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The Effects of Descriptions of Personal Experiences on Students' Learning and Behavioral Intentions Toward Peers with Attention Deficit/Hyperactivity Disorder

Lee Saecker
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To the Graduate Council:

I am submitting herewith a dissertation written by Lee Saecker entitled "The Effects of Descriptions of Personal Experiences on Students' Learning and Behavioral Intentions Toward Peers with Attention Deficit/Hyperactivity Disorder." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Christopher H. Skinner, Major Professor

We have read this dissertation and recommend its acceptance:

Amy L. Skinner, Sherry K. Bain, Richard A. Saudargas

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Amy L. Skinner, Dissertation Co-Chair

We have read this dissertation
and recommend its acceptance:

Sherry K. Bain

Richard A. Saudargas

Accepted for the Council:

Carolyn R. Hodges, Vice Provost and
Dean of the Graduate School

(Original signatures are on file with official student records)

**The Effects of Descriptions of Personal Experiences on
Students' Learning and Behavioral Intentions Toward
Peers with Attention Deficit/Hyperactivity Disorder**

A Dissertation Presented for
the Doctor of Philosophy in Education Degree
The University of Tennessee, Knoxville

Lee B. Saecker
August 2009

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DEDICATION

This document is dedicated to all my friends and family that supported me throughout my time in graduate school. I wouldn't have been able to get this far without their constant support and encouragement. A special dedication to my parents, Rawls and Hope Saecker, who were always willing to lend an ear and give me support when I needed it. Their unending love and encouragement throughout my life has helped me get where I am today. Lastly, I would like to dedicate this document to my family members that are no longer with us: Marcella Lee Rawls, Wellington Saecker, Joyce Saecker, Edward Saecker, and Norman Bradshaw. Thank you for always believing in me and teaching me that life is not about the destination, but the journey.

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ABSTRACT

Through a post-test only design, students' knowledge and behavioral intentions toward their peers with Attention Deficit/Hyperactivity Disorder (AD/HD) were investigated. Students were shown a video that provided them with factual information about AD/HD. The experimental group viewed a video that contained descriptions of personal experiences (e.g., seductive information) in addition to factual information, while the control group received factual information only. Results show that adding descriptions of personal experiences to facts about AD/HD may be enough to enhance learning, but may not be enough to change behavioral intentions. On the knowledge scale, there is an interaction between the two knowledge-question categories (those addressed with facts only and facts with descriptions of personal experiences) and both experimental and control groups. This effect was such that the experimental group had a higher score on the knowledge-question category that addressed the descriptions of personal experiences than those addressed by facts only. Future researchers should focus on eliminating ceiling effects caused by inadequate measures and exploring the causal mechanisms behind the interaction.

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CHAPTER I

LITERATURE REVIEW

Attention Deficit/Hyperactivity Disorder (AD/HD) is one of the most prevalent and researched behavioral disorders affecting children's academic achievement and relationships with teachers and peers (Barkley, 2003). The quality of peer relationships is affected by the child's behavior and factors outside of the child (e.g., peer perceptions, teacher attitudes). Children with AD/HD are known to show characteristics, such as hyperactivity and aggression, that are associated with poor peer relationships for all children. As there are misunderstandings regarding AD/HD, providing factual information and personalization of AD/HD (through descriptions of personal experiences) may enhance classmates' knowledge of AD/HD and their perception of peers who have AD/HD.

Peer Relationships: General Findings

Measurement of Peer Relationships

Researchers often focus on peer behaviors, behavioral intentions, and attitudes to determine the nature of peer relationships. Behaviors are usually measured through observational methods, as well as behavioral intentions scales. Though the behavioral intentions scales do not measure actual behavior, they can be a reliable and valid measure of how students' would behave toward a hypothetical person or situation (Bell & Morgan, 2000; Fortini, 1987; Friedrich, Morgan, & Devine, 1996; Roberts & Lindsell, 1997; Roberts & Smith, 1999; Swaim & Morgan, 2001). In measuring peer attitudes, the

most common method is sociometrics. Sociometric ratings involve peer nominations and/or ratings to determine the extent to which a child is liked or disliked in the classroom and to identify the target child's sociometric (or social) status (Bierman, 2004). Most of the studies reviewed used either peer nominations or peer ratings, both a type of sociometrics.

In peer nominations, students are usually asked to name a designated number of people they "like the most" and "like the least" within their peer group. Based on the number and type (e.g., liked or disliked) of nominations a child receives, he or she can be placed into one of five categories of social status. These categories include popular (many "liked most", few "liked least"), controversial (many "liked most", many "liked least"), neglected (few "liked most", few "liked least"), rejected (few "liked most", many "liked least"), and average (no consistent pattern) (Bierman, 2004). While peer nominations often place a student into nominal categories, peer ratings place students on a continuum from least preferred to most preferred.

There are two types of peer ratings: peer preference ratings and descriptive peer ratings. Peer preference ratings measure the extent to which a child would like to play with or work with his or her classmates. Descriptive peer ratings are similar to peer preference ratings, except more specific attributes are rated (e.g., friendly, bossy, mean, smart). Both assessments are comprised of various statements about activities and Likert-scale response sets (e.g., I would like to play with him: 1= not at all to 5= very much). Students are asked to rate each person in the classroom (or specified group) on each item.

The Impact of Peer Relationships

The specific social status and rating children are given by their peers is an important factor because attitudes toward peers and relationship patterns are formed early and are relatively stable. As early as pre-school, children are more likely to interact with peers who are nominated as “liked” than with peers who are nominated as “disliked” (Masters & Furman, 1981). The social status that the child attains (e.g., popular, rejected, neglected) often carries over to new situations and remains stable (Dodge, 1983). Thus, rejected boys’ status is often re-established in an unfamiliar situation fairly quickly and is resistant to change over time (Bagwell, Molina, Pelham, & Hoza, 2001; Bryan, 1976; Coie & Kupersmidt, 1983). Because peer rejection appears to be fairly stable over time, it may lead to long-term impairment for the rejected child (Bagwell et al; Bryan).

Children who experience rejection and negative peer relationships are at risk. Those who are rejected by their peers tend to exhibit more behavior problems than neglected, popular, or average children (French & Waas, 1985). Children with unsatisfactory peer relationships are more likely to experience depression, somatization, and interpersonal sensitivity disorders (Compas, Slavin, Wagner, & Vannatta, 1986). Also, they may be at a higher risk for anxiety, behavioral and mood disorders, substance abuse and delinquency as teenagers (Centers for Disease Control and Preventions [CDC], 2005b). As adolescents they are more likely to drop out of school and commit criminal acts, particularly those who display high levels of childhood aggression (Parker & Asher, 1987).

Peer relationships can influence a child's reactions to major life events, social interaction patterns, attitudes toward school and education, educational goals, and achievement (Campbell & Paulauskas, 1979; Johnson, 1981). Positive peer relationships may serve as a protective factor. For children coming from adverse situations, friendship serves as a moderator that can lead to more adaptive outcomes in life. Positive peer interactions during school may lead a child to have more positive attitudes about school, which in turn may lead to less truancy, harder work, and better grades (Criss, Pettit, Bates, Dodge, & Lapp, 2002; Milich & Landau, 1982).

Factors that May Impact Peer Relationships in Children

Researchers have investigated several factors that may result in classmates rejecting peers. Correlates of social status include social behaviors and social knowledge (Maedgen & Carlson, 2000; Milich & Landau, 1982). When a child exhibits inappropriate social behaviors, he or she is more likely to be rejected (Milich & Landau). Rejected boys are more likely to engage in physical aggression and disrupt on-going activities, and less likely to engage in appropriate social behaviors, such as cooperative play and interaction in structured group activities (Coie & Kupersmidt, 1983; Dodge, 1983). Social behaviors can be influenced by social knowledge, such that greater social knowledge of a child is correlated with more positive social behaviors and less rejection of a partner on structured tasks (Grenell, Glass, & Katz, 1987). One measure of social knowledge is the rejected child's perceptions of the behavioral intentions of his or her peers.

Students with poor social status may be more likely to misjudge their peers' intentions. Researchers found that when children in Kindergarten and grades 2 and 4 watched a videotape of one child provoking another child and described the behavior of the children in the video, students considered deviant tended to label neutral behaviors as hostile (Dodge, Murphy, & Buschsbaum, 1984). Thus, socially deviant children may not read social cues correctly, which may cause peers to reject them. A specific type of student that may exhibit deficits in social knowledge and behaviors, and therefore may be more likely to be rejected, is a child with a disability.

Factors that May Impact Peer Relationships in Children with Disabilities

On sociometric scales, children who have a disability tend to receive more nominations on the socially "undesirable" scales and more negative ratings on peer preference scales (Bickett & Milich, 1992; Bryan, 1976; Kistner & Gatlin, 1989); therefore, they are more likely to be rejected by their peers (Horne, 1982). Students also are more likely to exhibit negative attitudes toward children with disabilities (Bak, Cooper, Dobroth, & Siperstein, 1987; Friedrich et al., 1996; Swaim & Morgan, 2001; Wetstein-Kroft & Vargo, 1984). These negative peer ratings, peer nominations, and attitudes may be impacted by a number of factors. The perceptions peers hold of their classmates with a disability may be influenced by characteristics and experiences of the student (e.g., knowledge of a disability, degree of contact, age and sex), ease of interaction, and the label identifying the classmate as having a disability.

Characteristics and experiences of the student. The experiences students have had with people with disabilities, as well as their demographics (age and sex), may affect the beliefs and attitudes students eventually hold toward their peers with a disability. Children who have knowledge of a person with a disability have more favorable beliefs and more positive attitudes toward people with disabilities (Furnham & Gibbs, 1984). Students who have a high degree of contact with peers with disabilities are more accepting and positive in their attitudes toward the disability and exhibit more accurate knowledge about the causes of certain disabilities (Furnham & Gibbs; Noland, McLaughlin, Howard, & Sweeney, 1993; Voeltz, 1980). Most studies reviewed showed that older (upper-elementary grades) children, as well as females, held more positive, optimistic attitudes toward other students who had a disability (Bak et al., 1987; Furnham & Gibbs; Laws & Kelly, 2005; Noland et al.; Voeltz).

Ease of interaction. Attitudes toward peers with a disability can be based on willingness to have social contact with the child with a disability and the social consequences of that interaction (Voeltz, 1980). Children's attitudes and the amount of control they perceived having over interactions were predictors of intentions to interact with children with physical disabilities. When children perceived interaction and friendship toward peers to be easy, they were more likely to engage in those behaviors than if the interaction was perceived as difficult or effortful (Roberts & Lindsell, 1997; Roberts & Smith, 1999). In summary, social influence and perception of ease of

interaction may override underlying attitudes when interacting with a peer with a disability.

Labeling. Children may be rejected due to labeling of the child by the school; merely being identified as having a disability may play a role (Bryan, 1976; Furnham & Gibbs, 1984; Laws & Kelly, 2005; Roberts & Lindsell, 1997). Based on vignette studies, labels alone affect children's attitudes toward their peers with a learning disability (LD). General education children may view children who are placed in a resource room as being more capable than children placed in a special class. Resource room children are described as those who spent most of their day with their homeroom class and only left for an hour, whereas special class students spent most of their day in a classroom for children with special needs (Bak et al., 1987).

Summary of Peer Relationships: General Findings

A child or adolescent's peer relationships can lead to both positive and negative outcomes in life. Social status within a relationship can have a significant impact on a child, especially if that status is rejection. Internal characteristics such as aggressive and uncooperative behaviors, lack of social knowledge, and misperceptions of social behaviors are factors that may lead to rejection of children. Children with disabilities also are more likely to be rejected. External characteristics often impact children with disabilities, with characteristics of the peer group (younger, male) and their perceptions (difficult interactions) leading to more negative attitudes and fewer interactions. A child

with a specific disability, such as AD/HD, that exhibits symptoms similar to behaviors that correlate with peer rejection may be more likely to experience rejection.

Peer Relationship Problems with Children who Have AD/HD

Definition and Prevalence

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) lists several diagnostic criteria for AD/HD. The specific symptoms fall into one of two categories: inattention and hyperactivity-impulsivity. The inattention symptoms include behaviors such as failing to give close attention to details, sustain attention, follow through on instructions, and finish schoolwork. Some examples of hyperactivity include behaviors such as fidgeting, squirming, leaving the classroom when it is not expected, and running, climbing, and/or talking excessively. Impulsive behaviors include blurting out answers, interrupting, and difficulty waiting for a turn. The symptoms displayed by the child will vary depending on the specific subtype. There are three subtypes of AD/HD: Combined, Predominantly Inattentive, and Predominantly Hyperactive-Impulsive. The Combined Type displays the symptoms for both inattention and hyperactive/impulsive subtypes. The Predominantly Inattentive and Predominantly Hyperactive-Impulsive each meet only the subtype criteria (DSM-IV-TR, 2000).

