991). Comorbidity of attention deficit hyperactivity disorder with conduct, depressive, anxiety and other disorders. American Journal of Psychiatry, 148 (5), 564-577.

Buitelaar, J. K., Van Der Gaag, R. J., Swaab-Barneveld, H., & Kuiper, M. (1995). Prediction of clinical response to methylphenidate in children with attention-deficit hyperactivity disorder. Journal of American Academy of Child and Adolescent Psychiatry, 34 (8), 1025-1032.

Calhoun Jr., & Greenwell-Iorillo, E. (1997). Attention-deficit hyperactivity disorder: Mountain or a molehill? Reading & Writing Quarterly, 14 (1), 83-106.

Cantwell, D. P. (1996). Attention deficit disorder: A review of the past 10 years. Journal of American Academy of Child and Adolescent Psychiatry, 35 (8), 978-987.

Cipkala-Gaffin, J. A. (1998). Diagnosis and treatment of attention-deficit/hyperactivity disorder. Perspectives in Psychiatric Care, 34 (4), 18-25.

Danforth, J. S. (1998). The outcome of parent training using the behavior management flow chart with mothers and their children with oppositional defiant disorder and attention-deficit hyperactivity disorder. Behavior Modification, 22 (4), 443-473.

Colton, D. L., & Sheridan, S. M. (1998). Conjoint behavioral consultation and social skills training: Enhancing the play behaviors of boys with attention deficit hyperactivity disorder. Journal of Educational and Psychological Consultation, 9 (1) 3-28.

Dielman, M. & Franklin, C. (1998). Brief solution-focused therapy with parents and adolescences with ADHD. Social Work in Education, 20 (4), 261-268.

Dumas, M. C. (1998). The risk of social interaction problems among adolescents with ADHD. Education and Treatment of Children, 21 (4), 447-461.

DuPaul, G. J., Eckert, T. J., & McGoe, K. E. (1997). Interventions for students with attention-deficit/hyperactivity disorder: One size does not fit all. School Psychology Review, 26 (3), 369-381.

Eberstadt, M. (1999). Why Ritalin rules. Prescription drug for attention deficit disorder. Policy Review, April-May, 1-8.

Erk, R. R. (1997). Multidimensional treatment of attention deficit disorder: A family oriented approach. Journal of Mental Health Counseling, 19 (1), 3-22.

Estrada, A. U., & Pinsof, W. M. (1995). The effectiveness of family therapies for selected behavioral disorders of childhood. Journal of Marital and Family Therapy, 21 (4), 403-440.

Evans, S. W., Axelford, J. L., & Sapia, J. L. (2000). Effective school-based mental health interventions: Advancing the social skills training paradigm. Journal of School Health, 70 (5), 191-194.

Firestone, P., Crowe, D., Goodman, J. T. & McGrath, P. (1986). Vicissitudes of follow-up studies: Differential effects of parent training and stimulant medication with hyperactives. American Orthopsychiatric Association, 56 (2), 184-194.

Frankel, F., Myatt, R., Cantwell, D. P., & Feinberg, D. T. (1997). Parent-assisted transfer of children's social skills training: Effects on children with and without attention-deficit hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 36 (8), 1056-1064.

Frazier, M. R. & Merrell, K. W. (1997). Issues in behavioral treatment of attention-deficit/hyperactivity disorder. Education and Treatment of Children, 20 (4), 441-462.

Goisman, R. M. & Zrebiec, J. F. (1996). Combined behavioral and psychodynamic supervision of social skills training groups. International Journal of Group Psychotherapy, 46 (3), 417-423.

Greene, R. W., Biederman, J., Faraone, S. V., Ouellette, C. A., Penn, C., & Griffin, S. M. (1996). Toward a new psychometric definition of social disability in children with attention-deficit hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 35 (5), 571-578.

Hepler, J. B. (1997). Evaluating a social skills program for children with learning disabilities. Social Work with Groups, 20 (3), 21-36.

Hinshaw, S. P. (1992). Externalizing behavior problems and academic underachievement in childhood and adolescence: Causal relationships and underlying mechanisms. Psychological Bulletin, 111 (1), 127-155.

Jenson, C. E., Green, R. G., Singh, N. N., Best, A. M., & Ellis, C. R. (1998). Parental attributions of the causes of their children's behavior. Journal of Child and Family Studies, 7 (2), 205-215.

Jenson, P. S., Martin, D. & Cantwell, D. P. (1997). Comorbidity in ADHD: Implications for research, practice and DSM-V. Journal of the Academy of Child and Adolescent Psychiatry, 36 (8), 1065-1079.

Kotkin, R. (1998). The Irvine paraprofessional program: Promising practice for serving students with ADHD. Journal of Learning Disabilities, 31 (6), 556-564.

Landau, S., Milich, R., & Diener, M. B. (1998). Peer relations of children with attention-deficit hyperactivity disorder. Reading and Writing Quarterly, 14 (1), 83-106.

Landau, S., & Moore, L. A. (1991). Social skill deficits in children with attention-deficit hyperactivity disorder. School Psychology Review, 20 (2), 235-251.

Maedgen J. W., & Carlson, C. L. (2000). Social functioning and emotional regulation in the attention deficit hyperactivity disorder subtypes. Journal of Clinical Child Psychology, 29 (1), 30-42.

McMahon, R. J. (1994). Diagnosis, assessment, and treatment of externalizing problems in children: The role of longitudinal data. Journal of Consulting and Clinical Psychology, 62, (5), 901-917.

