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Supporting Children with Attention-Deficit/ Hyperactivity Disorder: Using Group Counseling to Help Increase Understanding and Self-Concept

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Running head: SUPPORTING CHILDREN WITH ADHD

Supporting Children with Attention-Deficit/Hyperactivity Disorder: Using Group
Counseling to Help Increase Understanding and Self-Concept

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I would like to dedicate this research project to my friends, family, and boyfriend, my site supervisor, Mike Cusimano, and all my classmates and professors at SUNY Brockport. Thanks to them, I was able to survive graduate school, and help make a difference in the lives of children. I would also like to thank the faculty and staff at Fred W. Hill Elementary School for helping to make this project successful.

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Abstract

The study was conducted to help add knowledge to the literature about supporting children diagnosed with Attention-Deficit/Hyperactivity Disorder. It was hypothesized that through the use of group counseling, self-concept and knowledge and understanding of the disorder would increase. The Piers-Harris Self-Concept Scale and a self-constructed survey were the instruments used in the study. The results of the study showed that the level of self-concept of the students in the counseling group did not increase but their knowledge and understanding of ADHD did. The researcher concluded that group counseling similar to that in the study could serve as a useful form of treatment for school counselors in trying to support the emotional well-being of students with ADHD.

Supporting Children with Attention-Deficit/Hyperactivity Disorder: Using Group
Counseling to Help Increase Understanding and Self-Concept

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most controversial labels given to elementary children today. It is estimated that from 1990 to 1998 the number of American children and adults diagnosed with ADHD rose by over 4 million (Frame, 2003). Today that number is still rising, and the only certainty about the disorder is that there are several theories about what the disorder actually is, what the roots of it are, and what treatments are best to use (Pozzi, 2000). While the controversy continues, many children are struggling to win what is sometimes a losing battle as they go through their lives with ADHD. Hundreds of studies have been conducted to try and come up with the best form of treatment for the disorder (Kollins, Barkley, & DuPaul, 2001; Friemoth, 2005; Gunjan, 2005; Barkley, 2000; Frame, Kelly, & Bayley, 2003).

Researchers have recognized that symptoms of ADHD are often tagged with problems with academics and interpersonal relationships. These difficulties can result in a lowered self-esteem (Aust, 1994; Frame, Kelly, & Bayley, 2003; Wachtel, 1998). Often, just knowing that they are different, or “labeled” with the disorder can cause an increase in negative thoughts and feelings towards self (Rafalovich, 2004). While many researchers recognize the importance of a multimodal treatment plan (a plan that includes several interventions) that may include education and group counseling, there has not been extensive research in these two areas in regards to students with ADHD.

Most of the researched treatment plans for children aim at reducing behaviors that interfere with the child’s school day, particularly paying attention and reducing hyperactivity. Medication and behavioral interventions are the two treatments most likely to be found in

schools, both of which have proven effective in reducing problematic behaviors. An overview of these forms of treatments will be discussed in this review. As the treatments are discussed, one can see that the majority of them target problem behaviors and not necessarily the emotional effects that may result from having ADHD. The remaining portion of the review will discuss the findings of the effects of group counseling and psycho-education with children who have diseases or disorders, and then more specifically with children who have been diagnosed with ADHD.

Review of the Literature

Studies have shown that parental education can help parents understand the disorder and may help them implement techniques to reduce problem behaviors (Aust, 1994; White & Rouge, 2003) however, little has been studied about the effects of educating the students themselves about their own disorder and how it works in their bodies (Schachar, Jadad, Gauld, Boyle, Booker, Snider, et al., 2002). Studies with patients in medical settings concluded that educating the patients about their disease or procedure they're going through can help to reduce anxiety and stress and increase understanding (Nolan, Desmond, Herlich, & Hardy, 1986). In this study, it is hypothesized that by providing children with information about ADHD, they will gain understanding, thus increasing positive self-thoughts and feelings. Therefore, information about patient education is included in this review. A similar argument rises for studying how a support group can help students with ADHD.

As we look at people that may be experiencing alcoholism or cancer, it has been shown that providing these people with support groups can help meet their emotional needs, often leading to a change in thinking and behaving. A group setting can also help to form a sense of universality, in that it helps participants reduce feelings of loneliness or the thought that "I'm the

only one". As with these examples that will be presented in the following review, this study hypothesizes that through participating in a counseling group and sharing experiences there will be an increase in their self-concepts.

In reviewing the literature, there seems to be a big gap when it comes to concentrating on the emotional effects of ADHD and ways to increase positive thoughts and feelings of self. This study looks at using a combined psycho-educational/support group with fourth and fifth grade students diagnosed with ADHD to raise their positive thoughts and feelings of self.

Treatments

Over the past forty years there have been thousands of studies that focused on three main approaches to treating ADHD. Pharmacological approaches, behavior approaches and cognitive-behavioral approaches are the three treatment categories that have gained the most attention (Abikoff & Hechtman, 1996). While researchers mention the use of counseling and education, these forms of treatments have been little studied.

Medication. Stimulant medication has become the most widely used method of treatment for students with ADHD (Watchtel, 1998). Friemoth (2005) argues that stimulant medication is the most effective treatment for attention deficit/hyperactivity disorder in children. The most popular stimulant on the market today is methylphenidate, an amphetamine also known as Ritalin (Kollins, Barkley, & DuPaul, 2001). Stimulant drugs are prescribed for 600,000 to 1 million school children in the U.S (Barabasz & Barabasz, 1995), or 70-80% of all children diagnosed with ADHD. It has been found that stimulant therapy can provide dramatic early benefits (Millichap, 1998). Stimulants improve attentiveness, reduce hyperactivity, and improve ability to stay on task, which may in turn cause an improvement in social relationships (Watchtel, 1998). Many researchers argue that medication is a vital part of ADHD treatment.

Studies described by Kollins, Barkley, & DuPaul (2001) yielded results suggesting that pharmacological intervention is crucial for the treatment of ADHD symptoms.

Despite such positive outcomes, debate over whether or not stimulants are effective and safe continues to cause arguments between researchers. Barabasz & Barabasz (1995) wrote that these drugs do show an improvement in many ADHD symptoms, however they do not show an improvement in learning or academic achievement. While White and Rouge (2003) report that Ritalin is safe in the treatment of ADHD and is not addictive in children, they also warn that, if not used properly, the drug has great potential to be abused. Other researchers say that stimulants are not a good form of treatment and may actually cause patients harm. Side effects of Ritalin include insomnia, decreased appetite, stomachache, headache, and dizziness. Pozzi (2000) argues that Ritalin is over-prescribed and used not necessarily to help the child but to sooth parent angst. Side effects reported include a lowering in self-esteem and suppressed creativity. She also reports that the rate at which Ritalin is being prescribed is going up rapidly, while there is still so much that is not known about the diagnosis of ADHD nor the long-term effects of Ritalin. Kollins, Barkley, & Russel (2001) reported that studies measuring the long-term risks and benefits of using medications with children are limited. Results of some studies showed that medication for children with ADHD lacks the ability to improve grades, peer relationships, or defiant behavior over a long-term period (Gunjan, 2005). Kollins, Barkley, & Russel (2001) stated that relatively few studies have measured parent or teacher satisfaction with medication as a treatment. In addition, the number of studies measuring children's satisfaction with the medication is close to none.

Behavioral interventions. While medication is researched as the number one treatment for ADHD, behavioral management follows close behind (Barabasz & Barabasz, 1995). This includes behavior therapy, cognitive-behavior therapy, and neurofeedback.

