The purpose of this study was to investigate teacher and school psychologists’ knowledge of Attention-Deficit/Hyperactivity Disorder (ADHD). One hundred thirty-two kindergarten through 12th-grade general education teachers, special education teachers, and school psychologists responded to a 24-item questionnaire concerning treatment and possible causes of ADHD. The results supported the hypothesis that school psychologists’ knowledge level of ADHD would be significantly greater than the knowledge level of special and general education teachers, but did not support the hypothesis that the knowledge level of special education teachers would be significantly greater than the knowledge level of general education teachers. Increased years of professional experience was negatively associated with increased knowledge about ADHD. Implications and suggestions for future research are discussed. © 2009 Wiley Periodicals, Inc.

Attention-Deficit/Hyperactivity Disorder (ADHD) is currently conceptualized as a neurological condition that affects learning and behavior and is estimated to be present in approximately 3%–7% of the school-age population (American Psychiatric Association, 2000; Barkley, 2006; Barkley, Cook, Diamond, Zametkin, & Thapar, 2002). The revised edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition–Text Revision (DSM-IV-TR), specifies that ADHD consists of three subtypes that vary in the degree to which individuals present with difficulties with attention, impulsiveness, and hyperactivity (American Psychiatric Association, 2000). Although there is no established cause of ADHD, multiple factors likely contribute to the development of the disorder, including genetic and environmental factors (Weyandt, 2007). Various forms of treatment are available for ADHD, including pharmacological and nonpharmacological approaches such as behavioral, social, and academic interventions (DuPaul & Weyandt, 2006; Pelham, 1993). Despite the prevalence of ADHD, relatively little research has investigated teachers’ knowledge of the disorder (DuPaul, 2003). Recent research (Ohan, Cormier, Hepp, Visser, & Strain, 2008) has suggested that elementary school teachers possess greater knowledge in the area of ADHD symptoms and diagnostic methods than of the causes and treatments of the disorder.

School teachers play a major role in the assessment of children’s academic and behavioral problems (Stevens, Quittner, & Abikoff, 1998) and have been considered one of the most valuable sources of information with regard to diagnosis because they have daily exposure to children in a variety of clinically relevant situations. Consequently, teachers are often the first to make referrals for ADHD-related assessment, and these referrals have often been used as a predictor of a child’s symptoms (Sciutto, Terjesen, & Bender-Frank, 2000). Jerome, Gordon, and Hustler (1994) were among the first to assess teacher knowledge of ADHD and conducted a survey comparing American and Canadian teachers’ knowledge of and attitudes toward the disorder. Results indicated that teachers reported having had little opportunity to learn about ADHD, either within the context of
their education program or after they graduated. Although teachers’ scores on the knowledge section of the questionnaire used in the study indicated that their understanding of basic concepts about ADHD was “good,” relevance of dietary management and long-term prognosis were two areas in which teachers were found to be less knowledgeable. Teachers also tended to believe that children with ADHD will outgrow their symptoms by adolescence or adulthood (Jerome et al., 1994), an outcome which the literature suggests is unlikely for most individuals with the disorder.

Although the research has clarified a great deal about the causes of ADHD in recent years, myths surrounding the etiology of the disorder persist. Common myths regarding the causes of ADHD include the misattribution of the disorder to poor diet (preservatives, food colorings, aspartame), excessive consumption of foods high in natural or processed sugar, exposure to fluorescent lighting, exposure to tar and pitch, certain soaps and detergents, an overabundance of yeast in the diet, insect repellants, poor teaching style, poor parenting style, and a variety of environmental pollutants (Weyandt, 2007).

Misconceptions regarding the etiology of ADHD have resulted in the use of numerous interventions to reduce ADHD symptoms that have not been empirically validated, such as sensory integration training, mineral or vitamin supplements, caffeine, yoga, and homeopathic treatments (Weyandt, 2007). Various intervention strategies for students with ADHD to succeed in the classroom have been empirically validated by the literature, including the use of action-oriented tasks requiring active response; the provision of frequent feedback; the use of explicit instructions; highly structured academic tasks; stimulating materials (i.e., the addition of color to text); reduction of lengthier assignments to several smaller units; use of a multisensory approach (e.g., written and verbal instruction); the use of adaptive technology (completion of assignments on the computer rather than by hand); encouragement of note taking during presentations; study skills programs; positive reinforcement and reinforcement of work completion (Barkley, 2004; Weyandt, 2007).

