TEACHERS' PERCEPTIONS AND MANAGEMENT OF HYPERACTIVE CHILDREN IN EARLY CHILDHOOD PROGRAMS

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CHAPTER I

INTRODUCTION

In the past 20 years the number of children in early childhood programs has dramatically increased. There has been a new awareness of the emphasis on learning in the preschool years. The placement of children in preschool programs has also risen due to the increase of mothers with children under six years of age in the labor force. The statistics for 1948 (Women's Bureau, 1975, p.27) showed only 13 percent of working mothers with children under six years old. By 1974 that figure rose to 36.5 percent (Women's Bureau, 1975, p.27). According to Roby (1973),

> After years of neglect the United States is now turning its attention to infant and early childhood development programs. Child care is attracting increasing attention because of the American economy's growing dependency upon working mothers, the rise in single-parent families, and parents' increasing recognition that their young children benefit from good group experiences and early education (p.3).

As does any social agency or phenomena, these programs have experienced problems, which perhaps are magnified by their relative newness. The problems in quality child care have included overcrowding of children in less than adequate facilities, lack of financial support, untrained teachers working with the children, and an increasing number of exceptional children (such as those labeled "hyperactive") in the programs.

In recent years concern over and knowledge about children with learning disabilities has come into focus. Renshaw (1975, p.145-146) pointed out "widespread, general recognition of this syndrome is barely

ten years old. It was only unfolding as a recognized entity in medical literature in the mid-1950's." Wender (1973, p.3) identified the growing problems of hyperactive children, stating "there are probably 5 million hyperactive children in the United States. Exact figures are not available, but it seems likely that as many as 5 percent of school age children have hyperactive problems." Walker (1974, p.43) also noting the high incidence, reported that "hyperactivity has become an epidemic in this country."

Our educational system has moved toward the identification of the individual's needs and planning programs to meet those needs. Modern technology, more recently the computer, has been instrumental in making this possible. Extensive testing of children has been done to identify their development and future potential. These testing procedures often reveal more than just children's various intelligence stages. Also uncovered may be specific difficulties the child has in his or her learning abilities. Classroom observations by teachers and other professionals may also indicate that the child's capabilities deviate from the norm. "Hyperactivity" is one of the types of educational problems which can be observed in the classroom situation. The "hyperactive" child is, according to Stewart (1970, p. 94), "continually in motion, cannot concentrate for more than a moment, acts and speaks on impulse, is impatient and easily upset." The aspect of constant motion is a primary problem of concern for those who are in contact with the "hyperactive" child. Safer and Allen (1976, p. 145) stated "most teachers will face the problems of classroom management of hyperactive children."

Several methods of management of these children have been employed. These include control of diet, behavior modification, psychosurgery,

psychotherapy, and drug treatment. Perhaps because drugs as treatment are not fully understood, they have received widespread attention by educators, medical doctors, psychologists, and parents. One example of the concern about drug therapy was cited by Ladd (1970, p. 66), "Americans were jolted to learn that doctors in Omaha, Nebraska, are giving hundreds of school children so-called behavior modification drugs, to 'make them behave better in school'."

Safer and Allen (1976, p. 129) remarked "the school is usually the first to publicly single out the hyperactive child for his behavioral problems." Because the school has been in this role, it could be of importance to assist early childhood teachers to identify and help children. Safer and Allen (1976, p. 16) have also pointed out that "a careful history reveals that most hyperactives have a preschool history of restlessness and inattentiveness, the essential and the most frequently associated major feature of hyperactivity." In her book The Hyperactive Child, Renshaw (1975) emphasized the need to recognize hyperactive children at preschool age.

> A definite cluster of signs and symptoms make this condition rapidly recognizable. Screening programs at preschool or kindergarten level are needed to identify the thousands of little ones at high risk and who need further evaluation and work-up for definitive diagnosis and treatment planning (p. 5).

The importance of treatment at the earliest age possible for the "hyperactive" child has been recommended by Baker (1977).

With the placing of so many more children in early childhood programs, it should become possible for teachers to identify more "hyperactive" children earlier. But these teachers must have the ability to make referrals correctly and aid in diagnosis and treatment. Conrad (1976, p. 25), in recognizing the importance of the teacher in this position stated

"future studies should make greater efforts to interview teachers involved in identifying hyperactive children."

This study was concerned with the presence of the 'hyperactive" child in an early childhood program and the resulting problems of the child's presence in the program. The study was also necessary to discover teachers' need for information on how to effectively work with the "hyperactive" child.

Purpose and Objectives

The purpose of this study was to identify teachers' perceptions of and attitudes toward "hyperactive" children in early childhood programs and examine the guidance techniques teachers use with the "hyperactive" children. The specific objectives of this study were:

1. To determine if teachers in early childhood programs believe there to be "hyperactive" children in their programs.
2. To identify descriptive factors which teachers report to be related to these "hyperactive" children:
    a. age of child
    b. diagnosis of hyperactivity by medical personnel
    c. medication prescribed for behavior control
    d. change in child's behavior due to medication
    e. acceptance of child by peers
    f. ordinal position of child in the family
    g. quality of child's relationship with parents
    h. income level of child's family
    i. description of child's living arrangements
3. To obtain teachers' perceptions of "hyperactive" behavior in

children.

4. To obtain information concerning teachers' perception of problems in the classroom caused by children whom they judge to be exhibiting "hyperactive" behavior.
5. To examine reports of teachers' guidance techniques with "hyperactive" children:
    a. to identify the guidance techniques teachers use
    b. to examine the effectiveness of these guidance techniques
    c. to examine the relationship between training for working with special children and its benefits in identifying and managing the "hyperactive" child
6. To inquire if teachers want additional information and training about how to work with "hyperactive" children.

Assumption

The assumption of this study was:

1. The questionnaire respondents have had sufficient work experience in early childhood programs to enable them to have encountered a wide range of development in children.

Limitations

The limitations of this study were:

1. Not all of the teachers participating in the study will have the same knowledge and training with which to identify "hyperactive" children.
2. The study is limited by the inherent weakness of the instrument. Van Dalen (1962) pointed out that inventory type questionnaires

do not require subjects to perform at their maximum level, and a subject may give false responses either because he wishes to make a desired impression or because he lacks sufficient insight to make objective responses.

3. The questionnaire respondents' beliefs and perceptions may be temporary, changeable, and subject to rationalization.

CHAPTER II

REVIEW OF LITERATURE

Introduction

During approximately the same time span, Early Childhood Education and the "hyperactive" syndrome in children have received increased recognition of their importance. Teachers, along with other professionals, should be qualified to identify and guide the "hyperactive" child. Because many of the children labeled "hyperactive" can be helped through early intervention, it has become important that Early Childhood teachers be knowledgeable in the area of "hyperactivity" in young children.

The purpose of this chapter is to reveal several facets concerning the "hyperactive" child which the review of literature indicates are important. The review contains sections on: the definitions and characteristics as they relate to "hyperactivity"; the various causes of the "hyperactive" syndrome; important factors which should be considered in relation to identifying the "hyperactive" child; information in the area of treatment, including drug therapy and behavior modification, and guidance techniques.

Definition and Characteristics of "Hyperactivity"

The concern of this study was with teachers' perceptions of "hyperactive" behavior in young children. However, there was not one specific set of symptoms which defined this behavior. Children labeled "hyper-

active" can be classified according to varying degrees of manifestation of the syndrome. Indeed, it has been difficult for all those associated with the children who are called "hyperactive" to agree on the labeling term of this behavior problem. Many names have been assigned, including minimal brain dysfunction, hyperkinesis, hyperkinetic disorder, learning disability, hyperactive child syndrome, Strauss syndrome, and hypoglycemia, which all refer to a relatively synonomous meaning. Some authors have made a distinction between "hyperactive" children and those children afflicted with hyperkinesis (Jordan, 1972) or hyperreactivity (Marwit & Stenner, 1972). Still others have cited the quality of the child's activity as the prime concern (Forness, 1971; Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young Children, 1971). The labeling process has been a difficult one and its outcomes are not always positive. However, Payne, Kauffman, Brown, and De Mott (1974), recognized the

> . . . need to classify people in order to avoid total confusion and miscommunication. When labels are based on objective and relevant criteria, are applied by responsible professionals, and are used to communicate essential information about an individual, they can even be helpful to the individuals involved (p. 12).

The basic definition of "hyperactivity" has dealt with the amount of movement in which the child engages. "By definition, hyperkinesis refers to motor activity in excess of the range normal for age and sex" (Eisenberg, 1966, p. 593). For use in this study, the term "hyperactive" child means "a child who shows involuntary and constant overactivity which greatly surpasses the normal" (Laufer and Denhoff, 1957, p. 463). According to Gilmore (1975, p. 95) "His [the hyperkinetic child's] is not simply the ebullience of childhood, but a pathological state so severe that he literally cannot sit still or concentrate for more than a

few seconds."

Ellingson (1970, p. 67) described "hyperactive" children "as youngsters who live [with] an 'internal tornado' that is constantly threatening to break out." "Typically a child with this ['hyperactive child'] syndrome is continually in motion, cannot concentrate for more than a moment, acts and speaks on impulse, is impatient and easily upset" (Stewart, 1970, p. 94). "These are children who will be observed by their teachers to be fidgety, restless, easily frustrated, hard to manage, and unable to sit quietly" (Schrager & Lindy, 1970, p. 448).

