

**FACTORS CONTRIBUTING TO STRESS IN PARENTS OF  
CHILDREN DIAGNOSED WITH ATTENTION-  
DEFICIT/HYPERACTIVITY DISORDER**

**By**

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Submitted in partial fulfillment of the requirements

For the degree of

Masters in Education (Educational Psychology)

In the School of Educational Studies

In the

Faculty of Education

University of KwaZulu-Natal

Edgewood Campus

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January 2005

## DECLARATION

I, Yashica Prithivirajh, hereby declare that the dissertation entitled “Factors contributing to stress in parents of children diagnosed with Attention-Deficit/Hyperactivity Disorder” is the result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other University.

Prithivirajh

YASHICA PRITHIVIRAJH

10-01-2005

DATE

## **TO MY PARENTS**

For always supporting me in everything. You are both, my source of inspiration and my pillar of strength. Thank you for always being there for me.

## **ACKNOWLEDGEMENTS**

I wish to thank the following people who contributed in different ways to put this project together:

My supervisor, Dr. Z. Naidoo, for her guidance and support in completing this study.

Chandu Dacheppally for his statistical analysis of the data.

Mrs. Minnie Lottering for her expert secretarial skills which she put to good use as she assisted me in the lay out of the questionnaires. Your assistance is truly appreciated.

The Browns' School for granting me permission to conduct my research and to those specific educators who assisted in distributing and collecting the questionnaires so timeously, I am eternally grateful.

Dr. I. Cunard, my supervisor at my internship site, thank you for your direct and indirect assistance with this project.

The parents who participated so obligingly and co-operatively as the respondents in the study, thank you for sacrificing your time.

My parents and my daughter, Sasha-Leigh, thank you for your patience, your love, support and understanding through the difficult times.

Sean, this project would not have been possible without you. Thank you for always believing in me and showing me the light that is burning at the end of the tunnel. Thank you for your tolerance, encouragement, patience and understanding.

I thank God because "with God, all things are possible."

## **ABSTRACT**

The purpose of this study was to investigate which factors contributed to stress in parents of children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). The influence of the parents' gender on these stress factors as well as the way in which parents conceptualised extreme stress/burnout were also explored.

This study focused on parents whose children have been diagnosed with this disorder and attend the grade two classes at this special school. Thirty seven parents completed a survey questionnaire and semi-structured interviews were conducted with 10 of these parents. The researcher was able to determine which specific factors contributed to these parents' stress relating to parenting their ADHD child and also explored parents' conceptions of stress. The data was quantitatively and qualitatively analysed. The semi-structured interviews explored the parents' subjective stress experiences with their ADHD children and encouraged possible solutions from parents. Gender differences were also explored. The responses to the interviews were qualitatively analysed.

The results of this study have indicated that generally, parents perceive extreme stress/burnout in terms of physical and emotional symptoms. The factors contributing to extreme stress appeared to be associated with social problems of ADHD children, their inappropriate behaviours and school-related problems. Many possible solutions were offered by parents but they also indicated the need for support and understanding from significant others, such as spouses, teachers, family members, doctors and therapists. Parents of ADHD children in this study indicated that one's gender does play an important role regarding how a person copes with stress, with mothers generally experiencing far more stress than fathers.

The findings of this research were discussed in relation to previous findings from international literature. The study concluded with recommendations to the ADHD child's parents and teachers on understanding and supporting each other, and the ADHD child, in order to cope with this disorder.

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# **CHAPTER 1**

## **INTRODUCTION**

The purpose of this study was to investigate the factors that contributed to stress in parents of children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). The introduction of this study attempts to provide a brief summary on the background of ADHD, place it within the international and South African contexts, looking at its prevalence rates and associated problems within the family. The rationale and methodology utilized to carry out this research are also alluded to. Each chapter within this report is described at the end of the introduction under the heading, “Presentation of the contents”.

### **1.1 BACKGROUND AND CONTEXT**

Many people believe Attention-Deficit/Hyperactivity Disorder (ADHD) is the “disease of the nineties” because they hear so much about the disorder. In reality, it is not a new clinical problem. The only new thing is that a major effort began in the 1980s to educate parents and teachers about ADHD. Thus, more children and adolescents have been diagnosed as suffering from ADHD. Although the terminology to describe the condition has changed over time, the descriptions have remained consistent. These individuals show one or more of three sets of behaviours: hyperactivity, distractibility and/or impulsivity.

The term ADHD was first termed “hyperkinetic reaction of childhood” by the medical classification system in 1968 and with it came the concept of the hyperactive child (Silver, 1999). In 1980 the term changed to “attention deficit disorder” (ADD), emphasising distractibility with a short attention span and that hyperactivity or impulsivity might also be present. Two subtypes were used: ADD with hyperactivity and ADD without hyperactivity. A child needed only one of the three behaviours

(hyperactivity, distractibility or impulsivity) to have the diagnosis. In 1994, three subtypes were established (Barkley, 1998).

1. Individuals who are hyperactive, inattentive, and impulsive – mixed type.
2. Individuals who are primarily inattentive – inattentive type.
3. Individuals who are primarily hyperactive and impulsive – hyperactive-impulsive type.

These changes in names over the years do not reflect ambivalence on the part of the professionals who develop these classifications and guidelines. They reflect the rapidly expanding knowledge of this disorder and thus, the increase in diagnosis of ADHD children today.

### **1.1.1 PREVALENCE OF ADHD**

Attention-deficit/hyperactivity disorder (ADHD) is the most common neuro-behavioural disorder of childhood and among the most prevalent chronic health conditions affecting school-aged children (Herrerias, Perrin and Stein, 2001). Prevalent rates for ADHD vary substantially, partly because of changing diagnostic criteria over time, the absence of a reliable or valid diagnostic method, partly because of variations in ascertainment in different settings and the frequent use of referred samples to estimate rates. Therefore no firm data are available on its prevalence.

At least 10 percent of behaviour problems seen by general paediatricians are due to ADHD. Up to 50% of the children with behavioural problems seen by child psychiatrists have ADHD (Silver, 1999). Studies done in the United States and other countries, especially in New Zealand and Germany, suggest that about 3-6% of the school-aged population has ADHD (Herrerias, et al., 2001).

### **1.1.2 ADHD IN THE SOUTH AFRICAN CONTEXT**

Millions in South Africa have mental illnesses. One in four people worldwide will suffer from a mental or behavioural disorder some time in their lives. This means that 450 million people worldwide are currently suffering from one or more of these conditions, according to the World Health Organisation (WHO, 2004). Although there are no accurate statistics in South Africa on ADHD, small preliminary studies suggest that the prevalence rates in this country are similar to the Western countries (Health 24, 2000-2004).

The recognition of culture and ethnicity are extremely important in the development of ADHD, as culture shapes the environment in which behaviour is defined as inattentive, impulsive or hyperactive. This is not to say that ADHD is just a matter of cultural definition. ADHD is defined as a neurologically based, genetically transferred, developmental disorder. As such, ADHD is expected to be present all over the world, but cultural norms and rules will modify how the disorder is manifested. It is therefore essential that the ethnic, cultural and language factors be taken into account in considering the development, manifestation, diagnosis and treatment of childhood disorders.

Research in Africa has been hampered by lack of resources, problems in access and communication and political strife. In addition to differing cultural influences, African countries are faced with questions concerning differential diagnosis and co-morbidity when compared to Western countries (Madu, 2003). Tropical diseases like malaria and bilharzias, and consequences of malnutrition and hunger, may all lead to symptoms of inattention and/or restlessness, and thus methods for ruling out competing explanations should be developed (Madu, 2003).

Research among the different language groups in the Limpopo Province of South Africa indicates that ADHD is the most prevalent disorder also in South Africa and that the prevalence rates for ADHD subtypes are similar to Western rates for both genders in all

language groups (Meyer, 1998; Meyer, Eilersten, Sundet, Tshifularo and Sagvolden, 2002).

A study by Mako (2002) conducted in Gauteng, South Africa, revealed that there were no significant differences in the prevalence of ADHD symptoms in African children who were referred to a clinic for diagnosis and treatment and those in the community, except for the older girls (>10 years of age). This may be an indication that the symptoms of ADHD in boys and younger girls may not be perceived as being pathological and therefore either be acceptable in their specific culture or be ascribed to other causes. The symptoms of ADHD may not be recognized and therefore no intervention will take place.

It also indicates the necessity for community workers and teachers to be trained in the identification of ADHD. Especially in predominantly African communities with an acute shortage of specialized services, a lack of general awareness of the disorders and their consequences, and possibly some tendency to deny or conceal their presence, the importance of community-based diagnostic services and instruments is undeniable (Madu, 2003).

## **1.2 ADHD CHILDREN IN THE FAMILY CONTEXT**

Studies have demonstrated that family dysfunction is common in families with ADHD children and that family members often suffer serious psychological effects. Parents with ADHD children are tired. In addition to the normal stresses of family life, they are continually working on their child's behalf. They mediate, advocate, intervene, referee, pre-plan, negotiate and adapt until they are exhausted. In the meantime, they provide emotional support for their ADHD child, while trying to balance the attention given to the ADHD child with the attention given to other family members, not mentioning work pressures. No wonder they are stressed and worn out (Tuttle and Paquette, 1994).