Merrell, K. W., & Wolfe, T.M. (1998). The relationship of teacher-rated social skills deficits and ADHD characteristics among kindergarten-age children. Psychology in the Schools, 35 (2), 101-109.

Miranda, A., & Presentacion, M. J. (2000). Efficacy of cognitive-behavioral therapy in the treatment of children with ADHD with and without aggressiveness. Psychology in the Schools, 37 (2), 169-182.

MTA Cooperative Group (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. Archives of General Psychiatry, 56 1073-1086.

MTA Cooperative Group (1999). Moderators and mediators of treatment response for children with attention-deficit/hyperactivity disorder: The multimodal treatment study of children with attention-deficit/hyperactivity disorder. Archives of General Psychiatry, 56 1088-1096.

Murphy, K. R. & Barkley, R. A. (1996). Parents of children with attention-deficit/hyperactivity disorder: Psychological and attentional impairment. American Journal of Orthopsychiatry, 66 (1), 93-102.

Newby, R. F., Fischer, M., & Roman, M. A. (1991). Parent training for families of children with ADHD. School Psychology Review, 20 (2), 252-265.

Pelham, Jr., W. E. & Waschbusch, E. A. (1999). Behavioral Intervention in attention-deficit/hyperactivity disorder. In H. C. Quay & A. E. Hogan (Eds.), Handbook of Disruptive Behavior Disorders, (pp. 255-278). Kluwer Academic/Plenum Publishers, New York.

Pelham, Jr., W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for attention deficit hyperactivity disorder. Journal of Clinical Child Psychology, 27 (2), 190-205.

Posavac, H. D., Sheridan, S. M., & Posavac, S. S. (1999). A cueing procedure to control impulsivity in children with attention deficit hyperactivity disorder. Behavioral Modification, 23 (2), 234-253.

Richters, J. E., Arnold, L. E., Jensen, P. S., Abikoff, H., Conners, C. K., Greenhill, L. L., Hechtman, L., Hinshaw, S. P., Pelham, W. E., & Swanson, J. M. (1995). NIMH collaborative multisite multimodal treatment study of children with ADHD: I. Background and rationale. Journal of the American Academy of Child and Adolescent Psychiatry, 34 (8), 987-1000.

Samudra, K., & Cantwell, D. P. (1999). Risk factors for attention-deficit/hyperactivity disorder. In H. C. Quay & A. E. Hogan (Eds.), Handbook of Disruptive Behavior Disorders, (pp. 199-220). Kluwer Academic/Plenum Publishers, New York.

San Miguel, S. K., Forness, S. R., & Kavale, K. A. (1996). Social skills deficits in learning disabilities: The psychiatric comorbidity hypothesis. Learning Disability Quarterly, 19, 252-261.

Saunders, B., & Chambers, S. M. (1996). A Review of the literature on attention-deficit hyperactivity disorder children: Peer interactions and collaborative learning. Psychology in the Schools, 33 (4), 333-340.

Seidman, L. J., Biederman, J., Faraone, S. V., Milberger, S., Norman, D., Seiverd, K., Benedict, K., Guite, J., Mick, E. & Kiely, K. (1995). Effects of family history and comorbidity on the neuropsychological performance of children with ADHD: Preliminary findings. Journal of the American Academy of Child and Adolescent Psychiatry, 34 (8), 1015-1024.

Sheridan, S. M., Dee, C. C., Morgan, J. C., McCormick, M. E., & Walker, D. (1996). A multimethod intervention of social skills deficits in children with ADHD and their parents. School Psychology Review, 25 (1), 57-76.

Spencer, T., Biederman, J., Wilens, T., Harding, M., O'Donnell, D & Griffin, S. (1996). Pharmacotherapy of attention-deficit hyperactivity disorder across the life cycle. Journal of the American Academy of Child and Adolescent Psychiatry, 35 (4), 409-429.

Swanson, J. M., McBurnett, K., Wigal, T., Pfiffner, L. J., Lerner, M. A., Williams, L., Christina, D. L., Tamm, L., Willcut, E., Crowley, K., Clevenger, W., Khouzam, N., Woo, C., Crinella F. M., & Fisher, T. D. (1993). Effect of stimulant medication on children with attention deficit disorder: A review of reviews. Exceptional Children, 60 (2), 154-162.

Twoey, E. D. (1997). Social skills activities that enhance relationships of children with attention deficit hyperactivity disorder. Journal of Psychology and Christianity, 16 (1), 62-67.

Weinberg, H. A. (1999). Parent training for attention-deficit hyperactivity disorder: Parental and child outcome. Journal of Clinical Psychology, 55 (7), 907-913.

VITA

Graduate College
University of Nevada, Las Vegas

Tonya Gardner

Local Address:

2503 Magnet Street
North Las Vegas, Nevada 89030

Degrees:

Bachelor of Arts, Psychology, 1999
University of Nevada, Las Vegas

Special Honors and Awards:

Phi Kappa Phi Honor Society, 1998
Delta Chapter Phi Alpha Honor Society, 2000

Thesis Title: The effects of ADHD child and parenting groups

Thesis Examination Committee:

Chairperson, Dr. Lisa Rapp-Paglicci, Ph. D.
Committee Member, Dr. Stacey Hardy-Desmond, Ph. D.
Committee Member, Dr. Laurie Smith, Ph.D.
Graduate Faculty Representative, Dr. Susan Miller, Ph.D.