There have been several symptoms which many authors consistently use to describe the "hyperactive" child. They have included excessive motor activity, distractibility, impulsivity, and excitability (Werry, 1968; Stewart, Pitts, Craig, & Dieruf, 1966; O'Malley & Eisenberg, 1973; Stewart & Olds, 1973).

Other characteristics found as major behaviors associated with hyperkinesis by Marwit and Stenner (1972), were low frustration tolerance, short attention span, and overly aggressive. Schrager, Lindy, Harrison, McDermott and Wilson (1966, p. 636), reporting the behaviors of "hyperactive" children as rated by pediatricians, teachers, psychologists, psychiatrists, and social workers, stated that "75 percent or more of all groups felt these six behaviors to be primary: fidgets and restless, inattentive, hard to manage, can't sit still, easily distracted, and low frustration." Also rated by 50-75 percent of the sample were "anxiety, no self-control, and nervous." Similarly, Cantwell (1975, p. 58) stated "low self-esteem, poor self-image, depression, and a sense of failure are common."

Shiever's (1974, p. 42) study "established that teachers and

teacher trainees do possess a stereotype of hyperactivity." Her data showed that:

> The items identified as components of the stereotype seem to support the conclusion that teachers and teacher trainees are primarily concerned with disruptive classroom behavior. Three of these items . . . are short attention span, excessive movement, and impulsiveness (p. 41).

Price (1973) also found that graduates from and students in a university program for training early childhood teachers reported they needed more adequate preparation to meet the needs of the hyperactive child. From these two studies, one can conclude that teachers and teacher trainees believe they have worked with "hyperactive" children.

While it has been profitable for professionals to label children so that their needs can be better served, there has always been the possibility of misdiagnosis or application of an unnecessary label. The current treatment of "hyperactive" children with behavior-modifying drugs has made the area of correct identification even more important. Most young children very actively and joyfully explore the world. But "hyperactive" children's activity level has gone beyond this to the extreme so that they are not able to contain their constant motion or profit from learning opportunities. The adults responsible for diagnosing the "hyperactive" child must be able to make the distinction. Walker (1974) stated:

> We must also keep in mind that hyperactivity can be a convenient label for children who are hard to control for other reasons. Frequently a rigid school teacher sees a normal, active, curious child as overactive (p. 48).

The Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children (1971) found:

> Essentially healthy children may have difficulty maintaining attention and motor control because of a period of stress in school or at home. It is important to recognize the child

> whose inattention and restlessness may be caused by hunger, poor teaching, overcrowded classrooms, or lack of understanding by teachers or parents (p. 3).

Holt, cited in Henthoff, (1970) has advocated a cautious approach to labeling.

> Children have a great deal of energy; they like to move about; they live and learn with their muscles and bodies, not just their eyes and ears. When adults try to compel them to remain still and silent for long periods of time they resent and resist it (p. 33).

Renshaw (1975) also made the distinction between a normally active child and one who is occasionally overactive.

> The fact that a child is able to sit still when interested; to concentrate when involved with a specific task; to complete it without being excessively distracted, is an important clue that the episodes of fidgeting and preoccupation do not indicate a true 'Hyperkinetic child' . . . (p. 37).

Causes of "Hyperactivity"

"Hyperactivity" has been one of the most noticeable learning disabilities because of the obvious abnormality in the child's behavior. Yet, while it has been relatively easy to diagnose and even prescribe some treatment for "hyperactive" children, it has been very difficult, in most cases, to determine what causes true "hyperactivity". Renshaw (1975, p. 96) pointed out this fact when she stated "much more is known about how to treat hyperkinetic reaction than why it occurs."

According to the Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children (1971)

> We know little about definitive causes. The disorder has been ascribed to biological, psychological, social or environmental factors, or a combination of these . . . in many instances, it is not yet possible even to speculate as to original causes (p. 2).

Cantwell (1975, p. 12) agreed as he wrote that "It is likely that many different etiologic factors, either alone or in combination, can lead to the syndrome."

The authors who did report possible clues to the cause of "hyperactivity" vary widely in their opinion as to its etiology. In some of the earliest studies done on the cause of "hyperactive" children, Laufer, Denhoff and Solomons (1957) found a physical anomoly: dysfunction of the diencephalon.

> Such dysfunction . . . exposes the cortex to unusually intense storms of stimuli from peripheral receptors coming through the diencephalon and the reticular activating system and may interfere with the function of the cortex and its relationship with diencephalon (p. 48).

According to Jordan (1977), supporting the theory of physical deficiency,

> Medical science has not yet determined the exact nature . . . at times the disability behaves like an allergic state of nerve tissues. Sometimes hyperkinesis appears to be a state of underdeveloped nerve tissues. In this case it appears that the insulating sheath surrounding nerve fibers was not fully formed at birth.

Feingold (1975) has reported that a child's diet may be the cause of "hyperactivity". He has theorized that many "hyperactive" children have developed the condition because of food additives, specifically artificial colors and flavors and the preservative, BHT. He thinks that the tendency for "hyperactivity" is inborn and by eating certain foods, children irritate this condition. In reporting the findings of one of his studies, Stewart (1970) related these results:

> The patients [hyperactive children] did tend, however to have a history of feeding problems, disturbed sleep and generally poor health in the first year of life, and many had been handicapped by delayed development of speech and poor coordination. All of this suggested the possibility of inborn difficulties (p. 97).

From the behavioral point, the cause of "hyperactivity" has stemmed from a conditioned environmental basis. Anderson (1964, p. 48) stated in his study, "since hyperactivity can be 'shaped out' experimentally, it is reasonable to assume that at some time it has been shaped in."

Cantwell (1975) examined the genetic factors which purportedly played a role in the "hyperactive" child syndrome and reported:

> Very little evidence is available on the effect of the family environment on the hyperactive child. What little evidence there is suggests that certain familial variables do affect the long-term outcome of children with the syndrome (p. 103).

Similarly, Renshaw (1975, p. 39) said "very rarely does a child show symptoms without there being causal or resultant problems in other members in the family." Ellingson (1970) proposed the cause of "hyperactivity" to be:

> The central nervous system requires a variety of trace chemicals, secreted by the body, in order to function in normal fashion. The absence or inadequate supply of some of these chemical elements makes normal functioning of the central nervous system, and consequently of the individual, impossible (p. 67).

Walker (1974) has expressed another point of view. He pointed out that those persons involved in the diagnosing of the "hyperactive" child must treat each child's case entirely individually without simply relying on one of the standard causes. He gave several examples of "hyperactivity" that could have been dismissed if the patient had simply been treated with Ritalin without further investigation into the cause of "hyperactivity". A summary of these examples and causes follows:

1. A 5-year-old girl with a heart problem that resulted in a lack of oxygen.
2. An 8-year-old boy with a low level of glucose.

3. A 9-year-old boy with a calcium deficiency.
4. A 10-year-old boy with brain lesions causing subtle seizure activity.
5. A 7-year-old boy with mixed dominance of the brain which resulted in dyslexia and behavior problems.

Each of these children had been labeled as "hyperactive" previous to their encounter with Walker and yet he showed none of their "hyperactive" problems result from the causes reviewed in this chapter.

Identification of the "Hyperactive" Child

The emphasis of this study was on the presence of the "hyperactive" child in an early childhood program. One of the specific objectives was to determine if teachers in early childhood programs believe there to be "hyperactive" children in their programs. Stated in different terms, one of the objectives was to determine if teachers identified some of the children in their early childhood programs as exhibiting "hyperactive" behaviors. The literature review shows that many children have been identified by a variety of persons as "hyperactive" in their preschool years.

The majority of "hyperactive" children have not been identified as such until enrollment in public school at the age of five or six. Two major factors contribute to the diagnosis being made at this particular time. One is because the parent may have been interacting with the child on a one-to-one basis. With the necessary attention, the child's hyperactivity is not nearly as noticeable as when he/she is placed in an environment with many other children and few adults. As Minde (1971, p. 7) reported, "they must sit still longer, must concentrate more and receive

less individual treatment" at school than at home. The parents may also have no previous experience against which to judge the child's behaviors and, therefore, while recognizing that the child is extremely active, think that all children behave in this manner. Conrad (1976, p. 35) expressed this belief as he wrote "parents normalize behavior because they do not have ready conceptual categories for deviant behavior (as professionals do) and, at least at first, have a vested interest in seeing the behavior of their child as 'normal'." A concurring opinion has been written by Ross and Ross (1976) who believe that the child may not be identified during the preschool years because

> . . . the type of environmental pressures that exacerbate it to the problem level are absent, the household may be so chaotic that the behavior passes unnoticed, or the parents are so tolerant or inexperienced that the behavior is not viewed as unusual (p. 23).

Cantwell (1975) commented about this factor when he stated:

> It is when the hyperactive child reaches the school system that the diagnosis is most often and most easily made. Behaviors which were disturbing, but tolerable in the home setting are not so easily tolerable in a classroom setting (p. 10).