It is not easy living with an ADHD child. Their constant activity, short attention span and their inappropriate behaviours are annoying, frustrating and upsetting. Then there are

school-related problems, where the ADHD child's teacher complains about his or her class behaviour and incompleteness of tasks. Friends and family members cannot understand the ADHD child's behaviour and describe them as "naughty" and suggest that parents be more strict concerning discipline. The siblings of ADHD children also experience frustration and embarrassment especially amongst their friends (Silver, 1999).

Findings have been consistent in indicating that compared with other children, those with ADHD come from families often characterized by marital dissatisfaction and separation of their parents, family relationships characterized by conflict, and experience of more stressful life events in the past year (Barkley, Fischer, Edelbrock and Smallish, 1991). If anyone thinks being an ADHD child is difficult, try parenting one. For as out of control as ADHD children act, their parents often feel equally out of control in their ability to tame the ADHD symptoms.

The usual methods of discipline don't work with ADHD children, and most parents arrive at psychologists' rooms worn to a frazzle by the behaviour of their child, and they usually feel they are to blame, or blame each other. The ADHD child feels bad too. They arrive feeling labeled as uncontrollable and naughty. They lack self-confidence and self-esteem. Often the whole family is at crisis point, each member blaming the others for creating the problem although each may secretly fear that it may all be his or her fault. Parents with ADHD children are people searching for solutions. They are desperately in need of support and understanding (Pentecost, 2000).

Some of the most frequently mentioned stressors parents associated with raising their ADHD child included: parent guilt and worry, parents' perceptions that other people might think they may be the cause of the problem, difficult behaviours of the ADHD child both at school and at home, disagreement between parents about how to deal with the problem, added financial burdens, sibling resentment and finding competent professional services (Latson, 1995)

There can be unique frustrations about parenting a child with ADHD that can spill over to create difficulties for an entire family. Parents are usually so busy trying to attend first and foremost to the problems experienced by their child, that they often fail to take heed of the specific stressors in their lives, nor the need to learn how to cope with them so as to reduce their own stress. Parenting children with ADHD presents special challenges. Professionals working with parents need to recognize the difficulties parents face when dealing not only with the child's everyday problems but also the associated social and emotional problems of school failure.

### **1.3. RATIONALE**

The researcher was given the opportunity to serve an internship at The Browns' School, which is a long-term remedial school for learners with special needs, where a significant number of learners are diagnosed with ADHD. During parent interviews and meetings, many parents, especially mothers of ADHD children, requested assistance with parenting their ADHD child. Parents appeared quite desperate, displaying several symptoms of extreme stress/burnout. Surprisingly, not many fathers sought help.

On reviewing the existing literature on parents' stress with ADHD children, the researcher discovered that most research was conducted overseas and, there appeared to be a paucity of research on coping mechanisms for parents with ADHD children. Furthermore, the available literature in the South African context was almost non-existent. These parents at the school were desperate for help and given the lack of information, the researcher realized a need for this study. In order to assist parents reduce their stress levels with their ADHD child, the first line of inquiry should be: What specifically is causing the stress? Thereafter, why? Lastly, how can it be prevented or better managed. Therefore the need for this study.

## **1.4 PURPOSE OF THE STUDY**

The purpose of this study was to explore the factors that contributed to stress in parents of children diagnosed with Attention-Deficit/Hyperactive Disorder (ADHD). It also explored parents' perceptions of extreme stress/burnout, and the effects of gender on stress responses. Their current coping skills and possible solutions were also investigated. Based upon these informed observations, family members, teachers and interventionists are able to help families with ADHD children cope better with this difficult situation.

## **1.5. METHODOLOGY**

The research approach was quantitative as well as qualitative. The study incorporated survey questionnaires and semi-structured interviews with parents of ADHD children. The quantitative data was analysed statistically using the computer programme, the Statistical Package for the Social Sciences (SPSS), and the qualitative data was analysed using content analysis according to common emergent themes.

## **1.6 THE CRITICAL QUESTIONS THAT FRAMED THIS RESEARCH WERE:**

- How do parents of ADHD children conceptualise burnout?
- What factors contribute to their burnout?
- Are there gender differences in terms of stress factors?

## **1.7. PRESENTATION OF THE CONTENTS**

**Chapter One:** This chapter has provided the introduction to this study, including the background, context, the purpose, methodology and the rationale for this study.

**Chapter Two:** Reviews the literature on ADHD children and on parental stress with ADHD children. It also presents a theoretical overview relevant to this study.

**Chapter three:** This chapter provides a description of the research methodology, research instruments and the procedures employed to analyse the data yielded by this study.

**Chapter Four:** The research data are presented and the results are reported.

**Chapter Five:** This chapter will focus on the interpretation and discussion of the results.

**Chapter Six:** This chapter concludes the study, indicates the limitations of the study and makes possible recommendations.

This chapter has attempted to provide an introduction to this study, including the background, context, purpose, methodology and the rationale for this study. The following chapter, **Chapter 2**, reviews the literature on ADHD children and the literature on parental stress with ADHD children. It also presents a theoretical overview relevant to this study.

## CHAPTER 2

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

The purpose of this study was to investigate the factors that contributed to stress in parents of children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). This chapter provides an overview of the definition and theories on the causes of ADHD, parental stress with ADHD children and an understanding on why systems theory has been utilized as the appropriate framework for this research project. This review is based on available international literature and not local literature due to the paucity of available literature on research conducted on ADHD children within the South African context.

#### 2.1. WHAT IS ADHD?

“Phil, stop acting like a worm,  
The table is no place to squirm.”  
Thus speaks the father to his son,  
Severely says it, not in fun.  
Mother frowns and looks around  
Although she doesn’t make a sound.  
But, Phillip will not take advice  
He’ll have his way at any price.

He turns,  
And churns,  
He wiggles  
And jiggles  
Here and there on the chair;  
“Phil, these twists I cannot bear.”  
(Heinrich Hoffman, 1863 in Silver, 1999)

In 1863, Heinrich Hoffman wrote the above nursery rhyme about a boy who was restless, fidgety, hyperactive, and a behavioural problem to his family. By today's classification system, this boy would be diagnosed as having ADHD (Silver, 1999).

Inattention is usually manifested in academic, occupational or social situations, with individuals having ADHD failing to give close attention to details or making careless mistakes at different tasks. Attentional problems at home are shown by failure to follow through on parental requests, and inability to stick to activities. At school, inattention is usually evidenced by a failure to complete academic assignments. Hyperactivity may be manifested by fidgetiness, twisting in one's seat, an inability to remain seated when expected to, by being often "on the go", or by talking excessively. Impulsivity may be manifested by impatience, so that individuals with the disorder show difficulty in delaying responses or in awaiting their turn. At home, it is expressed by difficulty remaining seated during meals, or completing homework. In the classroom, it is evidenced by blurting out answers (Essau, McGee and Feehan in Essau and Petermann, 1997).

Attention-Deficit/Hyperactivity Disorder (ADHD) is usually first diagnosed in children and adolescents. It is characterized by inappropriate degrees of inattention, impulsivity and/or hyperactivity (Mehl-Madrona, 2003). Children with ADHD are typically:

- Impulsive
- Forgetful
- Restless to the point of disruption
- Bored
- Anxious
- Angry

Although many individuals present with symptoms of both inattention and hyperactivity-impulsivity, there are individuals in whom one or the other pattern is predominant. The appropriate subtype (for a current diagnosis) should be indicated based on the

predominant symptom pattern for the past 6 months (American Psychiatric Association, 2000).

### **Attention-Deficit/Hyperactivity Disorder, Combined Type.**

This subtype should be used if six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Most children and adolescents with the disorder have the Combined Type.

### **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type.**

This subtype should be used if six or more symptoms of inattention but fewer than six symptoms of hyperactivity-impulsivity have persisted for at least 6 months. Hyperactivity may still be a significant clinical feature in many such cases, whereas other cases are more purely inattentive.

### **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type.**

This subtype should be used if six or more symptoms of hyperactivity-impulsivity but fewer than six symptoms of inattention have persisted for at least 6 months. Inattention may often still be a significant clinical feature in such cases. (American Psychiatric Association, 2000).

## **2.2 HOW IS ADHD DIAGNOSED?**

The criteria for ADHD focus on behaviours that adults find frustrating and disruptive.

Few mental health professionals can recite the American Psychiatric Association diagnostic criteria as delineated in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) (American Psychiatric Association, 1994), even for the diagnoses they routinely use but the diagnostic standards are important in setting clinical and research trends. The existence of the diagnoses also influences how millions of parents and teachers view the children in their care. Most teachers and many parents of young people have heard of “hyperactivity” and, more specifically, Attention-Deficit/Hyperactivity Disorder (ADHD) (Breggin and Breggin, 1995).