Studies of ADHD knowledge among teachers have revealed that educators hold several specific misconceptions about the disorder (Arcia, Frank, Sanchez-LaCay, & Fernandez, 2000). One of the most common misconceptions about ADHD is that symptoms are caused by, or can be modified through, dietary changes (Barbaresi & Olsen, 1998; DiBattista & Shepherd, 1993; Jerome et al., 1994). Teachers also tend to have inadequate knowledge about the side effects of stimulant medications (Barbaresi & Olsen, 1998; Kasten, Coury, & Heron, 1992). More recently, Ghanizadeh, Bahredar, and Moeini (2006) investigated the knowledge of and attitudes about ADHD among elementary school teachers. The results showed that teachers held false beliefs about causation of ADHD, with 53.1% of the participating teachers attributing the disorder to “parental spoiling” of the student. One third of the teachers believed that ADHD may be caused by excessive consumption of sugar. Of particular concern was the perception of 39.8% of the educators surveyed that the educational achievement of students with ADHD would ultimately be lower than that of students without an ADHD diagnosis. Although most students with ADHD are serviced in a mainstreamed setting, little information is available regarding preparedness of general education teachers to work effectively with these students (Reid, Vasa, Maag, & Wright, 1994). Teachers also have been found to greatly overestimate the prevalence of ADHD in their classrooms, particularly in classrooms of a larger than average size (Glass & Wegar, 2000, Havey, Olson, McCormick, & Cates, 2005).

Kasten, Coury, and Heron (1992) examined teachers’ knowledge and attitudes regarding the use of stimulants with children with ADHD. Their results indicated that teachers were not receiving adequate preparation in this area during their educational training and that training efforts of existing teachers needed to be improved, especially for general education teachers. Nonetheless, several recent studies suggest that many teachers prefer a combination of medication and behavior plan in managing students’ ADHD (Glass & Wegar, 2000; Havey, Olson, McCormick, & Cates, 2005). Kos, Richdale, and Jackson (2004) investigated the relationship between various teacher characteristics
and teachers’ knowledge about ADHD, comparing perceived and actual ADHD knowledge across current primary school teachers and recent college graduates from education programs preparing to enter their first year of teaching. Results indicated that teacher knowledge was significantly correlated with experience in teaching a child with ADHD and currently employed teachers obtained higher scores than graduates entering the field concerning factual knowledge about ADHD. These results are discrepant from those of Jerome, Washington, Laine, and Segal (1999) who found teachers and education students to be similar in factual knowledge of ADHD. In a similar study, Beckle (2004) examined the knowledge and attitudes of practicing teachers regarding ADHD and compared them to those of undergraduate education students. The results confirmed the existence of knowledge gaps, with teachers being more knowledgeable about ADHD, although both practicing teachers and undergraduate education students possessed some accurate information about the disorder. Furthermore, most participants regarded ADHD as a valid diagnosis with implications for the school setting and expressed a desire for comprehensive training about the disability. As a whole, the existing literature suggests that determining how to best educate students with ADHD is a complex and detailed process that continues to change and evolve.

In 2004, Vereb and DiPerna explored the relationships among teachers’ knowledge of ADHD, knowledge of common treatments for ADHD, and acceptability of different approaches to treatment of ADHD (medication and behavior management). Results indicated that teachers’ knowledge of ADHD, years of teaching experience with students with ADHD, and history of related training demonstrated positive relationships with ratings of medication acceptability. In addition, teachers’ participation in ADHD training was positively correlated with knowledge of ADHD and acceptability of behavior management strategies. Snider, Busch, and Arrowood (2003) assessed both general and special education teachers’ knowledge, opinions, and experience related to the diagnosis of ADHD and its treatment with stimulant medication. Results revealed that teachers had limited knowledge about ADHD and the use of stimulant medication. Teachers’ opinions about the effect of stimulant medication on school-related behaviors were generally positive, although special education teachers’ opinions were described as being more positive than were those of general educators.

