The efficacy of attribution theory for predicting MSW's orientations towards treating children with attention deficit disorders

Robert Theodore Perry

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THE EFFICACY OF ATTRIBUTION THEORY FOR PREDICTING MSW'S ORIENTATIONS TOWARDS TREATING CHILDREN WITH ATTENTION DEFICIT DISORDERS

A Project
Presented to the
Faculty of
California State University, San Bernardino

In Partial Fulfillment
of the Requirements for the Degree Master of Social Work

by
Robert Theodore Perry
June 2001
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ABSTRACT

An overview of Attention Deficit Disorders is given along with a description of attribution theory and issues facing MSWs in CPS type settings. A questionnaire was administered to Masters of Social Workers (MSWs) employed by the Department of Children's Services San Bernardino, California to test the hypothesis that Masters of Social Work (MSW) workers attitudes towards children with Attention Deficit Disorders (ADD/ADHD) are affected by the perceived cause of the disorders. No statistically significant results were found to support the hypothesis. However, relevant data from the questionnaire regarding issues of MSWs treating children with ADD/ADHD are discussed. Recommendations for MSWs in CPS setting were made, along with recommendations for further research.
ACKNOWLEDGMENTS

I wish at this time to thank both the social worker that took custody of my infant child when I was not yet ready to be a good parent and the social worker that said that I should go back to school. It is people like you that showed me that this is an important profession and that there is a way that worthwhile things can be done to help people lead useful productive lives.
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CHAPTER ONE
INTRODUCTION

Attention Deficit Disorders affect approximately 3-5% of school age children in the United States (American Psychological Association, 1994). It is very likely that ADD/ADHD probably affects an even larger percentage of children that come to the attention of workers in Children's Protective Services settings (prenatal drug exposure, poor parenting etc.). Due to the pervasive nature of Attention Deficit Disorders across multiple settings and the lack of conclusive knowledge about the etiology of these disorders, treatment modalities are often both complicated and hard to implement for children with ADD/ADHD (Cantwell, 1996). Thus, when CPS workers encounter these clients on their already burgeoning caseloads, they might be less than willing to undertake the complicated and often time consuming handling of such children. Furthermore, because of a clear etiology for these disorders, it is often perceived that children with ADD/ADHD are sometimes at fault for their behaviors (Weiner, 1991). Some plausible causes that the behavior of children is located within the child but not outside of the child are: acting out for attention, modeling of parents or siblings, conduct problems, and lack of discipline (O'Leary, 1980).
Attribution theory has proposed that when people who are displaying behavior difficulties are blamed for their problems, it is often perceived that the cause of the problem lies within the person and is not caused by some outside factor (Weiner, 1991). Consequently, people who are found to be at fault for their behavior are less likely to receive help for their problems. Thus, when CPS workers encounter children with Attention Deficit Disorders, they might be less than willing to act as advocates for these children and also less likely to either coordinate or work with the multidisciplinary teams that are important to the treatment of ADD/ADHD disorders. This is especially true if the CPS worker attributes the cause for the ADHD behaviors to being the fault of the child. Negative attitudes towards children with ADD/ADHD become even more relevant when it is realized that children in CPS type settings are sometimes taken out of their existing treatment spheres and placed in new settings (i.e. new schools, different doctors, foster homes).

The focus of this study was to better understand CPS worker's attitudes towards children with ADD/ADHD type disorders. Furthermore, the study looked at MSW workers perceptions as to what the etiology for attention deficit disorders is in school-aged children and whether or not those perceptions affected a willingness to work with
children with ADD/ADHD. The research data was generated from both supervisors and line workers in a CPS setting who hold MSW degrees.

Implications for the research are that if the attitudes of MSWs are indeed affected by their perceptions of the etiology of the disorders, then additional training might be necessary to better educate the MSWs in CPS settings. Perhaps workshops specifically tailored to dealing with children with ADHD on CPS caseloads. Furthermore, if demographic information shows that CPS workers carry a significant number of cases of children with ADD/ADHD, recommendations might be made to schools of social work to strengthen the educational components of their programs that pertain to ADD/ADHD in school aged children.

Finally, it is hoped that this research will further emphasize the importance of making clear and concise assessments and diagnoses when dealing with children who exhibit ADHD behaviors. This is the most important component to developing and maintaining the best treatment regimens for children exhibiting ADD/ADHD behaviors.

The formal research question reads as follows: Does the perceived cause of Attention Deficit Disorders in children affect MSWs attitudes towards treatment of children with Attention Deficit Disorders
Attention-deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) are the labels given to a cluster of behavioral characteristics identified in a substantial number of children and adults. The essential features of ADD are a persistent pattern of inattention that is more frequent and severe than that typically observed in persons at a comparable level of development (APA, 1994). Often symptoms of ADD are accompanied by additional behavioral characteristics of hyperactivity and/or impulsivity that can lead to individuals being diagnosed as having symptoms of Attention Deficit Hyperactivity Disorder (ADHD) (APA, 1994). ADD/ADHD are common disorders in children, with an estimated prevalence of 3-5% in the population (APA, 1994). Although its actual incidence may fluctuate within the population, ADD/ADHD is by no means specific to any particular subgroup. It is a disorder that is independent of socio-economic status, as well as educational levels (Anastopoulos, 1997). Furthermore, the disorders are also distributed fairly evenly across ethnic, racial, and religious groups. However, ADD/ADHD appears to occur much more often in boys than in girls. The ratio of boys to girls within clinical samples has been reported to be as high as 6:1, whereas in
community samples the ratios are lower, approximately 3:1 (Barkley, 1990).