Attention Deficit/Hyperactivity Disorder, a Behavioral Disorder, is often co-morbid with a variety of disorders that have symptoms affecting peer relationships. Samples from studies showed high rates of co-morbidity with other Behavioral Disorders

(Reid, Maag, Vasa, & Wright, 1994), Oppositional Defiant Disorder (ODD; Barkley, 2003; Barkley, Fischer, Smallish, & Fletcher, 2006; CDC, 2005a; Hoza et al., 2005), and Conduct Disorder (CD; Barkley; CDC; Hoza et al.), and Anxiety Disorders (Barkley; CDC; Hoza et al.). In addition, approximately half of students between the ages of 6 and 11 years old diagnosed with AD/HD also may have a specific learning disorder (SLD), with many receiving special education services for SLD (CDC; Reid et al.). Those with co-morbid SLD are perceived by teachers as exhibiting more behaviors indicating social perceptiveness difficulties and having serious problems with peer rejection and peer popularity than children with either AD/HD or SLD alone (Flicek, 1992; Flicek & Landau, 1985; Sprouse, Hall, Webster, & Bolen, 1998). Having one of these co-morbid disorders may lead to an overrepresentation of these children in the rejected social status group (Hoza et al.).

Attention Deficit/Hyperactivity Disorder is not a rare disorder. Depending on who is making the diagnosis, prevalence of the disorder ranges from 2% to 18% in community samples (CDC, 2005c). The *DSM-IV-TR* (2000) lists the prevalence rate between 3% and 7% in school-aged children. In 2003, approximately 7.8% of children between the ages of 4 and 17 years old living in the United States had ever had a diagnosis of AD/HD. The disorder is 2.5 times more common in males than females (CDC). Over 80% of students who have AD/HD (not identified through Individuals with Disabilities Education Act) spend all or most of their time in the general education classroom (Reid et al., 1994).

The Impact of Peer Relationships on Children with AD/HD

Children with behavioral disorders appear to face greater impairments in their peer relationships than children without a behavioral disorder (CDC, 2005b). Laws and Kelly (2005) found that children's attitudes toward school-aged children with both a disability and behavior problems were generally negative; therefore, it is important to consider how having a behavioral disability, such as AD/HD, can influence peer relationships.

Childhood impairment due to AD/HD can affect social status and perceived social support in adolescent peer relationships (Bagwell et al., 2001; Brown & Borden, 1986; Milich & Landau, 1982; Newton-Howes, 2004; Pelham & Bender, 1982). Boys with AD/HD are less preferred, more disliked, and more often rejected than their non-diagnosed peers (Erhardt & Hinshaw, 1994; Hinshaw, Zupan, Simmel, Nigg, & Melnick, 1997; Treuting & Hinshaw, 2001). Children in grades 3 through 6 with more severe AD/HD-type behaviors perceive less overall social support and less support from classmates and close friends (Demaray & Elliot, 2001). Because peer rejection appears to be resistant to change, the combination of low social status (Bagwell et al.; Bryan, 1976) and perceived low social support can lead to negative internalizing behaviors.

Adolescents with AD/HD are less socialized, have fewer interpersonal interactions, and lack self-discipline and confidence (Waddell, 1984). Hyperactive adolescents tend to have lower self-esteem, a negative self-image (e.g., think of themselves as an inadequate person who is dissatisfied with their own behavior), are

judged by clinicians to have lower levels of overall adjustment, and are more likely to show evidence of pathology (Slomkowski, Klein, & Mannuzza, 1995; Waddell). Feelings of loneliness that come from a lack of meaningful relationships with other people may make children, including those with AD/HD, feel worthless, hopeless, helpless, powerless, and alienated (Aronson, Wilson, & Akert, 1999).

Impact of Behavioral Factors on Peer Relationships in Children with AD/HD

Researchers have studied many variables that correlate with the negative peer relationships of children with AD/HD. However, it is ultimately the child's behavior that has the most impact on the child and his or her peers. Although being identified as disabled can hinder peer relationships, researchers have shown that descriptions of AD/HD behaviors are enough, without the label of AD/HD, to elicit negative attitudes and negative first impressions toward children who exhibit AD/HD symptoms (Cornett-Ruiz & Hendricks, 1993; Law, Sinclair, & Fraser, 2007).

Impact of AD/HD behaviors on the child with AD/HD. Classmates' perceptions of children with AD/HD may vary depending on specific behaviors or AD/HD subtypes. Classmates disliked behavioral attributes of the Hyperactive and Combined Types of AD/HD and were indifferent to the Inattentive and non-AD/HD symptoms (Jenkins & Batgidou, 2003). These findings indicate that it is possibly the specific behavioral characteristics of students with AD/HD that impact students' perceptions. In particular, hyperactivity, aggression, and inattention may affect the social status of students with AD/HD.

Hyperactivity is associated with both negative social and academic outcomes. Boys with hyperactivity have deficits in their knowledge of how to maintain relationships and handle interpersonal conflict, as well as deficits in their social knowledge and behaviors (Grenell et al., 1987; Hoza, Waschbusch, Pelham, Molina, & Milich, 2000). Both hyperactive boys and girls have fewer close friends, more trouble keeping friends, and more social problems (Bagwell et al., 2001; Barkley et al., 2006; Milich & Landau, 1982). They are lower on peer preference ratings, more often rejected, less well-liked, and have fewer dyadic friends than students without hyperactivity (Bagwell et al.; Hoza et al., 2005; Jenkins & Batgidou, 2003; Klein & Young, 1979; Milich & Landau). Additionally, hyperactivity may lead to academic underachievement and an increase in grade retention for children with AD/HD, which also may lead to rejection (Barkley, Fischer, Edelbrock, & Smallish, 1990; Barry, Lyman, & Klinger, 2002).

Aggressive behavior in children with symptoms of hyperactivity may play a significant role in defining their social status (CDC, 2005b). Researchers have found that aggressive children are often actively disliked by their peers and that aggression in boys strongly predicts peer rejection (Erhardt & Hinshaw, 1994; Whalen & Henker, 1985). Children with AD/HD are usually rated as more aggressive and noncompliant than comparison children (Klein & Young, 1979; Landau & Moore, 1991; Maedgen & Carlson, 2000). They also are more likely to ignore their peers and show anger toward them (Flick, 1996). Hinshaw and Melnick (1995) ran a summer camp with boys who had AD/HD with and without co-morbid aggression. Through behavioral observations, peer

nominations, parent reports, and confidential individual interviews, the researchers found that the boys participating in the summer camp reported verbal and physical aggression as negative features of the camp. Aggression was rated as the most toxic form of behavior by all the boys.

Inattentive behaviors are not as salient as hyperactivity or aggression, but can still lead to negative social outcomes for children with AD/HD. Students who exhibit symptoms of the Predominantly Inattentive subtype of AD/HD may be perceived as shy or withdrawn (CDC, 2005b). These children are often passive and show deficits in social knowledge (based on self-reports) (Maedgen & Carlson, 2000). AD/HD also may impact these children in school, with the assumption that inattention causes many of the problems. However, researchers found that hyperactivity (not inattention) may be a main factor in the increased grade retention of children with AD/HD (Barkley et al., 1990).

Impact of AD/HD behaviors on the peers of the child with AD/HD. Children with AD/HD and ADD can negatively influence the actions of their peers in the classroom (Whalen & Henker, 1985). Researchers found that when they mixed dyads of children to include one child with AD/HD and one without, the mixed dyads engaged in more controlling behaviors, exhibited a greater frequency of aggression, completed fewer math problems, and were less compliant with peer commands than dyads in which both students did not have AD/HD (Clark, Cheyne, Cunningham, & Siegel, 1988; Cunningham & Siegel, 1987). In Landau and Milich's (1988) study on the social role-playing of children on a TV Talk Show, children with ADD failed to adjust their social

communication behaviors when the demands of the situation changed (role of host to guest). In both studies, the behaviors and response styles of the boys with AD/HD and ADD resulted in their non-AD/HD or non-ADD partner's alteration of responses. In these mixed dyad situations, partners without AD/HD or ADD exhibited an inability to adjust social communication patterns and a more controlling, less cooperative pattern of responding (Cunningham & Siegel; Landau & Milich).

Summary of Peer Relationship Problems with Children who Have AD/HD

AD/HD is a common disorder in general education classrooms that may affect the social status of students with the disability. The specific behaviors of the child with AD/HD, which include hyperactivity, aggression, and inattention, may influence both peer attitudes and behaviors in the classroom. Children and adolescents who have AD/HD are more likely to suffer negative outcomes including peer rejection. Interventions targeting the peers of children or adolescents with AD/HD may enhance the quality and quantity of social interactions of students with AD/HD.

Treating the Problem

Many interventions for children with AD/HD focus on the child's behaviors (Brown & Borden, 1986; Bussing, Gary, Leon, Garvan, & Reid, 2002; DuPaul, Eckert, & McGoey, 1997; DuPaul, Stoner, & O'Reilly, 2002; Ingersoll & Goldstein, 1993). Other interventions focus on assisting the parent or teacher with behavior management techniques (Bekle, 2004; Brook, Watenberg, & Giva, 2000; DuPaul et al., 2002; Heiman, 2005; Kos, Richdale, & Hay, 2006). An often overlooked component of

interventions for children or adolescents with AD/HD is addressing their peers (DuPaul et al., 2002). Interventions to reduce the negative social impact of having AD/HD should target peers' attitudes and awareness (Horne, 1980; Mrug, Hoza, & Gerdes, 2001). Because children are young, their attitudes are malleable. Changing a child's attitudes may lead to behavioral change and result in more acceptance (Aronson et al., 1999; Royal & Roberts, 1987; Voeltz, 1980). Therefore one solution to address social problems in children with AD/HD is to change the perceptions, attitudes, and behavioral intentions of classmates.

Common AD/HD Myths

Due to the prevalence of AD/HD in the classroom, many students are aware of the disorder. However, these students may lack accurate knowledge about the disorder and may have formed preconceived notions based on media and popular culture. Researchers have identified over ten common misconceptions held by students, teachers, and parents. These myths include factors involved in symptoms, diagnosis, treatments, and outcomes. Specific myths addressed in the literature are that children will outgrow ADD or AD/HD (Barbarese & Olsen, 1998; Booth et al., 2000; Ellison, 2003; Learning Assessment & Neurocare Centre, 2006; Richard & Russell, 2002; Scitutto, Terjesen, & Frank, 2000), a diagnosis is made only by a physician and not a psychologist (Reeve, 1990; Richard & Russell), ADD or AD/HD occurs in males only (Ellison; Richard & Russell), AD/HD is over-diagnosed (Booth et al.; Ellison; Learning Assessment & Neurocare Centre; Richard & Russell), medication causes more problems than it helps in AD/HD (Booth et al.;

Ingersoll & Goldstein, 1993; Learning Assessment & Neurocare Centre; Richard & Russell), there is a set intervention that works for children with AD/HD (Richard & Russell), AD/HD is caused by poor diet and/or discipline (Barbaresi & Olsen; Bekle, 2004; Booth et al.; Ellison; Ingersoll & Goldstein; Learning Assessment & Neurocare Centre; Richard & Russell; Sciotto et al.), all children with attention deficit disorders are hyperactive (Barkley, 2003; DSM-IV-TR, 2000; Richard & Russell), allergies cause AD/HD (Richard & Russell), and it is not possible to accurately diagnose ADD or AD/HD in children or adults (Booth et al.). One approach to correct these misconceptions is to provide accurate information about the disorder.

The Impact of Accurate Information on Attitudes, Behaviors, and Behavioral Intentions

Knowledge of a disability may improve peer perceptions and interactions (Furnham & Gibbs, 1984; Grenell et al., 1987; Noland et al., 1993; Roberts & Smith, 1999; Voeltz, 1980). Researchers have studied the effects of providing factual information on individuals' attitudes, behaviors, and behavioral intentions toward people with disabilities. Results from studies on disorders and health conditions such as obesity, Autism, and Tourette's syndrome (TS) may provide insight as to whether providing factual information improves students' attitudes, behaviors, and/or behavioral intentions toward their peers with a disability.

Obesity. Researchers studied the effects of providing medical information through a brief (less than 2 min) educational video about childhood obesity on children's attitudes and behavioral intentions (Bell & Morgan, 2000). Children in the third through sixth

grades were assigned to one of three video conditions where they observed either a child of average weight, an obese child, or an obese child with a male voice-over providing a brief explanation of the child's medical condition. Results varied by age and showed that providing medical information had a positive effect on attitudes toward an obese peer only with younger children (older children showed no difference), and a negative effect on the academic behavioral intentions of older children. Therefore, Bell and Morgan found that providing factual information had a minimal positive effect on children's attitudes and behavioral intentions toward a peer presented as obese. A similar study was conducted with children with Autism.