The second reason that many children are identified upon entering school has been explained by Renshaw (1975).

> . . . the greatest peak of recognition of the 'hyperactive' child is between five and seven years of age, when the child is expected to conform to the norms of other children of his own age in the kindergarten or first grade setting (p. 3).

Safer and Allen (1976) also wrote why they believe children are identified as "hyperactive" at school age.

> For the child, his hyperactive pattern first becomes an obvious problem for life-adjustment in the classroom. Here he faces failure, punishment, and behavior demands for attention and motor inhibition unparalleled elsewhere in his life (p. 145).

In a discussion about teachers as identifiers of the "hyperactive" child, Conrad (1976, p. 44) concluded "the school is a better identifier of hyperactivity than parents and has definitions of hyperactivity more congruent with prevailing medical definitions than do parents." Renshaw (1975, p. 3) reported on teachers identifying the "hyperactive" child as she stated "it is entirely expectable and quite appropriate that teachers should recognize and attempt to assist the excessively hyperactive child . . ."

The teachers generally referred to in the literature are those employed in the public school sector. Ross and Ross (1976) discussed how the teacher's report has helped the pediatrician to diagnose the "hyperactive" child. This report has in the past not been available until the child reached public school. However, with the growth in concern over "hyperactive" children and the increase of children in early childhood programs, the teacher of the pre-school aged child can aid in identification of the "hyperactive" child.

Much has been written concerning the possibility of the "hyperactive" child being identified before reaching elementary school. Cantwell (1975) has reflected on this issue:

> The typical child with the hyperactive child syndrome is generally brought to professional attention early in his elementary school years. However, careful questioning usually reveals symptoms present from early childhood (p. 5).

Another comment by Cantwell (1975, p. 22) has indicated that he believes "it is highly unusual for a classic hyperactive child to go unnoticed by anyone until the age of six, seven or eight years old." Laufer and Denhoff (1957, p. 464) have written that abnormal behavior may not be readily observed until the child begins to walk and "may then seem to burst into an ever-widening circle of activity." A report from Stewart

(1970, p. 96) has indicated that "the hyperactive children's troubles had generally started at a very early age. About half of the mothers had begun to notice that their child was unusual before he was two years old." Stewart and Olds (1973, p. 195) suggested "problems with school may appear in nursery school . . ."

Treatment of the "Hyperactive" Child

Various methods of treatment have been employed in managing the "hyperactive" child. These range from 1) examination of the child to identify internal causes to 2) ignoring the cause and proceeding with treatment of the individual's behavior. The literature review showed a wide variation in types of treatment and discrepancies in the success of the treatment. The type of treatment recommended depends in part upon who is dealing with the child. Whereas doctors or other medical personnel may be inclined to prescribe drugs for control of the "hyperactive" child, parents and teachers may employ environmental changes or behavior modification methods to help the child control his/her behavior. Regardless of the type of treatment, Sulzbacher (1975) stated:

> . . . it is crucial in the long run that the child be consistently reminded that the ultimate responsibility for how he behaves is his own, that he is fully accountable for it, and that regardless of any treatment prescribed by physicians, teachers, or parents, the important decisions are still up to him (p. 941).

Cantwell (1975, p. 173) pointed out the most important factor involved in any treatment program when he stated "treatment must be individualized and based on a comprehensive assessment of each child and his family." In agreement with Cantwell, Walker (1974) wrote

> . . . the hyperactive child's problem can almost always be identified and treated if the physician is willing to take the time and trouble to run thorough diagnostic tests and

evaluate the resulting quantitative data (p. 43).

Werry (1968) has also devoted his attention to the matter of diagnosis being an important consideration in treatment. He concluded:

> The physician has to remember that the goal with the hyperactive child is not to make an ordinary medical diagnosis, but rather to make an adequate assessment of his behavior, his intellectual and cognitive functioning and his family environment (p. 587).

Fish (1971, p. 115) addressing the issue of drugs as treatment and their relation to adequate diagnosis, remarked "It is poor treatment if children are given medication without having had an adequate diagnostic evaluation for the educational problems . . ." Millichap (1968, p. 1527) found that "drugs are useful in the symptomatic treatment of hyperkinetic and perceptually handicapped children, but their administration should be preceded by a careful clinical evaluation."

Minde (1971, p. 14-18) suggested three major types of management of the "hyperactive" child's behavior, "1) Medical management 2) Educational management 3) Environmental management." According to Bax (1972, p. 86) doctors "can play a most valuable role in the school helping teachers . . . to approach children individually and to understand the nature of their problems." Thus, medical management does not always have to be drug therapy. However, Cantwell (1975, p. 173) explained that drug treatment has been "the easiest, least time-consuming and most frequently used intervention technique in the management of the hyperactive child."

Combining the areas of medical and educational management, Forness (1971, p. 163) commented "it is particularly important for the physician to involve the child's teacher in monitoring any program of medication." Safer (1971, p. 494) remarked "to say, as some do, that only the parents

and the prescribing doctor are involved is to deny the obvious major school aspects of the problem." Safer and Allen (1976, p. xi) "concluded that for hyperactive children the school is a vital area for management intervention." Chess (1960, p. 2380) wrote, "In school, these children require special recognition by the educational staff of their need for release of motor drive so that a successful school experience can ensue." Forness (1971, p. 160) stated "indeed, each hyperactive child should be dealt with according to his or her own level of readiness for classroom functioning."

Two types of methods employed as environmental management are special diets and behavior modification. Feingold (1975) theorized that hyperactivity is an allergic reaction. He has found that:

> . . . this is the circumstance which exists with a genetically predisposed group of the HLDS: [hyperactive learning disability] children within this specific group suffer adverse reactions triggered by one or more chemicals contained in the synthetic flavorings and colorings (p. 143).

When these natural salicylates and synthetic irritants are removed from the child's diet the child's behavior improves.

"While behavior modification has not been used extensively with hyperactive children, it is clear that such approaches to classroom management and motivation have demonstrated their usefulness," pointed out Forness (1971, p. 167). Safer and Allen (1976, p. 132-133) have written ". . . behavior therapy has repeatedly been of demonstrable benefit for the classroom behaviors of misbehaving, learning-impaired children."

Werry (1968, p. 594) stated the behavior modification principle in practical terms. He explained that the "hyperactive" child's manipulation of people and systems "can be avoided only by a well-defined rule system with liberal reward for good behavior (by praise and attention)

and prompt and just punishment (such as isolation) for deviation from the rule system."

Papalia and Olds (1975, p. 474) suggested "parents and teachers can often help hyperactive children to do better at home and in school through the use of a variety of special techniques." Several sources have provided guidelines for planning an environment conducive to the control of hyperactive children (Eisenberg, 1966; Renshaw, 1975; Chess, 1960; Day Care 8 Serving Children With Special Needs, 1972). Baker (1977, p. 15) capsulized the scope of the management guidelines when she wrote, "The program should be structured so that the child has the freedom to be active. If the child can't sit still as long as the other children, don't expect him to."

The use of stimulant drugs to treat "hyperactive" children has caused controversy among persons involved with these children. Bradley (1937) reported the use of stimulant drugs for the treatment of hyperactivity. Safer (1971) emphasized that

> . . . 5% of school children show a consistent pattern of developmental hyperactivity, inattentiveness and a learning deficit; between 35 to 60% of these children show a dramatically beneficial response to stimulant medication . . . (p. 444).

The Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children (1971, p. 4) stated "when the medication is effective, the child can modulate and organize his activities in the direction he wishes." "The primary object of medication is not to calm the child" wrote Oettinger (1971, p. 165). His remarks continued, "rather it is to improve the functioning of the brain so that the child becomes more normal in his thinking and responses, and thus, secondarily, his behavior reverts to normal."

Fish (1971, p. 114) explained that the drugs stimulate and bring up the central nervous system activity from being under-aroused to a normal level. "In general, the basic response to stimulants is a heightening of central nervous system activity." When the normal level has been achieved "the children act calmer and less restless."

Ellingson (1970) has displayed opposition to those who believe drug therapy should not be used with "hyperactive" children. She stated:

> For it would be a disaster if a fearful and uninformed public response to sound, though unfamiliar, medical-educational practice were to sweep away the only chance that a great many children have to function normally in the classroom (p. 67).

Stewart (1970, p. 98) has suggested primarily limited use of drugs to treat "hyperactive" children. He stated "we therefore employ drugs only to enable a hyperactive child to make a good start in school and prevent him from becoming resentful and insecure."

Jordan (1972) reported teachers as advocates of drug therapy for "hyperactive" children.

> Teachers who have witnessed the remarkable transformation in classroom behavior through this medication [Ritalin] advocate its use. Ritalin can make the difference between bedlam and order. With this kind of relief available for hyperkinetic youngsters, teachers see little logic in the protests that are raised against medication in the classroom (p. 141).

Safer and Allen (1976) expressed a similar opinion concerning teachers favoring the use of drugs.

> . . . administrators and teachers who have seen the dramatic effects of stimulants on hyperactive children tend then to advise the parents to take the child to the family doctor. They would like the hyperactive-misbehaving student medicated to improve the child's educational adjustment and for the sake of classroom harmony (p. 233).