Typically, some children with ADD/ADHD are reported to have had a difficult temperament since birth or early infancy, with the majority having been first identified by their parents and caregivers as deviant from normal between the ages of 3 and 4 (Barkley, 1989). Some of the behaviors that preschool age children with ADD/ADHD exhibit are: excessive activity, mischievousness, an unusual amount of non-compliance to parental requests, and difficulty in toilet training. However, it is usually not until preschool or elementary school that the presence of the disorder comes to the attention of both medical and educational professionals (Barkley, 1990; Kottman, Robert & Baker, 1995). By the time of entry into formal schooling at about 6 years of age, most children who will eventually be identified with ADD/ADHD will have become substantially different from their peers in the areas of sustained attention, impulsivity, and restlessness (Barkley, 1990). In parallel fashion, aggression, defiance, and other oppositional behaviors may also have been identified in children by this age (Ross & Ross, 1982). The consequences of behavior characterized as consistent with these additional anti-social behavioral characteristics, especially in the absence of appropriate diagnosis and treatment, are usually substantial and negative. Children
with symptoms of ADD/ADHD are more likely to veer into a more severe path of maladjustment in later years compared to children with ADD/ADHD who do not develop aggressive-defiant behaviors (Ross and Ross, 1982).

During the elementary years, the majority of children with ADD/ADHD experience varying degrees of poor school performance. These problems in school are usually related to the behavioral characteristics of ADD/ADHD, including failure to finish assigned tasks in both school setting and at home, disruptive behavior during class activities, and poor peer relations with schoolmates (Barkley, 1989; Pelham and Bender, 1982). Because of this disruptive school behavior, the learning and acquisition of knowledge in the children experiencing ADD/ADHD is usually erratic (Kottman, et al., 1995). This in turn leads to deficiencies in the areas of reading, spelling, math, handwriting, and language, which culminates in the need for additional educational assistance (Barkley, 1989).

As adolescents, some of the children affected by ADD/ADHD may experience a decrease in their symptoms, and upon assessment, may enter into the range of what is considered normal behavior and development (Barkley, 1989). However, many children suffering from ADD/ADHD continue to have trouble with school, at home, and in the community throughout adolescence (Weiss & Hechtman, 1994). Furthermore, adolescents with ADD/ADHD also exhibit higher
rates of risk behaviors, as indicated by both higher rates of automobile and bicycle accidents. As adults, individuals diagnosed with ADD/ADHD as children continue to exhibit symptoms of the disorder. A subset of these individuals experience substance abuse, high rates of depression, and low self esteem (Weiss & Hechtman, 1994).

Etiology

The etiology of ADD/ADHD is basically unknown. It is unlikely that one etiological factor is responsible for the entire cluster of behaviors that compose ADHD. It is more likely that the interplay of both psychosocial and biological factors coalesce into a final common pathway that leads to the syndrome (Cantwell, 1996). One theoretical cause of ADHD is a genetic predisposition. Children born to active, impulsive, aggressive parents frequently display the same traits as their birth parents (Barkley, 1990). Adoption studies demonstrate that ADD/ADHD problems are more likely to have a genetic component than an environmental one (Barkley, 1990). For example, the concordance rates for ADD/ADHD were 51% in monozygotic twins and 33% in dizygotic twins (Goodman and Stevenson as cited in Cantwell, 1996).

Despite the high probability of genetic predisposition towards ADD/ADHD, other biological theories abound. A theory proposed by Feingold (1973) suggests that
ADHD might be a result of food additives. However, other well-controlled studies have not given much support to Feingold's theory (Barkley, 1990). A more plausible biological explanation would be to target catatomatic abnormalities in individuals with ADD/ADHD (Cantwell, 1996). Research in this area points to low dopamine and norepinephrine turnover in certain parts of the brain, which results in ADHD symptoms (Dupaul & Stoner, 1994). This explanation rests mainly on the positive results of the use of various psycho-stimulants (such as Ritalin) that increase the availability of dopamine and norepinephrine in the brain. However, no single transmitter has been identified in the treatment of children with ADD/ADHD (Dupaul & Stoner, 1994).

Another plausible theory is that children with ADD/ADHD have greater-than-normal thresholds for arousal by stimulation: in other words, as environment stimulation decreases, hyperactivity and inattention increase in order to maintain an optimal level of central nervous system arousal (Zental, 1985).

In addition to the many potential biological causes of ADD/ADHD, environmental factors are also believed to play a role in the etiology of these disorders. However, such factors are usually not considered to be the primary cause of the disorder (Cantwell, 1996). Environmental and psychological factors are much more likely to act as risk
factors to the onset, duration and severity of ADD/ADHD in children (Barkley, 1990). One such theory proposed by Bettelheim (as cited in Oatman, Neale, & Davidson, 1995) is that children who are genetically predisposed to have ADHD may be born to parents that have less than adequate parenting skills. These poor parenting skills might actually a result of parents having experienced ADD/ADHD symptoms themselves. The negative behaviors of a child who already has a tendency to engage in both excessive activity and moodiness, is further exacerbated by parents who have either become resentful or impatient towards the child. This resentfulness and impatience quickly becomes a two-way battle that cannot help but affect the child's behavior in the classroom environment. Evidence supporting Bettelheim's theory is that children with ADHD who receive stimulant medications often begin exhibiting more compliant behaviors (Barkley, 1990). Compliant behaviors by the children, in turn, lead to less commanding and less negative behaviors by the parents.

Another psychological theory about the etiology of ADD/ADHD is based on learning principles. O'Leary (1980) proposed that children with ADD/ADHD might be receiving reinforcement for their actions. For example, by acting out in the classroom, a child who desires more attention can elicit more attention (albeit negative attention). This consequence, in turn, leads to more of the same
negative behaviors. Furthermore, O'Leary proposed that some ADD/ADHD behavior may also be modeling of the behavior of parents or siblings. Finally, some other psychological risk factors that might have an influence on the onset and magnitude of ADD/ADHD are family and environmental factors such as: 1) parenting styles that are either overly permissive or overly strict, 2) inadequate parental attention to the child, 3) poor parental/child relationships, 4) the stress of urban residence, 5) socioeconomic status, and 6) parent psychopathology (Barkley, 1990).