Autism. Researchers measured the effect of providing information through a brief (less than 2 min and 15 sec) video intervention on Autism on the attitudes and behavioral intentions of third-and sixth-grade children (Swaim & Morgan, 2001). Each child was assigned to one of three conditions: no Autism, Autism, and Autism/Information. In the no Autism condition, a child actor behaves normally and interacts appropriately with another person, while a voice-over talks about the child in the video, describing personal experiences unrelated to the disability (e.g., things he likes to do, places he likes to go). In the Autism condition, the same child actor is displaying autistic behaviors and interacting in a way characteristic of people with Autism, while the voice over was the same as in the no Autism condition. The Autism/Information condition is the same as the Autism condition, with the addition of brief descriptions of Autism in the middle of the script provided by a voice –over (e.g. he has Autism, sometimes he waves his hands

around or spins around). Results from attitudes and behavioral intentions measures show that providing information about Autism had no effect on either children's attitudes or behavioral intentions. However, some research findings suggest a similar intervention may have a range of effects.

Tourette's syndrome (TS). Friedrich et al. (1996) conducted a study similar to Swaim and Morgan's (2001) Autism study, where third- and fifth-grade children were assigned to one of three brief (less than 2 min) video conditions about TS and assessed on their attitudes and behavioral intentions. The three conditions were no TS, TS (only motor tics), and TS/Information. The conditions were similar to those in the Swaim and Morgan (2001) study, except the behaviors exhibited were those typical of people with TS and the information provided was in first-person by the actor (e.g., I have Tourette's), rather than in a third-person voice-over. Results show that providing information about TS had no significant effect on the ratings of either attitudes or behavioral intentions.

Woods (2002) found that providing a 13-min video that displays people of different ages discussing their experiences with TS, and providing general information about TS had an effect on college student attitudes and behaviors. Each student was assigned to one of two conditions: educational video, no educational video. Both groups saw a video still of an actor (no TS symptoms) and then watched a 2-min video of the actor displaying TS symptoms. Only one group watched the additional educational video. After watching the video, attitude and social proximity measures were administered.

Results show that the group who viewed the educational video had more positive attitudes and more pro-social behaviors toward persons with TS.

In a follow-up study, Woods and Marcks (2005) conducted the same study as Woods (2002) with the addition of a third condition and measure. College students were assigned to one of three conditions: video, educational video about TS (same as Woods video), and educational video about depression (9-min video about facts and personal experiences with depression). They were then assessed on attitudes, behavioral intentions, and actual behaviors. Results show that individuals who viewed the TS video had more positive attitudes toward persons with TS. However, the results for behavior and behavioral impact were unclear. The group that received the TS education video had higher behavioral intentions scores (more likely to interact) and engaged in more pro-social behaviors than the group that viewed the educational video on depression, but exhibited no difference from the control group on these measures. Therefore, TS education did not necessarily improve behavioral intentions, but did improve attitudes.

The findings from the Friedrich et al. (1996), Woods (2002), and Woods and Marcks (2005) studies on obesity, Autism, and TS are unclear as to whether providing education is an effective means of improving attitudes, behaviors, and/or behavioral intentions. While some studies showed that providing information improved attitudes, others showed that it was not helpful, or it may vary by age. The effect of education on behaviors and behavioral intentions also is unclear. Providing information about a disability can have a positive, negative, or no impact on the behaviors or behavioral

intentions of students. Given the inconsistent results, studies measuring the impact of education on attitudes, behaviors, and behavioral intentions may be missing an important outcome measure. If the factual information provided was not learned, then it may not have an impact on attitudes, behaviors, and/or behavioral intentions.

The Impact of Accurate Information on Learning

Researchers have shown that children who have knowledge of a person with a disability have more positive attitudes toward people with disabilities (Furnham & Gibbs, 1984). Therefore, research that addresses knowledge and learning as an outcome may provide insight into the impact of education on student attitudes. Two studies that measure the impact of providing information on student learning address AIDS and Bipolar Depression.

AIDS. Smith and Katner (1992) studied the impact of various forms of AIDS education on high school seniors' knowledge, attitudes, and behaviors. All participating students attended a 50-min lecture from an AIDS specialist who presented basic facts about AIDS and personal stories of several young patients. Students were then divided into three groups for additional educational opportunities. Groups attended either a question-and-answer session with their physical education (PE) teacher/health professional, a presentation by a young person with AIDS, or a role-playing activity with their PE teacher/health professional. Students were immediately given an AIDS-related knowledge and attitude measure. They also were administered the same knowledge and attitude measures, with the addition of a behavioral measure, 5 weeks later. Results show

that from pre-test to post-test, students made gains in knowledge, showed more positive attitudes toward persons with AIDS, and displayed less risky sexual behaviors. The role-play and presentation by a young person with AIDS resulted in the most positive changes in attitudes. The presentation by a young person with AIDS was perceived as more worthwhile, more interesting, and less embarrassing than the other two activities.

Bipolar Depression. Mathis and Skinner (in press) compared the effects of a standard 35- to 45-min lecture on bipolar depression to the same lecture supplemented with revelation and descriptions of personal experiences with the disorder. College students were given a pre-test and post-test questionnaire to assess learning as an outcome. Results show that regardless of lecture type, college students scored higher on the post-test than the pre-test, suggesting that learning occurs when information alone and information in combination with descriptions of personal experiences related to the disability are provided to students.

While Smith and Katner's (1992) AIDS study showed a similar impact of providing education on learning, they did not isolate the impact of providing information from the impact of providing descriptions of personal experiences related to the disability. Mathis and Skinner (in press) separated these two variables and found that college students who received the lecture in combination with descriptions of personal experiences related to the disability scored significantly higher on the post-test measure of learning than on the pre-test. Therefore, descriptions of personal experiences may have an impact on learning.

Descriptions of Personal Experiences

Descriptions of personal experiences provided in a lecture can have a positive impact on learning. These descriptions can assist in elaboration during the learning process and increase student interest in a lecture. According to cognitive theory, elaboration is the process of linking new information to already known information. Providing an example is one method of elaboration that may increase the likelihood that new information will be learned (Gagne, Yekovich, & Yekovich, 1993). Descriptions of personal experiences of someone with a disability can provide examples of how the disability affects daily life. Descriptions of personal experiences also can provide an element of interest within a lecture, which can be useful to engage a class and enhance learning (Shirey & Reynolds, 1988; Smith & Katner, 1992; Stowell, 1994; Wade, Schraw, Buxton, & Hayes, 1993). However, if these descriptions are too novel or emotionally-involving (e.g., seductive information), they may have a negative impact.

Seductive Information

Descriptions of personal experiences may be considered a type of seductive information which can hinder learning facts about a disability. Seductive information provided in a text or lecture consists of details that are novel, irrelevant, active, concrete and/or personally involving, as well as emotionally interesting (Garner, Brown, Sanders, & Menke, 1992; Harp & Mayer, 1998). These details are low in importance and high in interest (Wade & Adams, 1990).

In assessments of learning based on reading texts and listening to lectures, more seductive details are remembered (and remembered better) than main ideas that contain general, abstract, and structurally important details (Garner et al., 1992; Garner, Gillingham, & White, 1989; Harp & Maslich, 2005; Harp & Mayer, 1997). Seductive details also can result in fewer problem-solving solutions being generated and transferred to new situations (Harp & Maslich; Harp & Mayer, 1998; Mayer, Heiser, & Lonn, 2001). This recall and problem-solving solution differential is referred to as the seductive details effect, which may exist for a variety of reasons. Researchers found that readers viewed factual details as important yet difficult to learn because they are dense with information and uninteresting. Seductive details were found to be easy to read, highly memorable, and interesting; therefore, these details were read more quickly (Wade & Adams, 1990; Wade et al., 1993).

Seductive details do not always interfere with recall of information. Schraw (1998) found that seductive details did not interfere with overall story recall or recall of main ideas, but there were differences between context-dependent and context-independent types of seductive details. Context-independent details are those that are considered interesting regardless of whether they are read in context or out of context (in isolation) and context-dependent details are those considered more interesting when read in context. Context-dependent seductive details may be seen as more interesting when read within a meaningful context and remembered better than main ideas. Another method to reduce the seductive details effect is placing seductive details at the end of a

text or lecture (Harp & Mayer, 1998; Rowland, Richards, & Skinner, unpublished manuscript).

Summary and Purpose

Students with AD/HD may have trouble with their social relationships because of their behaviors and their peers' attitudes, labels, and misunderstandings of the disability. These factors may lead to poor peer interactions. Given the numerous myths that surround AD/HD, providing students with accurate information may help change student perceptions. Studies have shown that providing factual information can lead to more positive attitudes, behavioral intentions, actual behaviors, and learning (Mathis & Skinner, in press; Smith & Katner, 1992; Woods, 2002; Woods & Marcks, 2005). However, not all studies have shown that providing factual information has a positive effect on peer attitudes, behaviors, or behavioral intentions toward someone with a disability (Bell & Morgan, 2000; Friedrich et al., 1996; Swaim & Morgan, 2001; Woods & Marcks).

Several studies used an intervention that provides a combination of factual information and descriptions of personal experiences (Smith & Katner, 1992; Woods, 2002; Woods & Marcks, 2005). However, these studies do not distinguish between the impact of factual information and that of descriptions of personal experiences. Mathis and Skinner (in press) conducted a study that factored out the variable of descriptions of personal experiences and found that the addition of descriptions of personal experiences enhanced learning. However, measures of attitudes and behavioral intentions were not

included. Therefore, the purpose of the current study is to determine the effect of descriptions of personal experiences on high school students' learning and their behavioral intentions toward peers with AD/HD. Given inconsistent research findings, it is unclear if providing descriptions of personal experiences will enhance behavioral intentions; however, current research suggests that unless descriptions of personal experiences are a type of seductive information, the descriptions should enhance learning.

CHAPTER II

MATERIALS AND METHODS

Participants and Setting

Participants included 62 secondary students from a high school in the Southeastern United States. Students ranged in age from 15 to 18 years old and were in the 10th through 12th grades. There were 23 males and 39 females, with 83.9% Caucasian, 14.5% African American, and 1.6% Asian American/Pacific Islander. There were a small percentage of students who listed their second race as Caucasian (1.6%) or Latino/a (1.6%). Of the students who participated, 12.9% reported ever having a disability, with 6.45% of students having AD/HD. Most students (66.1%) knew someone who had AD/HD, while 75.8% of students knew someone with a disability in general. Students were enrolled in Psychology and Sociology classes at this high school. There are approximately 1,472 students attending this high school. The student body is 52% male and 48% female. The ethnicities represented are 2% Asian, 2% Hispanic, 21% Black, and 75% Caucasian. See Table 1 for a summary of demographic information by assigned group (i.e., control or experimental).

Two high school Psychology teachers and one high school Sociology teacher agreed to participate and sent home informed consent forms. Only those students who signed assent forms (see Appendix A) and whose parents signed consent forms (See Appendix B) were asked to participate in this study. The study took place in a high school general education classroom that was equipped with smartboard technology.

Table 1. Summary of Participant Demographic Information

Participant Characteristic	Control		Experimental	
	N	Percentage	N	Percentage
Male	13	43.3	10	31.3
Female	17	56.7	22	68.8
Caucasian	26	86.7	26	81.3
African-American	4	13.3	5	15.6
Asian/Pacific Islander	0	0	1	3.1
Age 15	4	13.3	9	28.1
Age 16	8	26.7	9	28.1
Age 17	11	36.7	8	25
Age 18	6	20	6	18.8
Sophomore	11	36.7	15	46.9
Junior	8	26.7	10	31.3
Senior	11	36.7	7	21.9
Have AD/HD	2	6.7	2	6.3
Know someone with AD/HD	18	60	23	71.9
Have a disability	5	16.7	3	9.4
Know someone with a disability	22	73.3	25	78.1

Materials

Experimenter constructed materials used in this study included video-tapes, assessment materials, and procedural integrity observation sheets. A video camera and editing equipment were used to construct the two tapes used in this study. The smartboard classroom where the study was conducted had an overhead projector and DVD player, so all classrooms displayed the video with the same visual and sound technology. Results were obtained using computers and the SPSS software.

Design and Statistical Analysis Procedures

A post-test only design was used determine if altering a video designed to dispel myths regarding AD/HD by including descriptions of personal experiences delivered by the speaker enhanced participants' accuracy on an assessment of AD/HD knowledge and behavioral intentions toward peers with AD/HD. Two educational videos were constructed. The experimental video contained both descriptions of personal experiences and factual information about AD/HD. The control video was constructed by removing the descriptions of personal experiences, so only factual information about AD/HD was provided.