Shane and Shane (1969, p. 30) forecasted that "new drama will play on the educational stage as drugs are introduced experimentally to improve

in the learner such qualities as personality, concentration, and memory."

The use of drugs, most commonly methylphenidate and amphetamines, has been opposed by parents, and many professionals including medical personnel and educators (Schrag & Divoky, 1975; Stewart, 1970; Walker, 1974; Feingold, 1975). "There is a widespread belief that children given amphetamines may become addicted," wrote Eisenberg (1973, p. 160). As Roger Rapoport (1971) reported:

> Though Ritalin may make kids manageable, some experts believe it may cure the symptoms without getting at the cause; worse yet, such drugs may absolve parents and teachers of their inherent responsibilities and, beyond that, introduce youngsters to drug use at an early age (p. 40).

However, Eisenberg (1973, p. 160) refuted this belief as he stated "it is unjustified because it is contrary to clinical fact. Dosages for hyperactivity are not toxic and do not make children 'high'." According to the Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children (1971, p. 4), "The young child's experience of drug effects under medical management does not seem to induce misuse."

One of the alternatives to drug treatment for the "hyperactive" child is behavior modification. Ayllon, Layman and Kandel (1975) conducted a study to investigate the benefits of behavior modification versus drug therapy. They found that whereas the children's level of hyperactivity rose above its initial level when the use of Ritalin was discontinued, hyperactivity was continuously controlled through a systematic reinforcement schedule for acedemic performance. Ayllon et al. (1975, p. 145) concluded "The control of hyperactivity by medication, while effective, may be too costly to the child, in that it may retard his academic and social growth . . ." Safer and Allen (1976, p. 132-133)

stated "the evidence shows that behavior therapy is the most successful nonchemical treatment for the school problems of the hyperactive child."

Anderson (1964) obtained positive results from his research study on behavior modification with hyperactive children. From a similar behavior modification project completed by Patterson, Jones, Whittier and Wright (1965, p. 224) it was concluded that the "data offer strong support for the efficacy of behavior modification techniques for the control of the hyperactive child."

Although psychotherapy was reported in the literature as a means of treatment for "hyperactive" children, it has not been employed at nearly the high level that other methods have. According to Ross and Ross (1976, p. 176-177), the therapist's view of the child's problem will help to determine its treatment. If the problem is viewed as physiological, a "physical means of treatment, usually drugs, will naturally be utilized. If hyperactivity is considered a psychological problem in the usual sense . . . some form of exploratory individual psychotherapy naturally follows treatment." At the present time the amount of literature available indicates that physical control of the "hyperactive" child is favored over psychological therapies.

Another type of treatment employed in behavior management of the "hyperactive" child has been psychosurgery. Balasubramaniam, Kanaka, and Ramamurthi (1970) report:

> . . . the experience of 115 cases of behavior disorders treated by various operations. The operation choice has been stereotaxic amygdalotomy. This operation has proved to be useful in the management of patients who previously could not be managed by any other measure (p. 22).

Likewise, Narabayashi, Nagao, Saitio, Yoshida and Nagahata (1963) have summarized their use of surgery with behaviorally disturbed children as

they stated:

> We feel that the improvement in the behavior of these children accomplished by means of neurosurgery with a minimum of risk and a lack of side-effects is of such magnitude that for the first time it offers a practical means for such control (p. 10).

One of the important factors to consider in the treatment of "hyperactive" children has been, along with diagnosis and method of treatment, how soon the intervention takes place. Eisenberg (1973, p. 151) stated "the hyperkinetic child requires treatment; if he is simply left to 'grow out of it,' the school failure secondary to hyperactivity usually produces profound personal and social dysfunction in later life." The benefits of early treatment were pointed out by Stewart and Olds (1973, p. 197) "parents can help to prevent years of misery by acting early." Not only are parents to be considered, but as Renshaw (1975, p. 85) stated "a child's right to treatment as early and as adequately as possible, should be respected." Baker (1977, p. 13) has written "the earlier children receive help with their problems, the easier it will be either to overcome what emotional damage has been done or to prevent such damage." Masland (1973, p. 396) reported "many children might be helped long before they get to school if early recognition and proper intervention could be accomplished."

Implications for this Study

The literature reviewed has shown that there has not been an exact definition or concise set of characteristics which describe the "hyperactive" child. A study focusing on teachers' perceptions of "hyperactive" childrens' behavior can give insight to the definition of "hyperactivity". A wide variety of causes and treatments have been theorized, however,

diagnosis and management must always be approached on the basis of the individual child. The use of drug therapy has received widespread recognition and should be investigated to determine how many children have actually been placed on drugs to control "hyperactivity". Behavior and environmental managements have proven successful, but how many children are actually benefitting from these kinds of treatments needs to be researched. Early treatment has been reported as beneficial for the "hyperactive" child who can possibly be identified before reaching public school age.

CHAPTER III

RESEARCH PROCEDURES

The purpose of this study was to identify teachers' attitudes toward "hyperactive" children in Early Childhood programs and examine the guidance techniques teachers in the programs are using with the children. This chapter contains an explanation of the type of research, the description of the sample, the development of the instrument, the administration of the instrument, and a brief explanation of the data analysis.

Type of Research

For the purpose of this study, descriptive research methods were chosen for the procedure and data collection. As Best (1977, p. 116) stated "a descriptive study describes and interprets what is." To enable the researcher to describe teachers' attitudes toward and use of guidance techniques with "hyperactive" children, a study was conducted to reveal the teachers' beliefs. The survey method through use of a questionnaire provided insight to the research problem.

Population and Sample

The population of this study consisted of early childhood programs in the city of Tulsa, Oklahoma. Tulsa is a progressive metropolitan city in northeastern Oklahoma. The population of Tulsa at the time of this study was 330,350.

The population of early childhood programs used in this study was selected from the 1977 edition of the Yellow Pages published by Southwestern Bell Telephone Company. A total of 144 listings was found in the "Day Nurseries" section of the Yellow Pages. The section entitled "Churches" was also reviewed to locate any early childhood programs operated by the churches but not included in the "Day Nurseries" section. A total of 13 church-related programs were added to the 144 "Day Nurseries" listings. The names were cross checked so that no listing was included in the sample twice. Three more early childhood programs, Holland Hall, Early Childhood Development Center, and Tulsa Area Vocational Technical School, were not found in the Yellow Pages, but were added to the sample in an effort to include all possible early childhood programs in the sample.

The common factor of these programs is that they serve young children whose ages vary from birth to 12 years old. The programs differ in location, type of services offered, number and ages of children served, and employee qualifications.

From the total population of 160 early childhood programs, 28 centers served as the sample. The sample included 28 centers due to the limited time in which the researcher had to conduct the study. The thesis committee recommended that the minimum number of centers in the sample would be 20 and the researcher visited as many more as possible to increase the size of the sample. Each of the additional centers visited was selected by the same random procedures used for selecting the initial group of 20. The name of each center was written on a strip of paper and then the papers were drawn out of a hat one at a time and recorded. The centers were contacted by telephone and asked to participate in a master's thesis

study by filling out a questionnaire. As a result of the telephone contact, 11 programs were eliminated from the study for one of three reasons: (1) although they were listed in the Yellow Pages under Churches or Day Nurseries they did not provide services to preschool age children on a consistent basis throughout the week (2) they refused to participate in the study (3) they were located outside the Tulsa city limits. Two were removed from the sample as their owner requested that the researcher visit one of the owner's other centers.

Instrumentation

The review of literature showed no specific instrument sufficient for surveying a population in order to obtain information pertinent to the problems of this research study. Therefore, the instrument design, Questionnaire on Hyperactive Children, (Appendix A) stems from the researcher's experience with children, areas identified as important in the literature, basic survey techniques from Best (1977) and Compton and Hall (1972), and guidance from the researcher's thesis committee members. The questionnaire consists of directions and four areas relating to the information necessary for the study. These areas are (1) Teacher; (2) Child; (3) Management Procedures; (4) Teacher Interest In Information. Thirty-one items are listed so that the respondent either places a check mark by a statement or writes in the answer to fit his/her beliefs. Three early childhood teachers initially evaluated the instrument for clarity and purpose. The final draft of the instrument was submitted to four persons with child-care experience in early childhood programs. They judged it in regard to clarity of the questions and appropriateness for use with the caregivers serving as the sample. These persons recom-

mended that the instrument would be a clear and concise measure of teacher's perceptions and management of "hyperactive" children if the researcher would verbally explain Items 27 and 31 while administering the instrument. The researcher incorporated these suggestions into the administering procedures.