Diagnosis and Assessment

The diagnosis of children with ADD/ADHD presents numerous challenges to pediatricians, teachers, psychologists, and social workers. One significant problem lies in the lack of a single assessment tool that can conclusively establish a diagnosis of ADD/ADHD in children (Hinshaw, 1994). Rather, information from multiple sources must be weighed and grouped together in such a way as to ensure that the child suspected of experiencing ADD/ADHD is accurately diagnosed (Cantwell, 1996; Barkley, 1990). This is true because quite often the symptoms from ADD/ADHD mimic those of other psychiatric disorders, developmental disorders, and medical or neurological disorders (Cantwell, 1996). As such diagnosis of ADD/ADHD
is often a diagnosis of exclusion (Kwasman, 1995). Exclusion works by first eliminating all other potential causes of the target behaviors. Other potential causes for such behaviors that must first be excluded before making a diagnosis of ADD/ADHD might be eyesight problems, neurological problems, learning disabilities (i.e. Dyslexia), psychiatric disorders, and psychosocial problems (Kwasman, 1995). In order for experts to make a diagnosis of ADD/ADHD, multiple assessments and office visits are usually necessary (Kottman, Robert, & Baker, 1995). Appendix A lists the current diagnostic criteria for ADD/ADHD from the DSM-IV (APA, 1994). The diagnostic criteria include two categories with nine symptoms listed in each. The categories are inattention and hyperactivity/impulsivity. Six of the nine symptoms should be present in each category for diagnosis. Depending on the symptom cluster, the diagnosis can be categorized as follows: 1) ADD/ADHD combined type if the criteria of both categories are met; 2) ADD, predominately inattentive type, if only criteria for inattention category are met, and 3) ADHD, predominately hyperactivity--impulsivity type, if the criteria for hyperactivity-impulsivity are met. Furthermore, to make the diagnosis for ADD/ADHD the DSM-IV (APA, 1994) also requires that the symptoms be present before the age of seven. Some symptoms must be clinically significant in two or more settings such as
school and home, and the symptoms may not occur exclusively during the course of another developmental disorder. Overall, the formulation of an assessment for ADD/ADHD requires the use of reliable and valid instruments that sample behavior in a variety of natural settings (Hinshaw, 1994). More often than not, a correct diagnosis of ADD/ADHD is made from the input from a combination of information from a combination of information from pediatricians, psychologists, teachers, and family members (Kottman et al, 1995).

Treatment

Many of the same factors that complicate the assessment process can also affect treatment outcomes. Foremost among these are the lack of cross-situation occurrence of primary ADD/ADHD symptoms and the relatively high incidence of co-morbid conditions (Barkley, 1990). Such circumstances make it highly unlikely that any singular treatment approach can satisfactorily meet all the clinical management needs of children with ADD/ADHD (Anastopolous, 1997). For this reason, clinicians must often employ multiple treatment strategies in combination, each of which address a different aspect of the child's psychosocial difficulties.

Among the treatments that have received adequate support and empirical testing are pharmacotherapy (usually
stimulants), parent training in contingency management methods, parent training counseling, classroom applications of contingency management techniques, and cognitive-behavioral training (Anastopolous, 1997).

Perhaps the most successful and controversial of the aforementioned treatments is the use of stimulant medications. Stimulants are a class of drugs that include methylphenidate (Ritalin), pemoline (Cylert), Dextrostat, and Dexedrine (Taylor, 1997). These stimulants account for over 95% of ADD/ADHD medication therapy in the United States with Ritalin being by far the most common stimulant used in therapy for children with Attention Deficit Disorders (Kwasman, Tinsley, & Lepper, 1995; Taylor, 1997). The primary effects of these stimulants are an increased attention span and decreased hyperactivity and impulsivity (Taylor, 1997). Substantial improvements in these areas often produce other positive changes in these children, including increased self-esteem and perception of self-control, as well as decreased moodiness (Taylor 1997; Barkley, 1990). However, despite the success of these stimulant treatments, they are not always appropriate for all children and their use is often considered controversial (Anastopouls, 1990).
Challenge to Social Workers

Children suffering from Attention Deficit Disorders (ADD/ADHD) present a difficult challenge for both public school personnel and mental health professionals (Barkley, 1990; Kottman, 1995). This is true because the disorder occurs across a variety of settings and requires the input from many sources when making a diagnosis and designing a treatment. Normally, children who have Attention Deficit Disorders are referred for assessment and treatment in the first three years of elementary school (Weiss and Hechtman, 1993).

There are a variety of reasons why assessment does not usually occur until elementary school. First, behavior that was tolerated by parents and nursery school teachers is not acceptable to elementary school teachers who have 30 or more students in their classes (Weiss and Hechtman, 1993). Furthermore, children with ADD/ADHD at this developmental level are required to work in co-operative groups, work in very structured environments, meet new disciplinary demands, and exhibit new cognitive abilities. Due to the nature of the disorders of ADD/ADHD as described in the DSM-IV (APA, 1994), children with these disorders have a hard time succeeding both socially and academically. Thus, it traditionally falls in the hands of school psychologists, teachers, and other school personnel to both diagnosis and coordinate treatment of children.
with ADD/AHD (Power, Atkins, Osborne, & Blum, 1994; Kottman, Rhonda & Baker, 1995).

Overall, the literature has shown that school psychologists are usually in the best position to administer help to children with ADD/ADHD (Kottman, Rhonda & Baker, 1995). First, school psychologists are in a setting in which children with ADD/ADHD are most likely to exhibit problem behaviors (Barkley, 1990). They are also in a position to both access children in multiple naturalistic settings (i.e. classrooms, playgrounds, and lunchrooms) as well as to obtain the perspectives of multiple peer informants (Atkins & Pelham, 1991). Consequently, school psychologists may be able to consult more effectively with teachers and develop working relationships with them than their non-school based counterparts (Power et al., 1993).

An important responsibility for school psychologists in this vein is both the monitoring and implementation of various treatment approaches in multiple settings (Kottman et al., 1995). This includes the appraisal of resources in both the home and school (i.e. teacher capabilities for implementation of prescribed treatments, and parental capabilities for implementation of prescribed treatments. Finally, perhaps one of the most important roles of school psychologists and social workers in the treatment of children with ADD/ADHD is to act as a facilitator of
communication between the school, parents, teachers, administrators, pediatricians, and other clinicians whenever it is deemed necessary.