A post-test only quasi-experimental design was used because applying a pre-test may have introduced a testing effect that could have contaminated the results (Campbell & Stanley, 1966). Specifically, pre-testing may have made students aware of the questions and facts supplied in the knowledge assessment and artificially inflated scores. Additionally, a pre-test may have cued the students in the experimental group to attend to

the factual information on the video as opposed to the descriptions of personal experiences.

A series of independent samples t-tests was used to determine if there were significant differences across learning and behavioral intention scores based on factual information alone or a combination of factual information and descriptions of personal experiences. A 2-way Analysis of Variance (ANOVA) and paired samples t-tests were used to measure differences on the knowledge question categories (i.e., control, facts only, and facts with descriptions of personal experiences) between the control and experimental groups. All results were considered significant at the $p \leq .05$ level.

Independent Variables: The Two Tapes

Factual Information

Both experimenter-constructed video tapes contained the same factual information designed to dispel common myths and assumptions held about AD/HD. The content was developed by researching common myths. Since scientific research on the most common myths about AD/HD is sparse, the myths were drawn from everyday literature, such as journal articles, parenting and professional books, and websites of national and local resource centers. The myths that appeared to be addressed most often across these documents were chosen as the focus for the script. Table 2 describes the myths that were found in the research.

As the purpose of the current study was to address common myths, each of the myths with at least three citations was addressed in the video. These myths included:

Table 2. Common Myths Listed by Number of Citations

Myth	Number of Times Cited in Literature	Source
Children will outgrow ADD/AD/HD/disorder of childhood	6	Barbarese & Olsen (1998); Booth et al. (2000); Ellison (2003); Richard & Russell (2002); Learning Assessment & Neurocare Centre (2006); Sciotto et al., 2000)
Diagnosis is made only by a physician (not a psychologist)	2	Reeve (1990); Richard & Russell (2002)
ADD/AD/HD occurs in males (few instances in females)- Gender issues	2	Ellison (2003); Richard & Russell (2002)
It's not AD/HD that causes outcome problems, but poor effort and work habits	1	Richard & Russell (2002)
AD/HD is over diagnosed-teachers don't want active learners	4	Booth et al. (2000); Ellison (2003); Learning Assessment & Neurocare Centre (2006); Richard & Russell (2002)
Medication is not necessary in AD/HD	2	Booth et al. (2000); Reeve (1990); Richard & Russell (2002)
Children with AD/HD are over-medicated	2	Booth et al. (2000); Ellison (2003)
Medication causes more problems than it helps in AD/HD (stunted growth)	4	Booth et al. (2000); Ingersoll & Goldstein (1993); Learning Assessment & Neurocare Centre (2006); Richard & Russell (2002)

Table 2, cont.

Myth	Number of Times Cited in Literature	Source
Medication is all that is needed to take care of AD/HD	2	Learning Assessment & Neurocare Centre (2006); Richard & Russell (2002)
There is a set intervention that works for children with AD/HD	1	Richard & Russell (2002)
AD/HD is caused by poor diet and/or discipline	8	Barbaresi & Olsen (1998); Bekle (2004); Booth et al. (2000); Ellison (2003); Ingersoll & Goldstein (1993); Learning Assessment & Neurocare Centre (2006); Richard & Russell (2002); Sciutto et al., 2000)
Hyperactivity is a component of all children with attention deficit disorders	3	Learning Assessment & Neurocare Centre (2006); Reeve (1990); Richard & Russell (2002)
If AD/HD is diagnosed, the child must be classified under Special Education in the school system	1	Richard & Russell (2002)
The disability of AD/HD accounts for all the problems in these children/ does not consider co-morbidity	2	Reeve (1990); Richard & Russell (2002)
All children with AD/HD have an SLD/ do poorly in school	1	Reeve (1990)
Allergies cause AD/HD	1	Richard & Russell (2002)

Table 2, cont.

Myth	Number of Times Cited in Literature	Source
AD/HD kids are learning to make excuses, rather than take responsibility for their actions	1	Booth et al. (2000)
It is not possible to accurately diagnose AD/HD in children or adults	1	Booth et al. (2000)
Minority Children are Over-Diagnosed with AD/HD and Over –medicated	1	Ellison (2003)
AD/HD is not a real disorder, just a sign of the times	3	Booth et al. (2000); Ellison (2003); Learning Assessment & Neurocare Centre (2006)

1. AD/HD is not a real disorder, it's just a sign of the times
2. AD/HD is over-diagnosed
3. Medication causes more problems than it helps in AD/HD
4. Hyperactivity is a component of all children with attention deficit disorders
5. AD/HD is basically due to bad parenting and lack of discipline
6. AD/HD is caused by a poor diet (Numbers 5 and 6 were split into two separate myths, listed in Table 2 as one myth)
7. Children will outgrow ADD/AD/HD

In order to increase the pool of items designed to assess learning from the tape, five other myths that were mentioned once or twice in the literature were addressed on the tape. These myths were:

1. ADD/AD/HD occurs only in males
2. Medication is all that is needed to "take care" of AD/HD
3. AD/HD always accounts for all the problems experienced by the child
4. It's not AD/HD that causes outcome problems, but poor effort and work habits
5. All children with AD/HD do poorly in school

The myth concerning gender was included because gender plays an important role in the manifestation of symptoms for AD/HD and much of the research is conducted with boys. The use of medication in treating children with AD/HD is controversial, so another myth about medication was added: that medication is all that is needed to treat the disorder. AD/HD is likely to be co-morbid with other disorders; therefore inappropriate behaviors may be accounted for by a disorder other than AD/HD. This fact is often overlooked in the classroom, and teachers and students assume that AD/HD accounts for all the problems experienced by the child, so this myth was included. The last two myths about poor work habits and doing poorly in school were chosen because this study was being run in the school and addressed behavioral intentions and knowledge beliefs of students. If the objective was to change current behavioral intentions in the school

system, then some of the myths addressed needed to involve the classroom and work habits of a student with AD/HD.

The Control Script

A video was presented of a male discussing important aspects of AD/HD, as well as addressing common myths. The presentation was in a conversational/personal style since conversational speech may cause students to actively process incoming speech and lead to better retention of information (Mayer, Fennell, Farmer, & Campbell, 2004; Moreno & Mayer, 2000). The control script followed the sequence of providing an introduction, addressing each myth, then stating factual information (see Table 3 for list of myths, facts, and fact sources). The introduction consisted of the speaker revealing that he is a student at the local university, and he will be speaking about AD/HD and addressing some of the common misperceptions of the disorder. The control video lasted approximately 5 min and 44 sec.

The Experimental Script

Both the experimental and control tapes included identical factual information. However the experimental tape also includes descriptions of personal experiences delivered by the speaker. Information for these descriptions was gathered by interviewing a 29 year-old male who has had a diagnosis of ADD since he was 12 years old. Questions in the interview revolved around the above listed myths and addressed descriptions of personal experiences involving life with AD/HD. Since the person interviewed did not have experience with AD/HD (he was ADD), further personal experiences were gathered

Table 3. Myths, Facts, and Fact Sources

Myth	Fact	Fact Source
AD/HD is not a real disorder; it's just a sign of the times.	AD/HD is a real, inherited, genetic disorder. Some believe it is due to behavioral disinhibition.	DSM-IV-TR (2000); Barkley (2003)
AD/HD is over-diagnosed	AD/HD occurs in only 3-7 % of the population. Many females are not diagnosed because the symptoms are not as visible. Receiving the diagnosis comes from many team members and is not just given based on a recommendation by a teacher.	DSM-IV-TR (2000); Richard & Russell (2002)
AD/HD is basically due to bad parenting and lack of discipline	AD/HD is more common in first-degree biological relatives of children with AD/HD than the general population. It is also hypothesized to be due to problems in executive functioning (behavioral disinhibition)	DSM-IV-TR (2000); Barkley (2003); DuPaul & White (2004); Richard & Russell (2002)
AD/HD is actually caused by a poor diet	No convincing evidence that sugar has marked adverse effects on the behavior of elementary –school-age children, including children with AD/HD (only a small percentage appear to be vulnerable)	DSM-IV-TR (2000); Barkley (2003); Ingersoll & Goldstein (1993); Milich, Wolraich, & Lindgren (1986); Richard & Russell (2002)
Hyperactivity is a component of all children with attention deficit disorders	Hyperactivity comprises only one cluster of symptoms. Many people who have AD/HD primarily exhibit the inattentive symptoms.	DSM-IV-TR (2000); Barkley (2003); Richard & Russell (2002)

Table 3, cont.

Myth	Fact	Fact Source
It's not AD/HD that causes outcome problems, but poor effort and work habits	Parts of the symptoms of AD/HD include inattention (difficulty organizing tasks, sustaining steady, consistent work, etc.). One of the characteristics of AD/HD is an uneven achievement pattern	DSM-IV-TR (2000); Barkley (2003); Reeve (1990); Richard & Russell (2002)
ADD/AD/HD occurs only in males	While AD/HD occurs more frequently in males, females can also have AD/HD	DSM-IV-TR (2000); DuPaul & White (2004); Reeve (1990); Richard & Russell (2002)
AD/HD always accounts for all the problems experienced by the child	Some children with AD/HD can have other disorders that affect their behaviors and their relationships with their friends. These children are more likely to have Conduct Disorder, Anxiety Disorders, and even Learning Disorders in combination with AD/HD.	Barkley (2003) ; Barkley et al. (2006) ;CDC (2005a) ; Hoza et al. (2005); Reid et al. (1994)
All children with AD/HD do poorly in school	While symptoms of AD/HD may affect a student's school work, doing poorly in school is not a direct symptom of AD/HD. Their achievement level is within the normal range, it is the incomplete assignments and homework not turned in on time that affects the most. AD/HD is not a learning disability.	DSM-IV-TR (2000); DuPaul & White (2004); Reid et al., (1994)

Table 3, cont.

Myth	Fact	Fact Source
Medication all that is needed to “take care” of AD/HD	While a large percentage of people respond well to medication, the best treatment is a combination of medication and behavioral/educational strategies.	Booth et al. (2000); Learning Assessment & Neurocare Centre (2006)
Medication causes more problems than it helps in AD/HD	There is no evidence that treatment with medication leads to stunted growth. If anything, taking methylphenidate (or Ritalin) can lead to mild insomnia and appetite increase/ reduction.	Barkley (2003); Ingersoll & Goldstein (1993); Richard & Russell (2002); Wilens (1999)
Children will outgrow ADD/AD/HD	While some children do outgrow AD/HD, many (between 50 and 80%) continue to exhibit symptoms into adolescence and adulthood. The symptoms are still present, just managed better.	DSM-IV-TR (2000); Barkley (2003); Barkley et al.(1990); DuPaul & White (2004); Newton-Howes (2004); Richard & Russell (2002)

through a website that posted personal experiences of children with AD/HD, ages 7 to 23 (Children's Hospital Boston, 2007). Personal experiences targeting the classroom and peer interactions were used.

In the experimental video condition, after the same general introduction as the control script, the speaker identifies himself as having AD/HD by saying the following "Before we get started, I want to let you all know that I have AD/HD, so a lot of this information is personal for me." He then discusses factual information about AD/HD, while occasionally interspersing descriptions of personal experiences into the dialogue. To keep the interspersal effect, not every myth addressed included a description of personal experience. Only six of the myths in the experimental condition included a description of personal experience and factual information. The other six myths were addressed with factual information only. Information was always presented in the following sequence: myth, fact, description of personal experience (when applicable), and presented in the dialogue in a logical order. Table 4 describes the personal experiences that addressed each myth. The myths are listed in the table in the order they appear in the video. The experimental video lasted approximately 7 min and 33 sec. See Appendix C for the full script.

Researchers have shown that information provided in the beginning of a passage makes the seductive details effect worse (recall fewer main ideas) while information provided at the end reduces the effect (Harp & Mayer, 1998; Rowland et al., unpublished manuscript). A desired outcome of this study was for learning to occur, so to minimize

Table 4. Descriptions of Personal Experiences that Addressed Each Myth

Myth	Description of Personal Experience
AD/HD is not a real disorder; it's just a sign of the times.	My cousin and uncle both have AD/HD, and it was suspected that my grandfather did too, so you can see the genetic component in my family.
AD/HD is over-diagnosed	No Description of Personal Experience
AD/HD is basically due to bad parenting and lack of discipline	No Description of Personal Experience
AD/HD is actually caused by a poor diet	I can remember going to friend's birthday parties and not being allowed to eat any birthday cake- I think my friend's parents thought I was going to go crazy or something. It's funny because it wasn't the sugar I was eating that made me antsy all the time.
Hyperactivity is a component of all children with attention deficit disorders	No Description of Personal Experience
It's not AD/HD that causes outcome problems, but poor effort and work habits	In school, all I remember thinking was how many minutes were left in the class period or until I would be able to do something fun. It's not that I was lazy, just that I could never focus in the moment and always felt like my mind was running a billion miles a minute. Now even at work, I have trouble staying focused on everyone's conversations at meetings and remembering everyone's names.
ADD/AD/HD occurs only in males	My cousin I told you about earlier that also has AD/HD is a girl.
AD/HD always accounts for all the problems experienced by the child	No Description of Personal Experience

Table 4, cont.