Administration of Instrument

At the time of telephone contact requesting that the center serve in the sample, a meeting time was designated when the researcher could visit the program and the teacher could fill out the questionnaire. During this meeting the researcher handed the questionnaire to the teacher asking him/her to read the directions, ask any questions he/she might have pertaining to any of the items, and to complete all the items to the best of his/her ability. The respondent was also verbally reminded of the confidentiality of his/her answers. During the time the respondent filled out the questionnaire the researcher offered assistance only if it was requested. If the respondent asked about Item 19 he/she was told the following were example answers: destroying property, demands too much attention, hurts others. If the respondent asked about Item 22 he/she was told these examples: decline to play with the child, complain about him/her, make statements such as "I don't like you." The researcher then asked the respondent to include anything else that he/she could think of that fit his/her particular situation pertaining to Item 19 or 22. When the respondent declared he/she was finished with the questionnaire the researcher examined it in an effort to make sure that each item had been answered. Unfortunately not every questionnaire in the sample was totally completed. The researcher believes this to be

due partially to the situation in which the instrument was administered. Frequently the caregiver was supervising a group of children at nap or play while completing the questionnaire and therefore could not devote his/her whole effort to the instrument. Not only were these distractions present, but also perhaps the lack of the respondent's interest or inability to think through the meaning of the item may have detracted from the completion of the questionnaire by the teacher. In each case the researcher encouraged the respondent to answer each item, however the results show that this suggestion was not always followed. One questionnaire was eliminated from the study because so few items were answered.

Analysis of Data

The data gained through use of the questionnaire were examined by two methods: (1) frequency and percentage, (2) range and median. Answers to the open-ended questions are discussed and relevant information listed in Appendix B. Tables are used to present a clear picture of the data.

CHAPTER IV

RESULTS AND DISCUSSION

This study was conducted to identify teachers' perceptions of "hyperactive" behavior in young children and the guidance techniques used with the children. More specifically, the objectives were to 1) determine if teachers believed there to be "hyperactive" children in their programs; 2) identify descriptive factors which are related to these "hyperactive" children; (3) obtain teachers' perceptions of "hyperactive" behavior in children; 4) obtain information concerning teachers' perceptions of problems in the classroom caused by children whom they judge to be exhibiting "hyperactive" behavior; 5) examine reports of teachers' guidance techniques with "hyperactive" children; 6) inquire if teachers want additional information and training about how to work with "hyperactive" children.

A questionnaire was developed to assess teachers' attitudes toward, perceptions of and guidance techniques used with "hyperactive" children. Results from the instrument have been assembled in this chapter according to the four areas on the questionnaire: Teacher, Child, Management Procedures and Teacher Interest. Data gained from the respondents has been examined through calculation of (1) frequency and percentage and (2) range and median. Range and median was chosen for this study because of the wide wariation in answers. To achieve a clearer picture of the results, the median has been reported rather than the average.

The results contained in this chapter have been categorized according to two groups of questionnaire respondents. The first group is composed of the three respondents whose answers on the questionnaire stated that they did not believe they have ever worked with a "hyperactive" child. The data compiled on the second group show they perceived they have a "hyperactive" child in their class now or have worked with one in the past.

Data have been assembled into tables for easy comprehension where applicable. All other items have been reviewed in narrative. A complete list of respondents' answers for the open-ended questions 18 and 19 has been included in Appendix B under Tables XII and XIII.

Respondents in Group One

Only three persons surveyed in the random sample of 28 centers indicated they had never experienced working with a "hyperactive" child. These persons all were employed at Day Care Centers. Two of them worked with children age 2½ or younger. The other worked with children ages 4 and 5. The formal training of these three people included one with an Elementary Education degree, one with some community courses or observations and one with no formal training. None of the respondents had received training for working with special children (such as "hyperactive"). The years of experience reported by the teachers were two, three and fourteen. The breakdown according to total program size and number of children in their specific class was 110 total and 11 in class, 15 total and 5 in class, and 35 total and 19 in class.

The researcher believes that the possible reason for two of the respondents to have answered that they have never experienced working with

a "hyperactive" child is because of the children's ages. Many children are not identified as "hyperactive" until they enter into a formal school situation. However, there were persons in the sample who did answer that they worked with children who were "hyperactive" at ages one, two and three.

Respondents in Group Two

Teacher

This study was conducted with a sample population in Tulsa, Oklahoma. Table I presents data concerned with the Teacher section of the questionnaire. The respondents indicated that they were employed at Day Care Centers, Preschools and Nursery Schools. Five caregivers indicated they had no formal training. Twelve teachers had college degreees in Early Childhood Education or another field (mostly other Education areas or Home Economics). The amount of experience working with young children ranged from one week to 25 years with a median of four-and-one-half years. The investigator believes this wide range to be a reflection of the sample in which the center personnel themselves decided who would complete the questionnaire. Only eight teachers, approximately two-thirds, indicated they had had special training for working with special children (such as "hyperactive").

The size of the programs ranged from twelve children to 285 children. Nearly one-third of the centers served a total of 26-45 children throughout their weekly program. The center with a total enrollment of 285 children operates as a preschool program with a different group of children in the mornings and afternoons. Class sizes ranged from six to 26 children. The size of the classes varied widely because of the age

TABLE I

CHARACTERISTICS OF THE SUBJECTS

Variable	Classification	Number	Percent
Formal training*	No formal training	5	20
	Some community course or observation	4	16
	Vocational training	1	4
	Some college	7	28
	College degree in Early Childhood Education	2	8
	College degree in Elementary Education	1	4
	College degree in other field	9	36
Years of experience as teacher of young children	1 week - 1½ years	5	20
	2 years - 3 years	7	28
	4 years - 8 years	5	20
	9 years - 15 years	4	16
	20 years - 25 years	4	16
Training for working** with special children	Yes	8	33
	No	16	66
Facility where employed	Play School	0	0
	Preschool	6	24
	Nursery School	3	12
	Laboratory School	0	0
	Day Care Center	19	76
	Head Start	0	0
Total number of** children in program	12 - 20	5	21
	26 - 45	8	34
	50 - 70	6	26
	80 - 285	4	17
Number of children in class	6 - 10	7	28
	12 - 15	9	36
	20 - 22	6	24
	25 - 26	2	8

*Respondents were able to choose more than one item.
**N = less than 25 due to incomplete responses on these items. Percentages based on responses obtained.

of the children in the class and the number of teachers in the class. Slightly more than one-third of the classes were in the 12-15 children division. The ages of the children in the programs ranged from two months to 12 years. This item was intended to discover what the ages of the children in the teacher's specific class were in order to determine the ages with which teachers were working when they believed they had a "hyperactive" child in their class. However, wording of the item did not specifically yield the type of information desired. Table I shows the distribution of the children's ages. The median age was five years old.

Child

Information concerning the "hyperactive" children the teachers have worked with was gained to develop a general picture of the "hyperactive" child and the problems created by his/her presence in the classroom. Eighteen of the teachers surveyed in this study answered "Yes" they think they have a "hyperactive" child in their class or group now. This represents 72% of the sample. Fourteen or 56% of these respondents believed they have more than one "hyperactive" child. Answers to the question "if more than one hyperactive child in your class or group now, how many?", revealed that six teachers believed they had one additional "hyperactive" child, four teachers believed they had two additional "hyperactive" children, three teachers believed they had three additional "hyperactive" children and one teacher believed that she had seven more "hyperactive" children in her class. The investigator believes that the response of a teacher who thinks there are eight "hyperactive" children in a class of twelve is open to serious question. Seven teachers, or

28%, indicated that they did not think they had a "hyperactive" child in their class or group at the time they completed the questionnaire. Eighty-eight percent of the respondents answered that they had worked with a "hyperactive" child before now. These 22 answers ranged from one to 24 "hyperactive" children worked with in the past, with a median of three children. The answers of higher numbers of "hyperactive" children which teachers worked with in the past came from teachers with the greater number of years of experience. It was more difficult for these teachers to remember exactly the number of "hyperactive" children they had worked with and their answers frequently reflected an estimate rather than an exact number.

Table II represents teachers' experience with "hyperactive" children according to the child's age. The data have shown that the sample of teachers working in early childhood programs believe they see young children exhibiting "hyperactive" behaviors as early as age one.

The age ranges for the "hyperactive" child at the time the teacher worked with him/her were from one to eight-years-old. The mean age for the "hyperactive" child when the teacher worked with him/her was four years old.

Eleven or 44% of the "hyperactive" children on whom teachers based their questionnaire responses, were reported to have been diagnosed as "hyperactive" by medical personnel. The investigator was surprised at this high percentage reported for this random sample of centers. Several other teachers indicated either in writing on the questionnaire or verbally with the researcher that they believed the "hyperactive" child did need to see a doctor for medical attention or guidance, but that the parents were not cooperative in this matter. Fourteen or 56% of the

TABLE II

PERCENTAGE OF TEACHERS REPORTING EXPERIENCE WITH "HYPERACTIVE" CHILDREN BY AGE

Age of Child	Percentage of Teachers*
1 year	12
2 years	16
3 years	52
4 years	68
5 years	60
6 years	32
7 years	16
8 years	12

*Respondents were able to choose from more than one item.

respondents indicated that the "hyperactive" child had not been diagnosed by medical personnel. Eight of the children diagnosed as "hyperactive" by medical personnel were on medication to control their hyperactive behavior. This number represents 32% of the sample who reported they had a "hyperactive" child in their program. It also means that 72% of the children diagnosed as "hyperactive" by medical personnel were medicated to control their "hyperactive" behaviors. One subject answered "Yes" the child was diagnosed as "hyperactive" by medical personnel but then could not report as to whether or not the child was on medication. Only two of the respondents knew the type of medication being given to the "hyperactive" child. These answers were "mellaril" and "amphetamines and others". The only daily dosage was reported as "50 mg, 3 times a day."