In addition to the involvement of school psychologists in the treatment of children with ADHD, social workers often find themselves in the position of having to intervene at both the individual case level and the system level for such children (Muller, 1993). The activities of social workers who work with children with ADD/ADHD can include participation in special education assessment and placement, individual counseling, group counseling, parent counseling and education, teacher training, classroom consultation, liaison between home and school, program planning in the school, and program planning in the community (Staudt, 1991). Often, it is the social worker acting under the auspices of the Children's Protective Services (CPS) who is assigned the job of providing treatment for children with ADD/ADHD. As such, the role of social worker becomes even more complicated. CPS workers must either provide alternate resources for the children who are removed from their homes, or must help to maintain and improve existing resources when children stay with their parents (Schene, 1998).
Attribution Theory

Burgeoning caseloads, often 40 or more per CPS worker, have in part lead to the copiously high turnover rates of MSWs in CPS settings (Thompson, personal communication). Furthermore, job satisfaction is often a debilitating factor that can cause painful shortfalls in the treatment of client within any mental health setting. Due to the pervasive nature of ADD/ADHD across multiple settings and the lack of conclusive knowledge about the etiology of these disorders, the treatment of children with ADHD is a particularly complicated undertaking (Cantwell, 1996). Thus, when CPS workers encounter clients with ADD/ADHD, they might be less than willing to provide the complicated and time consuming treatment necessary for these clients.

Currently, there is an ongoing debate about both the alarming trend of over diagnosis of ADD/ADHD in school age children and the over prescribing of stimulant medication for children exhibiting ADD/ADHD behaviors (Desgranges, Desgranges, & Karsky, 1995). This debate hinders the ability of social workers to provide proper treatment by causing the workers to operate with inaccurate misconceptions and expectations when treating children with ADD/ADHD.

The complexity of either establishing medical or psychological diagnoses (thus providing correct treatment)
is well documented in cognitive psychological research (Beach, 1997; Elstein, Schulman, & Sprafka, 1978). In the Brunswickian lens model, as described in Elstein et al. (1978), a judge (i.e. social worker), must make a judgment about an event (i.e. child exhibiting ADD/ADHD behaviors) based on a set of cues that are sometimes unreliable. These cues are derived from both the environment and from within the perceiver, with the final judgment being based on a correlation between activities within the perceiver as he judges the environment (Beach, 1997). As such, the eventual validity of the diagnosis and subsequent treatment of ADD/ADHD is dependent on both the environment and the perceiver (Beach, 1997). In other words, when a CPS worker has preconceived attitudes about the treatment of ADD/ADHD that are incorrect, the treatment that follows will not be optimal.

Another research theory that supports the complexity of making correct judgments and the consequent actions caused by these perceptions can be found in the expectancy research by Rosenthal and his colleagues. In his research, Rosenthal (1978) provided judgment cues to teachers that were incorrect (i.e. that a child was predisposed to do well in school). Consequently, the teachers, in the context of their misconceptions, acted in such a way that the children fulfilled the teacher's incorrect expectations. Thus, children who are perceived to be
suffering from ADD/ADHD might very well be treated by social workers, both consciously and unconsciously, in such a way that they either act out their disorder or receive treatment that somehow furthers their negative behaviors.

An additional theoretical perspective that is relevant to these issues is attribution theory. Attribution theory states that the perceived responsibility for the cause of a behavior can affect a helper's attitudes and behaviors in both negative and positive ways (Weiner, 1993). In other words, if the person judging another feels that the person being judged is at fault for his or her behaviors, then, the helper is less motivated to help the person in need. One example given by Weiner (1991) is that of obesity. If the person doing the judging feels that the obese person is lazy, does not exercise, does not really want to change, or has no discipline, then the person doing the judging may conclude that the obese person is at fault and does not deserve any help. However, if the person making judgments feels that the obesity is not the fault of the obese person and can be attributed to either a thyroid problem or genetics, then the person who is in the position to help will be much more likely to provide positive assistance. The same scenario can play out when social workers come into contact with children who either exhibit
or have been diagnosed with ADD/ADHD. Social workers who have negative perceptions of the child, especially if they perceive the problem to be the fault of the child, will probably be less willing to provide the help the child needs to have a positive treatment outcome. In fact, research with teachers has shown that teacher's attributions about the motivations and other causal factors underlying problem student behavior affect their expectations about what can be done to improve the situation, and these in turn affect the goals that teachers set and strategies they employ in attempting to realize their goals (Brophy & Rohrkemper, 1981).

Previous research with school nurses has shown that when treating children with ADD/ADHD, the nurses had more negative perceptions of children when they thought the nature of the problem was an internal mechanism (fault of the child) vs. an external problem out of control of the child (Lozano, Kwasman, & Tinsley, 1998). Some plausible causes for the behavior of such children being located within the child are: acting out for attention, modeling of parents or siblings, conduct problems, and lack of self-discipline (O'Leary, 1980). Conversely, the social workers that perceive the problem behaviors to be neurological, environmental, poor parenting, and genetics might be more willing to provide services for children with ADD/ADHD.
CHAPTER THREE

METHODS

Participants

Questionnaires were distributed to all 180 Master of Social Workers (MSWs) employed by the Department of Children's Services (DCS) within the County of San Bernardino, California. The Department of Children's Services San Bernardino operates under a traditional Children's Protective Services format. CPS type agencies typically provide services for both neglected and abused children and their families. The services provided are designed to improve and protect the quality of the children's lives. If it is deemed necessary, CPS employees can even take custody of children who fall under the auspices of CPS.