Myth	Description of Personal Experience
All children with AD/HD do poorly in school	I could have done without being made an example in front of my classmates when I made mistakes or didn't hear what was being said because my mind wasn't in the classroom – I was busy watching a plane go by or anything outside. With the help of medication, I was able to do my homework and concentrate more, so I managed to make mostly As and Bs, with a few Cs in high school.
Medication is all that is needed to “take care” of AD/HD	No Description of Personal Experience
Medication causes more problems than it helps in AD/HD	When I wasn't on medication, I was distracted, among other things. Basically, I was getting in trouble in school all the time. After being diagnosed with AD/HD, I started taking medication and everything turned around. I was more calm in school and I was able to sit and have conversations without getting antsy. I now take Ritalin whenever I need to focus on my work. Oh, and I am 6 ft. 2 inches tall and obviously not stunted in my growth.
Children will outgrow ADD/AD/HD	No Description of Personal Experience

the possibility of a negative seductive details effect, personal experiences were not loaded in the beginning of the dialogue. Rather, personal experiences were interspersed throughout the passage, immediately following the related content.

Dependent Variables: The Two Measures

Questionnaire Packet

Following the videotape presentation, the students in each condition were asked to complete a questionnaire packet (see Appendix D). The packet consists of demographic questions, credibility questions, a behavioral intentions scale, and knowledge questions. The demographic questions inquired about the student's age, gender, race, year in school, if they had AD/HD, had a close friend or family member who had AD/HD, had any disability, or knew anyone who had any disability. The credibility questions asked the students if the speaker in the video was knowledgeable about AD/HD, gave accurate information about the disorder, and if he (the speaker) had AD/HD. This last credibility question was included to see if students felt the speaker projected behaviors that participants construed as symptoms of AD/HD.

Behavioral Intentions Scale

The behavioral intentions scale used in this study was a modified version of the *Behavioral Intention Scale* (see Appendix D). This measure has been used in several studies to successfully measure the behavioral intentions of children when interacting and forming friendships with peers with disabilities (Laws & Kelly, 2005; Roberts & Lindsell, 1997). This scale was developed for the Roberts and Lindsell study on

children's attitudes and behavioral intentions toward peers with disabilities and is based on the work of Robert Selman on the growth of interpersonal understanding, specifically the friendship domain. The scale also is based on the Friendship Activity Scale used by Siperstein, Bak, and O'Keefe (1988) for their study on children's attitudes toward and their social acceptance of peers with intellectual disabilities. The *Behavioral Intention Scale* was piloted by Roberts and Lindsell before use in their study to assess reliability and validity. The results showed an internal consistency of .89, and interviews revealed that 4th- grade students understood all aspects of the questionnaire and they completed them reliably and accurately. Factor analysis showed that one factor accounted for 51.8 % of the total variance.

The attitude scale from the Laws and Kelly (2005) study describes situations that include increasingly more intimate aspects of a friendship, ranging from "I would go up to him/her to say hello" to "I would share a secret with him or her." The response alternatives were Yes, Probably Yes, Probably No, and No. A reliability analysis of the 10 items used in the Laws and Kelly study yielded a Cronbach's alpha of .86. The same questions and format were used in the current study with a few minor wording changes to adapt the study to more "American" language as opposed to British terminology (i.e., changing sweets to candy, tea to cookout, cinema to movies, and play to play video games). Statements to measure behavioral intentions in a social situation included:

- I would go up to him/her to say hello
- I would sit beside him/her in class
- I play with him/her during break
- I would offer him/her some of my snack

- I would choose him/her to be on my team during PE
- I would work with him/her on a class project
- I would invite him/her over to my house for a cookout
- I would go to the movies with him/her
- I would go to his/her house to play video games
- I would share a secret with him/her

The other modification was the addition of a section on academic interaction.

Grenell et al. (1987) found that hyperactive subjects were rated by their peers as less likely to achieve academic success and less desirable potential work partners in school than students who were not hyperactive. Because the current study took place in a school and attempted to change peer behavioral intentions within a classroom environment, it was practical to include attitude questions concerning academic behavioral intentions. These statements were set up in a similar format and response style. They also increased in severity with respect to degree of working together collaboratively in the classroom. The statements were developed by the primary author based on previous classroom experience. Statements to measure behavioral intentions in academic situations included:

- I would choose him/her to be in my discussion group
- I would choose him/her as a study partner
- I would work on a class paper with him/her
- I would do a short group presentation with him/her
- I would teach a class session with him/her

Knowledge Scale

The Knowledge Scale was modified from Sciutto and Feldhamer's (1994) *Knowledge of Attention Deficit Disorders Scale (KADDS)*, a scale designed to address misconceptions teachers may hold about AD/HD. The original scale includes 39 statements presented with a True, False, or Don't Know response format and has three

subscales: Associated Features, Symptoms/Diagnosis, and Treatment. The overall scale has high internal consistency (between .80 and .90) and moderate to high test-retest correlations (between .59 and .76).

The statements were modified in several ways. First, not all of the statements were used. Rather, 12 statements that were directly addressed in the script were included. In the experimental video, six of these statements were addressed with facts and descriptions of personal experiences, while the other six were addressed with facts only. In addition to these 12 questions, there were six questions that were not addressed in the script. These extra questions were randomly selected from the KADDS scale and served as a measure of previous knowledge of AD/HD. The 18 questions may have varied in difficulty and the unaddressed and addressed questions were not matched for difficulty level. The other change was the response format. Rather than a True, False, or Don't Know response, students were given multiple choice questions. There were two incorrect responses for each statement and one correct alternative. The distractors often involved several of the myths, and the correct alternative addressed the factual information presented in the video. Table 5 describes the myths, the question number that addresses the myth, and the presence of descriptions of personal experiences. See Appendix D for the full Attention Deficit/Hyperactivity Disorders Knowledge Questions.

Table 5. Questions Addressing the Myths

Myth	Addressed by Question Number:	Addressed with Description of Personal Experiences
AD/HD is over-diagnosed	1	No
AD/HD is basically due to bad parenting and lack of discipline	3	No
AD/HD is not a real disorder	4	Yes
Medication causes more problems than it helps in AD/HD	6	Yes
Hyperactivity is a component of all children with attention deficit disorders	7	No
Children will outgrow ADD/AD/HD	8	No
It's not AD/HD that causes outcome problems, but poor effort and work habits	10	Yes
AD/HD is actually caused by a poor diet	11	Yes
ADD/AD/HD occurs only in males	13	Yes
All children with AD/HD do poorly in school	14	Yes
AD/HD always accounts for all the problems experienced by the child	16	No
Medication is all that is needed to "take care" of AD/HD	17	No
NOT addressed in the video	2, 5, 9, 12, 15, 18	N/A

Procedures

All students in two high school Psychology classes and one Sociology class were given the opportunity to participate in the experiment. Upon receiving the signed informed consent forms, the study was explained to the students and they were asked to sign assent forms on the day the study occurred. The data collection took place in one day. Before the study was conducted, the teachers and research assistants were asked not to talk about the study with the students except to answer general questions. A set-response sheet was given to all teachers and research assistants in order for responses to questions to be similar. They also were asked not to enter or leave the classroom during the video, so there would be no distractions during the experiment.

On the day of the study and prior to student arrival, the researchers set up the DVD player and projector. At the start of the class period, students participating in the study were gathered into one classroom. Students not participating were sent to an alternate classroom where they worked on their regular class assignments. The primary researcher then introduced herself and her assistants, thanked the students for participating and ensured all of the students had signed consent forms (Appendix B). She read the assent form (Appendix A) to the students and asked them if they had any questions and if anyone had decided not to participate.

Participating students were then divided into two groups through counterbalanced assignment. Students alternated counting off by the letters E and C to designate their group placement. Students in Group E received the experimental condition, while those

in Group C received the control condition. There were a total of 62 participants with 32 placed in Group E and 30 placed in Group C. All students in Group E were asked to remain in the room, while Group C was asked to gather their belongings and regular class assignment and escorted to an alternate classroom where they worked on their regular class assignment. Group E was then read the following instructions:

We are going to be watching an informational video about Attention-Deficit/Hyperactivity Disorder. The video is approximately 7 minutes and 33 seconds long. After the video is over, I am going to ask you to complete a packet. There will be some questions about you, as well as some questions about the video. Please do not talk during the video or when you are completing these packets. Does anyone have any questions? Thank you again for participating in this study.

Directions were repeated as necessary to assure that each student understood what was expected of them. Group E was shown the informational video with the descriptions of personal experiences. Immediately following the video, the Attention Deficit/Hyperactivity Disorder Questionnaire Packets were distributed to the students with the following instructions read aloud as the experimenter reviewed the packet:

These are the packets that you are to complete. Please write in your first and last name on the front sheet (point to where write name). The first section asks for information about you- your age, your gender, race, year in school, etc. and then some questions about the speaker in the video. The next section asks you to circle one answer that best reflects your behaviors towards someone with Attention Deficit/Hyperactivity Disorder. You have to circle one, and ONLY one, of the responses provided. You cannot write in your own answer and you cannot circle more than one response - just pick the ONE response that BEST reflects your behavior. Please be honest and give your true opinion. The last section is a multiple choice knowledge section. On these multiple choice questions, you also can only pick ONE response (no writing in or circling more than one) – there is only one correct answer. Just try your best on these items and to answer every question. If you have any questions, raise your hand. Also, when you are finished,

raise your hand and either Emily or I will come to pick up the packet and your assent form. After you have turned these 2 things in, you can work on your regular class work. Again, please do not talk until everyone has turned in their completed packets. Thank you.

The students then completed the questionnaire packets. Upon Group E's completion of the questionnaire packet, Group C returned to the classroom and Group E was escorted to the alternate classroom. Group C then received the same instructions as Group E with the length of the video as the only difference. Rather than saying the video was 7 minutes and 33 seconds, the experimenter stated it was 5 minutes and 44 seconds. The total completion time for the questionnaire packets was less than 10 min for all groups. Two students in the control group who appeared to be talking or cheating had a mark put on their packets and their results were not included. When both groups had completed the experiment, they were all brought into the same room where the experimenter stated:

Thank you all for your time. I am going to be coming in to your classroom in a few weeks to break down the study and explain everything that you did today, as well as go over the results of the study and some research techniques. Does anyone have any questions? Have a great Spring Break and see you in a few weeks.

Procedural integrity and interscorer agreement were both gathered for this study. Both research assistants checked off the procedural checklist (Appendix E) as the primary experimenter ran the study. Results show that procedural integrity was present 100% of the time. Packets were scored by the primary experimenter. Twenty percent of the packets were randomly selected and scored by the secondary experimenter. The number of agreements and disagreements in scoring were calculated. The number of agreements

was divided by the number of agreements plus disagreements then multiplied by 100.

Interscorer agreement was 100% for 20% of the assessment sheets.

CHAPTER III

RESULTS

Because knowledge of a disability may influence behavioral intentions, the analysis of knowledge assessments will be presented first, followed by a description of the analysis of the behavioral intentions data. Finally, a summary of our descriptive statistics from the acceptability survey will be provided.

Knowledge

The knowledge scale contained 18 knowledge questions. These 18 questions were divided into three categories, each with six questions. Six questions were not addressed in the presentation and therefore represent the unaddressed question category. Six questions were addressed by only facts in both videos (facts only), and the remaining six questions were addressed by both facts and descriptions of personal experiences in the experimental condition and only with facts in the control condition (facts with descriptions of personal experiences). Table 6 provides the summary statistics for the knowledge scales across groups and question categories.

Comparison of Facts Only and Facts with Descriptions of Personal Experiences

A two (question category, facts only and facts with descriptions of personal experiences items) by two (groups, experimental and control group) ANOVA was used to test for differences on the knowledge scale. Table 7 provides a summary of this analysis.