In addition to regular and special education teachers, school psychologists also play an important role in the assessment and treatment of children diagnosed with ADHD and can offer crucial information concerning medication management. In a study performed by Frankenberger, Farmer, Parker, and Cermak (2001), school psychologists reported that, on average, nearly 20% of their caseload involved working with children diagnosed with ADHD. Gureasko-Moore (2004) examined school psychologists’ medication-monitoring techniques for students with ADHD and found that almost 55% of the respondents (school psychologists) were involved in monitoring the effects of medications for these students. Not only are school psychologists in a position to work directly with children diagnosed with ADHD, they are also in the position to disseminate current scientific information about the disorder to professionals within the schools. In 2003, Demaray, Schaefer, and Delong surveyed school psychologists to investigate their training and current assessment practices for ADHD in the schools. The respondents reported that they received adequate training in the assessment of ADHD and that this training stressed the importance of using multiple informants, methods, and settings. The most effective means to gather this type of information are teacher and parent rating forms and interviews, direct observation, and review of work samples.

It is imperative that school psychologists be provided with relevant and current information on all aspects of the diagnosis and treatment of ADHD. Research concerning school psychologists’ knowledge of ADHD is virtually nonexistent, however. Because school psychologists provide such crucial information regarding students diagnosed with ADHD, whether it is medication effectiveness or identifying problem behaviors, it is imperative to investigate the knowledge of school psychologists. Teachers, however, spend more time with children who have ADHD than does anyone else.
in the school system, and are thereby in a unique position to work with the students in managing the disorder. Furthermore, they play a crucial role in working with other school personnel in the diagnostic process and in educating parents about how to best help their child manage the disorder and achieve his full potential. It is critical, then, for classroom teachers to have a thorough, accurate understanding of the current research concerning ADHD.

The purpose of the present study was to assess teacher knowledge (general education and special education) and school psychologists’ knowledge of ADHD. Although the training of school psychologists typically involves at least a basic overview of the disorder, the training of a general education teacher may not. Consequently, the first hypothesis was that the knowledge level of school psychologists would be significantly greater than teacher (special education and general education) knowledge. Similarly, in light of the fact that special educators are more likely to have been exposed to accurate information about ADHD as part of their training program, it seemed plausible that they would have greater knowledge of the disorder than their general education counterparts would have. Specifically, the second hypothesis was that the knowledge level of special education teachers would be significantly greater than that of general education teachers. Finally, we posited that even teachers and school psychologists whose training programs insufficiently informed them about ADHD would, through firsthand exposure and professional development opportunities, have acquired more information about the disorder during their careers. Therefore, the third hypothesis was that the knowledge level of both groups of teachers (special education and general education) and school psychologists with more years of professional experience would be significantly greater than the knowledge level of teachers and school psychologists with fewer years of professional experience.

**Method**

**Participants**

A sample of kindergarten through 12th-grade educators \(N = 132\) volunteered to participate in the study. General education classroom teachers \(N = 42\), special education classroom teachers \(N = 36\), and school psychologists \(N = 54\) comprised the sample. A majority of participants (75%) were female. The majority of the participants were recruited from school districts in Eastern Washington State. Table 1 provides a comparison of demographic information for each of the three groups. Respondents reported a wide range in terms of years of experience (from 1 to

<table>
<thead>
<tr>
<th>Sample Size</th>
<th>School Psychologists</th>
<th>General Educators</th>
<th>Special Educators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender of Participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>43 (79.6%)</td>
<td>29 (69%)</td>
<td>31 (86.1%)</td>
</tr>
<tr>
<td>Male</td>
<td>11 (20.4%)</td>
<td>13 (31%)</td>
<td>5 (13.9%)</td>
</tr>
<tr>
<td>Years Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>1–41</td>
<td>2–35</td>
<td>1–36</td>
</tr>
<tr>
<td>Mean</td>
<td>11.08 ( (SD = 9.08) )</td>
<td>16.93 ( (SD = 9.69) )</td>
<td>14.51 ( (SD = 9.15) )</td>
</tr>
<tr>
<td>Ages of Students Served</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>22 (40.7%)</td>
<td>8 (19%)</td>
<td>19 (52.8%)</td>
</tr>
<tr>
<td>Secondary</td>
<td>11 (20.4%)</td>
<td>34 (81%)</td>
<td>15 (41.7%)</td>
</tr>
<tr>
<td>Both Elementary and Secondary</td>
<td>19 (35.2%)</td>
<td>2 (5.6%)</td>
<td></td>
</tr>
</tbody>
</table>
Teacher and School Psychologist Knowledge of ADHD