Procedure

The questionnaires were distributed to each of the 180 MSWs through the inter-office mailbox system within the Department of Children's Services. Each questionnaire was accompanied by a cover letter explaining the nature of the project, an informed consent letter, and a debriefing statement (see appendix A). A stamped envelope addressed to the researcher accompanied each of the questionnaire packets. Participation was voluntary, and 60 out of the 180 social workers (33%) completed the questionnaire.
Materials

Because no instruments designed to ascertain whether or not MSWs' attitudes are related to perceptions of the etiology of Attention Deficit Disorders currently exist, a questionnaire was developed for this purpose (see Appendix A). Some of the questions were multiple-choice, some were Likert type, and some were typical ratio demographic questions. The possible Likert responses were: 1) Strongly Disagree, 2) Disagree, 3) Agree, and 4) Strongly agree. Because of a lack of internal consistency for the questionnaire (α=.28), a pattern matrix was developed for the questionnaire using the KMO method, principal axis functioning, a scree plot, and Eigen values. Two relevant factors emerged: 1) 'Attribution' (meaning that ADHD symptoms are seen as the fault of the child), and 2) 'attitude' (indicating the belief that ADD is a disability, deviant, and negative). A third factor, identified by this researcher as 'knowledge', was also evident and seemed to be related to the knowledge and training that the social workers had about the issues of treating children with ADHD.

Attribution Measurements

The first attribution question, Number 6 on the questionnaire, asked if ADD/ADHD was caused by neurological components, psychological components, both
neurological and psychological components, environmental components, or other causes. These believed or perceived causes for Attention Deficit Disorders are well documented in the literature (Barkley, 1990; Anastopoulous, 1990; & Cantwell, 1996). In keeping with attribution theory, neurological manifestations of disease and behavior are usually not perceived as being the fault of the person who is exhibiting them whereas psychological and mental problems are more often perceived as being the fault of the person who exhibits them (Weiner, 1991).

Question 6 also asks whether the respondent believes that ADD/ADHD is both psychological and neurological. This answer points to the existence of an interaction of internal and external factors attributing to the disorders. As such, the perception that a disorder has both internal and external factors might very well interfere with an MSW being able to make a judgment regarding the locus of the problem and could also interfere with the eventual willingness to provide treatment of the patient (Brophy & Rohrkemper, 1981).

Other questions that were designed to elicit subtle expression of attribution included question 13, which asked whether ADD/ADHD is the fault of the parents (as opposed to fault of the child). Question 19 required respondents to say whether or not they believe ADD/ADHD is a medical problem (as opposed to fault of child), and
question 22 asked whether MSWs believe that schools expect too much from school-aged children (again as opposed to fault of the child). The last attribution question, question 24, examined the belief that ADD/ADHD may be the result of SES and therefore out of the control of the child.

Finally, as mentioned above, an "Attribution" factor was developed using the pattern matrix. The questions from the questionnaire that were combined into this factor were: 1) children should be taught to behave (question 11), 2) psycho-stimulant medications are over prescribed for children with attention deficit disorders (question 21), and 3) ADD/ADHD are over diagnosed in school aged children (question 16). This combination points to the existence of an "attribution" that it would be the child's fault for having such behaviors.

Attitude Measurements

The attitude the MSWs have towards their work with children with ADHD was measured by questions number 10 and 23. The first of these, question 10, asked respondents to rate the enjoyment they feel when working with ADHD children. This question was designed with the support of theory that people with a disorder thought to be internally controllable are less likely to illicit the help of trained professionals because the professionals
either do not like them, or feel they should be punished (Weiner, 1993). Attitude as it was measured by question 23, asked social workers' perception of the experience of treating children with ADD/ADHD was measured. Attitude was further measured by using the factor 'Attitude' developed in the pattern matrix. The questions from the questionnaire combined into the ''Attitude'' factor included: 1) children with attention deficit disorders need special schools (question 25), 2) children with attention deficit disorders are hard to handle (question 14), 3) ADD is a disability (question 17), 4) who should be in charge of diagnosis and treatment (question 8), 5) and treating children with Attention deficit disorders has been nothing but a positive experience (question 23). "Attitude," is a measure with negative, deviant, and disability connotations.

Data Analysis

Descriptive statistics were computed for the questionnaire. Demographic information pertinent to the study included means for age, years of experience working at the Department of Children's Services (DCS), and number of clients on the MSWs' caseloads. Also important to consider was the number of children with ADD/ADHD that were presently on the MSWs' caseloads for comparison with typical prevalence rates of ADD/ADHD in the normal
population of school-aged children. Frequencies for all the questions on the questionnaire were also generated and will be reported as necessary. Cross-tabulations were done using the cause of ADHD (question 6) across both question 10 (enjoy/do not enjoy working with children with ADHD) and question 23 (working with children with ADHD has been nothing but a positive experience).

To test the hypothesis stating that the attitudes of the MSWs are affected by their perception of the cause of ADHD, a t-test was computed using question number 6. To perform the t-test, choices of etiologies for ADHD were recomputed into factors that read either internally caused or externally caused. "Neurological" and "Environmental Causes" were combined to read externally caused etiological factors. "Psychological", "Both psychological and neurological", and "Other" were recomputed to read internally caused. These new categories were computed across the new continuous data factor of "attitude" towards ADHD.

To further test the hypothesis that MSWs' attitudes are affected by their perceived cause of ADHD, three ANOVA tests were performed. All three ANOVA's used the attribution question (question 6). The attitude questions for the ANOVAs were: 1) enjoy treating children with ADHD (question 10), 2) treating children with ADHD has been
nothing but a positive experience (question 23), and 3) the continuous data of the "Attitude" factor question.
CHAPTER FOUR

RESULTS

Descriptive Results

The distribution of gender for the 60 MSWs who participated in the study was 46 females (76%) and 14 males (24%), with a mean age of 43.68 years. The average length of time working for the Department of Children’s Services for the sample was seven years. The mean caseload size for the sample was 21.14 cases, with the mean number of children reported to have ADD/ADHD on the caseloads of 3.34 children (15.7%).