The essential feature of ADHD is a persistent pattern of inattention and/or hyperactivity/impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the Predominantly Inattentive Type. Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (American Psychiatric Association, 2000).

### **2.2.1 DIAGNOSTIC CRITERIA FOR ADHD**

According to the American Psychiatric Association (2000), the following criteria are necessary for diagnosing ADHD:

A. Either (1) or (2):

- (1) six or more of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

## **INATTENTION**

- (a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- (b) Often has difficulty sustaining attention in tasks or play activities.
- (c) Often does not seem to listen when spoken to directly.
- (d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
- (e) Often has difficulty organizing tasks and activities.
- (f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
- (g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
- (h) Is often easily distracted by extraneous stimuli.
- (i) Is often forgetful in daily activities.

(2) six or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

## **HYPERACTIVITY**

- (a) Often fidgets with hands or feet or squirms in seat.
- (b) Often leaves seat in classroom or in other situations in which remaining seated is expected.
- (c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
- (d) Often has difficulty playing or engaging in leisure activities quietly.

- (e) Is often “on the go” or often acts as if “driven by a motor”.
- (f) Often talks excessively.

## **IMPULSIVITY**

- (g) Often blurts out answers before questions have been completed.
  - (h) Often has difficulty awaiting turn.
  - (i) Often interrupts or intrudes on others (e.g., butts into conversations or games).
- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment are present before age 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

The diagnosis must be made on a number of observations, since ADHD is not a defined biological entity, but a collection of symptoms and behaviours. Typically, parents and teachers complete questionnaires, children are observed at home and at school, psychological tests are administered, and a clinical interview of the child and the family is conducted.

One assessment tool is the use of behavioural rating scales in the identification of ADHD. The Conners Teacher’s Rating Scale (CTRS), developed in 1969 by C. Keith Conners, has been used extensively since its publication. This instrument is important because of its wide acceptance. The CTRS has been in use for about 25 years.

Although our understanding of ADHD has changed over the years, the preference for the scale has continued stable. The CTRS has a 4-point scale. It includes the following ratings: Not at all present, Just a little present, Pretty much present, and Very much present. There are 28 items in the scale with several questions that collect demographic information from the respondent. Both the child's teacher and a parent complete the scale. A discrepancy score should be determined from the two completed questionnaires to determine whether the child is exhibiting ADHD symptoms (Mehl-Madrona, 2003).

Other rating scales include the Conners Abbreviated Symptoms Questionnaire (ASQ), developed by C. Keith Conners in 1969. This 10-item scale is often used for screening purposes to identify hyperactive children. Clearly, an evaluation should integrate multiple informants and look at the child in a comprehensive manner since no single test can effectively diagnose the disorder.

## **2.3 THE THEORIES OF THE CAUSES OF ADHD**

Once parents become aware that they have a child or adolescent with ADHD and have accepted this reality, they inevitably ask, "How could this have happened? Why me?" They believe that if they knew what causes ADHD, they would know how to cure it. Or they might be looking for something to blame for the problem or something to avoid so that it won't happen to someone else in the family (Silver, 1999).

### **WHAT CAUSES ADHD?**

There is no single answer. In many cases, there are several factors thought to be associated with ADHD. These factors are both genetic and environmental. These include:

- genetic and hereditary factors
- neurobiological conditions and pathologies
- prenatal influences
- nutritional factors and deficiencies

- environmental/toxin influences

(Zametkin; Nordahl and Gross, 2000)

Health professionals stress that since no one knows what causes ADHD, it doesn't help parents to look backward to search for possible reasons. There are too many possibilities to pin down the cause with certainty. Scientists, however, do need to study causes in an effort to identify better ways to treat, and perhaps someday, prevent ADHD. They are finding more and more evidence that ADHD does not stem from home environment, but from biological causes. When you think about it, there is no clear relationship between home life and ADHD. Not all children from unstable or dysfunctional homes have ADHD. And not all children with ADHD come from dysfunctional families. Knowing this can remove a huge burden of guilt from parents who might blame themselves for their child's behaviour (Point, 2003)

#### **ADHD IS NOT USUALLY CAUSED BY:**

- too much television
- food allergies
- excess sugar
- poor home life
- poor schools

(Point, 2003)

The exact cause of ADHD remains undetermined, but over the past decades, scientists have come up with several possible theories about what causes ADHD and the prevailing theories relate to neurobiological, genetic and environmental factors (Mehl-Madrona, 2003).

## **2.4 STRESS AND BURNOUT**

Everyone has stress in their lives. Stress can help people make the most of opportunities and what they do, or it can cause health problems. We all realize that stress occurs in our lives every day. Sometimes it feels like the demands that are placed on us are overwhelming. We feel like “checking out” when our minds and emotions are on overload (Kendall, 1998).

Burnout is a physical, mental and emotional response to constant levels of high stress. Most cases are work-related. Burnout usually results in physical and mental fatigue, and can include feelings of hopelessness, powerlessness, and failure. Burnout often arises from excessive demands that are either internally imposed (such as having very high expectations of yourself) or externally imposed (by family, work or society). It occurs when you are unable to meet these demands, become frustrated, and deplete your energy through unrelenting stress (Canaff, 2004).

### **2.4.1 WHAT IS STRESS?**

Stress is a feeling of tension and excitement or pressure to do well which alerts the body to be ready to put a big effort into whatever a person is doing. Stress can come, for example before a race or exams, when there is a lot to do at work or home, or a special thing to do, or when there is something scary that might happen. Stress is part of everyday living and gives you energy to succeed and do well. Stress makes your body produce chemicals that “get you going” such as adrenalin (epinephrine). Many people like the feeling of tension and excitement that they bring.

Some people believe that being always stressed and busy makes them more important, but it also means that you don't have much time for relationships with others. The chemicals that the body makes when stressed, are there to help a person fight what is stressing them or to run away from it. When a person does not use the chemicals to do this sort of physical work, the chemicals can cause some harm to the body. This is one of

the reasons why doing exercise when you feel stressed can make you feel less stressed (Miller, 1998).

The following are common stressors in people's lives (Dunn, 1997)

- separation/divorce
- violence
- single parent home
- children with learning disabilities
- peer pressure
- blended family
- fast pace of daily schedule
- poverty or unemployment
- television
- school related stress
- success (work/academic)

Stress becomes a problem when, instead of helping a person to do better, it causes him to do less well, or causes health or relationship problems. Stress can be harmful if something is happening that is too big for the person to manage, or if there are too many things happening, all causing smaller stresses at once. Sometimes stress problems can "creep up on you" so you are not really aware of too much stress until things start going wrong. The following can be signs of too much stress (Miller, 1998):

- being easily upset or angry
- having problems sleeping
- smoking or drinking alcohol more than usual
- headaches
- feeling overwhelmed and helpless
- worry/anxiety

- poor concentration
- tight neck
- racing heartbeat
- stomach problems

## **2.4.2 PARENTAL STRESS**

The idea that children can cause stress in parents is an often exploited scenario in cartoon pages. “Dennis the Menace” has tormented his parents and other adults for decades, and Calvin, the little boy in the cartoon series “Calvin and Hobbes,” kept a record on his calendar of how often he drove his mother crazy. Similarly, in the non-cartoon world, the question of whether children cause stress yields numerous raised hands in any group of parents. Indeed, a considerable number of publications in the psychological literature supports the argument that children are a major source of stress for their parents (Crnic and Acevedo, 1995).

Stress is part of parenting. Parents can be overwhelmed by the responsibilities of caring for their children and balancing work and the family, and can feel they do not have enough support. All families experience normative and transitional life event stressors such as birth, death, and moving. In addition, parents are subject to the inherent chronic stressors of parenting. Parental psychological stressors are related to the worries that parents have about the physical safety and the growth and development of their children. Parents generally take pride in their children’s accomplishments and are hurt by their children’s failures (Latson, 1995).

## **2.4.3 PARENTAL STRESS WITH SPECIAL NEEDS CHILDREN**

Parenting is particularly difficult and stressful when children do not measure up to family or community expectations. When a child is diagnosed with learning disabilities, all of the attention is focused on helping the child and other family members’ feelings and

frustrations are overlooked (Latson, 1995). Parents of special needs children often find themselves trying to burn the candle at both ends.

It seems the stresses and strains they endure on a daily basis go far and beyond what they would believe themselves able to cope with. Often they feel like an elastic band which has been stretched beyond breaking point (Miller, 1998).

In a study by Sherry, R. Latson (1995) investigating stress associated with parenting a child with learning disabilities, the results revealed that parents of children with learning disabilities perceived far more stress in their role as parents than did parents of children without learning problems. Some of the most frequently mentioned stressors these parents associated with raising their children with learning disabilities were:

- parent guilt
- worry about the future
- parents' perception that other people think they might be the cause of the problem
- difficult behaviour of children with learning disabilities
- feeling a need to protect their child
- disagreement between parents about the existence of a problem
- increased financial burden
- finding competent professional services
- sibling resentment of attention given to the child with learning disabilities

Parental stress can be grouped according to three categories: internal stress, external stress and physiological stress (Johnston, 1996).