41 years) with a mean of 13.9 years. General education teachers reported the greatest mean experience (16.93 years), higher than that of both special education teachers (14.51 years) and school psychologists (11.08 years). School psychologists in this sample were more likely to work with elementary students (40.7%) or both elementary and secondary students (35.3%), whereas a majority of general education teachers reported working with secondary students (81%). Special educators in the sample were divided more evenly in terms of grade level, with 53.8% reporting that they worked with elementary students, 41.7% with secondary students, and 5.6% with both levels of students.

Materials

To assess teacher and school psychologist knowledge of ADHD, the researchers used a published questionnaire entitled The ADHD Beliefs Scale (Johnston & Freeman, 2002). The scale includes 24 questions and uses a 7-point Likert scale that requires participants to read 24 statements regarding ADHD. For each statement, the respondent was asked to circle one of seven responses representing his or her knowledge of the accuracy of the statement, including “Disagree,” “Neutral,” and “Agree.” Points range from 1 to 7 points for each item, with a score of 4 being equal to “neutral.” A score lower than 4 is considered “Disagree,” and a score higher than 4 is considered “Agree.” The ADHD Beliefs Scale consists of statements covering two domains related to knowledge of ADHD (appropriate treatment options for children with ADHD and possible causes of ADHD), including both reasonable (empirically validated) beliefs and false beliefs (those not supported by extant research) statements. The ADHD Beliefs Scale assesses individuals for a variety of beliefs regarding the causes of and treatments for ADHD. Completing the scale requires the individual to indicate the degree to which he or she agrees with a series of common beliefs about ADHD. Beliefs that have been supported by the literature comprise the “reasonable beliefs” subscale, and beliefs that have not been validated by the literature comprise the “false beliefs” subscale. Individual items assess beliefs regarding the efficacy of behavior management (e.g., “Training parents in behavior management is a useful treatment for ADHD”); “Clear, consistent rules and consequences are helpful in treating children with ADHD”); the efficacy of medication (e.g., “Medication is a safe treatment for ADHD”; “I would not hesitate to medicate my child if a doctor recommended it”); perceptions surrounding the etiology of the disorder (e.g., “ADHD results from parents being inconsistent with rules and consequences”; “ADHD is related to parents’ use of poor discipline strategies”); and perceptions related to treatments and interventions (e.g., “Special diets are often helpful for treating ADHD”; “Vitamin therapy is useful in treating ADHD”). In 2002, Johnston and Freeman conducted a factor analysis on the scale that revealed a two-factor solution, and accounted for 39% of the variance. The two factors were labeled “false beliefs” and “reasonable beliefs.” Four items did not load above .30 on either factor, and, as such, were omitted from the scoring. Extensive reliability and validity information was not available for the scale, but internal consistency for the two identified factors was found to be adequate, with Cronbach’s alpha = .73 – .77 (Johnston, Hommersen, & Seipp, 2008).

Design and Procedure

The present study was a between-groups design. The independent variable (educator position) included three levels: special education teacher, general education teacher, and school psychologist. There were two dependent variables in this study (test of knowledge of ADHD): (a) reasonable beliefs and (b) false beliefs. The criterion for inclusion in the study was that the respondent be a current, full-time employee in Washington State, functioning as an elementary or secondary classroom teacher or school psychologist. Persons excluded from participation in the study consisted of Washington State administrators, substitute teachers, and classified school personnel. Due to the low numbers of school psychologists, as compared to the number of teachers in the participating school districts,
the researchers recruited additional school psychologist respondents via a random sample mailed to 100 practicing school psychologists in the state of Washington.