Attribution

When answering question 6 on the questionnaire (what is the cause of ADHD in school-aged children), 14 MSWs (23.3%) reported they believed the cause of the disorder to be neurological, one MSW believed it was psychological, 36 MSWs (60%) said the disorder was a combination both psychological and neurological components, three MSWs (5%) reported that the cause of the disorder was environmental, and six of the MSWs stated the cause was 'Other' (all six of these reported that the cause is a combination of all the mentioned factors).

Responses to question 7, 'What is the best treatment modality for children with attention deficit disorders,' resulted in one response indicating the belief that
psycho-stimulants are the best treatment. Five social workers (8.3%) reported that behavior modification was the best treatment modality, and 52 social workers (86.7%) said that a combination of behavior modification and psycho-stimulants was the best way to treat ADHD.

MSWs overwhelmingly reported that ADD/ADHD is over-diagnosed in school-aged children as 48 of the MSWs (80%) stated they believe the disorders are over diagnosed, and only 12 of the MSWs stated they felt the disorders were not over-diagnosed. Fifty-one (85%) of the social workers reported that psycho-stimulant medications were over-prescribed for children with ADD/ADHD, and nine social workers (15%) said they were not.

The item stating that "parents are most at fault for their children's behaviors" (question 13), was answered as follows: fourteen of the MSWs (23.3%) responded "strongly disagree", thirty-four (56.7%) responded they disagreed, nine (15%) stated it was the parents fault, and three "strongly agree" that parents were at fault for their children's behaviors.

Question 19, which stated "ADD is not a medical problem" was answered as follows: 18 MSWs marked "strongly disagree", 35 marked "disagree", three said they agreed that ADHD was not a medical problem, and two marked "strongly agree".
Attitude

The MSWs in the sample were about evenly divided in their responses to the question asking whether or not they enjoyed working with children with ADD/ADHD (question 10). Twenty-seven of the social workers stated that they did not enjoy working with these children, and 26 of the social workers responded that they did enjoy working with these children. When the social workers were asked if they felt working with children with Attention Deficit Disorders was a positive experience (question 23), 44 (63.3%) of the social workers reported that it was a negative experience, while 12 (20%) said that it was a positive experience.

In response to the item "Children with ADD/ADHD are extremely hard to handle" (question 14), nine of the social workers (15%) marked "strongly agree" and 32 (53.3%) marked "agree", while 17 marked "disagree", and two marked "strongly disagree".

Training and Knowledge

The responses to the question asking whether or not MSWs felt they received enough training from the Department of Children's Services in how to treat and relate to children with ADD/ADHD (question 9) were as follows: 46 of the MSWs (76.6%) felt that they did not receive enough training, and 13 (21.7%) felt that they had
received adequate training to work with ADHD children.
When asked if their co-workers had adequate knowledge
about children with ADD/ADHD (question 12), forty-three of
the MSWs (74%) felt that their co-workers did not have
adequate knowledge about ADHD children, and 16 (26%) said
that their co-workers had adequate knowledge about
children with ADD/ADHD. When asked if schools give
adequate counseling for children with ADD/ADHD, fifty-six
of the social workers (93.3%) felt that schools are not
providing enough counseling for these children, while four
social workers (6.7%) felt that they did.

Research Hypothesis

An independent t-test showed that there was not a
significant difference on the attitude measure between
MSWs who felt that control of behaviors for children with
ADD/ADHD were internal, and MSWs who reported that
behaviors for these children were external (t=.152, df=51
p>.05).

An ANOVA and a Duncan post-hoc test were conducted.
In examining the variable describing whether or not MSWs' experience treating children with ADHD had been either positive or negative (question 23), no significant relationship between the overall experience of treating children with ADHD and the MSWs' etiological perception of the cause of ADHD (question 6) was found (f=1.099, p>.05).
A second ANOVA and Duncan post-hoc test was conducted. In examining the variable describing whether or not MSWs enjoy treating children with ADHD (question 10), no significant relationship between how much MSWs enjoyed treating children with ADHD and the MSW's etiological perception for the cause of ADHD (question 6) was found ($f=1.536, p>.05$).

A final ANOVA and Duncan post-hoc test was conducted. In examining the factor analysis variable 'Attitude' that MSWs hold towards treating children with ADHD, no significant relationship between the overall 'attitude' and the MSWs' etiological perception for the cause of ADHD (question 6) was found ($f=.318, p>.05$).

All three ANOVAs were conducted with one of the categories removed from the question pertaining to perceived cause of ADHD (question 6). This was done because there was only one response to the etiological choice of 'Psychological', which made it impossible to perform a post-hoc analysis.
The research hypothesis that MSW attitudes towards children with ADHD would be related to the perceived cause of the disorder did not gain support in the present study. This differs from previous research with nurses that found significant results when attitudes were measured across the perceived cause of a disorder (Lozano, et al., 1998). There are a number of possible causes for the present outcomes. First, the nurses in the aforementioned study were school nurses and work in a much different environment than do the MSWs in the present study. School nurses traditionally work in a context that requires them to have very limited contact to the children they are treating. More often than not, school nurses' interactions with ADHD children are limited to dispensing pills once or twice a day (Lozano et al., 1998). This could also be due to the fact that school nurses are often responsible for hundreds of children at any given time. MSWs in a Children's Protective Services (CPS) setting on the other hand, have smaller caseloads, visit the homes of the children, and have more prolonged contact with ADHD children on an individual basis and may therefore formed more well-defined opinions of whether or not they enjoy working with these children. Because of the greater
exposure over time, social workers may also gave a more realistic view of what is transpiring in the children's lives. Another viable reason that MSWs might have different attitudes than school nurses about ADHD lies in the world-view adopted by the social work profession. Social workers for the most part are trained in a bio-psycho social model. In the bio-psychosocial model, the social worker takes into consideration the biological aspects, psychological aspects, and the social aspects in their approach to diagnosis and treatment of clients. Nurses, on the other hand, are more likely to develop their diagnosis and treatment plans from a more biological model (medical model). This argument is supported in the MSW responses to the question of perceived etiology (question 6) for the disorder of ADHD. In their responses, sixty percent (n=36) of the social workers reported that it was a combination of psychological and neurological components that caused ADHD. In other words, they felt both internal and external causes were responsible for ADHD symptomatology. In the nurse's study only 39% of the nurses thought that ADHD was a combination of both psychological and neurological components (Lozano, et al., 1998).