Behavior therapy involves introducing and using rewards and punishments with children to produce favorable outcomes. The approach may also be called “social learning” based on techniques first developed by B.F. Skinner (Wachtel, 1998). Aust (1994) stated that training parents in behavior management techniques can often help with the child’s symptoms once the techniques are put into place. Behavior programs in school can also be a part of a child’s treatment (Aust, 1994). Barabasz and Barabasz (1995) reported that there have been over 5,000 articles published about behavior therapy, many of which are related to managing ADHD. They also report that there can be significant problems with behavior therapy. Often times, children do not respond to it, it must be continuous to remain effective, and it is very hard to implement with children that have ADHD because of the nature of their behaviors. Wachtel (1998) reported that this form of treatment is not as effective as medication.

Cognitive behavior therapy has to do with changing the child’s mindset to think differently about situations so that they will then behave differently (Barabasz & Barabasz, 1995). Children go through a series of 10-20 sessions, moving from simple to complex skills (Wodrich, 2000). Some examples of ways children are taught to change their thinking include planning in advance, stopping to think, and conflict resolution skills (Wachel, 1998). In a study looked at by Schachar, Jadad, Gauld, Boyle, Booker, Snider et al. (2002), there was an improvement in self-esteem when cognitive-behavioral therapy was used as a form of treatment. Self-monitoring is another example of a cognitive behavior technique that is often used in schools (Wodrich, 2000). When students self-monitor, they observe their own behaviors and

keep track of when they perform those behaviors. In a study conducted by Shimabukuro and Prater (1999), students with ADHD who used self-monitoring during a reading comprehension period showed improvement of on-task behavior.

While some studies have revealed the benefits of cognitive behavior therapy, other studies show that it is an ineffective treatment for children with ADHD. Barabasz and Barabasz (1995) stated that using cognitive behavioral approaches with children with ADHD has proven ineffective or does not provide lasting effects. Wachtel (1998) reported that cognitive training is not an effective alternative to medicine, and that studies using cognitive behavioral therapy have shown no improvements of ADHD symptoms. Wodrich (2000) agreed that, “it (cognitive behavioral therapy) can not be regarded as a principal treatment for ADHD” (p. 229).

Neurofeedback is a treatment that’s goal is permanent normalization. It is intended to teach children to normalize their brainwave responses to stimuli, that is, “to decrease the time spent in slow wave activity and increase the time spent in the fast activity required for focused attention and concentration on tasks” (Barabasz & Barabasz, 1999, p. 4). The downfall to this approach is that it is not conducted in schools and it takes up to 80, one-hour sessions to complete (Barabasz & Barabasz, 1999; Barkley, 2000). It is also very costly, averaging several thousand dollars (Barkley, 2000).

Counseling. Aust (1994) reported that individual, small-group, or family counseling can help children with ADHD by helping to reduce depression and anxiety, and problems with behavior, relationships, and self-esteem. Individual therapy can be very helpful to a child with ADHD, because they may be in need of a caring, supportive, or understanding person, even more so than a child without ADHD (Wodrich, 2000). Abikoff and Hechtman (1996) stated that individual psychotherapy can help a child raise his or her self-esteem, self-effectiveness, and

understanding of the disorder, and change his or her thinking about their negative experiences.

Wodrich (2000) mentioned that although individual therapy can't prevent symptoms, it can help prevent damage to the child's self-esteem.

Family therapy may add great benefit to the effects of medication (Friemoth, 2005). Because the ADHD can indirectly affect all members of the family, doing therapeutic work with the entire family can be very beneficial (Wodrich, 2000). Watchell (1998) stated that therapy does address psychological consequences of ADHD, and can help raise low self-esteem that often results in children with ADHD. He warned, however, that counseling does not help the root problem, which is physical and not psychological. Aust (1994) agreed that although counseling has potential benefits for children with ADHD, it alone has only a limited positive effect. Many other researchers agree that one treatment alone is not the best way to treat ADHD. This review will look more at group counseling and psycho-education, their benefits, and how they may help children with ADHD later in the paper.

Multimodal treatment. In recent years, researchers found that using multimodal treatment, also referred to as an integrated or multidisciplinary approach, is more useful and produces better outcomes than using one approach alone. Some researchers found that using just two combined treatments improves outcomes. Barkley (1998) suggested that medication helps to raise the benefits of behavior therapy alone. In a study using behavioral modification, students with no medication did not show improvement, but students with just a low dose of medication did just as well as the students with a higher dose of medication in improving symptoms (Wachtel, 1998). Friemoth (2005) also found evidence that non-pharmacologic therapies may add benefit to the effects of medication. He goes on to state that, "when combined with medication, those treated with behavioral therapy showed slight improvement in social

skills, anxiety, aggression, oppositional behavior, and academic achievement over medication alone” (p. 166). Pozzi (2000) added that using both pharmacological and psychological therapy is valuable and even necessary in severe cases, because the disorder can often bring about disruption in family life. White and Rouge (2003) agreed, saying that using medication alone is not an appropriate form of treatment.

Other researchers think that treatment should involve a whole slue of interventions. Aust (1994) described the ideal multimodal treatment as including education for child, family, and school personnel, medication, special education, counseling, and training parents. Bowley and Walther (1992) explained that a multimodal approach involves the physician, school psychologist, family, classroom teacher, and school counselor. White and Rouge (2003) argued that management of the disorder should include medication combined with behavior therapies, environmental manipulation, and educational options. A team involving the child, family, school personnel and health care provider should carry this out. Although the American Academy of Child and Adolescent Psychiatry includes medication, behavior modification, environmental modifications, multiple psychological therapies, therapeutic recreation, and education on ADHD as recommended forms of treatment, they stress that each treatment should be individualized, and may not include all of these (Bussing & Gary, 2001). Barkley (1998) found that when parents were involved in any sort of treatment plan, the plan only seemed to work for those parents who were motivated to come to trainings and did not produce promising results in a randomized study. Even when a multimodal treatment plan is put in place, results of such plans can be very extensive and interpretation of results may take years (Barkley, 1998). It seems that because of the difficulty of measuring effects of counseling and education on children with

ADHD, there has been limited research done. This does not mean, however, that these forms of treatments are not useful.

Emotional Effects of ADHD

As research has shown ADHD most likely has a physiological cause, that is, its origin is caused by something that is wrong within the body, not something psychological. Even though the root of the problem is physiologically based, there are often psychological effects that accompany or are caused by ADHD symptoms or being labeled with the disorder. These include depression, anxiety, and behavior, relationship and self-esteem problems (Aust, 1994). Children with ADHD are often labeled as troublemakers which can lead to excessive discipline and lower self-esteem (White & Rouge, 2003). They may also start to compare themselves with others and are often met with negative views (Fame, Kelly, and Bayley, 2003). Children with ADHD are often criticized and rejected by peers as well as adults. Frame, Kelly, and Bayley (2003), found that "difficulties in thinking and behavior might negatively affect academic performance, vocational success, and social emotional development," (p.225). They also found that pre-adolescents with ADHD had lower perceptions of self-worth than those without ADHD.

Solden (1996) argued that even if the disorder is found early, it does not prevent psychological consequences from forming. One main consequence she found with girls growing up with ADHD is a distorted self-concept, which can lead to other psychological effects. Barabasz and Barabasz (1995) found that even taking medication can cause lowered self-esteem due to taunting by peers. The social consequences from being labeled with ADHD can have a very negative affect on students. Rafalovich (2004) reported that the ADHD label is often a permanent fixture throughout a child's life, and many are concerned that this label may lead to a negative self-concept, eventually leading to social ostracism.