After acquiring approval from the University’s Institutional Review Board, recruitment began. The first procedure for recruiting teachers and school psychologists from school districts involved the primary investigator meeting with representatives from each district participating in the study to obtain permission to recruit district personnel as participants. After permission was obtained, principals at participating schools were contacted to identify one faculty member per school to act as a coordinator for the dispersal and collection of the scales. Meetings were scheduled between the investigator and the on-site school coordinators. During these meetings, the investigator oriented the school coordinators to the research forms and questionnaire. Prior to filling out the forms, participants were instructed to read through the letter introducing the study, which addressed voluntary participation and instructed participants on how to complete the forms. Participants were informed that participation was voluntary, and that by completing and returning a demographic questionnaire and ADHD Beliefs Scale he or she had given his or her consent to participate in the study. The completed forms were returned to a central collection area. The amount of time between the dispersal of the scale and the collection was determined by teacher schedule and the number of forms returned, to a maximum of two weeks. The final procedure was for the school coordinator to mail the completed forms to the principal researcher.

Regarding procedures for recruiting school psychologists, an investigator mailed one survey, a cover letter of informed consent with instructions, and a self-addressed, stamped envelope to a random sample of individuals taken from a state list of all practicing school psychologists in the state of Washington. Forms were not mailed to school psychologists working in school districts that were previously approached through direct contact for recruitment of respondents.

**RESULTS**

A multiple analysis of variance (MANOVA) technique was used to test the following hypotheses: (a) the knowledge level of special education teachers as indicated by their score on the ADHD Beliefs Scale (agreeing with reasonable beliefs and disagreeing with false beliefs) would be significantly greater than general education teachers in both the reasonable belief domain and the false belief domain; (b) the knowledge level of school psychologists as indicated by their score on the ADHD Beliefs Scale (agreeing with reasonable beliefs and disagreeing with false beliefs) would be significantly greater than teacher (special education and general education) knowledge in both the reasonable belief domain and the false belief domain; and (c) the knowledge level of teachers (special education and general education) and school psychologists with more years of professional experience would be significantly greater than the knowledge level of teachers and school psychologists with fewer years of professional experience as indicated by their score on the ADHD Beliefs Scale (agreeing with reasonable beliefs and disagreeing with false beliefs).

Table 2 presents mean scores for the reasonable and false beliefs subscales of the ADHD Beliefs Scale for special education teachers and general education teachers (higher scores on the reasonable beliefs subscale represent greater knowledge; lower scores on false beliefs subscale represent greater knowledge). Cronbach’s alpha for the reasonable beliefs subscale for this sample was .754, and for the false beliefs subscale was .870. Regarding the hypothesis that special education teachers would score higher on the reasonable subscale and lower on the false subscale, MANOVA results were significant: F(3,71) = 4.29, p < .05 Wilks’ lambda = .889. Follow-up analyses of variance (ANOVA) revealed no significant differences between scores on the reasonable belief subscale or the false belief subscale when comparing special education teachers and general education teachers. Regarding the hypothesis that school psychologists would score significantly higher on the reasonable subscale
and significantly lower on the false subscale, results were significant: F(3,119) = 16.38, p < .0001; Wilks’ lambda = .784 (see Table 3).

To test the third hypothesis, the correlation between years of experience and reasonable beliefs was analyzed. Although it was expected that educators who were more experienced in working with all types of students would have greater knowledge about ADHD, the data suggested that this is not the case. In fact, quite the opposite was true: In several correlational analyses, it was found that educators with more years of experience were actually less knowledgeable about ADHD. Educators with more years of experience had both more false beliefs (p = .012; Pearson’s r = 0.224) and fewer reasonable beliefs (p = .049; Pearson’s r = −1.75) about ADHD than their less-experienced peers.