## **INTERNAL PARENTAL STRESS**

Internal stress factors come from within the individual and include attitudes, perceptions, assumptions, and expectations. Expectations of parents about their child lie at the root of burnout. When expectations about parenting are not met, the first thought is “What did I

do wrong?” Therefore, parents must learn how to develop realistic expectations and how to recognise when negative self-talk defeats effective coping. Parents should identify their own self-defeating assumptions and think of alternative messages. They must be kind to themselves, to accept themselves and their child as fallible, and to boost their own self-confidence by noting and using personal strengths and talents (Johnston, 1996).

The following beliefs lead to internal stress (Johnston, 1996):

1. Giving 100% every day is what every parent is expected to do.
2. The success or failure of my children depends entirely on me.
3. I will never be bored as a parent.
4. I will be seen by society as a good and honourable person because of the effort I put into being a good parent.
5. I refuse to let anyone else care for or influence my children.
6. I should always deny my own needs for rest and recreation in order to help my children.
7. I should do everything for my children and not require that they take on the responsibilities when they are old enough to do so.
8. I should spend every possible moment with my children.
9. I should feel guilty if I need a break or want some attention for myself.
10. One role in my life can satisfy all my needs and can support all my dreams.
11. My children should appreciate everything I do for them.
12. My children must like me.
13. Other people must see me as a good parent, able to handle everything.

## **EXTERNAL PARENTAL STRESS**

External forces also impinge upon parents of youngsters with learning disabilities. Neighbours, friends, and relatives don't understand why such a normal-acting child is having academic problems. Teachers frequently don't fully understand the ramifications of the child's problems. Parents are called upon by the school to help make decisions about the child's academic programme but often feel helpless as the child's advocate

because of their own lack of understanding. Because external stressors are those that are situational, and often involve relationships with others, parents are encouraged to develop assertiveness skills. Problem-solving techniques, time management, and goal setting are helpful when dealing with stressors associated with raising children and running a household. Because coping with a child with learning disabilities is so emotionally draining, parents also are encouraged to develop intimacy skills and a support system (Miller, 1998).

External stress factors (Miller, 1998) include the following:

1. Dealing with school about child's placement or programme.
2. Coping with difficult child behaviours.
3. Educating neighbours and relatives about the child's problems.
4. Helping siblings understand the problems associated with learning disabilities.
5. Getting the child in the right school.
6. Helping the child with homework.
7. Financial pressures.
8. Working with the spouse on child management.
9. Carpools.

## **PHYSIOLOGICAL PARENTAL STRESS**

The final type of parental stress is physiological stress. Parents of children with learning disabilities need to recognize that children with learning disabilities require exceptional amounts of energy. In order to replenish energy, parents need to be sure they get sufficient rest, eat well-balanced meals, and exercise vigorously. Parents need to learn meditation or relaxation techniques to use when they feel stressed, anxious, or fatigued. The following physiological stressors are commonly found in parents of children with special needs (Latson, 1995):

1. Diet
2. Exercise
3. Rest

#### 4. Recreation

Parenting children with special needs presents special challenges. Professionals working with parents needs to recognize the difficulty parents face when dealing not only with the child's every day problems but also the associated social and emotional problems of school failure.

### **2.4.4 PARENTAL STRESS WITH ADHD CHILDREN**

Parents of children with behaviour problems, particularly children with ADHD, experience highly elevated levels of daily child-rearing stresses (Abidin, 1990). Children with ADHD disregard parental requests, commands, and rules; fight with siblings; disturb neighbours; and have frequent negative encounters with schoolteachers. Children with ADHD have problems paying attention, controlling impulses, and modulating their activity level (Pelham and Lang, 1999).

The disturbed and conflictual nature of parent-child interactions in families with a child who has ADHD has been demonstrated in several research studies. Children with ADHD are less compliant to their parents' instructions, sustain their compliance for shorter time periods, are less likely to remain on task, and display more negative behaviours than their normal, same-age counterparts do (Wells, 2000). In what Johnston (1996) recently labelled a "negative-reactive" response pattern, mothers and fathers of ADHD children display more directive and commanding behaviour, more disapproval, fewer rewards that are contingent on the child's pro-social and compliant behaviours, and more overall negative behaviour than the parents of normal children do (Mash and Johnston, 1983; Wells, 2000).

Studies with ADHD adolescents and their parents show continuation of elevated levels of negative interactions, angry conflicts, and less positive and facilitative behaviour towards each other, relative to normal adolescents and their families (Wells, 2000). In addition to disrupted parent-child interactions, the family life of children and adolescents with

ADHD is often characterised by discord and disharmony. Studies have shown that relative to parents of normal children, parents of ADHD children experience a higher degree of stress in their parenting role (Baldwin, Brown and Milan, 1995 in Wells, 2000). Increased rates of maternal depression, as well as marital conflict, separation, and divorce have also been noted. Some of these associations may reflect genetically linked disorders in parents and offsprings. They may also reflect personal, emotional, and marital responses to the high rates of aversive behaviour displayed by the child with ADHD; high rates of negative parent-child interaction, and care giver burden associated with being the parent(s) of a child with ADHD (Wells, 2000).

These previous findings imply that decreases in negative parent-child interactions, as well as parenting stress, maternal depression, and conflict between the marital/parenting dyad are important secondary outcomes of treatment of the child with ADHD and his family. These facets of family life, singly and collectively, are difficult and unpleasant in their own right. Negative parent-child interactions are of etiological significance in disruptive behaviour disorders and predict greater non-compliance in classroom and play situations as well as greater covert stealing (Pelham and Lang, 1999).

Children with behaviour problems, particularly those with such externalizing disorders as ADHD, can adversely affect their parents' mental health (Mash and Johnston, 1990). Childhood externalizing problems frequently result in stressful family environments and life events affecting all family members, including parents. For example, numerous investigators have reported higher rates of current depression in mothers of children who were referred to a clinic because of behavioural problems than in mothers of healthy children (Fergusson; Lynskey and Horwood, 1993). In addition, a significant correlation exists between daily parenting hassles (e.g. experiencing difficulty finding a baby sitter, having to talk to a child's teacher, or coping with fighting among siblings) and child behaviour problems. Thus, studies investigating the distressing effects of deviant child behaviour on the immediate reactions and long-term functioning of parents have shown that exposure to difficult children is associated with dysfunctional parental responses (Pelham and Lang, 1999).

In a study by Pelham and Lang (1999) on the influences of child behaviour on parental drinking, it was concluded that after interacting with the deviant children, the mothers of ADHD children showed greater physiological distress (that is, significantly increased heart rate and blood pressure) than after interacting with the normal children. These mothers also showed greater subjective distress (that is, increased negative affect; decreased positive affect; and increased self-ratings of unpleasantness, unsuccessfulness, and ineffectiveness). Furthermore, the mothers consumed approximately 20% more alcohol after interacting with the deviant children than after interacting with the normal children (Pelham and Lang, 1999).

Summarizing across the research on families of ADHD children it has generally been found that parent-child difficulties have been observed. Mothers of ADHD children reported less parenting self-esteem and more stress than mothers of normal children. Increased levels of depression, psychiatric disorders, substance abuse, family adversity, marital dissatisfaction, parenting stress and criminal activities have also been found in families of ADHD children (Johnston, 1996).

In a study examining the social and psychological functioning of biological parents of ADHD children (Murphy and Barkley, 1996), it was found that these parents had inherent impairments or deficiencies themselves, such as: lower self-esteem, higher levels of depression, self-blame, and social isolation; marital disturbances; antisocial behaviour; alcoholism; hysteria or affective disorder; or learning disabilities.

Given the theories on the causes of ADHD (genetic) and the theories on parental stress, can one really find the results of this study surprising? Some call the times we live in “the age of anxiety”. Fractured marriages, disconnected families and harried parents make stress an everyday occurrence to many of our children.

## **2.5 THEORETICAL FRAMEWORK**

The social-relations orientation to psychological counseling and therapy, unlike other orientations, has its principle focus on systems. A systems approach asserts the group and the family as its basis, rather than only the individual. From a systems perspective, there are various approaches to family therapy, namely: the Psychodynamic, Functionalist and Strategic approaches. These are not the only approaches that have made an impact on family therapy research, but they are appropriate for the purposes of this research study. In order to understand this, it is important firstly to define what family means and then to look at how systems theory can be utilised to explain the impact of an ADHD child on the family system as a whole.

### **2.5.1 CONCEPTIONS OF THE FAMILY**

We've heard it so many times (and probably said it so many times); "The family is the basic unit of society." The problem with a phrase becoming so common is that it turns into a cliché and we get so used to it that we don't think very hard about what it means. If the family is truly the basic unit of society, then it is of enormous importance and it should have profound influence on us as individuals and on all the other (larger) units and levels of society. If family is the basic and indispensable unit, then every other level and type of institution we create, from neighbourhood councils to nations should exist and function in order to protect, maintain, and strengthen families (Eyre, 2004).