Table 6. Summary of Knowledge Scale Descriptive Statistics

Scale	Control			Experimental		
	N	Mean	SD	N	Mean	SD
Total Knowledge	30	12.77	2.28	32	12.75	2.36
Unaddressed Questions	30	2.30	1.39	32	2.25	1.16
Facts only Questions	30	5.40	.86	32	5.13	1.18
Facts with Descriptions of Personal Experiences Questions	30	5.07	.91	32	5.38	.79

Table 7. Two-way ANOVA Results

Source of Variance	Type III Sum of Squares	df	Mean Square	F	Sig.
Knowledge Question Category - Main Effect	.05	1	.05	.08	.78
Group- Main Effect	.01	1	.01	.01	.93
Knowledge Question Category x Group Interaction	2.63	1	2.63	4.02	.05
Error	39.33	60	.66		

Table 7 shows no significant main effects for either group, $F(1, 60) = .08, p = .78$, or question category, $F(1, 60) = .01, p = .93$. The ANOVA revealed a significant group by question category interaction, $F(1, 60) = 4.02, p \leq .05$. Figure 1 depicts this interaction. Within-group analysis showed that participants in the experimental group had lower scores on the knowledge questions that were addressed with facts only ($M = 5.13$) than on the knowledge questions that were addressed with facts with descriptions of personal experiences ($M = 5.38$). Those in the control group showed the reverse pattern, with a higher mean score on the facts only questions ($M = 5.40$) than on the questions addressed with facts with descriptions of personal experiences ($M = 5.13$).

The control group did not receive the additional descriptions of personal experiences. Therefore, we would expect their performance to be equivalent across the facts only and facts with descriptions of personal experiences question categories. However, they scored higher on the 6 facts-only questions. If there was no effect of adding the descriptions of personal experiences we would expect a similar pattern in the experimental group. This did not occur, suggesting that adding the descriptions of personal experiences influenced the experimental groups' performance based on question category. Specifically, adding the descriptions of personal experiences may have enhanced their performance on the 6 descriptions of personal experience questions and/or interfered with their performance on the facts only questions.

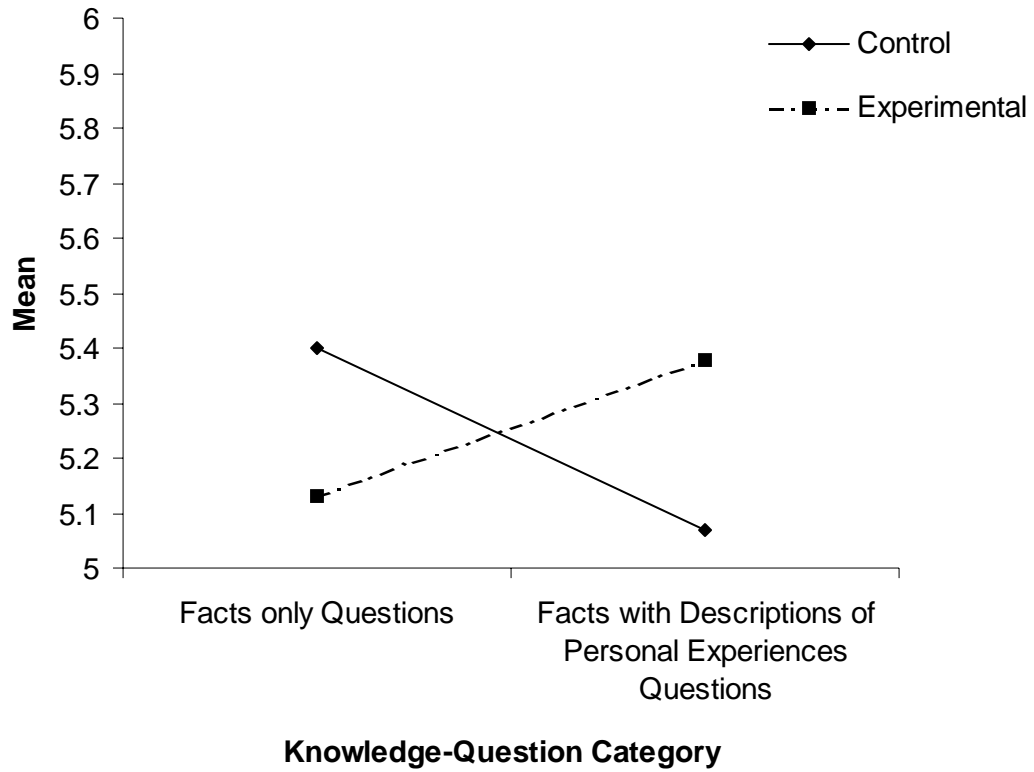


Figure 1. Interaction Between Control and Experimental Groups on Facts Only and Facts with Descriptions of Personal Experiences Questions

Comparison of Unaddressed Questions

The six unaddressed questions were not addressed in either video. A between-subject analysis yielded a mean score of 2.30 ($SD = 1.39$) for the control group, and 2.25 ($SD = 1.16$) for the experimental group. An independent samples t-test showed that the differences between the control and experimental group were not significant, $t(60) = 0.15, p = 0.88$. These results suggest that neither group had stronger knowledge of AD/HD prior to viewing the presentation.

Paired samples t-tests were used to compare student performance on the 6 unaddressed questions (myths not covered in the video) to the questions that were addressed in the video (i.e., facts only and facts with descriptions of personal experiences questions). Table 8 provides the summary of the within-subject analyses. Students in both the control and experimental groups performed significantly better on the questions that were addressed in the video, relative to the questions addressing myths not covered in the video. Paired samples statistics reveal a significant difference between the facts with descriptions of personal experiences questions and the unaddressed questions for the experimental group, $t(31) = 13.99, p = .00$, and for the control group, $t(29) = 10.09, p = .00$. When comparing the facts only questions to the unaddressed questions, similar differences were found for the experimental group, $t(31) = 12.87, p = .00$, and for the control group $t(29) = 12.60, p = .00$. These data suggest that myths taken from the literature were valid and that all students learned from watching the video.

Table 8. Summary of Unaddressed Question Comparisons

Knowledge Question Category Comparisons	Control			Experimental		
	N	t-score	<i>p</i> -level	N	t-score	<i>p</i> -level
Facts Score and Unaddressed Questions	30	12.60	.00	32	12.87	.00
Facts with Descriptions of Personal Experiences and Unaddressed Questions	30	10.09	.00	32	13.99	.00

However, interpretation of these comparisons must be tempered because we cannot be sure that the addressed and unaddressed items were equally difficult.

Total Knowledge

For the total knowledge scale (all 18 questions) there was little difference between the control ($M = 12.77$, $SD = 2.28$) and the experimental group ($M = 12.75$, $SD = 2.36$). An independent samples t-test showed these difference were not significant, $t(60) = .03$, $p = .98$.

Behavioral Intentions

The behavioral intentions scale can be divided into three sets of scores: social, academic, and combined. The responses for each item were scored on a scale from 1 to 4 points. There was a total of 15 items, so the highest possible total score was 60. Table 9. provides a summary of descriptive statistics for the Behavioral Intentions Scales.

The total score is a combination of both the social and academic scores. For the control and experimental groups, the means were 44.00 ($SD = 9.26$) for the control group and 44.59 ($SD = 7.86$) for the experimental group. An independent samples t-test showed that these differences were not significant, ($t(60) = -.27$, $p = .79$).

The academic subscale was composed of 5 items that addressed students' willingness to interact with peers with AD/HD on various academic tasks. The social subscale consisted of 10 items that addressed students' willingness to interact with their peers with AD/HD on a more social level. To place these cluster scores on similar scales, we calculated and analyzed average item response scores. For the academic items, the mean for the control group was 2.65 ($SD = .77$) and the mean for the experimental group was 2.63 ($SD = .67$).

Table 9. Summary of Behavioral Intentions Scale Descriptive Statistics

Scale	Control			Experimental		
	N	Mean	SD	N	Mean	SD
Social	30	3.07	.63	32	3.14	.55
Academic	30	2.65	.77	32	2.63	.67
Combined	30	44.00	9.26	32	44.59	7.86

An independent samples t-test showed these differences were not significant, ($t(60) = .12$, $p = .90$). For the social items, the mean for the control group was 3.07 ($SD = .63$), and the mean for the experimental group was 3.14 ($SD = .55$). An independent samples t-test showed that these differences were not significant ($t(60) = -.47$, $p = .64$).

Across all students, behavioral intentions scores suggest students report being likely to interact with students with ADHD. Statistical analyses suggest that adding the descriptions of personal experiences had no impact on behavioral intentions.

Acceptability

Participants were asked acceptability questions about the speaker in the video and the video intervention. Table 10 summarizes the percentage results for the student opinions of the speaker in the video. Results show that overall, both the control and experimental groups felt that the speaker was knowledgeable and accurate in regards to the information he provided about AD/HD. As expected, most students in the experimental group felt the speaker had AD/HD, while most in the control group felt he did not.

Table 11 summarizes the video opinion results. Both groups indicated that the video was useful, informational, and felt they learned from the video. Additionally, most participants in both conditions found the video boring and reported that they did not change their opinion about AD/HD because of the video, nor were they more likely to interact with someone with AD/HD because of the video. One interesting result was that the control group was more likely to say the video was worth their time than the experimental group.

Table 10. Summary of Student Opinions on Speaker in Video

Speaker Characteristic	Control			Experimental		
	N	Yes	No	N	Yes	No
Knowledgeable	30	93.3%	6.7%	32	96.9%	3.1%
Accurate	30	90.0%	6.7%	32	96.9%	3.1%
Has AD/HD	30	16.7%	83.3%	32	81.2%	18.8%

Table 11. Student Opinions on Video Intervention

Student Opinion	Control			Experimental		
	N	Yes	No	N	Yes	No
Useful	17	70.6%	29.4%	19	52.6%	47.4%
Informational	17	94.1%	5.9%	19	78.9%	21.1%
Boring	17	70.6%	29.4%	19	84.2%	15.8%
Worth their time	17	58.8%	41.2%	19	36.8%	63.2%
Learned from the video	17	88.2%	11.8%	19	78.9%	21.1%
Changed Opinion because of video	17	23.5%	76.5%	19	26.3%	73.7%
More likely to interact because of the video	17	35.3%	64.7%	19	31.6%	58.4%

CHAPTER IV

DISCUSSION

The applied and theoretical implications of this study are discussed in the current chapter. Limitations of the study are addressed and directions for future researchers are provided.

Theoretical Implications

One purpose of the current study was to determine if providing facts and descriptions of personal experiences enhanced learning in comparison to providing facts only. Previous research suggested that unless descriptions of personal experiences were a type of seductive information that interfered with learning, more learning should occur in the descriptions of personal experiences condition (Mathis & Skinner, in press; Smith & Katner, 1992). However, if the additional information was a type of seductive information, then providing this information may interfere with learning.

The results of this study show there was no main effect for both the question category (e.g., facts only or facts with descriptions of personal experiences) and providing descriptions of personal experiences. However, the significant interaction suggests the possibility that a) the descriptions of personal experiences interfered with learning the fact only questions, b) the descriptions of personal experiences aided in learning the facts with descriptions of personal experiences questions, or c) a combination of both. If the descriptions of personal experiences aided in learning the facts with descriptions of personal experiences questions, these findings support previous

researchers who found evidence that additional information about personal experiences enhances learning (e.g., Mathis & Skinner, in press). If the descriptions of personal experiences interfered with learning the facts only questions, these findings support a seductive details effect (e.g., Garner et al., 1992). Specifically, the experimental group participants may have attended to and applied more cognitive resources to the information in the video that had descriptions of personal experiences, leaving fewer cognitive resources available to apply to information addressed with facts only, creating a seductive details effect for information that was not addressed with seductive details.

Cognitive theories surrounding the seductive details effect have focused on placement. Placing seductive details before important content may direct attention and working memory to the seductive details and divert these cognitive resources away from the important content and appropriate schema formation (Garner et al., 1989; Harp & Mayer, 1989; Mayer et al., 2001; Rowland et al., unpublished manuscript). In the current study, the seductive details (descriptions of personal experiences) were placed after the facts they were related to, and therefore may not have had any effect on the related questions. The seductive details effect may have been more pronounced for the unrelated questions because the presentation of seductive details often preceded the facts unrelated to the seductive details.

The category of seductive information that best defines the descriptions of personal experiences (context-dependent or context-independent) may provide insight to both conclusions. Descriptions of personal experiences may be context-dependent

seductive details that do not interfere with learning of their related facts, but interfere with learning the unrelated facts (Schraw, 1998).

Mathis and Skinner (in press) used across group procedures to compare learning when the descriptions of personal experiences were included (experimental group) and excluded (control group), however, they did not assess the impact these variables would have on behavioral intentions. Another purpose of the current study was to determine if adding descriptions of personal experiences would enhance behavioral intentions. Our results suggest that providing descriptions of personal experiences had no impact on behavioral intentions. However, the learning data prevent us from drawing conclusions.

Previous researchers have found that knowledge of a disability can enhance the probability of people interacting with someone with that disability (Furnham & Gibbs, 1984). Thus, our findings on knowledge would be expected to impact our findings related to behavioral intentions. Because we found no difference in learning (total knowledge score) we cannot draw theoretical conclusions related to behavioral intentions.