Lack of Research

The lack of research in treatments other than medication, behavioral therapy, and cognitive-behavioral therapy is another reason for the study in this paper. In a literature review study of long-term treatment of ADHD, Schachar, Jadad, Gauld, Boyle, Booker, Snider, et al. (2002) found that pharmacologic interventions were studied more frequently than non-pharmacologic ones. Even though medication is the most widely researched treatment, we still know little about how the medication enhances peer relationships and self-esteem. They also concluded that, “rigorous treatment research among representative sample of ADHD individuals is needed.” (p. 337). The researcher in this study agreed that in her own research ample studies were found using medication as treatments for ADHD, however very few studies were found using group counseling or psycho-education as a treatment.

Group Counseling

A support group with a person-centered focus rather than cognitive behavioral focus was chosen because of the lack of research done with these sorts of groups (Shechtman & Pastor, 2005). Peebles-Wilkins (2004) stated, “Not much has been written during the past five years on group intervention with children to improve diverse relationships or resolve conflicts associated with difference.” (p. 195). The few studies of this type that have been conducted show significant results.

In their study comparing a cognitive behavioral group approach to a humanistic approach in a group setting for children with learning disabilities, Shechtman and Pastor (2005) found that focusing on information processing and problem solving skills appeared to be less effective than encouraging emotional release, generating cathartic experiences, developing insight, and receiving support through intimate relationships. They continued that even though the group

focus was not academic, by concentrating on the emotional and social difficulties it increased motivation to cope with academic difficulties. Their results also indicated that the humanistic group treatment was more effective in increasing self-efficacy and helping with social rejection. Peebles-Wilkins (2004) noted that group intervention can help reduce social isolation for children, while providing an opportunity to improve understanding among diverse groups.

Shechtman and Gluk (2005) found that the most significant therapeutic factor in a counseling group with children with a variety of social and emotional problems was group cohesiveness. This included such elements as encouragement and support, acceptance, liking, and attraction to the group. The study also found that children liked being listened to, were comforted knowing that others had similar problems, and that others helped to make their problems seem smaller. This study is one of very few that look at therapeutic factors in children's groups (Schectman & Gluk, 2005).

In a study with children of alcoholics, Riddle and Bergin (1997) concluded that group counseling significantly improved participants' self-concept as well as lowered their anxiety. Results of this study also showed an increase of participants' perceptions of their intellect, appearance, behavior, and popularity. Specifically, the authors noted that the counseling helped students express their feelings, learn about alcoholism, develop coping strategies, acquire skills to communicate, and recognize commonalities with other children of alcoholics. In a study working with adopted school-age children Kizner (1999) reported that group counseling sessions helped the children understand that other children experience the same feelings and that it's okay to talk about them. Kizner concluded that all the children in the group benefited from the study through responses from the counselors and the participants about the sessions. Bacha, Pomeroy, and Gilbert (1999) conducted a study that involved group counseling for children with HIV.

Results showed that through participation in group counseling, children gained a sense of universality which alleviated negative feelings associated with social alienation. It also seemed to raise children's self-esteem, with comments from the participants such as "I like me with AIDS," and "I feel better now even if I'm still sick." (p. 305). Another study which used group counseling for inner-city elementary students with behavioral problems found that group counseling can make significant positive changes in reducing acting out behavior (Brantley & Brantley, 1996). Brantley and Brantley (1996) added that both the pupils and the counselors found the counseling group approach to be profitable and enjoyable.

Group counseling with children with ADHD. Bowley and Walther (1992) reported that even though school counselors may have little time to provide individual therapy to children, they can use group counseling to save time and still help improve self-esteem, social skills, impulse control, and organization-study skills. Schwiebert and Sealander (1995) stated that group counseling for children with ADHD can help address issues of self-esteem, social skills, and dealing with their disorder. As in groups of children with other problems, children with ADHD that are in a counseling group often benefit by feeling less different and more supported (Tarrver-Behring & Spagna, 2004). In a study testing the effectiveness of a support group with preadolescents with ADHD, results showed that participants increased their scores for perceived social acceptance, perceived athletic competence, perceived physical appearance, and perceived global self-worth (Frame, Kelly, & Bayley, 2003). It was concluded that preadolescents with ADHD might benefit from a support group, because it improves the way they look at themselves.

Psychoeducation

We often hear patient education and immediately think of hospitals. Research shows that patient knowledge of their illness is very important for effective treatment (Nolan, Desmond,

Herlich, & Hardy, 1986). Nolan et al. reported that many patients have confusion and unrealistic beliefs about their illness, its long term effects, and treatment rationale. In a study with children with HIV, Bacha, Pomeroy, and Gilbert (1999) found that through teaching children about HIV, they gained an understanding of their illness which produced better dispositions in their daily lives. Mel Levine referred to education for children with learning disabilities as well as other disabilities as demystification (Levine, 1999). He described demystification as a process where an adult helps a child by describing for a child his or her strengths or weaknesses, particularly pointing out where a break in learning has occurred along the learning pathway. Levine states, "...it is hard for a student to work on something if he doesn't even know what it is called!" (Levine, 1999). In a study by Riddle and Bergin (1997) results showed that teaching children about alcoholism through group counseling sessions helped to demystify the subject, and in turn allowed children to explore their feelings.

Psychoeducation with children with ADHD. Wiggins, Singh, Getz, and Hutchins (1999) conducted a study using adults with ADHD to assess the effects of a psycho-educational group. It was found that the group did significantly help the adults with their ADHD in three areas. Post-test results for the counseling group compared to a control group showed significant differences in four subscales including disorganization, inattention, emotional liability, and self-confidence/self-esteem. The treatment group post-test scores were significantly higher than the control group scores in all four areas except the self-confidence/self-esteem subscale (Wiggins, Singh, Getz, & Hutchins, 1999). The authors gave a possible explanation for the decrease in self-esteem for the treatment group that the adults might have become aware of their difficulties in their every day life for the first time. Even though the results were based on an adult population, it does add to the limited knowledge of the usefulness of psycho-educational

counseling groups for people with ADHD. Webb and Myrick (2003) used a counseling group with children that had ADHD for their study. Its focus was on increasing understanding of the disorder and how it impacted student performance in school. Results showed an increase in self-understanding and school success behaviors.

The research done in this study looks specifically at how group counseling with a combined person-centered and psycho-educational focus affects children's self-concepts and knowledge and understanding of ADHD. It was hypothesized that students who participated in the counseling group would show an increase in their self-concept as well as their knowledge about ADHD, while the control group would show no change.

Methods

Participants

A non-random sample of participants was obtained for this study from a fourth and fifth grade elementary school in a suburban area of western New York. Nine students between the ages of 9 and 11 were used in this study; five for the counseling group, and four for the control group. Four out of the five students in the counseling group were available for the post-test, while three out of the four students in the control group were available for the post-test. Literature has shown that the most effective number of participants in counseling groups with children is between 3 and 4 (Rosenthal, 2002). All the students in the study were professionally diagnosed with Attention-Deficit/Hyperactivity Disorder.

The students were obtained by first obtaining a list of students that had been diagnosed with ADHD from the school nurse. The nurse also added names of children whom she knew were diagnosed, but not yet on the list. Because of the logistics of time in the school, some students were crossed off the list who were not available at the times the researcher was holding

the groups. Also because of time restraints, the four students in the control group came from the same classroom in the school. The students in the counseling group were each from a different classroom, but had similar times for lunch (when the counseling group was held).