"The family is the basic unit of society"; this title phrase can be explained according to the following definitions by Zinmeister of American Enterprise (Eyre, 2004):

"Basic unit": "That which the rest is made of" as in the bricks in a brick wall. The most fundamental organization. The closest and most personal level of relationships and responsibility.

"Society": Civilisation. The order by which we live together and co-operate to work for the common goal. Society is us, the people, organized and divided and governed by our political, societal, and cultural institutions (Eyre, 2004).

“Family”: Despite current attempts to dilute or pervert the word, family will always best be defined as a person with his or her spouse and/or children. Only two events create or add to family:

1. Marriage
2. Birth or adoption

Politically and economically, family can be thought of as one, two, or three generations of related persons living under one roof (Eyre, 2004).

This implies that if the bricks in the brick wall are unsound and crumbly, then no matter how well the wall is designed, laid out, constructed, maintained, mortared or organized, it’s going to fall down. There is a mountain of scientific evidence showing that when families disintegrate, children often end up with intellectual, physical, and emotional scars that persist for life (Eyre, 2004).

Most definitions of the family reflect traditional and cultural beliefs and these are delimiting and problematic. These include traditional terminologies such as the nuclear family, the conjugal family or the extended family and these are also limiting because they imply some form of stability, which limits the real dynamics of family growth, change and development. Then there are labels such as ‘adoptive families’, ‘one-parent families’, ‘re-marriage families’ ‘co-habiting families’, ‘same-sex families’ and so on. These merely serve a descriptive purpose, but do not provide any clear definition of the concept (Elliot, 1984).

A more appropriate and useful stance is to consider the function of families. Common to all specifications of various types of families is the notion of the familial, referring to social institutions based on biological and/or social reproduction. Within the family system there exists a degree of emotional and mutual dependency between members within the unit. An appropriate definition of the family is illustrated in the following statement:

“The family is that group within which the most fundamental appreciation of human qualities and values takes place – ‘for better for worse’: the qualities of truth and honesty,

of falsehood and deceit; of kindness and sympathy, of indifference and cruelty; of co-operation and forbearance, of egotism and antagonism; of tolerance, justice and impartiality; of bias, dogmatism and obstinacy; of generous concern for the freedom and fulfillment of others, of the mean desire to dominate – whether in overt bullying or in psychologically more subtle ways”.

(Fletcher, 1974, p.132 cited in Elliot, 1984)

## **2.5.2 SYSTEMS THEORY**

In terms of systems thinking, each family is a totality, that is, it is more than the sum of its parts. But it is also made up of smaller parts or subsystems of which the individual is the smallest. These subsystems might include the sibling, parental or spousal subsystems. With the emphasis on relationships, neither the individual nor the environment can be ignored. The family is a complex network of relationships and emotions that cannot be studied using the instruments designed for the isolated study of individuals (Relvas, 1997). Within the family, all members are reciprocally tied to all other family members. What happens to one member of a family affects the stability of the entire family system. The purpose of this study was to investigate the factors that contributed to stress in parents of children diagnosed with ADHD. By using the principles of systems theory, the researcher was able to develop the test instruments for this study and analyse the results that were yielded.

Family therapists tend to adopt systems theory for their own because of its usefulness in describing human interactions (Becvar & Becvar, 1996). Systems theory is less of a theory and more of a way of thinking. Auerswald, (1985) refers to a new way of ‘thinking about thinking’ or a new epistemology. This, he suggests, is a new set of rules governing thought. This is profoundly different from the predominant thought system of the Western world. The so-called Newtonian world-view is inappropriate for explaining social relations as it is bound by linear notions of causality. Keeney (1979) states that the medical model of psychopathology is based on this outdated way of thinking as it is depicted as atomistic, reductionistic and anti-contextual. Systemic epistemology, on the

other hand, is based on inter-relationships, complexity and context. Systems theory emphasizes circularity of effects as each part influences and is mutually influenced by other parts within the system (Becvar & Becvar, 1996). In this way, systems thinking could be referred to as a meta-theory, because of its all-encompassing nature.

### **2.5.3 FAMILY THERAPY**

The term Family Therapy could more appropriately be called Relationship Therapy. Both are built on the assumption of systems theory. This theory describes relationships and patterns of interactions within a social arena. Since it is the family that has the greatest impact on our everyday existence, this is the context in which family therapists operate and give most of their attention. Broadly, family therapy brings together members of the same family, the assumption being that a person experiencing problems related to family life cannot be treated apart from the family (Sdorow, 1993). Family therapy tries to improve communication between members who learn to give and receive feedback from each other. An atmosphere is created so that no individual is blamed for the family's problems.

### **2.5.4 THE PSYCHO-DYNAMIC APPROACH**

Becvar and Becvar (1996) suggest that psycho-dynamic approaches to family therapy be termed transgenerational and thus not strictly systemic in nature. They focus on changing the individual and thereby effecting a dynamic shift in family patterns. Their basic assumptions are firstly that emotional illness is developed in relationships with others and secondly, that the relationship between client and therapist is the best treatment for emotional illness. There is however a paradox in speaking about psychoanalytic family therapy. Psychoanalysis focuses on the intra-psychic domain whilst family therapy stresses relationships. The difference is that psychoanalysis places emphasis on the internal world, whereas family therapy places greater emphasis on the external world.

Theorists operating from this perspective generally follow the traditions of psychoanalysis, yet assume that problems in relationships existing within the client's current family life requires intrapsychic exploration and the resolution of unconscious object-relations resulting from early parent-child relationships. The differentiation of the individual is the catalyst for change and progresses towards the transformation of relationships within the entire system. One of the best known proponents of the psychodynamic approach to family therapy is Murray Bowen (Becvar & Becvar, 1996).

### **2.5.5 THE STRUCTURALIST APPROACH**

Like other family therapies, the structural approach considers the patterns, processes and transactions that occur within the family system. The structure of the family refers to the way in which it is organized. A family operates through repeated transactional patterns that become fairly persistent and these patterns serve to regulate the behaviour of family members. They therefore provide a set of rules for behaviour, of which the individuals are rarely aware (Becvar & Becvar, 1996). All families develop some form of hierarchy, usually with the parents in the position of greatest authority.

The main goal of therapy is structural change of the family. Therapy provides a concrete explanation of structures that lead to dysfunction and moves the family towards alternative structures of operation. Various systemic principles are adopted in this approach, namely, stability and change and openness and closeness. A delicate balance ensues between these ideas. The family must remain stable whilst at the same time, undergoing appropriate structural change. Stability and change are two sides of the same coin. Change is inevitable and serves to maintain the family's survival and to maintain its stability (Relvas, 1997). Boundaries between subsystems must be both open and closed, in other words, a level of semi-permeability should be encouraged.

All families experience events over time that can lead to crisis situations. Examples are the birth of a child, sickness, death, divorce, an extra-marital affair, and children leaving

home. Whether they are sudden or expected, they all provide a challenge for the family and therefore necessitate a change in family structure and a re-alignment of roles.

One of the principal proponents of the structural approach is Salvador Minuchin. Structural therapists believe in becoming part of the system they are treating and join the family within their home. The therapist ascertains the family's underlying structure and then attempts to transform the structure by suggesting alternatives (Becvar & Becvar, 1996). It is often the case that one member is designated the identified patient. The structural therapist may need to change this perception and to get the family to focus on relationships instead, to evolve an appropriate family structure to accommodate the individual pathology. Parents are always consulted first to re-affirm the parent/executive role, so important to Minuchin's 'ideal family' (Becvar & Becvar, 1996).

## **2.5.6 THE STRATEGIC APPROACH (MILAN SCHOOL)**

A basic premise of strategic theorists is that people define their problems from their own particular perspective or framework. They therefore can only see possible solutions from that same framework and this limits the options. If a problem were to be reframed from another perspective, it would cease to be a problem. Reality is based on perception. Things are not the way they are, rather, they are what they are because they have been perceived and conceptualized as such (Becvar and Becvar, 1996). The aim of the strategic therapist is therefore to change people to view another perspective of the same situation. The family is not seen as pathological or dysfunctional, rather they are merely 'stuck' in terms of redundant patterns of interaction.

Symptoms are seen as strategies to define the nature of a relationship. They serve an important function within the family and help to maintain the family. They are associated with complex reciprocal feedback mechanisms within systems (Becvar and Becvar, 1996). Typically, strategic therapists search for 'triads' of behaviour patterns.

These often contain both parents and a child. A child misbehaves, the father is usually inattentive but his intervention is heavy-handed, the mother compensates by over-nurturing the child, the father feels alienated and reverts to a peripheral role, the child wishes for the father's attention, the child misbehaves. This description appears to follow a linear sequence. Rather, it is illustrative of circularity, a pattern of behaviour that has no cause. The cycle has no beginning and no end, forming an interwoven network where all members are reciprocally tied to all other family members.

One team of researchers who have worked within the parameters of the strategic model is the Milan School, consisting of Selvini Palazzoli, Boscolo, Cecchin and Prata. The technique of 'circular questioning' is principally associated with the Milan School of Strategic Therapy. Circularity means 'the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change' (Palazzoli, Boscolo, Cecchin and Prata, 1980). Each member of the family is asked questions about how they perceive relationships. The therapist takes responsibility for what happens in the sessions, but takes no responsibility for change. This is totally up to the family.