Five persons answered "Yes" they had observed a change in the child's behavior since he/she began taking the medication. One person did not check either "Yes" or "No", but made the comment "he went in phases, I guess because of a buildup in resistance to medications" under "if so, describe." One person checked "No" and made the comment "no observance because he was on it continuously." Other comments made which describe the observed change in the child's behavior were:

1. attention span lengthened, calmer to talk to
2. calms child down
3. calmer
4. more cooperative, follows directions much better
5. bad attitude, doesn't participate (acted better before he started medication)

Although eight persons answered "Yes" on the child receiving medi-

cation and six of them made comments describing the child's behavior, five people checked the "No" (meaning no observed change in behavior). It must be assumed that the other three persons responding to the question did not read it clearly.

Table III shows the degree of problem the "hyperactive" child causes within the class setting. Only four of the respondents rated the child as causing little problem and six rated the child as causing a moderate problem. Sixty percent, 15 of the teachers, indicated that the child caused a great degree of problem for the class. The researcher finds these statistics to be an indication that most teachers feel that "hyperactive" children do cause a significant problem within the class.

Table IV presents the terms which teachers think best describe the child's "hyperactive" behaviors. The two behaviors rated most often (84%) were "overactive" and "disturbs others". "Restless behavior" was used to describe the "hyperactive" child's behavior by 80% of the respondents. Seventy-two percent of the responses indicated the "hyperactive" child was "hard to manage." "Moves continually" and "short attention span" were checked by 68% of the teachers. These behaviors generally correlate with those reported in the review of literature by experts in the field. Only 12% of the respondents thought the "hyperactive" child to be "learning disabled". This, too, correlates with the general consensus of the professionals concerned with "hyperactivity".

Although the teachers chose descriptive behaviors which are fairly widely used in connection with the "hyperactive" child, many of them had great difficulty in defining hyperactivity. A complete list of the definitions as the teachers gave them is found in Table XII (Appendix B). The investigator judged seven responses made by the teachers to reflect

TABLE III

DEGREE OF PROBLEM HYPERACTIVE CHILD
CAUSES FOR CLASS

	Little	Moderate	Great
Frequency	4	6	15

TABLE IV

CHARACTERISTICS OF HYPERACTIVE BEHAVIOR

Descriptive Term	Number	Percent
Inattentive	10	40
Learning Disabled	3	12
Overly Aggressive	16	64
Restless	20	80
Overactive	21	84
Impulsive	16	64
Disturbs Others	21	84
Hard to Manage	18	72
Short Attention Span	17	68
Easily Excited	14	56
Talks Continually	13	52
Moves Continually	17	68
Easily Frustrated	15	60
Easily Distracted	14	56

a serious lack of understanding concerning the "hyperactive" child as related to the information found in the review of literature. These were:

1. Aggressive, no direction. Gets along very well with adult on a one-to-one basis. Always wants to be first, monopolizes group activities.
2. Disturbed (mentally - abnormal behaviors).
3. Inability to organize things in their own mind in order to accomplish their goals.
4. Overly aggressive.
5. When the child cannot work in a normal situation with a normal span of interest.
6. A child who cannot be calmed in a positive way.
7. Child's inability to concentrate and retain what he sees.

Table XIII (Appendix B) gives a complete list of teachers' responses to Item 19: "What sort of problems does the hyperactive child pose within the class setting?" The list is composed of the teachers' original answers. Where respondents gave answers which were the same or similar they were grouped together to best show their significance. The answers varied widely, but six items were mentioned much more than the others. They were:

1. Unable to sit still, moving constantly (restless, overactive).
2. Disturbing class or others.
3. Bothers and hurts other children (hitting, pinching, biting).
4. Destroys equipment (destructive).
5. Disrupts (causes commotion, distracts other children in group).
6. Discipline problem (will not accept discipline, hard to manage).

Table V presents the data for amount of time teachers have to spend to help the "hyperactive" child keep his/her behavior in control like the rest of the children in the class. Forty-four percent or 11 of the teachers rated this item in the moderate category. The numbers reported in the great category, 8, and little category, 6, do not indicate a strong preference by the respondents. These responses were interesting in comparison with the answers for Item 16 "What degree of problem does the hyperactive child cause for your class?". The answers reported show a discrepancy in the degree of problem the child causes for the class, rated as great by 60% of the population, and the amount of time the teacher has to help the "hyperactive" child with behavior control. The investigator believes this may indicate that teachers have not devoted as much time as they might to benefit the "hyperactive" child and the rest of the class.

TABLE V

AMOUNT OF TEACHER TIME SPENT IN BEHAVIOR CONTROL OF HYPERACTIVE CHILDREN

	Little	Moderate	Great
Frequency	6	11	8

Table VI reports the degree of acceptance the "hyperactive" child has with his/her peers. Only five children were reported as being dis-

liked by their peers. The majority of the children were either moderately or greatly accepted. One teacher said "the other children like the hyperactive child as he is a comedian." This is not in agreement with the literature review. Ross and Ross (1976, p. 42) remarked "often . . . his peers, and particularly his school-mates, dislike him [the hyperactive child]." Stewart and Olds (1973, p. 195) wrote "the impulsiveness, impatience, excitability, overactivity, and short attention span that characterize the hyperactive child often make him the outcast of the classroom . . ."

TABLE VI

DEGREE OF PEER ACCEPTANCE OF HYPERACTIVE CHILD

	Little	Moderate	Great
Frequency	5	9	11

Item 22 concerning the rejection displayed by the "hyperactive" child's peers towards him/her was not answered by four teachers. Only seven teachers' answers reflected that they understood the meaning of the question. These are the items listed by the teachers:

1. Refuse to play with him. Gets tired of being around him, tries to ignore him, at times say don't like him, talks about him.
2. No one wants to sit by him or play with him. They say he's

mean and "tough".

3. Children sometimes become angry with the hyperactive child because of disruptive behavior.
4. Refusal to play with him, ridicule.
5. Children seem afraid of her.
6. Children defend themselves.
7. Ignoring, will not play with, questions behavior.

Thirteen of the respondents, more than half, judged the "hyperactive" child to have a warm loving relationship with parent/s. One teacher indicated the child's relationship was only "fair".

Only one teacher estimated the income level of the "hyperactive" child's parents to be "very well off". Eight parents' income level was estimated by the teachers to be a "low income". Sixty percent, 15 of the "hyperactive" childrens' parents, were believed to have a "moderate income". Two authors (Feingold, 1975; Minde, 1971) have concluded that hyperactivity is present in all levels of socioeconomic status. White and Charry (1966) have found that the rate of hyperactivity does not appear to be prominently influenced by socioeconomic factors, although there is a tendency for more hyperactivity to occur in lower socioeconomic class families.

The data for the description of the childrens' living arrangements are compiled in Table VII. Forty-four percent of the "hyperactive" children reported in this random sample live with their mother only. This is contrast with the fact that none live with the father only. Fourteen children live in two parent families, eight with both parents; four with natural parent and step-parent; one with adopted parents; and one with grandparents. This could perhaps indicate that more children with

TABLE VII

DESCRIPTION OF CHILD'S LIVING ARRANGEMENTS

Arrangement	Number	Percent
Mother only	11	44
Father only	0	0
Both parents	8	32
Natural parent and step-parent	4	16
Other	1	4
Adopted parents	1	4
Grandparents	1	4

single parent families, in this instance the woman, are in day care. Or it could be interpreted as problems encountered in and contributing to the reason for the family to have only one parent could enhance the child's tendency towards "hyperactivity." The literature did not show information concerning this problem aside from Renshaw's (1975, p. 39) comment "very rarely does a child show symptoms [of hyperacitivity] without there being causal or resultant problems in other members in the family." The investigator believes this number of children from single parent families would suggest need for further information about stress related to the family environment. More specifically, it raises a question as to whether a relationship exists between incidence of "hyperactive" children and family structure.

The ordinal position of the child in the family, presented in Table VIII, did not reveal that the "hyperactive" children in this sample are characterized by one specific place in order of birth. The frequency does not vary widely, as eight of the children reported to be "hyperactive" were the only child in the family, seven were the oldest and five "hyperactive" children were in the middle and youngest positions in the family.

Management Procedures

The information gained from Item 27 is represented by Tables IX and X. Table IX shows the guidance techniques teachers use and the frequency with which they are used. The investigator believes that the guidance techniques as reported reflect that most of the teachers use positive guidance. Table X presents the guidance techniques which teachers rated as most effective when used with the "hyperactive" child. Unfortunately

TABLE VIII

ORDINAL POSITION OF CHILD IN THE FAMILY

Position	Number	Percent
Only child	8	32
Oldest child	7	28
Middle child	5	20
Youngest child	5	20

TABLE IX

GUIDANCE TECHNIQUES AND HOW OFTEN TEACHERS USE THEM

Technique	Frequency of Use		
	Never-Seldom	Sometimes	Often-Always
Physical punishment	19	3	2
Verbal reprimand	5	4	15
Isolation (time out)	8	7	10
Praise or reward	2	3	19
Ignoring	14	6	3
Setting limits	4	5	13
Deprivation of something	10	8	7
Letting the child go his/her own way	23	1	1
Other			
Physical affection - Hugs and kisses	1		
Personal communication			1
Assisting teacher with special jobs			1
Consultation			1

TABLE X

GUIDANCE TECHNIQUES RATED AS MOST EFFECTIVE WITH THE HYPERACTIVE CHILD

Technique*	Frequency
Praise or reward	8
Isolation	5
Setting limits	3
Deprivation of something	3
Physical punishment	3
Ignoring	2
Verbal reprimand	1
Letting the child go his/her own way	1

*Respondents were able to choose from more than one item.

many teachers did not rate the guidance techniques. The data that was reported, however, indicated again that most of the teachers use positive guidance in most situations.