**DISCUSSION**

The purpose of the present study was to assess teachers’ (general education and special education) and school psychologists’ knowledge of ADHD. Specifically, it was hypothesized that (a) the knowledge level of special education teachers as indicated by their score on the ADHD Beliefs Scale would be significantly greater than that of general education teachers on both the reasonable belief subscale and the false belief subscale, (b) the knowledge level of school psychologists would be significantly greater than teacher (special education and general education) knowledge in both the reasonable belief subscale and the false belief subscale of the ADHD Beliefs Scale, and (c) the knowledge level of all participants with more years of professional experience would be significantly greater than that of participants with fewer years of professional experience. The results of this study supported the second hypothesis, but not the first or third.

With regard to the first hypothesis, the present findings did not support a significant difference between general education teacher knowledge and special education teacher knowledge of ADHD.
In both groups, accurate knowledge appeared limited, as evidenced by the fact that general education teachers agreed with more false beliefs than they did reasonable beliefs. Examining the false beliefs, general education teachers and special education teachers agreed most often with the statement, “Special diets are effective treatments for ADHD,” a widely accepted myth that has emerged frequently in prior research (Weyandt, 2007). Post hoc analyses revealed, however, that special education teachers demonstrated a significant difference between their mean score on the reasonable beliefs subscale and their mean score on the false beliefs subscale. It appears as though special education teachers either agreed more strongly with the reasonable beliefs or they agreed to some degree with a greater number of reasonable beliefs than did the general education teachers. With the lack of research that is available in this area, it has not been established with any degree of certainty whether special education teachers have received more in-depth training than general education teachers in this area, or whether the opportunity to interact more often with students diagnosed with ADHD has led them to produce these results. Future research is warranted to gain clearer insight into these questions. Examining the responses provided by the general education teachers, these participants appear to hold several other false beliefs as well, including a belief that “one day a medical cure for ADHD will be found” (42%), and that “vitamin therapy may effectively treat the symptoms of ADHD” (28%). Based on these findings, it would appear that most general education teachers possess a general lack of knowledge of ADHD, a finding echoing the research of Yasutake, Lerner, and Ward (1994), who found that teachers reported receiving a lack of training in ADHD and acknowledged the need for additional training concerning this disorder.

These results are noteworthy considering the prevalence of ADHD among school-age children and the fact that most of these children will be served in the mainstream setting, a reality acknowledged by most general education teachers (Rathvon, 1999). It is highly plausible that problems associated with students with ADHD will be compounded when they are placed in a classroom with teachers who possess a low level of knowledge of effective treatments or insufficient understanding of the possible causes of ADHD. Furthermore, because school psychologists typically rely on teachers for student referrals for services, the identification of effective treatments of ADHD is largely dependent on teacher knowledge of this disorder. The results of the present study, however, suggest that general education teachers lack such knowledge, a finding consistent with a 1992 study performed by Children and Adults with Attention Deficit Disorders (CHADD) that found that 89% of the teachers surveyed had not received training in ADHD, yet 98% felt that they needed this training (Weyandt, 2007).

Results revealed that, although special education teachers included in the study fared slightly better, they remained “neutral” on several false and reasonable beliefs, including: “Self-control training is an effective treatment for ADHD” and “Social skills training is an effective treatment for ADHD.” These results imply that special education teachers do not possess a substantial level of knowledge about ADHD, especially in the areas of effective treatments. If special education teachers hold the false belief that students are in control of their behavior, they may expect students to demonstrate a level of classroom behavior that is beyond their capacity in the absence of appropriate supports. The establishment of such unrealistic expectations for students with this type of disorder can contribute to low self-esteem for the student and frustration for the teacher. In 1994, Reid and colleagues compared the perceptions of elementary school teachers with and without ADHD training, finding that teachers without training expressed a lack of confidence in their ability to effectively teach students with ADHD.

The second hypothesis, that the knowledge level of school psychologists would be significantly greater than teacher knowledge in both domains, was supported by the data. This finding is encouraging, perhaps a testament to the greater training and experience that these professionals have in evaluating students with medical and emotional/behavioral disorders. Generally speaking, school
psychologists work with fewer students than do teachers, but are in a position to collaborate with parents, teacher, specialists within the school, and outside medical agencies and to design and monitor student interventions—in effect acting as a safety net for children with disorders who are passing through the school system (National Association of School Psychologists, 2005). The finding that school psychologists have a significantly greater knowledge of ADHD than teachers suggests that these professionals may be better qualified than teachers to identify students with the disorder as well as to help establish and evaluate effective interventions for students with ADHD.