### **2.5.7 A SYSTEMS THEORY PERSPECTIVE OF THE INTERACTIONS WITHIN A FAMILY WITH AN ADHD CHILD**

Studies have demonstrated that family dysfunction is common in families with ADHD children and that family members often suffer serious psychological effects (Shelton, 1998). When one family member is hurting, everyone feels the pain. Everyone reacts to the pain – parents, brothers, sisters, and grandparents. Everyone in the family needs to understand the behaviours resulting from ADHD and their reactions to these behaviours. It is not easy to live with a child or adolescent with ADHD. Their constant activity, noise, or getting up and down during meals is annoying. Their short attention span and difficulty staying on task when reading or doing activities is frustrating.

Their interrupting, calling out, and inappropriate or potentially dangerous behaviour is upsetting. Homework time is a struggle, if not a battle. Parents watch their son or daughter playing with others and see how different his or her behaviour is compared to the others'. Teachers complain about the child's class behaviour or the incompleteness of tasks. Neighbours call to tell parents what he or she did. The other children are angry with their sibling and want their parents to "make him stop" or "tell her to be quiet". And since parents don't understand what's going on either, they get frustrated and angry. Worse, they feel helpless, not knowing what to do (Dunn, 1997).

All of these experiences will be made worse if each parent reacts to his or her frustration, confusion, and anger in a different way. One parent tries to be understanding and permissive, and the other insists on firmness and punishment. One parent tries to keep the peace, and the other withdraws, using work or some other excuse not to be home in the evening. When home, this parent often handles his or her helplessness by blaming the other parent for all of the problems. Rather than each parent supporting the other through this family crisis, each begins to clash with the other (Biederman; Milberger; Faraone; Kiely; Guite and Mick, 1995).

The other children in the family have a rough time too. They react with frustration, anger and embarrassment when their friends are over and see the ADHD sibling acting out. They feel stressed and they want their parents to "fix the problem". Soon the whole family is dysfunctional. No one is happy. No one feels like being understanding and nice to the child or adolescent with ADHD (Kaplan; Crawford; Fisher and Dewey, 1998).

Parents' and siblings' ills will become so great that everyone forgets that the child or adolescent with ADHD is hurting too. He or she is the direct recipient of the looks and reactions of disappointment, disapproval, and anger. This child has only had one brain all his or her life and doesn't know that it is different. He or she is confused. Why do I always get into trouble? What is everyone so mad about? I didn't do anything! (Silver, 1999).

Often added to these stresses on each family member is the lack of help from others. Numerous complaints to the family doctor are met with “He’ll outgrow it” or “You have just got to relax.” Grandparents remind parents that if they were more strict and firm, there would be no problems. Teachers make parents feel as if their son or daughter is “bad” and that they need to make him or her “better”. Those looks from others in the grocery store or shopping mall communicate the same messages – the child is bad and the parent does not know how to parent (Silver, 1999).

It is normal for a parent to have difficulty fully accepting that their child is different. Often they experience a series of reactions not too different from the reaction of grief that people have when someone dear to them dies, although this grief is of a lesser intensity. If the initial feelings of denial, anger, or guilt are not resolved, a parent might move into a chronic state of experiencing these feelings and reactions (Kendall, 1998).

A parent in chronic denial may continue to “doctor shop” in a constant search for the doctor with the magic answer or magic cure or for someone who will say that nothing is wrong with the child. If the chronic anger is not resolved, a parent may continue to project it. Nothing can go right. “After all the time and money...my child is no better.” Such a parent feels miserable about his or her circumstances. The other parent reacts to this chronic anger by distancing himself or herself rather than encouraging support and co-operation in helping their son or daughter. The other children feel the anger and wonder why their parent is so upset all of the time (Kendall, 1998).

When a parent’s guilt persists, all suffer as well. At times the parent handles the unresolved guilt by becoming overly dedicated to the child or adolescent with ADHD. Not far under the surface is the anger at having to do so much. Some parents may handle the unresolved guilt by withdrawing from other social and/or family contacts and by totally dedicating themselves to the child. Some parents carry this to the point where they have almost no energy left for relationships with the other children in the family or with their partner. The result is a dysfunctional family and a strained marriage (Silver, 1999).

The reactions of the other children in the family might be made worse because parents expect too much of these children. When the ADHD child gets parents frustrated and angry, parents often cry, yell, hit, withdraw, or pout. Yet if these siblings yell or hit or cry because they are also frustrated and angry with their ADHD sibling, parents often punish or reprimand them. Parents forget these children are human too and are also entitled to these feelings. Some siblings of children with ADHD become worried and feel anxious because of lack of information from their parents. Sisters and brothers may become angry, often fighting with the ADHD child. “How come I have to make my bed in the morning and she doesn’t?” or “He broke my toy, and you didn’t do anything” or “Why is it that when I do something, I get punished and when he does the same thing, I am told that I have to be more understanding?” (Kendall, 1999).

Another source of anger is the amount of time and energy that parents spend with the child who has ADHD, causing jealousy. Siblings are sometimes teased at school about the ADHD child and they might feel embarrassed to bring their friends home to play because the ADHD child might act silly or become hyperactive. Sisters and brothers may feel guilty too, especially guilty when they are angry and the message from parents is “He can’t help it” or “It’s not her fault”. Due to feelings of anger or guilt, a brother or sister might act out these feelings against the sibling with ADHD. They might tease and provoke this child to encourage misbehaviour. They might do something themselves and then set up this child to be a scapegoat. As the parent punishes the child with ADHD, this sibling smiles and gets a feeling of revenge (Silver, 1999).

It seems the plight of children with disabilities that a younger brother or sister is not only supernormal and delightful but precocious, quickly passing him or her socially and academically. These siblings have lots of friends. They are praised for their behaviour. They excel in school. The contrast may create a conflict with parents. On one hand, these parents are delighted and proud. On the other hand, these successes make the child with ADHD look even worse. There are no easy ways to prevent some or all of these feelings from surfacing in a family with an ADHD child (Silver, 1999).

ADHD is a life disability, affecting all aspects of life. For many, ADHD is a lifetime disability as well. The resulting emotional, social, and family problems can become as great a disability as the primary disability of ADHD itself. Children and adolescents with ADHD need all the help they can get. Parents of such children are equally in need of help.

## **2.6 COMMENT**

This study attempted to investigate the factors that contributed to stress in parents with ADHD children. The causes and theories of ADHD and stress were described in this chapter. Systems theory was identified as the appropriate theoretical framework to elucidate the disturbed and conflicting nature of parent-child interactions in families with a child who has ADHD. The cycle has no beginning and no end, forming an interwoven network where all members are reciprocally tied to all other family members.

Family therapy as discussed above, clearly directs our attention to the possibility that by improving communication within the family, teaching family members problem-solving skills, and helping parents re-establish their position as authority figures, psychologists can help improve the behaviours of the ADHD child and thereby improve family interactions. By parents being aware of which factors are contributing to their stress/burnout in parenting their ADHD child, they can learn to use stress management techniques, which could assist them to respond more calmly to their child's behaviour. By changing the family environment, and parenting styles, reduction in parental stress could be achieved.

The point that is being made here is that interrelationships among people within a system such as the family are dependent on the development and maintenance of behaviour problems which arise primarily out of frustrations. The ADHD child, the siblings and the parents all need support. Support can be provided by other people such as the ADHD child's school/teachers, psychologists, friends and family members. Basically, support can be provided by meaningful interpersonal relationships.

The following chapter, **Chapter 3**, will discuss the research methodology employed in the study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

This chapter provides a description of the research method and design used in the study.

#### **3.1 PURPOSE OF STUDY**

The purpose of this study was to investigate the factors that contributed to stress in parents of children diagnosed with ADHD. The study focused on critical questions rather than on hypotheses.

The critical questions investigated were:

- How do parents of ADHD children conceptualise extreme stress/burnout?
- Which factors contribute to parental stress/burnout with ADHD children?
- Are there gender differences in terms of stress factors?

#### **3.2 STATISTICAL ANALYSIS**

The Statistical Package for the Social Sciences (SPSS) computer programme was utilized to analyse the data. Descriptive statistics (frequencies and percentages), which are used to describe the variables of interest, were used to analyse the questionnaires in this study. Inferential statistics (Chi Square), allowed the researcher to determine whether there were any differences between male and female respondents and the variables of interest on the questionnaires. The semi-structured interviews were analysed qualitatively, by setting up a classification scheme of common themes as prescribed by content analysis.

#### **3.3 RESEARCH DESIGN**

This research was an investigative study about which factors contributed to parent burnout/stress with ADHD children. Gender differences and stress were also investigated. The study was also descriptive in nature in that, it described specific conditions that existed within a family unit that gave rise to stress when parenting an ADHD child. The semi-structured interviews also allowed the parents to describes their subjective stress

experiences. The research approach was quantitative as well as qualitative. Parents of ADHD children participated in survey questionnaires and semi-structured interviews.