Limitations and Directions for Future Research

Before discussing applied implications, future researchers should address several limitations associated with the current study. On both the knowledge and behavioral intentions scales, the responses given could be a cause for concern. On the behavioral intentions scale, the majority of items were answered in a positive direction. Similarly, the scores on the knowledge scale questions that were covered on the tape (i.e., facts only and facts with personal experiences) were very high. Both response patterns suggest that

ceiling effects may have hindered our ability to find significant differences on either scale.

There are several factors that may have caused students to respond positively to the behavioral intentions scale. There is a possibility that students may have responded in a socially acceptable manner, responding that they would interact with someone with AD/HD in a certain situation when in fact they would not. Also, the prevalence of AD/HD in schools is so high that it is possible that many students may already have friends with AD/HD. Based on previous research, this prior exposure may have caused students to respond in a positive manner to the behavioral intentions scale (Furnham & Gibbs, 1984; Noland, McLaughlin, Howard, & Sweeney, 1993; Voeltz, 1980).

Future researchers should address these limitations. For example, they could include items designed to assess social acceptability response bias. Younger students may not have as much experience interacting with peers with AD/HD. Therefore, another option is to run the study with younger students who may be less likely to exhibit such biased responding. Another alternative to dealing with response bias would be to directly assess behavioral interactions in natural settings (Woods & Marcks, 2005).

Ceiling effects on both the knowledge and behavioral intentions measures also may be addressed by altering the target disability. For example, future researchers could conduct similar studies with less prevalent and well-known disabilities. Additionally, research could target disabilities with more social stigma and those associated with more negative stereotypes. Finally, researchers could target disabilities that are more visible.

For example, targeting information about Tourette's syndrome may reduce the probability of ceiling effects on the behavioral intentions scale.

In the current study students were not given a pre-test because we felt that pre-testing may have caused them to focus on material that would later be post-tested (i.e., introduced a testing effect). However, because we did not pre-test we could not assume that item difficulty levels were equal. Future researchers conducting similar studies may want to use the Solomon four-group design where two groups are pre-tested and two groups are not pre-tested. The pre-test would allow researchers to gauge the difficulty of items and determine if pre-testing enhanced learning.

To make the main effect of knowledge item clusters significant, researchers should investigate changes to the assessments. The addition of more questions on the knowledge scale that have a higher range of difficulty and are less straightforward would help differentiate between students who learned and those who did not. Also, changing the response format from multiple-choice questions to a recall format, such as fill-in-the-blank or writing a narrative response may be a more sensitive measure of learning.

Changing the content of the video also may enhance the possibility of the study yielding significant main effects for knowledge. The information provided in the video was brief and very straightforward when addressing myths. In fact by definition, myths may be very interesting information. Future researchers can make the main points more subtle by removing the direct statement of myths and extending the length of the video.

The sequence of descriptions of personal experiences information and facts only information in the video was random. Given that placement of seductive information has had a fairly consistent impact on learning, future researchers could experimentally manipulate this sequence of information to further clarify the causal mechanism that accounted for our interaction. For further clarification of the interaction found for the group that received the descriptions of personal experiences, future researchers should investigate whether adding the descriptions of personal experiences enhances learning the related facts or interferes with learning the subsequent unrelated facts. Conducting across group studies where one group receives the descriptions of personal experiences for all facts and other groups receive descriptions of some facts may allow researchers to answer this question.

Also future researchers could compare videos that only include descriptions of personal experiences, with videos that include only facts, and videos that include facts and descriptions of personal experiences. If descriptions of personal experiences alone can improve behavioral intentions, then these descriptions may be all that is needed. A third condition to investigate would be facts related to the disability and descriptions of personal experiences completely unrelated to the disability. These descriptions would be closer to context-independent seductive details where information is more unrelated than the current descriptions of personal experiences.

The current study may provide directions for applied researchers interested in trying to improve the social climate of the classroom for students with disabilities. The

current results revealed significantly greater accuracy on questions assessing knowledge of myths addressed on the video (facts and facts with descriptions of personal experiences questions) when compared to myths not addressed on the video. The current study suggests that providing information about a variety of disabilities through an informational video can easily correct myths and enhance students' understanding of the disability, regardless of the additional descriptions of personal experiences. This change in knowledge may have an impact on the classroom environment and the peer relationships that occur within that environment by reducing pre-conceived notions that may have a negative impact on the child with a disability. Having a child with a disability or a parent/guardian provide information about the disability may help other children in the classroom, or even the teacher, learn more about the disorder and its impact in the classroom and life outside of the classroom.

Results from the behavioral intentions scales may provide more specific guidance for educators. On the behavioral intentions subscales, the average response was calculated. The average response for an item on the Social Scale was about 3.07 and 3.14 for the control and experimental groups respectively. These data showed that most students, regardless of the video they viewed, were *probably* likely to interact with their peers with AD/HD on various social activities. The means for the Academic Scale were lower (2.65 and 2.63 for the control and experimental groups), suggesting that students in both groups were more ambivalent about interacting with peers with AD/HD on academic tasks (ratings between *Probably Yes* and *Probably No*). Analysis of item mean

data showed that most negative responses were to the following items: 1) interacting with children with AD/HD on a class project, 2) sharing a secret with them, 3) choosing them as a study partner, and 4) working with them on a class paper. The items with the most positive responses were 1) saying hello to the person, 2) sitting beside him or her in class, 3) playing with him or her during break, and 4) choosing him or her to be on his or her team during PE. The individual item analysis reveals that students may be reluctant to interact with their peers with AD/HD when the task is academic and more likely to interact when the task is social.

Previous research on exposure suggests that children who perceive interactions with people with disabilities to be easy and with little social consequence are more likely to engage in certain behaviors with that child than when they perceive the interaction to be difficult (Roberts & Lindsell, 1997; Roberts & Smith, 1999; Voeltz, 1980). Given previous and current research, teachers can use the situational information provided by the individual item analysis to increase peer interaction. Knowledge of situations in which a child is more likely to interact with someone with AD/HD can be useful in encouraging peer relationships in the classroom. The teacher can encourage small interactions by placing the students next to one another in the classroom or placing them on the same team during PE, which may lead to more interactions and more pro-social interactions. Increasing such interactions may allow students with AD/HD to develop their social skills and result in more positive peer relationships. Also, teachers can make the academic accomplishments of children with AD/HD more salient, thereby directing

attention to good academic work and decreasing the myth that all children with AD/HD are poor students. This may in turn cause other students in the classroom to be less hesitant about working with a student with AD/HD on an academic project.

Summary

Results from the study show myths regarding AD/HD could be corrected via a brief video addressing these myths. However, an interaction effect occurred which suggested that adding descriptions of personal experiences may have enhanced learning of information related to the descriptions of personal experiences (context-dependent effect) and/or interfered with learning of the information unrelated to these descriptions (seductive details effect). This interaction effect may have caused equivalent knowledge gains across both groups, preventing us from drawing any conclusions related to behavioral intentions. However, because peers' misunderstandings of a disability may negatively impact their interactions with classmates, clarification of the direction of this effect may have applied implications. For example, if the additional descriptions of personal experiences enhances learning, then videos could be altered to include such descriptions across all myths. Such descriptions may enhance students' understanding of a disability and perhaps behavioral intentions. These changes may improve the social status of students with disabilities, enhance the frequency of their interactions with peers, and enhance social skills of students with disabilities as their behavior is shaped by these interactions.

While there were no significant main effects in this study, item analysis suggests procedures that may improve everyday interactions within the classroom. Changes that include attention to tasks where students work with peers or in groups and providing more public feedback when students with AD/HD do well academically can possibly have an effect on peer interactions. Future researchers should attempt to determine if these small modifications in the classroom may enhance the quality and quantity of peer interaction and peer relationships with students with AD/HD, a group of students whom research has identified as at-risk for peer rejection and socialization problems (Bagwell et al., 2001; Brown & Borden, 1986; Demaray & Elliot, 2001; Erhardt & Hinshaw, 1994; Hinshaw et al., 1997; Milich & Landau, 1982; Newton-Howes, 2004; Pelham & Bender, 1982; Treuting & Hinshaw, 2001).

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APPENDIX

Appendix A: Student Assent Form

Dear Student,

My name is Lee Saecker and I am a graduate student at the University of Tennessee. I am currently looking into how you view other people your age who have Attention-Deficit/Hyperactivity Disorder. I am asking if you would be willing to participate in this research.

If you agree to participate, I will ask you to watch a video, then complete some questions about AD/HD and how you feel about people with AD/HD. It will take approximately 20 to 25 minutes. Participation will not affect your grade in any way. If you do not agree to participate, you will work on a teacher assignment during that class period.

This study is voluntary, which means you do not have to participate and can choose which questions you wish to answer. If at any time you choose to quit, just inform your teacher, _____, my advisors Dr. Amy Skinner (974-8090), Dr. Chris Skinner (974-8403), or myself (Lee Saecker), 776-1822. Furthermore, if you have any questions about the research, feel free to ask your teacher. He can also help you get in touch with either of the Dr. Skinners or me.

If you agree to participate in this research, please check the box below and sign the form in the space provided. Your help is deeply appreciated.

_____ I AGREE to participate in this research.

Print Name: _____

Student Signature: _____ Date: _____

Appendix B: Parental Consent Form

Dear Parent,

I am in my fourth year in the school psychology program at the University of Tennessee and currently working on research for my dissertation. This research involves examining peer attitudes toward students with Attention Deficit/Hyperactivity Disorder (AD/HD) as affected by the presentation of personal stories and factual information. I am seeking your consent for your child to participate in this study.

If you agree to allow your child to participate, your child will watch one of two videos providing information about AD/HD. One video will have facts about AD/HD and the other will have facts about AD/HD plus personal stories about having AD/HD. After completion of the video, your child will be asked to complete an attitudes scale and answer questions about the disorder. These worksheets will be administered in your child's *Psychology* class. The video will last approximately 10-15 minutes and completion of the attitude survey and questions should take no longer than 5-10 minutes, for a total of between 20 and 25 minutes. Participation in this study is voluntary which means your child does not have to participate and can stop at any time without penalty. Also, this study will have no effect on your child's grade. Only the researchers and the student's teacher will know the identity of the student completing the survey and questionnaire. Although results of our research may be shared with others through professional publications or presentation, your child's name will never be revealed.

If you have any questions about this consent form or this study, please feel free to contact my faculty advisors, Amy Skinner (974-8090) and Chris Skinner (974-8403), or me, Lee Saecker at 776-1822. If you agree to allow your child to participate in this research, please check the appropriate box and sign the form in the space provided for parental signature or legal guardian. Your help is deeply appreciated.

Sincerely,
Lee Saecker
University of Tennessee
Educational Psychology and Counseling
Knoxville, TN 37996
(865) 776-1822

Check One

_____ I DO agree to allow my child to participate in this research.

_____ I DO NOT agree to allow my child to participate in this research.

Child's Name: _____

Signature: _____ Date: _____

Parent or Legal Guardian

Appendix C: Video Script

Anything bolded was cut from the control information video

I am a student at the University of Tennessee and I am going to talk a little bit today about Attention-Deficit/Hyperactivity Disorder, or AD/HD. I don't know how many of you know someone who has AD/HD or have it yourselves, but I'm sure most of you already have some idea about what the disorder looks like. **Before we get started, I want to let you all know that I have AD/HD, so a lot of this information is really personal for me.**

OK, so the first thing we are going to talk about today is the reality of AD/HD. A lot of people think that children receive a diagnosis of AD/HD because they get on people's nerves and teachers and parents can't handle them. They think the diagnosis is just a sign of the times and that AD/HD is not a real disorder. If AD/HD wasn't a real disorder, then there wouldn't be risks later in life, there wouldn't be differences between children with AD/HD and children without it, and there wouldn't be a known cause for the disorder. The fact that children with AD/HD may have problems at work and school and in their relationships with other people, and the fact that genetic factors may play the greatest role in causing AD/HD, point to the reality of the disorder. **In fact, my cousin and uncle both have AD/HD, and it was suspected that my grandfather did too, so you can see the genetic component in my family.**

Going along the lines of people not believing AD/HD is a real disorder, a lot of other people believe it is over diagnosed. In fact, AD/HD occurs in only 3-7 % of the population, not as many as you would think, right? I think the reason we see more AD/HD cases these days is there is more awareness of the disability, more knowledge about it, and a more detailed definition.

So, what are some causes of AD/HD? Some people believe that AD/HD is caused by poor parenting. Yes, poor discipline can make certain symptoms of AD/HD worse, but it is not a cause of AD/HD.