The parents of the remaining students were called to inform them that a permission form was being sent home and to explain the research study. The students were then sent home with either a parental consent form for the counseling group or the control group. The children who brought back a signed consent form were then given a consent form to sign themselves. Of the children who signed a consent form, the resulting numbers of participants were 5 children in the counseling group and 4 children in the control group.

Of the five children in the counseling group, there were three males and two females. The four children in the control group were all male. Statistics show that boys are diagnosed with ADHD three to six times more than girls (Millichap, 1998). All four children were Caucasian. The school district in which the study was conducted was comprised of approximately 4,480 students in the 2003-2004 school year. The racial/ethnic origin distribution of students in the district was as follows: 1.5% American Indian, Alaskan, Asian, or Pacific Islander, 4% Black, 3.5% Hispanic, and 91.1% White. 1.4% of the students were limited English proficient. 17.1% of the students in the district were eligible for free lunch and 9.3% were eligible for reduced lunch. The annual attendance rate for the district was 95.7% and the rate of student suspensions was 4.2%.

Procedure

Counseling Group

The psychological intervention used in this study was increasing self-concept through a support/psycho-educational counseling group. During the time the group met the participants

had the opportunity to talk about their personal experiences with having ADHD, but were not required to share these experiences, and had the opportunity to learn about what ADHD is by being provided with age appropriate material about ADHD. Through sharing and/or listening to experiences of having ADHD, it was predicted that participants might gain insight and understanding about their own experiences, and feel comforted that others were experiencing similar situations. The investigator also predicted that the students may gain understanding about what they are going through by learning the facts about what the disorder is. This heightened understanding may positively affect the participants' thoughts and feelings about themselves (self-concept).

The behavior expected during the administration of the psychological intervention was that participants would start out being a bit hesitant to share ideas and demonstrate behaviors that showed they're bored or uninterested. As the group process continued, however, the behaviors expected included talking with one another, sharing ideas, and showing understanding through body language and verbal confirmation. The expected general behavior seen in the group was that it would be similar to the behavior shown in the classroom during that school day. The behavior of the investigator included showing empathy and unconditional positive regard, through facilitating the experiential part of group, and leading the group through activities, while involving the participants in the presentation of material. The investigator provided structure and limits, while still allowing the participants to direct where the interaction of group went.

No psychological or social consequences were anticipated, however, a possible psychological consequence was that students might experience feeling uncomfortable as they chose to share personal experiences. The specific steps that were taken to assure the proper operation and maintenance of the means used to administer the intervention were: 1) the group

met every week at the same time for six consecutive weeks. 2) The group made rules together at the second meeting including the “I pass” rule and confidentiality (keeping private other people’s stories) to ensure that students were not pressured into sharing or scared that what they said would come up outside of the group. 3) If at anytime a student wished to leave the group, they were allowed to leave. To assure confidentiality the students were instructed not to put their names on the survey. Instead, there was a number code 1-5 assigned to each student’s name. The codes appeared on both surveys. The consent forms with the students’ names were kept in a locked filing cabinet and shredded at the end of the project.

The plan for debriefing participants was to ask at the group at end of each meeting if everyone is in an okay place to end for the day. The investigator let the group know that if anyone wanted to talk privately that she was be available to do so. They were also notified that Michael Cusimano, the school counselor, was available for them to talk to.

The activities for the six counseling sessions are outlined as follows. One book, two workbooks, a poster, and a self-made worksheet were used in the activities.

Week 1:

- Make contract (group rules)
- Brainstorm: What is ADHD? Write students’ ideas on board/chart, and let them know that we will revisit the ideas during the next several weeks.

Week 2:

- Read Chapter 2 in *All Kinds of Minds* (Levine, 1993). Stop after each section and discuss story: How are you like or not like Eddie?

Week 3:

- Definition of distractible, hyperactive, impulsive, and inattentive: p. 10 in *Putting on the Brakes* (Quinn & Stern, 1993) and discussion of what ADHD stands for.
- ADHD checklist p. 11, *Putting on the Brakes*
- Feelings: p. 29 in *Getting a Grip on ADD* (Frank & Smith, 1994) and p. 25 +26, *Putting on the Brakes*

Week 4:

- How ADHD works in the Brain: p. 12 *Putting on the Brakes* and p. 18-20 *Getting a Grip*

- Medication and other ways to help with ADHD: p. 22-27 *Getting a Grip*

Week 5:

- Sharing what works and what doesn't work for me: p. 30 *Putting on the Brakes*
- Mel Levine's (1997) *Concentration Cockpit*

Week 6:

- How ADHD can help you: *ADHD: How it Can Help* worksheet (constructed by researcher; see Appendix L) and p. 26 +27 in *Putting on the Brakes*

Control Group

The participants in the control group of the study completed the Piers-Harris Self-Concept Scale and the first page of the self-constructed Group Survey in a group format with the investigator in a separate room in the school. They were not involved in the group activities and did not fill out the second page of the self-constructed Group Survey. The two tests were given twice as pre and post-test measurements, once before the counseling group began, and once after the last session. Again, to assure confidentiality, the students were instructed not to put their names on the survey. Instead, there was a number code 11-14 assigned to each student's name. The codes appeared on both surveys. The consent forms with the students' names were kept in a locked filing cabinet and shredded at the end of the project.

Evaluation

Instruments

Piers-Harris Self-Concept Scale for Children. The Piers-Harris Children's Self-Concept Scale (How I Feel About Myself) (Piers & Harris, 1969), was administered in a group format to both groups of students as a pre and post measurement. The investigator read the questions out loud and the students followed along. The scale is a self-report instrument used to measure children's self-attitudes and was designed mainly for the purpose of research with children's development of self-attitudes and correlates of these attitudes (Piers & Harris, 1969). It is

comprised of 80 yes/no response items and requires approximately 15-20 minutes to administer with no time limit. The scale is used typically with children in grades 3-12 but it is suggested that the items be read aloud to children in grades 3 and 4 and grades 5 and 6, if needed (Piers & Harris, 1969). The authors warn that when interpreting the scores, a difference in scores up to 10 points does not necessarily mean a change in self-concept, however, in general, the higher the score, the higher the self-concept. The mean self-concept score in the norm group according to Piers and Harris was 51.84 out of 80. In this study the investigator did not compare the counseling and control groups to the norm group, but instead compared each group to itself, pre and post, and to each other, pre and post.

There are six different clusters that can be scored separately on the test. They include: Behavior, Intellectual and School Status, Physical Appearance and Attributes, Anxiety, Popularity, and Happiness and Satisfaction. Piers and Harris (1969) maintained that the information from cluster scores should be read tentatively, but can be useful.

Piers and Harris (1969) reported that the internal reliability of the scales was tested using the Kuder-Richardson Formula 21, and results showed coefficients ranging from .78 to .93. The Spearman-Brown odd-even formula was also used with a sixth and tenth grade sample with resulting coefficients of .90 and .87. They also reported that the mean test-retest reliability coefficient was .72, which was judged as satisfactory for a personality instrument. The authors warned however, that individual scores could go up as much as 10 points without a change self-concept, and group means on a retest tended to go up even when no treatment has taken place. They attribute the rise to a possible increased familiarity with the test items, and stress the importance of using a control group before claiming change in self-concept.