### **3.3.1 THE SURVEY QUESTIONNAIRE**

The cross-sectional survey method is one of the simplest survey designs (Breakwell, Hammond and Fife-Schaw, 1995) as it involves relatively low cost and allows researchers to elicit information about a cross-section of the population under study and to make comparisons between subgroups (for example, males vs. females, older vs. younger people). This method was used with parents to firstly find out how they conceptualised extreme stress/burnout and secondly, to get a better understanding of which factors were perceived as stressors by them. This survey questionnaire also allowed the researcher to make comparisons between male and female respondents.

### **3.3.2 SEMI-STRUCTURED INTERVIEWS**

Subsequently, a sub-group from those that responded to the survey questionnaire was formed. It comprised of 5 males and 5 females with the highest scores from the survey questionnaire. This sub-group was asked to participate in semi-structured interviews to elicit more information on the parents' subjective stress experiences. The questions on the interview schedule were based on the responses from the questionnaires and were pre-prepared by the researcher.

The following objectives guided the semi-structured interviews:

- To explore in detail parents' specific stressors with their ADHD child.
- To investigate how mothers and fathers react to stress.
- Are there gender differences?
- To explore solutions from the parents.

### **3.3.2.1 METHOD OF ANALYSIS OF THE SEMI-STRUCTURED INTERVIEWS**

The data from the semi-structured interviews was analysed qualitatively using content analysis. Qualitative data is descriptive material, which may be collected by researchers from interviews or observations. The first step in dealing with qualitative data is to set up some type of classification system. The classification of open-ended material is known as content analysis (Breakwell, et al., 1995). Most theorists are adamant that content analysis should be viewed as a process of theory development and hypothesis testing. Developing a framework for categorizing qualitative data requires a sound theoretical basis for the results to be meaningful.

Once the researcher has established a reliable way of classifying the material into categories, clusters are then formed around related categories. These clusters will form themes that will be based on the descriptions of the experiences of the subjects (Breakwell, et al., 1995). There are a variety of ways of using the data. In this study because it is a descriptive study, qualitative methodology was used to study selected issues in detail thereby giving a more meaningful understanding to the subjective experiences of stress that these parents endure with their ADHD children.

### **3.4 THE SAMPLE (PARENTS)**

This study is based in the Kwa Santi District, Pinetown circuit, in the Ethekwini Region in Kwa Zulu-Natal. This particular circuit was chosen on the basis of accessibility, time constraints, expense and convenience because the researcher is currently serving her internship at this specialized school. The sample consisted of all parents of grade two children who have been diagnosed with ADHD. These children were identified as ADHD by their school medical records and the medical nurse at the school. Permission to proceed with the research was obtained from the Department of Education and Culture (see Appendix 1).

A total of 29 ADHD children were identified and 58 parents were identified as the sample for this study, comprising of 29 mothers and 29 fathers.

### **3.5 PROCEDURE**

A letter was written to the principal of the school. Permission was granted (see Appendix 2) and arrangements were made with both the grade two class teachers to hand out the questionnaires to the ADHD children who would deliver them their parents. The class teachers also made a note of it in their homework diaries. Two questionnaires were sent home if the child lived with both parents. The researcher collected these completed questionnaires from the teachers one week later. The semi-structured interview schedules were sent to the parents in the same manner and were returned to the researcher within one week.

### **3.6 MEASURING INSTRUMENTS**

#### **3.6.1 BIOGRAPHICAL QUESTIONNAIRE**

The questionnaire consisted of a covering letter to the parents explaining the nature and intention of the study and respondents were assured of confidentiality and anonymity. Participants were required to sign the attached signature page if they agreed to participate in this study after reading the parent letter and understanding the information.

Parents were required to provide information on the following:

- Name
- Age
- Gender
- Marital status
- Names and ages of children
- Relationship to the ADHD child
- Financial /employment status
- Highest level of education

- Medical background of family (any other members including respondent diagnosed with ADHD?)
- Contact telephone numbers

These were all structured questions and the aim of this questionnaire was to gather some information about the respondents' backgrounds (see Appendix 3).

### **3.6.2 EXTREME STRESS/BURNOUT QUESTIONNAIRE**

This section consisted of a description/definition of extreme stress/burnout. The respondents were required to indicate whether they experienced these symptoms with their ADHD child's behaviours and then they had to describe what extreme stress/burnout means to them. The objective of these questions was to get a better understanding of how these respondents conceptualise extreme stress/burnout. This question was also analysed qualitatively using content analysis. Gender effects were also investigated (see Appendix 4).

A questionnaire was specially constructed for the purposes of this research based on categories used in the Parenting Stress Index (PSI). The PSI is designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioural and emotional problems, and parents who are at-risk for dysfunctional parenting. The PSI can be used on parents as well as children until 12 years of age (Abidin, 2001).

The PSI was developed on the theory that the total stress a parent experiences is a function of certain salient child characteristics, parent characteristics, and situations that are directly related to the role of being a parent. The PSI identifies dysfunctional parenting and predicts the potential for parental behaviour problems and child adjustment difficulties within the family system by pinpointing sources of stress within the family.

The child characteristics include:

- Distractibility/hyperactivity

- Adaptability
- Reinforces parent
- Demandingness
- Mood
- Acceptability

The parent personality and situational variables component consists of 7 subscales:

- Competence
- Isolation
- Attachment
- Health
- Role restriction
- Depression
- Spouse

The PSI is particularly helpful in the early identification of dysfunctional parent-child systems, prevention programmes aimed at reducing stress, intervention and treatment planning in high stress areas, family functioning and parenting skills, assessment of child-abuse risk and forensic evaluation for child custody (Abidin, 2001).

The questionnaire that was constructed by the researcher comprised of a list of 25 factors/items that could be a possible source of stress for parents with ADHD children, based on the categories of the PSI. The questionnaire was devised using a categorical response format and respondents had to answer every question by placing an X in either the 'Yes' or the 'No' column (see Appendix 5).

The survey method was used to obtain descriptive information. The questionnaires were analysed quantitatively using SPSS and descriptive statistics (frequencies and percentages) were employed to describe the variables. Responses from mothers and fathers were also compared to see if there were any differences with regard to gender and parental stress.

### **3.6.3 SEMI-STRUCTURED INTERVIEWS**

The interviews were conducted with 10 parents, 5 mothers and 5 fathers from the original sample, who obtained the highest scores on the Burnout Questionnaire thereby being identified as the respondents with the highest stress levels. The interview schedule comprised of 5 open-ended questions, which were based on the responses from the Burnout Questionnaire that had the highest frequencies. The reason for the semi-structured interviews was to assist the researcher to elicit more in-depth information on the respondents' subjective experiences of stress (see Appendix 9).

The interview schedule was made up of questions that were open-ended in nature. With open-ended formats the respondent is asked to write down the response to a question in any terms that he or she sees fit (Rosnow and Rosenthal, 1996).

### **3.7 PILOT STUDY**

It is extremely useful to conduct pilot work, in order to try out the methods, materials and instruments in advance of running the full-scale study itself. Such pilot work should be conducted using a smaller group of subjects. Pilot work can be used to test out the various operational definitions and research methods, which are still under active consideration. It can also be used to see if subjects understand instructions, to ascertain how much time it takes to administer and have them returned to the researcher, to examine how reliable the measures are and to make modifications wherever necessary (Breakwell, et al., 1995).

In developing a questionnaire, pilot testing is absolutely necessary. This testing will enable the researcher to determine how apt the questions are, whether the items are worded properly, and whether the questions are in the appropriate order.

A pilot study was conducted in July 2004 at the same school with the parents of the grade three learners, who conformed to the characteristics present in the target sample used in the final study. A sample of 10 sets of parents (10 mothers and 10 fathers) were identified on the basis of the class teacher's knowledge of 10 learners who were diagnosed as

ADHD in that particular class. Although the sample consisted of 10 sets of parents, only 6 questionnaires were returned.

The following sources of error were identified, revised and the necessary changes were effected in the final instrument:

- One of the reasons for the poor response rate was the incorrect identification of ADHD children. The school medical records and the school medical nurse were the most reliable resources for this information. In the final study these resources were consulted before identification of the sample.
- Because only one questionnaire was sent home, in all 6 survey questionnaire responses, only the mothers filled in the questionnaires, even though the covering letter asked either mother or father to fill in the questionnaire. In the final instrument this was clarified by sending home two separate questionnaires labeled mother/father.
- Questions 10 and 11 were changed from 'your other children' to 'your other children/ relative's children' because some mothers responded by stating that they only had one child, the ADHD child.

### **3.8 FACE VALIDITY OF INSTRUMENT**

Content validation simply asks the question, 'Is the content of the test relevant to the characteristic being measured?' We may check the face validity of a test which is simply the subjective evaluation of the relevance of the test items. Having a test with clear face validity may also be useful in obtaining compliance from respondents since, if the items appear irrelevant, testees may become irritated. Content validation, then, is largely a qualitative process and it depends upon the tester having a clearly defined idea of what it is he or she wishes to measure (Breakwell; Hammond & Fife-Schaw, 1995).