Methodological issues may also have clouded the results of the study. First, the question on perceived etiology or cause of the disorder of ADHD (question 6)
cannot be broken into clean categories of internal and external causal factors. For example, neurological problems were equated to signify external causation, and psychological causation was equated to internal factors. This might have been appropriate if it were not for the use of the choice that allowed respondents to choose both neurological and psychological components, a factor of internalized causation/fault of the child. Instead, it would have been preferable to have a clear dichotomy between the choices of internal and external attribution of ADHD.

A second methodological issue is that the overall design for the questionnaire resulted in a lack of internal consistency (α=.28). The instrument appeared to possess sound face validity, but lacked the content validity necessary very to measure the variables under consideration.

One expected finding that did emerge from the data was children with ADHD are found in large numbers in MSW caseloads of San Bernardino County social workers. In the study, the average caseload size was 21.14 cases with 3.34 ADD/ADHD cases on each caseload. The percentage of children with ADD/ADHD was computed to be 15.7%. Furthermore, treatment of the large number of children with ADHD on MSWs' caseloads in the study was further
Department of Children's Services felt that neither they nor their co-workers were getting enough training in working with children with ADHD.

One pattern that repeatedly emerged in the data was that of the respondents having conflicting opinions. For example, when asked whether they believed psycho-stimulants were over-prescribed for school-aged children, most MSWs (85%) believed that psycho-stimulants are over-prescribed for children with ADHD. At the same time, most of the MSWs (86%) stated that a combination of psycho-stimulants and behavior modification was the best treatment for ADHD. This leads to internal conflicts in that on the one hand the MSWs are stating that too many psycho-stimulant are being dispensed and on the other hand it is part of the best treatment. Furthermore, the added factor that 80% of the social workers thought that ADD/ADHD are over-diagnosed, a pattern emerges that could only cause a dissonance in the MSWs who participated in the study.

Another example of possible internal conflicts when considering children with ADHD emerged in the questions regarding whether or not children with ADHD need special schools and whether or not children with ADHD are offered adequate counseling in their schools. On the one hand 93% of the social workers felt that children with ADHD did not get adequate counseling at their schools. However, at the
same time 85% felt special schools were not necessary for these children. The rhetorical question that comes to mind is that if children are not offered adequate counseling in the existing classroom/school might it not be better to have them in a different classroom/school?

Finally, is not surprising from the patterns that emerged from the data, that the MSWs answered heavily (73%) in the direction of negative attitudes about the experience of treating children with ADHD Question 23. At the same time, the MSWs, for the most part, were equally divided about whether or not they enjoyed treating children who are diagnosed with ADHD. Forty-five percent of the social workers said they did not enjoy treating a child with ADHD, whereas 43.3% of the social workers reported enjoying treating the child with ADHD.

Implications for Social Workers

One of the first implications for MSWs in a CPS-type setting is the need for more adequate training to deal with children with ADD/ADHD. The data in the study showed that the MSWs felt that they did not know enough about treating children with ADHD and that neither they nor their co-workers have adequate knowledge to engage in the treatment of children with ADHD. As mentioned previously, when a mental health professional has to make a treatment plan and the internal and external cues are distorted or
confused, he or she is more likely to make errors in treatment and have difficulties working on a treatment team (Elstein, et al., 1978).

One of the more important roles of CPS workers is that of co-coordinating services of a wide variety of disciplines. It would be extremely difficult for a social worker to work as a facilitator of services for a child with ADD/ADHD without a good knowledge base of the complexity of issues surrounding the necessary treatment of such children. In fact, it seems important for MSWs to assume the role of educator to fellow team members when it comes to working on a case that involves a child with ADD/ADHD. Another implication for MSWs, though it did not exhibit itself statistically in the data, is for the MSW to keep close watch on his or her attitudes towards children with ADD/ADHD, as to not allow those attitudes to be swayed by judgments whether correct, confused, or complicated.

Further research, if it is done, should be directed at more clearly understanding how Social Workers attitudes might affect their treatment plans or ability to work with certain types of clients. In the present research, the questionnaire did not tap effectively into what the internal and external attributions for childhood attention deficit disorders might be. For example, clear lines of attribution are hard to draw when you ask whether a
problem is either psychological or neurological. It might be more effective for future research would be to more directly ask the social workers where the cause of the disorder originates. For example, one might ask the social worker if ADHD behaviors are either the fault of the child or not the fault of the child, and are ADHD behaviors brought on by external causes or internal causes.

Attitude towards children with ADHD was also not clearly measured in the study. In the study, attitude was measured by the both experience of working with children with ADHD and whether or not the social workers enjoyed working with children with ADHD. Better questions might have included queries such as: If you know that a child is acting out, will you be willing to work with the child? If the problem is neurological, environmental, inherited, or parentally caused, will you enjoy working with the child?

Another possibility for better discerning attitudes is to provide vignettes for the social workers that present typical situations that might occur on their cases-loads and how those situations might affect their attitudes towards children with ADHD. For example, providing a vignette in which the child has been diagnosed with ADHD by a pediatrician and has been prescribed medications and comparing this situation to a vignette in which the child to act out at school even though on the medications, could provide a better assessment of
attitudes. By doing the research with vignettes instead of direct questions, more in depth and meaningful responses as to the attitudes that social workers have towards children with ADHD might be acquired. Furthermore, by using qualitative measures and responses, test taker biases might be circumvented in the case where the MSW is being asked whether or not they enjoy working with children with ADHD.
APPENDIX A:

DIAGNOSTIC CRITERIA
Diagnostic Criteria for ADD/ADHD

Either (1) or (2)

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
1) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
2) Often has difficulty sustaining attention in tasks or play activities
3) Often does not seem to listen when spoken to directly
4) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
5) Often has trouble organizing tasks and activities
6) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork and homework)
7) Often loses things necessary for tasks or activities (toys, school supplies)
8) Is often distracted by extraneous stimuli
9) Is often forgetful in daily activities.