The content validity of the scale was built by defining what was being measured as areas that children previously reported as qualities they liked or dislike about themselves. There are items on the test that cover all of these areas; however the scale does not cover every area to the same degree. Scores on the Piers-Harris were compared with scores on the Lipsitt's Children's Self-Concept Scales with a resulting correlation of .68. The Piers-Harris was also compared with scores on the big problems portion of the SRZ Junior Inventory and a correlation of -.64 was found. The children's self reports of self-concept have also been compared with teacher and peer ratings. The resulting correlations with four and sixth graders ranged from non-significant to .49. Girls' ratings and peer rating tended to correspond better with self-reports than teacher ratings. Specific correlations between the Piers-Harris and teacher and peer ratings of socially effective behavior were .43 and .31. The correlations with ratings of superego strength were .40 and .52, respectively.

Piers and Harris (1969) also predicted significantly different scores for different groups of children. In a study done with girls with mental retardation residing in a mental institution, it was predicted that the scores on the Piers-Harris would be significantly lower than the norm for the same chronological age and mental age. Results showed significantly lower scores with the girls who were institutionalized. The instrument was also given to children with mental retardation in special education classes, and results from this showed normal mean scores. It was determined that it was the institutionalization and not the mental retardation that was affecting the girls' self-concepts.

Self-Constructed Group Survey. Another instrument used to measure the effects of the counseling group was a self-constructed survey used to measure the student's pre and post-group knowledge of ADHD, as well as how the group helped or did not help them (see Appendix A

and B). The survey was given in a group format. The six items on the first page of the survey were in Likert format. This was given to both the counseling and control groups as a pre and post measurement. The two items on the second page of the survey each consisted of a question in Likert format and a question with a written response. This was given to only the counseling group as a post-group measurement.

Results

Piers-Harris Children's Self Concept Scale

The investigator hypothesized that the counseling group's post-test scores of the Piers-Harris Children's Self Concept Scale (PHCSCS) would be higher than the pre-test scores, as well as higher compared to the post-test scores of the control group. The results of the post-test showed that the average score did not go up for the counseling group, but dropped by 10 points. The post-test score for student 4 did not change, while the other three student's scores did. The scores for students 1 and 5 both decreased by 5 points which does not constitute a significant drop. The score for student 3 however, dropped dramatically by 12 points. This large decrease, as well as a high score for student 2, who only took the pre-test, resulted in a big drop in the average score on the post-test for the counseling group (see Appendixes C-E for full detail).

The average control group score on the PHCSCS showed an increase of approximately 13 points. The post-test score for student 12 showed a large increase of 23 points from the pre-test score. Student 13 also showed a significant increase, with a difference of 12 points between the pre-and post scores. Student 14 showed a slight increase of 5 points (See Appendixes C-E for full detail).

Four out of the six average cluster scores on the PHCSCS also went down slightly for the counseling group. These were clusters 1-3 (behavior, intellectual and school status, physical

appearance and attributes, and happiness and satisfaction). The two cluster scores that remained the same on the post-test were cluster 4 (anxiety) and cluster 5 (popularity). All of the average cluster scores went up slightly for the control group (see Appendixes F-H for full detail).

These results may show an overall decrease in self-concept for the counseling group and an overall increase in self-concept for the control group, however, as noted above, Piers and Harris (1969) state that within a range of 10 points, it is possible that self-concept has not necessarily changed, even though the scores may have. These findings support similar results in Wiggins, Singh, Getz, & Hutchin's (1999) study, where the treatment group post-test scores were lower than the control group scores on the self-confidence/self-esteem subscale.

The findings do not support the findings in Frame, Kelly, and Bayley's (2003) study who found that participants in a counseling group increased their scores for perceived social acceptance, perceived athletic competence, perceived physical appearance, and perceived global self-worth. It was concluded that preadolescents with ADHD might benefit from a support group because it improves the way they look at themselves. The results of the Piers-Harris Children's Self Concept Scale do not support the idea that the counseling group improved overall self-concept; however, through researcher observation and the self-constructed Group Survey, the way the children looked at themselves in regards to their disorder seemed to improve.

Self-constructed Group Survey

The hypothesis made for the first page of the self-constructed Group Survey, was that the average amount of knowledge according to the Likert scale would increase for the counseling group and remain relatively constant for the control group. The knowledge of ADHD did increase significantly for the counseling group according to responses circled on the post-test compared to those on the pre-test. On the pre-test, most of the responses circled for both groups

were “Not At All,” “A Little,” or “Some”. On the post-test, most of the answers for the counseling group moved up to “Some”, “A Lot”, or “Almost Everything”. The majority of the responses on the post-test for the control group remained between the “Not At All” and “Some” range (see Appendix I-K for details).

It was also hypothesized that the counseling group would show evidence of increased learning and satisfaction of the counseling group experience through their answers on the second page of the Group Survey. Out of the four students who took the post-test, three of the students marked that they learned “a lot” from being in the group, while one student marked that he/she learned “some”. Written responses from the students included, “I liked lunch bunch because now I know a lot about ADHD,” “It taught me what ADHD stands for and what it means,” and “It did help me because it taught me to tell other people my feelings.” Two out of the four students said they would recommend the group to another student, and one responded with “maybe”. One student responded “no”.

As the group went on, the process of sharing ideas and creating universality among members seemed to be accomplished. Often when a student was sharing what ADHD was like for them or an experience they had gone through, others would respond with “yeah, that happens to me, too!” or “sometimes I feel they way, too!” Overall, the group counseling sessions definitely seemed to help the students gain knowledge and understanding about the disorder, as well as gain a sense that they are not alone in dealing with it. These results show similar findings to that of Bacha, Pomeroy and Gilbert’s (1999) study with children who were HIV-positive. Children in the study responded similarly to the students in this study, saying “There’s other kids like me with AIDS” and “I feel better now even if I’m still sick” (p. 305). The process of both groups seemed to emphasize the importance of universality for children. Similarly, in a study by

Webb and Myrick (2003) children with ADHD who went through group counseling showed an increase in self-understanding. In this study, test results showed that overall self-concept did not rise, however, the group seemed to foster understanding of self surrounding the topic of ADHD. The results of the Group Survey showed that the level of knowledge and understanding about ADHD in the counseling group went up while the control group's level of knowledge remained relatively unchanged.

Discussion

The primary purpose of this study was to help children with ADHD understand the disorder and increase self-concept. Overall, the researcher expressed satisfaction with the study, and noted that it seemed to give the students a better understanding of the disorder, as well as ways to look at it as something positive in their lives. While results of the Piers-Harris Children's Self Concept Scale showed that self-concept did not increase, interactions within the group process seemed to induce positive emotions among the students. Results of the Group Survey showed enhanced understanding about the disorder as well as the students' overall satisfaction with the counseling group. The results of this study support literature that says group counseling can be a helpful treatment for students with ADHD (Aust, 1994; Wodrich, 2000; Abikoff & Hechtman, 1996). Through introducing education and support through group counseling, this study also supported the growing idea that ADHD must be treated through a multi-modal approach and that medicine alone cannot meet all the needs of students with the disorder (Aust, 1994; Bowley & Walther, 1992; Watchell, 1998). This study also maintains the thought that educating children with ADHD about their disorder can help in their understanding of the disease which may help students feel better about themselves (Webb & Myrick, 2003; Levine, 1999).

Limitations

Throughout the study, the author saw several factors as being limitations to the study. It's possible that many of the limitations caused a different outcome on the Piers-Harris Children's Self Concept Scale than what was hypothesized. If the limitations to this study are changed, future similar studies could produce more successful and more valid results.