Eight teachers reported under the Teacher section that they had some training for working with special children (such as hyperactive). The number of persons who marked an answer on this item (eleven for identifying and five for managing) shows that the respondents either did not read or understand the question. Of the eight who had received training, two of them said the training only moderately helped them in identifying the "hyperactive" child. Six respondents felt their training helped them very much in identifying the "hyperactive" child. Three teachers indicated that the training moderately helped them in managing the "hyperactive" child. The training helped five teachers very much in managing the "hyperactive" child.

Item 29 asked whether the teacher had sought help from others and if so from whom and what assistance was offered. One person checked "Yes" without giving an explanation. Three teachers checked neither "Yes" or "No" but gave the following explanation for "If so, who and what assistance did they offer?":

1. Lady from Children's Medical Center.
2. Suggested to mother that she get help with the child.
3. From parents. Parents don't usually want day care operators more involved.

Six respondents indicated they had not sought help from other people in managing the hyperactive child. Fifteen teachers marked "Yes" they had sought assistance. The answers received for the open-ended section of Item 29 were widely varied. The resource person reported as being con-

tacted most frequently for help was the parent. Eleven respondents indicated they had tried to contact the parent to confer that the problem exists, obtain suggestions about guidance and refer the parent for professional counseling. Four teachers also sought help from their colleagues or public school teachers. One public school teacher's advice was to check the diet the child was eating. The other public school teacher advised the day care respondent that she had requested tranquilizers for the "hyperactive" child. One respondent indicated she had contacted a psychologist who stressed to her the importance of consistency and "carrying out what you tell the child you will do." Other answers included Family and Children's Services, Children's Medical Center, In-service workshops or conferences, and Friends of Day Care speakers.

Fifteen or 60% of the sample indicated they would like additional assistance in managing the hyperactive child. Six persons answered "no" they did not want additional assistance. One of these six indicated that she answered "no" because the child had been removed from the early childhood program. Another one of the six answered "no" and remarked that she was no longer going to be involved in the child care business. Four persons did not answer this item concerning desire for additional assistance. The investigator has interpreted the questionnaire results of 60% of the teachers who want additional assistance to mean that "hyperactive" children today are creating a problem that teachers do not believe they have sufficient skills in handling.

Teacher Interest In Information

The respondents' answers in this section indicated that they were interested in receiving more information on how to best work with the

hyperactive child. Nineteen or 76% of the sample were very interested in getting more information. Three teachers or 12% indicated they were only moderately interested and two persons or 8% were not interested. One of those who answered "not interested" was no longer going to be involved in the child care business and therefore did not have an interest in further information. One respondent failed to indicate interest on the continuum, but did mark the preferred method for gaining information.

Table XI presents methods which teachers prefer for obtaining information on how to work with the "hyperactive" child. The method preferred by 76% of the sample was the pamphlet. Mini-workshop was the method chosen by 44% of the respondents.

TABLE XI

METHODS WHICH TEACHERS PREFER FOR OBTAINING INFORMATION ON HOW TO WORK WITH THE "HYPERACTIVE" CHILD

Method*	Number	Percent
Pamphlet	19	76
In-service training	10	40
Film	9	36
Discussion Group	10	40
Mini-workshop	11	44
College Credited Course	9	36
Book Learning	9	36
Other	0	00

*Respondents were able to choose more than one item.

CHAPTER V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Summary

The purpose of this study was to identify teachers' perceptions of and attitudes towards "hyperactive" children in early childhood programs and examine the guidance techniques teachers use with the "hyperactive" children. More specifically, the objectives were: 1) to determine if teachers believed there to be "hyperactive" children in their programs; 2) to identify descriptive factors which are related to these "hyperactive" children; 3) to obtain teachers' perceptions of "hyperactive" behavior in children; 4) to obtain information concerning teachers' perceptions of problems in the classroom caused by children whom they judge to be exhibiting "hyperactive" behavior; 5) to examine reports of teachers' guidance techniques with "hyperactive" children; and 6) to inquire if teachers want additional information and training about how to work with "hyperactive" children.

Because no instrument appropriate for measuring the investigator's specific interest relevant to this study was discovered, the Questionnaire on Hyperactive Children was developed. The intent of its design was to discern whether teachers in early childhood programs believed they had "hyperactive" children in their programs, what types of problems the "hyperactive" children caused within the program and how

teachers dealt with the problems.

The subjects were 28 teachers in early childhood programs employed in centers located in Tulsa, Oklahoma. The random sample included teachers from Preschools, Day Care Centers and Nursery Schools. The respondents represented a sample who vary widely according to training, years of experience and kind of facility where employed. The data was collected in March and May of 1978. The results of the questionnaire were examined through calculation of: 1) frequency and percentage and 2) range and median.

Results and Conclusions

Major results of the study were:

1. Teachers in early childhood programs believe they work with hyperactive children in their programs.

2. Sixty-four percent of the teachers had not received any training for working with special children (such as hyperactive).

3. Forty-four percent of the "hyperactive" children whom teachers based their responses on were reported to have been diagnosed as hyperactive by medical personnel.

4. Teachers reported that seventy-two percent of the children diagnosed as "hyperactive" by medical personnel were medicated to control their "hyperactive" behaviors.

5. "Hyperactive" children do cause a great degree of problem within the classroom.

6. Characteristics which teachers most often report describe the "hyperactive" child's behaviors are overactive, disturbs others, restless, hard to manage, and short attention span.

7. The teachers' reports indicated that they most often employ positive guidance techniques.

8. Seventy-six percent of the sample was very interested in getting more information on how to best work with the "hyperactive" child.

The result that teachers believe there are "hyperactive" children in their programs is in agreement with many experts who have reported that hyperactivity is one of the major childhood behavior disorders today and that as many as five percent of the elementary school population is described as being "hyperactive" (Walker, 1974; Ross & Ross, 1976; Wender, 1971; Feingold, 1975). The investigator expected to find and did find that a high number of teachers reported there are "hyperactive" children in their programs. Teachers' lack of training and preparation for their occupation certainly could contribute to the problem of planning an optimum environment which would decrease the likeliness of a child behaving in a "hyperactive" manner. The investigator believes that too often children are called "hyperactive" because an inadequately planned environment leaves them to move around excessively without displaying a genuine interest in anything.

Recommendations

Upon completing this study, the researcher can offer suggestions about the weaknesses discovered in the instrument, Questionnaire On Hyperactive Children, in an effort to improve the quality of information gained through its use. Although the changes made by the panel of judges were implemented, certain items on the questionnaire still did not yield the exact type of information desired by the investigator. Item 8, "Range of ages of children" needs to be changed to ask specifically for

either range for the total program or range for only the particular class, so that answers will be of a more uniform nature. The wording of Item 22 could also be changed to say "what form does the peer rejection toward the hyperactive child take?" The directions for Item 27 did not instruct the respondents clearly enough to both rate the guidance techniques as to how often they are used from 1 to 5 and rate the most effective techniques by circling the word in the left hand column. Treating this item to reveal two types of information was difficult for most respondents even after verbal explanation by the researcher. The desired information may be best attained through use of two separate items.

The most important guide which this investigator can suggest is to use the questionnaire in an interview situation whereby the investigator asks the questions and records the responses on the questionnaire sheet. This approach was not used in this study as the investigator believed the respondents would be more comfortable and therefore give more complete and honest answers if he/she filled out the questionnaire him/herself. However, in an attempt to gain more detailed information in which a response to each item is made, the interview method would offer advantages.

The investigator would also suggest that an item concerning the child's sex be included in the information on descriptive factors. The literature review clearly pointed out that far more males were afflicted with hyperactivity than were females and this area merits further investigation particularly in the preschool age category.

An interesting contrast could be developed between those who answer they have never worked with a "hyperactive" child and those who answer they have worked with a "hyperactive" child by asking the first group

to complete the definition on hyperactivity and Item 17, the terms which describe the hyperactive child's behavior. Perhaps this might help to explain the teachers' decisions regarding whether or not they have experienced working with a "hyperactive" child. The responses in this study seemed to indicate that teachers are very willing to label a child's behaviors as "hyperactive" without having a clear and appropriate definition of hyperactivity. Unfortunately the term "hyperactive" is used by many people as a "catch-all" phrase for behavior management problems, which may in fact be due to hyperkinesis, emotional stress, a poorly planned environment or other factors. Respondents' definitions of "hyperactivity" bear out the researcher's belief that the term has been used frequently in a slang fashion rather than in a professional sense.