When evaluating the depth of school psychologists’ knowledge of ADHD, it is important to examine the specific beliefs with which these participants agreed and disagreed. A score of 4.00 on any of the 24 statements on the ADHD Beliefs Scale indicates neutrality, and reveals a lack of certainty regarding knowledge of ADHD treatments or causes. Although significantly greater than teachers’ mean score for total knowledge, school psychologists’ score of 4.56 on the statement, “Individual child therapy is an effective treatment for ADHD,” and score of 4.81 on the statement, “Children with ADHD inherited the disorder from someone in the family,” reveal a sense of ambiguity regarding these statements, even though both are considered to be a reasonable treatment and possible cause of ADHD. Future research is needed to explore which reasonable and false beliefs are less known to school psychologists and how such gaps in knowledge can be corrected.

The third hypothesis, that school psychologists and teachers with more years of professional experience would demonstrate a greater knowledge of ADHD than would participants in these positions with fewer years of experience, was not supported. In fact, analyses revealed that participants with fewer years of professional experience demonstrated a significantly greater overall knowledge of ADHD than those with fewer years of experience. These findings suggest that the ability of teachers and school psychologists to identify appropriate treatments and possible causes of ADHD does not increase with years of experience. One possible explanation is that, in recent years, ADHD has become a much more well-studied and documented disability than it was in previous years. Therefore, contemporary training programs may be better prepared to instruct educators in recent years than they have been in the past. Another possible explanation is professionals who are more recently out of the training programs in college are more accepting of the research supporting the existence of ADHD. There is no research available to support these claims, however; research has shown that teacher knowledge and teacher-perceived confidence in working with students with ADHD has improved as a result of training programs (Niznik, 2005). Therefore, one could hypothesize that training programs are better equipped to prepare professionals in the education field than they have been in the past. However, additional research is warranted. Future studies should control for effects of time since training, through the covariance of teacher and psychologist years of experience since the conclusion of training.

It is important to note that the present study has several limitations. Differences in methods of sampling of participants might have led to unequal representation, and data regarding teacher knowledge, both special education and general education, were collected in only two school districts. Although adequate for an exploratory study such as this one, the sample size was not large enough to legitimately draw generalizable conclusions. Nevertheless, this preliminary foray into the area of interest clearly suggests that further investigation is warranted. Another limitation to this study is that information regarding the psychometric properties of the ADHD Beliefs Scale is limited. Although Johnston and Freeman (2002) used the scale to examine parental knowledge of ADHD and results revealed items on the scale loaded onto two distinct factors (reasonable beliefs and false beliefs), the current study is the first to use this scale to examine teacher and school psychologist knowledge of ADHD. Additional studies are needed to further examine the utility of the scale.

In summary, the results of the present study indicate that the knowledge level of general education teachers did not differ significantly when compared to special education teachers’ knowledge of
ADHD, on either reasonable or false beliefs. The knowledge level of school psychologists, however, was significantly greater than teacher knowledge on both subscales. A last finding, and perhaps the most unexpected, is that knowledge of ADHD was not found to be greater among teachers and school psychologists with more years of experience. In fact, teachers and school psychologists with fewer years of experience demonstrated greater knowledge of ADHD when compared to participants with fewer years of experience.

Both special education and general education teachers have more one-on-one contact with students than do any other school professionals. As such, professionals in this capacity are at a unique advantage to both identify possible occurrences of ADHD prior to diagnosis and implement strategic interventions with students once a diagnosis has been made. Given the statistics that suggest that one to two children in every classroom have ADHD (DuPaul, 2003), it is highly likely that every educator will face the challenge to effectively educate a student with ADHD. If educators are to effectively serve any disadvantaged population, they must build and maintain a knowledge base of the causes, effects, and effective interventions associated with the disorder. This study is among the first to explore teacher and school psychologist knowledge of ADHD and raises questions about the preparedness of educators concerning the most commonly diagnosed behavior disorder of childhood, namely ADHD.

REFERENCES