Time. The author believed that of all the factors affecting the outcomes of the study, time was the biggest. The group was held over a five-week period (two sessions during the last week), and the sessions were only 30 minutes in length. Sometimes the group would start several minutes late because the researcher often had to track kids down from different ends of the school. Many of the meetings seemed rushed and because the researcher wanted to cover several aspects of ADHD through group activities, limited time was left for general discussion amongst the group about the activities or their feelings. Three out of the five students in the counseling group ate their lunch during the group, which also took up time and sometimes caused distraction. Because of the short time span that the group ran, the author believed the time period was too short in which to re-test the students with the Piers-Harris Children's Self Concept Scale. Question also arose as to whether or not five weeks was enough to produce any change in the students' self-concepts, even if the group sessions were an hour long. Piers and Harris (1969) suggested that the test be given in long term studies rather than after day or week long treatment, however they did not mention how long "long-term" is. If the group was able to last twice as long and extend over a period of 10 weeks the author believed that more time could have been spent on talking with the children about their experiences and feelings about having the disorder. If this was the case, self-concept scores could possibly have been higher in the counseling group, as well as more valid.

Participants. The first limitation in regards to participants was that there was a very low sample size. A number of at least 15 students in each group could have produced better results. Instead of having only one counseling group and one control group, it would be better to have 3 or four of each group. Another limitation to the study was that two students, one in the control group and one in the counseling group, were not available for the post-test. If these students' scores were averaged in with the rest of the post-test scores the results could potentially have been different. An additional setback was that all of the students in the control group were from the same class, while the study group was made up of students from different classes.

Another possible limitation was that the participants in the study were not screened for low self-concept or self-esteem before being allowed in the study. In other words, the self-concepts of the students in the counseling group might have not increased, because the students already had high self-concepts. In fact, the pre-test scores showed that the all but one student had scores that fell above the mean. This suggests that they had average or above average self-concepts to begin with. This finding contradicts what Frame, Kelly, and Bayley (2003) reported in their study. They stated that pre-adolescents with ADHD had lower perception of self-worth than did their non-ADHD peers.

Instruments. The students completed the post-test PHCSCS with some reluctance. The researcher believed she was met with reluctance not because of the test's difficulty but rather the length of the scale (80 questions). The students had just taken the pre-test five weeks prior, and didn't fully understand why they had to complete the same test again. If the author was to do the study again, other types of instruments that measured self-concept or self-esteem that had a shorter administration time would be considered for use. Of course, if the sessions lasted 10 weeks, the length of the scale might not be as much of a problem.

Another observation the researcher made, that may have offset post-test scores, was the huge gaps between some of the students' pre and post-test scores on the PHCSCS; particularly, student 3 in the counseling group and students 12 and 13 in the control group. Student 3's post-test score went down 12 points. There are many reasons this may have occurred, however it is not believed that his/her self-concept dropped that dramatically as direct result of the counseling group experience. One possible explanation was that the student might have gotten off track on responding to the questions. After reading the question the student had to follow dotted lines across to the other side of the page where the responses yes/no were placed. It seemed that a student could easily skip a set of responses, and accidentally drop to the next set below. When realizing this happened, the student could have just circled an answer at random for the response set that was missed.

While this same situation may have happened with student 12 and 13 in the control group, it may be more likely that they were trying to answer in a socially acceptable fashion rather than putting their honest personal response. Piers and Harris (1969) stated that some children may get confused between how they actually feel or act and how they have been told to feel and act. Piers and Harris (1969) also state that scores often go up on the re-tests because of familiarity with the test.

While the self-constructed Group Survey seemed to show positive results, its biggest limitation was that it was not a published instrument. Therefore, the reliability and validity of the measurement could not be determined, except for face validity which, according to the results, seemed fairly high. In further studies, the researcher suggested that an already existing, published form of a test that measures knowledge of ADHD be used to increase the legitimacy of the results (the researcher was not able to find a previously published test). The researcher also

believed that the qualitative questions on the second page of the survey were useful in determining the success of the counseling group.

Environmental factors. In doing research, one must take into consideration environmental factors that affect the student's knowledge and attitudes. Some students might have had previously learned more about ADHD and talked about it more than others. One student mentioned that his/her teacher had read his/her class the book *All Kinds of Minds* (Levine, 1993). The way the students responded to some of the statements on the PHCSCS might have had to do with situations they had faced in school that day. An example of this would be if a student who wasn't normally picked on, was called a name in front of all his classmates on the bus. If a question such as "Do you get picked on in school?" was on the scale, the student, who would normally answer "no" to that question, might respond with "yes" that day.

Implications

This study adds important findings to the limited amount of studies that investigate group counseling to help students with ADHD, particularly when measuring self-concept and understanding of the disorder. When treating students with ADHD, there tends to be a lack of focus on the child's feelings and understanding around the disorder, but this study adds to that research and helps to prove that group counseling can be of great benefit. The activities presented in this study produced positive outcomes in the student's knowledge about ADHD as well as the importance of sharing feelings they have about how the disorder affects them. Through using similar methods and procedures, school counselors can easily meet the needs of several students who may be struggling with ADHD. This study also shows that some students with ADHD may need more help than others as far as raising self-concept and understanding

their disorder. The findings can aid school counselors with meeting the emotional needs of students in a school, rather than focusing solely on changing behaviors.

Recommendations

The researcher strongly believes that a similar study would prove more effective in showing an increase on the PHCSCS if students were screened for low self-concept or self-esteem before running it. (The researcher uses these terms interchangeably, because they have relatively the same meaning and self-esteem is a more commonly used term.) The researcher also believes that the results of this study show that any child, low self-concept or not, can benefit from a combined psycho-educational/support group because it can increase their understanding of the disorder and create a sense of universality. It is highly suggested that the group run for a longer period of time, preferably with longer sessions. Keeping the groups to a size of 3-5 students is suggested for ease of information distribution and discussion. Using too large of a group might not only be difficult for the person running the group, but it may hinder the amount of self-disclosing from students.

Another recommendation for future research is that the topics of self-concept and understanding of the disorder may want to be investigated separately or a relational study between the two might prove useful (how an increase in understanding affects self-concept). Researchers might want to focus more on results based on gender or use similar counseling groups with different age groups of children. With different ages, however, it is recommended that age-appropriate material is used (the material used in this study was intended for children in grades 3-6). Another option for investigators would be to look the effectiveness of group counseling combined with or without other interventions such as medication or behavior therapy. A closer look at each subscale on the PHCSCS could also be a topic of interest.

While the half of the results of the study didn't match the hypothesis, the results seemed to prove group counseling as an effective treatment for students with ADHD, none-the-less.

While many adults try to manipulate student behavior with medication and behavioral techniques, the child's emotional state can often get lost in the shuffle. This study was conducted to help remind school counselors that the emotional part of the child is just as important as the behavioral part of the child, and that group counseling can be an effective part of a multi-modal treatment for students with ADHD.

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Appendix A

GROUP SURVEY

Directions: Circle how much you know or don't know about the following statements. Answer the questions at the end. Please be honest. This is not a test. You don't have to put your name on it.

1. I know what ADHD stands for.

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

2. I know what ADHD is.

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

3. I understand why I act the way I do sometimes (This may be: not sitting still, not paying attention, daydreaming, doing or saying things without thinking first).

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

4. I understand how my brain can affect my actions.

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

5. I understand how medicine may work to help some kids change their behaviors.

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

6. I know why it is important to share my feelings.

NOT AT ALL A LITTLE SOME A LOT ALMOST EVERYTHING

Appendix B

Please circle the statement that best describes what you think.