Many studies similar to this one could be conducted to discover more or similar information such as a contrast between the "hyperactive" preschool age child and the "hyperactive" child in Elementary School. One recommendation would be that the study be repeated with a larger population to gain more information and verify the results of the present study. The researcher also recommends that the type of information requested by teachers on how to best work with hyperactive children be developed and distributed. This type of information would also need to include how to plan the best environment possible for the "normal" child so that teachers could see that many children's high level of movement is due to their developmental level which means they naturally explore and move around frequently.

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APPENDIXES

APPENDIX A

INSTRUMENT

QUESTIONNAIRE ON HYPERACTIVE CHILDREN

Your cooperation in this research is very much appreciated. Your contribution will help determine the number of hyperactive children in Early Childhood Education Programs and teachers' need for more information about working with these children.

Please complete the questionnaire by using the directions stated. Your responses will be strictly confidential. You may ask me any questions you have regarding an item on the questionnaire. Incomplete questionnaires CANNOT be used.

In order for the research to be accurate, if you do not believe you have ever worked with a hyperactive child, please complete the first section concerning the TEACHER and question 9 under the Child Section, and give it back to me. THANK YOU VERY MUCH.

TEACHER

1. Name (optional) _____

Education and experience -

2. Formal training: (Check one which best describes you)

____No formal training; ____Some community courses or observations;

____Vocational training; ____Some college; ____College degree in

Early Childhood Education; ____College degree in Elementary Education;

____College degree in other field (specify)_____

3. ____years of experience as a teacher with young children.

4. Training for working with special children (such as hyperactive)?
Yes____ No____

5. Presently working in [type of facility where employed (check)]
____Play School ____Nursery School ____Day Care Center
____Preschool ____Laboratory School ____Head Start

6. Total number of children in program _____

7. In your specific class, number of children _____

8. Range of ages of children _____

CHILD

9. Do you think you have a hyperactive child in your class or group now?
____Yes ____No (check) If more than one hyperactive child, how many?_

10. Total number of hyperactive children you have worked with before now?_____

11. In your teaching experience you have worked with the child who was hyperactive at age: (check as many as fits your situation.)

a. 1 year ____	d. 4 years____	g. 7 years____
b. 2 years____	e. 5 years____	h. 8 years____
c. 3 years____	f. 6 years____	

Please base your responses for the following items on one child who is in your class now or was in your class in the past.

12. Age of the hyperactive child at the time you worked with him/her?___

13. Child diagnosed as hyperactive by medical personnel? Yes___ No___

14. Child on medication to control his/her hyperactive behavior? Yes___
No___ If yes, what kind?_____Daily dosage?_____

15. Any observed change in the child's behavior since he/she began taking the medication? Yes___ No___ If so, describe_____
_____

16. What degree of problem does the hyperactive child cause for your class? (circle)

little problem great problem
1 2 3 4 5

17. Place a check mark by the terms which you think best describe the child's hyperactive behaviors:

____inattentive	____hard to manage
____learning disabled	____short attention span
____overly aggressive	____easily excited
____restless	____talks continually
____overactive	____moves continually
____impulsive	____easily frustrated
____disturbs other children	____easily distracted

18. In your own words, define hyperactivity_____

_____

19. What kind of problems does the hyperactive child pose within the class setting? (please list and rate by circling a number)

	not much				great
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5
_____	1	2	3	4	5

20. What amount of time do you have to help the hyperactive child to keep his/her behavior in control like the rest of the children in the class? (circle)

Little amount of time 1 2 3 4 5 Great amount of time

21. What is your opinion of the degree of acceptance the hyperactive child has with his/her peers? (circle)

They dislike him/her 1 2 3 4 5 They like him/her

22. If the hyperactive child is rejected by his/her peers, what form does the rejection take? (please list) _____

_____

Which of the following do you believe to be true concerning the family of the hyperactive child? (place a check by a true statement)

23. ____Child has warm loving relationship with parent/s.

24. Parents' estimated income level is ___below poverty ____low income ____moderate income ____very well off.

25. Child lives with: ____mother only ____father only ____both parents ____natural parent and step-parent; other_____

26. Child is: ____only child, ____oldest or ____middle or ____youngest of several children in the family.

MANAGEMENT PROCEDURES

27. Rate from 1 to 5 how often you use the following guidance techniques and circle those which are the most effective with the hyperactive child.

	never				always
physical punishment	1	2	3	4	5
verbal reprimand	1	2	3	4	5
isolation (time out)	1	2	3	4	5
praise or reward	1	2	3	4	5
ignoring	1	2	3	4	5
setting limits	1	2	3	4	5
deprivation of something	1	2	3	4	5
letting the child go his/her own way	1	2	3	4	5
other_____	1	2	3	4	5

28. If you stated under the TEACHER section that you had some training for working with special children (such as hyperactive), how much do you feel it has helped you in identifying and managing the hyperactive child? (circle)

	very little				very much
identifying	1	2	3	4	5
managing	1	2	3	4	5

29. Have you as a teacher sought help in managing the hyperactive child from other people? (such as parent, physician, psychologist, psychometrist, learning disabilities teacher, etc.) Yes____ No____ If so, who and what assistance did they offer?_____

_____

30. Do you want additional assistance? Yes____ No____

TEACHER INTEREST IN INFORMATION

31. Please indicate how interested you would be in getting more information on how to best work with hyperactive children and by what method you would most prefer to obtain the information.

not interested 1 2 3 4 5 very interested

(check one or more)

____pamphlet
____in-service training
____film
____discussion group
____mini-workshop
____college credited course
____book learning
____(other)_____

APPENDIX B

DATA

TABLE XII

TEACHERS' DEFINITIONS OF HYPERACTIVITY

1. Hyperactivity is too much energy used at the improper time and place. Too much movement. Can't be still long enough to get anything done.
2. Aggressive, no direction. Gets along very well with adult on a one to one basis. Always wants to be first-monopolizes group activities.
3. Disturbed (mentally-abnormal behaviors).
4. Excessive movement/action causing a lack of concentration or control.
5. A condition in which the individual is unable to remain still or to focus attention in one direction for only extremely short periods of time. Cause unknown.
6. Overly aggressive, restless, overactive, impulsive, short attention span, easily excited, easily frustrated, easily distracted.
7. A child that is very restless or overactive.
8. Overstimulation.
9. A child who at times cannot control the results or speed of his actions.
10. Inability to organize things in their own mind in order to accomplish their goals.
11. A child that is not easily calmed in big classes. Needs individual attention.
12. Constantly moving-inability to concentrate.
13. Overly aggressive.
14. Very restless, very cross, and hard to get along with other children, hard to manage.
15. When the child cannot work in a normal situation with a normal span of interest.
16. They never seem to rest, they're always on the move and cannot seem to stay interested in anything for a certain amount of time.
17. Hard to manage, someone who is all the time moving.
18. A child who cannot be calmed in a positive way.
19. The child seems at the mercy of his environment and reacts to situations in a frustrated manner. He seems to just overreact to everything.
20. Aggressive, overactive, uncontrollable behavior in excess of normal for age level.
21. Child's inability to concentrate and retain what he sees.
22. When a child demonstrates the behaviors listed in Item 17.

TABLE XII (Continued)

23. A child who is easily distracted, quick to action, with mouth and body in constant motion.
24. Illustrated by a restless, short-attention span, a very hard to manage child who is a discipline problem.
25. Child cannot seem to control himself, is never physically quiet, always on the move.

TABLE XIII

PROBLEMS WHICH TEACHERS REPORT HYPERACTIVE CHILDREN POSE WITHIN THE CLASS SETTING

Type of Problem	Little	Moderate	Great
Unable to sit still, moving constantly (restless, overactive)	0	6	5
Disturbing class or others	0	2	8
Bothers and hurts other children (hitting, pinching, biting)	1	2	5
Destroys equipment (destructive)	0	0	6
Disrupts (causes commotion, distracts other children in group)	0	4	2
Discipline problem (will not accept discipline, hard to manage)	0	1	4
Talks constantly, mostly to himself	1	0	3
Won't pay attention, short attention span	1	1	2
Impulsive, can't wait for his turn	1	2	0
Difficulty in learning	2	0	0
Can't share	0	0	1
Overly aggressive	0	1	0
Bossy	0	1	0
Mean	0	0	1
Excites others	0	0	1

TABLE XIII (Continued)

Type of Problem	Little	Moderate	Great
Instigates trouble	0	0	1
Cries in sleep	1	0	0
Behavior	0	0	1
Requires too much teacher time	0	0	1
Will not follow direction in group setting	0	0	1
Disrespectful to teacher in group setting	0	0	1
Will not participate in class	0	0	1
Cannot give explanation for actions	0	0	1
Refuses to keep shoes and socks on	0	1	0
Doesn't seem to like class time	0	0	1
Teacher wonders if she ever gets through	0	0	1
Fitting him in with the class	0	0	1
Keeping him stimulated	0	0	1

VITA 2

Connie Lu Clemons

Candidate for the Degree of

Master of Science

Thesis: TEACHERS' PERCEPTIONS AND MANAGEMENT OF HYPERACTIVE CHILDREN IN EARLY CHILDHOOD PROGRAMS

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