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
1) often fidgets with hands or feet or squirms in seat
2) often leaves seat in classroom or in other situations in which remaining seated is expected
3) often runs about or climbs excessively in situations in which it is inappropriate
4) often has difficulty playing or engaging in leisure activities quietly
5) is often "on the go" or often acts as if "driven by a motor"
6) often talks excessively
7) often blurts out answers before questions have been completed
8) often has difficulty waiting turn
APPENDIX B:

SAMPLE QUESTIONNAIRE PACKET
Dear Department of Children's Services Worker:

Helping children with ADD/ADHD is a significant part of a social workers' caseload in Children's Protective Services settings. We are asking you to help us find out more about how social workers think about their clients with ADD/ADHD. Hopefully, this knowledge will enable social workers to be more effective in creating both work environments and treatment plans that are more conducive to the treatment of children with ADD/ADHD.

Please complete the enclosed questionnaire about social workers attitudes and roles in working with ADD/ADHD in a Department of Children's Services context. Complete the questionnaire at your earliest convenience and return it to us in the enclosed postage paid envelope. Participation in the study is completely voluntary and you can withdraw at any time. Your answers will be completely anonymous, and used in aggregate with those of other social workers for research purposes only.

Diagnosing and treating children with ADD/ADHD, as you well know, is often both complicated and time consuming. Your truthful answers to these questions will help researchers such as ourselves to develop both better strategies and treatment modalities for helping these children in a Children's Protective Services environment. Without experts like you, we would be unable to accomplish
the goal of learning more about social worker attitudes and roles in a Department of Children's Services environment.

Sincerely:

Robert Perry MSW

Student
The following questions are designed to facilitate a better understanding of MSW's working at the Department of Children's Services and their attitudes and knowledge about Children with Attention Deficit Disorders.

Demographic information: Please fill in the correct answer.

1. Age _____
2. Sex 1. male _____ 2. female _____
3. How many years have you worked in DCS? _____ yrs.
4. How many case files do you carry at present? ____
5. How many case files do you carry at present that include Children with ADD/ADHD? ____ in the past year ____?

Knowledge and Attitudes about Attention Deficit Disorders. Please either circle or fill in the answer you feel is the most correct.

6. Do you feel that ADD is mostly a disorder that is caused
   1. neurological components
   2. psychological components
   3. both psychological and neurological components
   4. environmental components
   5. other, specify ___________

7. What do you think is the best treatment modality for ADD/ADHD?
   1. stimulant medications
   2. cognitive therapy
3. behavioral modification
4. combination of _______ and _______

8. Who should be the person most responsible for diagnosing and administering treatment for children with ADD/ADHD?
   1. school psychologists
   2. social workers
   3. pediatricians
   4. other ______

On a scale of 1 to 4 with 1 being strongly disagree and 4 being strongly agree rate the following by circling the answer that you feel is the closest to the truth.

9. Department of Children Services provides adequate training about children with ADD.
   Strongly Disagree   Disagree   Agree   Strongly Agree
   1     2     3     4

10. I enjoy having children with ADD/ADHD on my case load.
    Strongly Disagree   Disagree   Agree   Strongly Agree
    1     2     3     4

11. Children with ADD/ADHD should be taught to behave.
    Strongly Disagree   Disagree   Agree   Strongly Agree
    1     2     3     4

12. My co workers have adequate knowledge about children with ADD/ADHD.
    Strongly Disagree   Disagree   Agree   Strongly Agree
    1     2     3     4
13. Parents are most responsible for their children's ADD/ADHD behaviors.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

14. Children with ADHD are extremely hard to handle.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

15. Schools provide adequate counseling for children with ADD.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

16. ADD/ADHD are over diagnosed in school aged children.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

17. ADD/ADHD is a disability.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

18. ADD/ADHD children on my case load make up a disproportionate percentage compared to the general population.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4

19. Attention Deficit Disorders are not a medical problem.
Strongly Disagree  Disagree  Agree  Strongly Agree
1  2  3  4
20. Children with Attention Deficit Disorders are best served with a team approach.

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21. Psycho-stimulant medications are over prescribed for school aged children.

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22. Our school systems expect too much from school-aged children.

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23. Working with children with ADD/ADHD has been nothing but a positive experience.

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24. Attention Deficit Disorders are found mostly in poor families.

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25. Children with ADD/ADHD should go to special schools.

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Social Worker Attitudes Towards Children with Attention Deficit Disorders

Debriefing Statement

The study you have just completed was designed to investigate Social Worker attitudes towards children with Attention Deficit Disorders. In the study, the perceived cause of Attention Deficit Disorders were accessed and then weighed against the feelings that social workers might have about working children that have the ADD/ADHD type disorders. Furthermore, the attitudes were also weighed across the length of time that MSWs have been working in a CPS setting with the hope of seeing if there is some sort of correlation between time of service and attitudes towards children with ADD/ADHD. We are interested in these relationships because if attitudes about treating children with ADD/ADHD are affected by either length of service in a CPS setting or perceived cause of ADD/ADHD disorders, then it might be necessary to address these issues in either educational or training settings. Please do not share your comments with other MSWs at this time because doing so might affect the results of the study.

Thank you once again for your participation and I look forward to hearing from you if you have any further questions or ideas. Results for the study should be available in one to two months. If you become distraught
or upset in any way due to your participation in the study you can call the California State University Counseling Center at (909) 880-5040 and through the San Bernardino Department of Behavioral Health at (909) 387-7053. I look forward to having your input and I can be reached at either (909) 796-9443 or Rperry745@cs.com.

Sincerely,

Robert Perry MSW Student
REFERENCES


Power, T. J., Atkins, M. S. Osborne, M. L., & Blum, N. L. (1994). The school psychologist as manager of
programming for ADHD. School Psychology Review, 23, (2) 279-291.