1. Being in Lunch Bunch helped me.

NOT AT ALL A LITTLE SOME A LOT I DON'T KNOW

If lunch bunch did help you, explain how it helped you. If not, leave this blank.

2. I would recommend that other kids participate in Lunch Bunch.

NO YES MAYBE

Please tell what you liked or didn't like about Lunch Bunch.

Appendix C

Pre-test Raw Scores, Percentiles, and Stanines on Piers-Harris Children's Self Concept Scale for Counseling Group and Control Group

Counseling Group

| Student | Raw Score | Percentile | Stanine |
|---------|-----------|------------|---------|
| 1 | 58 | 63 | 6 |
| 2 | 68 | 89 | 7 |
| 3 | 48 | 36 | 4 |
| 4 | 55 | 55 | 5 |
| 5 | 64 | 79 | 7 |
| Average | 59 | 64 | 6 |

Control Group

| Student | Raw Score | Percentile | Stanine |
|---------|-----------|------------|---------|
| 11 | 59 | 66 | 6 |
| 12 | 43 | 24 | 4 |
| 13 | 59 | 66 | 6 |
| 14 | 68 | 89 | 7 |
| Average | 57 | 61 | 6 |

Appendix D

Post-test Raw Scores, Percentiles, and Stanines on Piers-Harris Children's Self Concept Scale for Counseling Group and Control Group

Counseling Group

| Student | Raw Score | Percentile | Stanine |
|---------|-----------|------------|---------|
| 1 | 53 | 49 | 5 |
| 3 | 30 | 8 | 2 |
| 4 | 55 | 55 | 5 |
| 5 | 59 | 66 | 6 |
| Average | 49 | 45 | 5 |

Control Group

| Student | Raw Score | Percentile | Stanine |
|---------|-----------|------------|---------|
| 12 | 66 | 85 | 7 |
| 13 | 71 | 94 | 8 |
| 14 | 73 | 96 | 8 |
| Average | 70 | 92 | 7 |

Appendix E

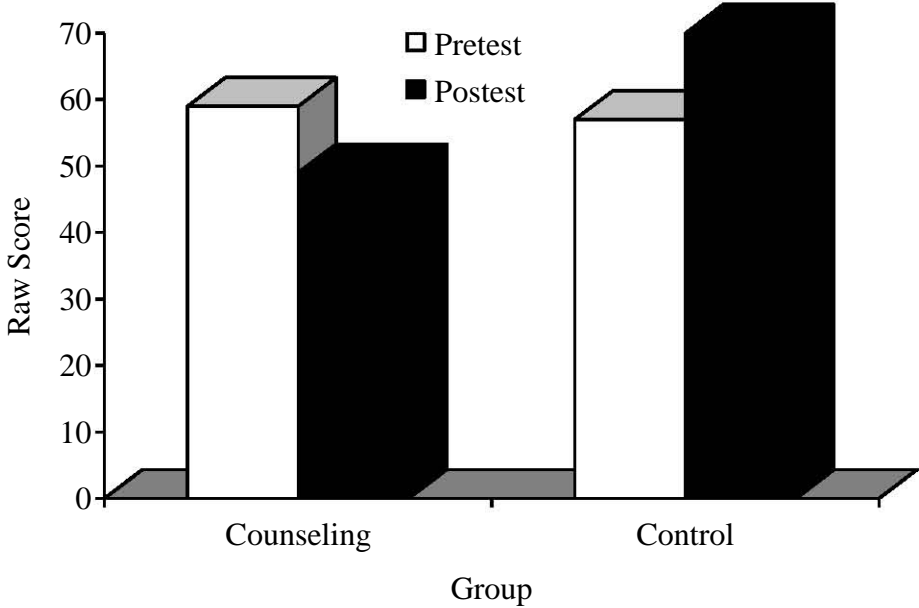


Figure E1: Average raw scores of Piers-Harris Children's Self Concept Scale for counseling and control groups

Appendix F

Pre-test Cluster Raw Scores on Piers-Harris Children's Self Concept Scale for Counseling Group and Control Group

Counseling Group

| Student | Cluster 1 | Cluster 2 | Cluster 3 | Cluster 4 | Cluster 5 | Cluster 6 |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|
| 1 | 12 | 13 | 6 | 13 | 7 | 9 |
| 2 | 14 | 15 | 12 | 13 | 11 | 9 |
| 3 | 15 | 11 | 7 | 8 | 3 | 9 |
| 4 | 11 | 11 | 8 | 9 | 8 | 6 |
| 5 | 14 | 16 | 13 | 9 | 7 | 8 |
| Average | 13 | 13 | 9 | 10 | 7 | 8 |

Control Group

| Student | Cluster 1 | Cluster 2 | Cluster 3 | Cluster 4 | Cluster 5 | Cluster 6 |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|
| 11 | 9 | 13 | 9 | 13 | 11 | 6 |
| 12 | 10 | 6 | 4 | 9 | 5 | 4 |
| 13 | 16 | 11 | 5 | 9 | 9 | 6 |
| 14 | 15 | 15 | 10 | 14 | 9 | 10 |
| Average | 13 | 11 | 7 | 11 | 9 | 7 |

Appendix G

Post-test Cluster Raw Scores on Piers-Harris Children's Self Concept Scale for Counseling Group and Control Group

Counseling Group

| Student | Cluster 1 | Cluster 2 | Cluster 3 | Cluster 4 | Cluster 5 | Cluster 6 |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|
| 1 | 11 | 13 | 5 | 10 | 7 | 8 |
| 3 | 12 | 4 | 5 | 5 | 1 | 7 |
| 4 | 9 | 13 | 9 | 11 | 10 | 6 |
| 5 | 12 | 15 | 9 | 13 | 8 | 8 |
| Average | 11 | 11 | 7 | 10 | 7 | 7 |

Control Group

| Student | Cluster 1 | Cluster 2 | Cluster 3 | Cluster 4 | Cluster 5 | Cluster 6 |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|
| 12 | 13 | 12 | 10 | 13 | 11 | 8 |
| 13 | 15 | 16 | 11 | 14 | 8 | 10 |
| 14 | 14 | 15 | 13 | 14 | 11 | 10 |
| Average | 14 | 14 | 11 | 14 | 10 | 9 |

Appendix H

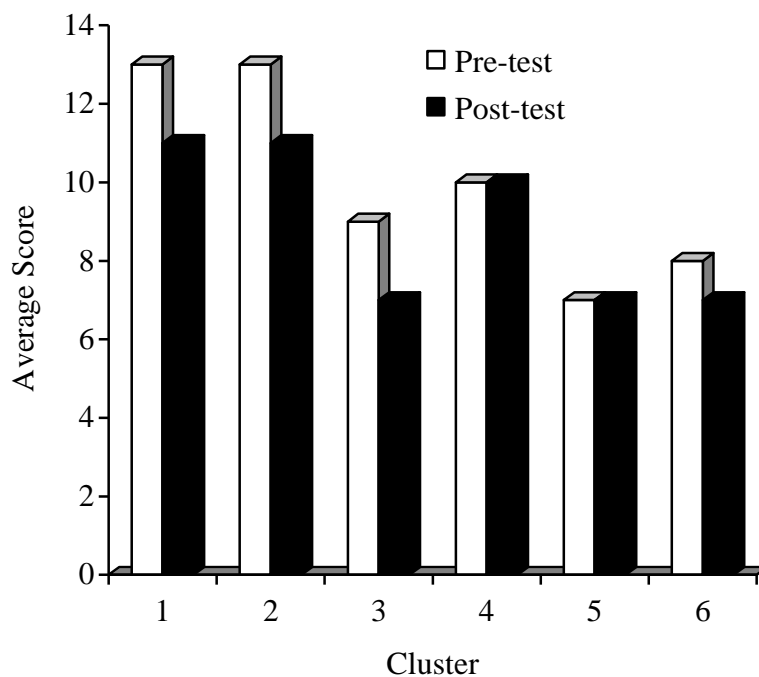


Figure H1: Counseling group cluster scores on Piers-Harris Children’s Self Concept Scale