Other people believe that it's a poor diet that causes AD/HD, like eating too much sugar and caffeine. In reality, AD/HD is more likely to be due to something called "behavioral disinhibition." Behavioral disinhibition may be due to things happening in the brain that cause a person to have trouble with self-control and with realizing the consequences of their actions- they're more focused on what's happening right now. So a poor diet does not cause AD/HD. **I can remember going to friend's birthday parties and not being allowed to eat any birthday cake- I think my friend's parents thought I was gonna go wild or something. It's funny because it wasn't the sugar I was eating that made me antsy all the time.**

Now that you have an idea of where the disorder comes from, let's talk a little about what it looks like. A lot of people think that all children with Attention Deficit are hyperactive. There are actually two sets of symptoms for AD/HD: inattention and hyperactivity-impulsivity. A person can either have both inattention and hyperactivity-impulsivity, which is called the Combined Type, or just one set of symptoms, called either Predominantly Inattentive Type or Predominantly Hyperactive-Impulsive Type, based on which set of symptoms they exhibit the most. Some of the symptoms of inattention include not being able to pay close attention to details, making careless mistakes, or having difficulty organizing tasks. Hyperactivity includes talking excessively or being fidgety, while impulsivity includes difficulty waiting for a turn and blurting out in class.

In discussing the symptoms of AD/HD, one common misconception is that everybody with AD/HD is just lazy, they're not motivated and don't try hard. Again, not true. Because children with AD/HD may have a hard time concentrating for long periods of time, they may appear to lack motivation and effort. However, this inattention is due to a real biological problem. **In school, all I remember thinking was how many minutes were left in the class period or until I would be able to do something fun. It's not that I was lazy, just that I could never focus in the moment and always felt like my mind was running a billion miles a minute. Now even at work, I have trouble staying focused on everyone's conversations at meetings and remembering everyone's names.**

You may also have heard that AD/HD only occurs in males. The fact is that AD/HD occurs in both males and females; however, the disorder is more frequent in males than females. Depending on the age of the person and the type of AD/HD, the ratio can be between 2:1 and 9:1. **My cousin I told you about earlier that also has AD/HD is a girl.**

Another misconception about AD/HD symptoms is that AD/HD accounts for all the behavioral problems experienced by a person. Some children with AD/HD can have other disorders that affect their behaviors as well. Children with AD/HD are more likely than children without AD/GD to have an Anxiety Disorder or a Learning Disorder in combination with their AD/HD.

Given the symptoms I just discussed, you can see how the disorder may affect some people's school work. However, that's another myth you may have- that all children with AD/HD do poorly in school. They may have symptoms that can harm their performance, but poor academic performance is not a symptom itself. And having AD/HD does not mean that the person is a poor student. **I could have done without being made an example in front of my classmates when I made mistakes or didn't hear what was being said because my mind wasn't in the classroom – I was busy watching a plane go by or anything outside. With the help of medication, I was able to do my homework and concentrate more, so I managed to make mostly As and Bs, with a few Cs in high school.**

Now that we have looked at causes and symptoms, let's look at treatment options. A lot of people think that medication is all that is needed to "take care" of AD/HD. While a large percentage of people respond well to medication, the best treatment is a combination of medication and behavioral/educational strategies.

On the other hand, a lot of other people believe that taking medication for AD/HD causes more problems than it helps in AD/HD and that there are long-term effects like stunted growth. AD/HD medication actually has little effect on the eventual height and weight of adults. **When I wasn't on medication, I was distracted, among other things. Basically, I was getting in trouble in school all the time. After being diagnosed with AD/HD, I started taking medication and everything turned around. I was more calm in school and I was able to sit and have conversations without getting antsy. I now take Ritalin whenever I need to focus on my work. Oh, and I am 6 ft. 2 inches tall and obviously not stunted in my growth.**

The last thing I want to talk about today is how long the disorder lasts. Another common myth is that children with AD/HD outgrow the disorder. In fact, some studies show that up to 50 to 80% of children with AD/HD will not outgrow the disorder. In most people, some symptoms continue in late adolescence and early adulthood. What usually happens is that most people learn to adapt to the condition and make adjustments.

Alright, that's all I have for today. Thanks for your time -

**Attention Deficit/Hyperactivity Disorder
Questionnaire Packet**

DO NOT OPEN THE PACKET UNTIL INSTRUCTED TO DO SO

Name: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION

1. Age (In years) _____

2. Gender: Male Female

3. Race: Please circle one

African American

Asian American/Pacific Islander

Caucasian

Latino/Latina

Native American/Alaskan native/ Hawaiian native

Other _____

4. Year in School: Please circle one

Freshman

Sophomore

Junior

Senior

5. Have you ever had a diagnosis of ADHD?

Yes

No

6. Have you ever had a close friend or relative with ADHD?

Yes

No

7. Have you ever had ANY disability?

Yes

No

(Optional) If yes, what? _____

8. Has anyone you have ever known had ANY disability?

Yes

No

(Optional) If yes, what? _____

9. Is the speaker in the video knowledgeable about ADHD?

Yes

No

10. Does the speaker give accurate information about the disorder?

Yes

No

11. Do you think the speaker in the video has ADHD?

Yes

No

We are interested in your opinions about students with ADHD. Please circle the one answer that best reflects your attitude towards someone with Attention Deficit/Hyperactivity Disorder:

Socially...

I would go up to him/her to say hello	No	Probably No	Probably Yes	Yes
I would sit beside him/her in class	No	Probably No	Probably Yes	Yes
I would play with him/her during break	No	Probably No	Probably Yes	Yes
I would offer him/her some of my snack	No	Probably No	Probably Yes	Yes
I would choose him/her to be on my team during PE	No	Probably No	Probably Yes	Yes
I would work with him/her on a class project	No	Probably No	Probably Yes	Yes
I would invite him/her over to my house for a cookout	No	Probably No	Probably Yes	Yes
I would go to the movies with him/her	No	Probably No	Probably Yes	Yes
I would go to his/her house to play video games	No	Probably No	Probably Yes	Yes
I would share a secret with him/her	No	Probably No	Probably Yes	Yes

Academically ...

I would choose him/her to be in my discussion group	No	Probably No	Probably Yes	Yes
I would choose him/her as a study partner	No	Probably No	Probably Yes	Yes
I would work on a class paper with him/her	No	Probably No	Probably Yes	Yes
I would do a short group presentation with him/her	No	Probably No	Probably Yes	Yes
I would teach a class session with him/her	No	Probably No	Probably Yes	Yes

Attention Deficit/Hyperactivity Disorders Knowledge Questions

Please answer the following questions regarding Attention-Deficit/Hyperactivity Disorders (AD/HD). *Bolded responses are the correct ones...*

1. Most estimates suggest that AD/HD occurs in approximately ___ % of school age children.
 - a.) **3-7**
 - b.) 15-19
 - c.) 25-30
2. Symptoms of depression are _____ found in AD/HD children than in non-AD/HD children.
 - a.) **more frequently**
 - b.) less frequently
 - c.) about the same
3. Current research suggests that AD/HD is the result of _____ .
 - a.) ineffective parenting skills
 - b.) brain damage at birth
 - c.) **impaired behavioral inhibition**
4. Which of the following does **NOT** provide evidence for AD/HD as a “real” disorder?
 - a.) numerous areas of impairment
 - b.) **parent and teacher intolerance**
 - c.) inheritance of the disorder
5. It is _____ for AD/HD children to have an inflated sense of self-esteem or grandiosity.
 - a.) very common
 - b.) somewhat common
 - c.) **uncommon**
6. Which of the following is **NOT** a side effect of using medication for AD/HD?
 - a.) appetite reduction
 - b.) **permanent stunted growth**
 - c.) difficulty sleeping
7. What are the two main symptoms of the Combined Type of AD/HD?
 - a.) Hyperactivity/impulsivity and depression
 - b.) Inattention and rule breaking behavior
 - c.) **Hyperactivity/impulsivity and inattention**

8. Most AD/HD children _____ their symptoms at the onset of puberty.
- a.) **maintain**
 - b.) change
 - c.) outgrow
9. When treatment of an AD/HD child is terminated, it is _____ for the child's symptoms to return.
- a.) **common**
 - b.) somewhat uncommon
 - c.) very uncommon
10. Children with AD/HD are likely to perform inconsistently in school because of _____.
- a.) poor effort and work habits
 - b.) laziness
 - c.) **difficulty concentrating**
11. For most children with AD/HD, a diet of sugar and caffeine _____:
- a.) **can make certain symptoms of AD/HD worse**
 - b.) can cause AD/HD
 - c.) leads to behavioral disinhibition
12. AD/HD children generally experience _____ problems in unfamiliar situations than in familiar situations.
- a.) more
 - b.) **less**
 - c.) about the same number of
13. In school age children, the occurrence of AD/HD in males and females is _____.
- a.) **more frequent in males**
 - b.) more frequent in females
 - c.) equivalent for males and females
14. Poor school performance is _____.
- a.) a symptom of AD/HD
 - b.) rarely exhibited by children with AD/HD
 - c.) **sometimes exhibited by children with AD/HD**
15. Children with AD/HD are typically more obedient with their _____.
- a.) mothers
 - b.) **fathers**
 - c.) grandparents

16. Children with AD/HD may be more likely to have ____ than children without AD/HD.

- a.) **Anxiety Disorder**
- b.) Mental Retardation
- c.) Autism

17. The most effective treatment for children with AD/HD involves _____:

- a.) medication only
- b.) behavioral/educational strategies only
- c.) **both medication and behavioral strategies**

18. A diagnosis of AD/HD by itself _____ makes a child eligible for placement in Special Education.

- a.) always
- b.) sometimes
- c.) **never**

Thank you for your participation in this study. Please turn your completed packet in to the experimenter in the classroom.

Appendix E: Procedural Integrity Checklist for the Primary Researcher

- _____ 1. Before enter the classroom, make sure there is a working DVD player and TV in the classroom, plugged in and ready to go.
- _____ 2. Make sure students in the classroom have informed consent forms
- _____ 3. Pass out assent forms, read it to them, and have students sign
- _____ 4. Divide classroom into two equal groups
- _____ 5. Send Group C to alternate classroom
- _____ 6. Once Group C leaves the room, state the following to Group E:

We are going to be watching an informational video about Attention-Deficit/Hyperactivity Disorder. The video is approximately 7 minutes and 33 seconds long. After the video is over, I am going to ask you to complete a packet. There will be some questions about you, as well as some questions about the video. Please do not talk during the video or when you are completing these packets. Does anyone have any questions? Thank you again for participating in this study.

- _____ 7. Start Video E
- _____ 8. Upon completion of the video, distribute packet E
- _____ 9. Review packet E:

These are the packets that you are to complete. Please write in your first and last name on the front sheet (point to where write name). The first section asks for information about you- your age, your gender, race, year in school, etc. and then some questions about the speaker in the video. The next section asks you to circle one answer that best reflects your behaviors towards someone with Attention Deficit/Hyperactivity Disorder. You have to circle one, and ONLY one, of the responses provided. You cannot write in your own answer and you cannot circle more than one response - just pick the ONE response that BEST reflects your behavior. Please be honest and give your true opinion. The last section is a multiple choice knowledge section. On these multiple choice questions, you also can only pick ONE response (no writing in or circling more than one) – there is only one correct answer. Just try your best on these items and to answer every question. If you have any questions, raise your hand. Also, when you are finished, raise your hand and either Emily or I will come to pick up the packet and your assent form. After you have turned these 2 things in, you can work on your regular class work. Again, please do not talk until everyone has turned in their completed packets. Thank you.

- _____ 10. Collect packets and assent forms when complete them.
- _____ 11. Once Group E finishes, have the secondary experimenter bring Group C into the classroom and take Group E to the alternate classroom.
- _____ 12. Once Group E leaves the classroom, read the following to Group C:

We are going to be watching an informational video about Attention-Deficit/Hyperactivity Disorder. The video is approximately 5 minutes and 44 seconds long. After the video is over, I am going to ask you to complete a packet. There will be some questions about you, as well as some questions about the video. Please do not talk during the video or when you are completing these packets. Does anyone have any questions? Thank you again for participating in this study.

- _____ 13. Upon completion of the video, distribute packet C
- _____ 14. Review packet C: same directions as above
- _____ 15. Collect packets and assent forms when complete.
- _____ 16. Once Group C finishes, have the secondary experimenter bring Group E back into the main classroom
- _____ 17. Once they have turned in all the packets and assent forms and the other group has entered the room, say:

Thank you all for your time. I am going to be coming in to your classroom in a few weeks to break down the study and explain everything that you did today, as well as go over the results of the study and some research techniques. Does anyone have any questions? Have a great Spring Break and see you in a few weeks-

VITA

Lee Bradshaw Saecker was born and raised on the Eastern Shore of Virginia in Accomac, VA. She graduated from Broadwater Academy in Exmore, VA in 1998, and continued her education at the University of Virginia in Charlottesville. In May 2002, she received a BA in Psychology with a minor in Sociology from UVA. She worked in Richmond, VA for 2 years before pursuing her PhD in School Psychology at the University of Tennessee. In May 2008, she received her Masters in Applied Education in the Educational Psychology program. Her final year in the doctorate program will consist of a year long internship with Monroe County schools in East Tennessee.