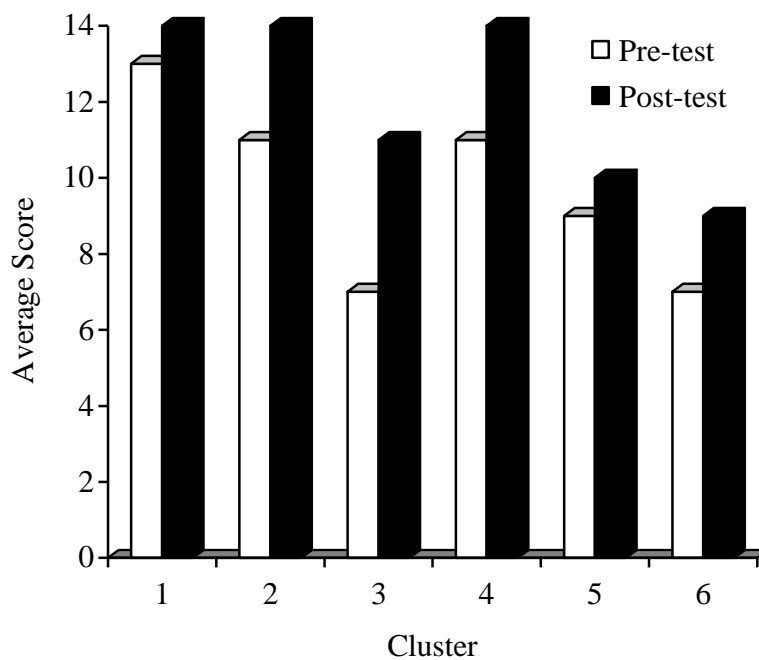


Figure H2: Control group cluster scores on Piers-Harris Children’s Self Concept Scale

Appendix I

Pre-test Number of Student Responses on Group Survey for Counseling Group and Control Group

Counseling Group

| | Not At All | A Little | Some | A Lot | Almost Everything |
|------------------------|------------|----------|------|-------|-------------------|
| Question 1 | 1 | 2 | 1 | 1 | 0 |
| Question 2 | 1 | 2 | 1 | 1 | 0 |
| Question 3 | 0 | 3 | 1 | 1 | 0 |
| Question 4 | 1 | 1 | 2 | 0 | 1 |
| Question 5 | 0 | 3 | 1 | 0 | 1 |
| Question 6 | 0 | 0 | 1 | 1 | 3 |
| Total Percent Answered | 10% | 37% | 23% | 13% | 17% |

Control Group

| | Not At All | A Little | Some | A Lot | Almost Everything |
|------------------------|------------|----------|------|-------|-------------------|
| Question 1 | 3 | 1 | 0 | 0 | 0 |
| Question 2 | 3 | 1 | 0 | 0 | 0 |
| Question 3 | 0 | 3 | 0 | 1 | 0 |
| Question 4 | 0 | 0 | 0 | 3 | 1 |
| Question 5 | 0 | 1 | 1 | 1 | 1 |
| Question 6 | 1 | 1 | 0 | 1 | 1 |
| Total Percent Answered | 29% | 29% | 4% | 25% | 13% |

Appendix J

Post-Test Number of Student Responses on Group Survey for Counseling Group and Control Group

Counseling Group

| | Not At All | A Little | Some | A Lot | Almost Everything |
|------------------------|------------|----------|------|-------|-------------------|
| Question 1 | 0 | 0 | 0 | 0 | 4 |
| Question 2 | 0 | 0 | 0 | 1 | 3 |
| Question 3 | 0 | 0 | 0 | 2 | 2 |
| Question 4 | 0 | 0 | 1 | 0 | 3 |
| Question 5 | 0 | 1 | 0 | 1 | 2 |
| Question 6 | 1 | 0 | 1 | 0 | 2 |
| Total Percent Answered | 4% | 4% | 8% | 17% | 67% |

Control Group

| | Not At All | A Little | Some | A Lot | Almost Everything |
|------------------------|------------|----------|------|-------|-------------------|
| Question 1 | 1 | 1 | 1 | 0 | 0 |
| Question 2 | 1 | 0 | 2 | 0 | 0 |
| Question 3 | 0 | 1 | 0 | 2 | 0 |
| Question 4 | 0 | 2 | 0 | 1 | 0 |
| Question 5 | 0 | 2 | 1 | 0 | 0 |
| Question 6 | 0 | 1 | 0 | 1 | 1 |
| Total Percent Answered | 11% | 39% | 22% | 22% | 6% |

Appendix K

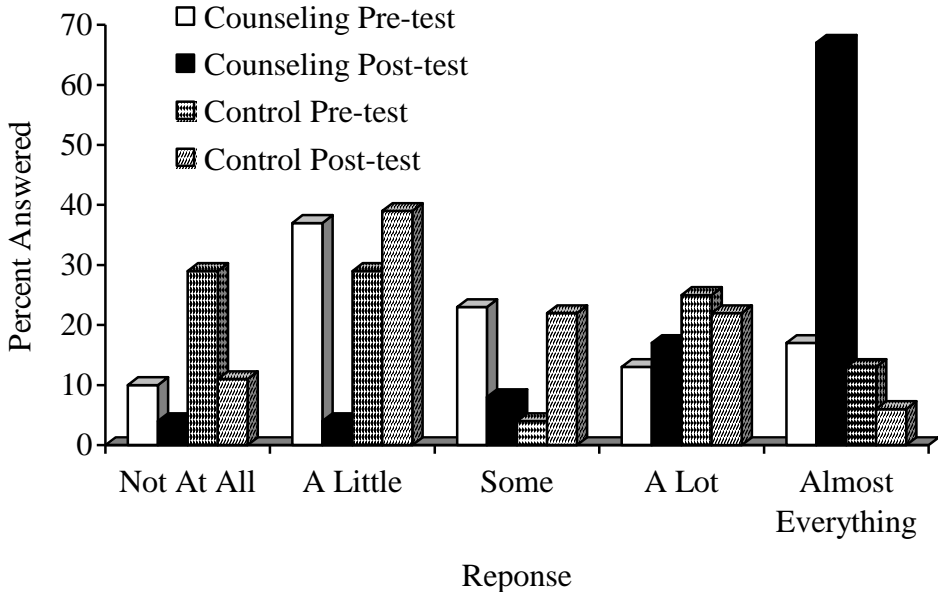


Figure K1: Results of Group Survey for counseling and control groups

Appendix L

ADHD: How it Can Help

Directions: Cross out the last “D” in ADHD at the top of the page. Why do you think we just crossed it out? As a group we’ll figure out the missing word. Then we’ll come up with examples of when we can use the words in our lives.

Hyper..... _ _ _ _ _

Example:

Impulsive..... _ _ _ _ _

Example:

Distractible..... _ _ _ _ _ _ _ _ (two words)

Example:

Answers: Hyper= energetic, Impulsive= quick, Distractible= eagle eyes