Three 'expert' judges (psychologists) at the researcher's internship site were asked to evaluate the relevance of the items on the questionnaire to the characteristic being measured. They reported no significant inconsistencies within the questionnaire.

### **3.9. SUMMARY**

This study incorporated both qualitative and quantitative methods of analysis of its data. The qualitative data was analysed using content analysis according to common emergent themes and the quantitative data was analysed statistically using the computer programme, the Statistical Package for the Social Sciences (SPSS). The qualitative data answered the critical questions pertaining to how parents of ADHD children conceptualised extreme stress/burnout and also recognised which specific factors contributed to their stress/burnout. The quantitative data analysis attempted to answer the critical question relating to gender differences in terms of stress factors.

The following chapter, **Chapter 4**, provides the results of the test instruments that were used in this study, namely the biographical questionnaire, the survey questionnaire and the semi-structured interviews.

## **CHAPTER 4**

### **RESULTS**

The purpose of this study was to investigate which factors contributed to stress in parents of children diagnosed with ADHD. The results as stated in this chapter attempted to address the following critical questions of the study:

- How do parents of ADHD children conceptualise extreme stress/burnout?
- What factors contribute to their burnout?
- Are there gender differences in terms of stress factors?

#### **4.1 QUESTIONNAIRE RETURN RATE**

The two grade 2 classes that were chosen to participate in the study yielded a sample of 58. Although 58 questionnaires were initially handed out to be completed by parents, only 37 were returned to the researcher. Therefore the return rate of questionnaires was 64% and was considered adequate considering the hectic lifestyles and time constraints of these parents. The 36% of questionnaires that were not returned is a significant number as this study was based on parent responses and they played a major role in this study due to their interactions with the ADHD child. Parents of these ADHD children provide important information for both, research and intervention purposes.

#### **4.2 ANALYSIS OF DATA**

The data obtained for this study was analysed quantitatively and qualitatively. The Statistical Package for the Social Sciences (SPSS) was utilized in data analysis of the questionnaires. Descriptive statistics and inferential statistics were used in this study. To answer the critical question relating to gender differences and stress factors, chi-square analysis was carried out. All significant findings are reported in terms of the 95% level of confidence ( $p < .05$ ). All percentages are rounded off to the next whole number in the tables and in the discussion of results. Parents' perceptions of extreme stress/burnout and

the semi-structured interviews were analysed qualitatively according to common themes that emerged during the analysis.

### **4.3 PRESENTATION OF RESEARCH FINDINGS**

The research findings from this study are presented in the form of descriptive statements, tables and themes. The tables are described in terms of frequencies and percentages. The following form the main areas of focus:

- Description of the sample (biographical questionnaire)
- Parents’ conceptualisations of extreme stress/burnout (survey questionnaire)
- Parent responses to stress factors (based on responses to questionnaire)
- Gender differences in response to stress factors (based on responses to questionnaire)
- Themes that emerged during the semi-structured interviews

#### **4.3.1 DESCRIPTION OF SAMPLE**

The sample in this study consisted of 37 parents who initially filled in a biographical questionnaire (refer to Appendix 3). The questionnaires were analysed descriptively. Frequencies and percentages were calculated for the total sample for all questions on the biographical questionnaire.

The following tables describe the sample of parents who participated in this study.

**Table 4.1 Profile of parents according to age**

<b>Age</b>	<b>Frequency</b>	<b>Percent</b>
20-29 years	4	11
30-39 years	20	54
40-49 years	13	35
Total	37	100

Table 4.1 indicates that 54% of parents fell in the 30-39 year age group, while 35% were between 40-49 years old. Eleven percent of the parents were between 20-29 years old.

**Table 4.2 Profile of parents according to gender**

<b>Gender</b>	<b>Frequency</b>	<b>Percent</b>
Male	17	46
Female	20	54
Total	37	100

Table 4.2 indicates that 46% of the sample comprised of males, while 54% comprised of female respondents.

**Table 4.3 Profile of parents according to marital status**

<b>Marital Status</b>	<b>Frequency</b>	<b>Percent</b>
Married	25	68
Divorced	12	32
Total	37	100

Table 4.3. reflects that more than half of the parents are married (68%) as compared to 32% who are divorced. In this particular sample, there were no single parents.

**Table 4.4 Profile of parents according to number of children**

<b>Number of children</b>	<b>Frequency</b>	<b>Percent</b>
One child	10	27
Two children	14	38
Three children	13	35
Total	37	100

Table 4.4 indicates that 38% of parents have two children families, 35% have three children and 27% of parents have only one child. No families in this sample had more than three children.

**Table 4.5 Profile of parents according to employment status**

<b>Employment Status</b>	<b>Frequency</b>	<b>Percent</b>
Employed	28	76
Unemployed	9	24
Total	37	100

With regard to the parents' employment status, 76% reported being currently employed at the time of filling in the biographical questionnaire. Twenty four percent were unemployed.

**Table 4.6 Profile of family income**

<b>Income</b>	<b>Frequency</b>	<b>Percent</b>
R1000-R3000	9	24
R3000-R5000	13	35
R5000-R10 000	11	30
Above R10 000	4	11
Total	37	100

Table 4.6 indicates that of the total sample, 35% of families have an income of R3000-R5000 per month. Thirty percent of families have an income of between R5000 and R10 000, 24% have an average income of R1000-R3000 and 11% have a family monthly income above R10 000.

**Table 4.7 Profile of parents according to their highest level of education**

<b>Highest level of education</b>	<b>Frequency</b>	<b>Percent</b>
Special std. 8	3	8
Less than matric	5	14
Matric	14	38
Diploma	12	32
Degree	2	5
Post graduate	1	3
Total	37	100

Table 4.7 illustrates that from the sample, 38% listed matric as their highest level of education, 32% were in possession of diplomas, 22% did not complete high school and 8% went up to special std.8 only.

**Table 4.8 Profile of the number of parents belonging to a medical aid**

<b>Medical aid status</b>	<b>Frequency</b>	<b>Percent</b>
Medical aid	21	57
Cash patient	16	43
Total	37	100

Table 4.8 indicates that while 57% of parents belong to a medical aid scheme, 43% are cash patients. The researcher was interested in investigating whether the cost of medication for ADHD children was an added financial burden to these parents.

**Table 4.9 Profile of number of ADHD child on medication**

<b>Medication status</b>	<b>Frequency</b>	<b>Percent</b>
Takes ADHD/herbal medication	32	86
Does not take any medication	5	14
Total	37	100

Table 4.9 indicates that 86% of parents reported that their ADHD children are on either ADHD/herbal medication, while 14% reported that their ADHD children are not on any medication.

**Table 4.10 Profile of parents with an ADHD/Learning Disorder diagnosis**

<b>Diagnosis</b>	<b>Frequency</b>	<b>Percent</b>
ADHD/Learning Disorder	22	59
No Diagnosis	15	41
Total	37	100

According to the results depicted in table 4.10, 59% of the parents from the sample reported being diagnosed with either ADHD or a Learning Disorder and 41% reported never being diagnosed with either ADHD or a Learning Disorder.

**Table 4.11 Profile of the number of ADHD children in each family**

<b>Number of ADHD children</b>	<b>Frequency</b>	<b>Percent</b>
1 Child	25	68
2 Children	12	32
Total	37	100

Sixty eight percent of parents reported having only one child with ADHD, while 32% have two ADHD children in the same family.

#### **4.3.2 PARENTS' PERCEPTIONS OF EXTREME STRESS/BURNOUT (SURVEY QUESTIONNAIRE)**

Parents' descriptions of what extreme stress/burnout means to them were recorded on the first page of the survey questionnaire (refer to Appendix 4). These descriptions were then qualitatively analysed using content analysis techniques. The responses from the 37 questionnaires were read and re-read several times until they could be categorized into themes. Eventually, two major themes emerged regarding parents' conceptualizations of stress:

1. Some parents conceptualized extreme stress/burnout according to physical symptoms or ailments.
2. Other parents conceptualized extreme stress/burnout relating to emotional/psychological indicators.

##### **4.3.2.1 PHYSICAL SYMPTOMS OF EXTREME STRESS/BURNOUT**

The following physical symptoms/ailments were described by parents as indicators of extreme stress/burnout:

- A sense of being extremely exhausted and drained of energy both, mentally and physically to the point where “doing anything takes an effort”.
- An inability to cope with day to day activities and duties due to being so tired.
- “On the go all the time”, “no time for your body or mind to rest”.
- “The only way to get some sleep is to take sleeping pills”.
- Neck tension, headaches and back aches.
- “Physically restraining the hyperactive child is exhausting, especially when the child is physically punching and kicking you whilst you are driving the car”.

- Some parents indicated problems “coping/balancing home and work 5 days a week, every week for the rest of your life, not that the week-ends are any better!” “Sometimes, it becomes too demanding, especially when you have deadlines to meet.
- “When you can’t take it any more, you explode because now it has become too much and then you vent your anger on somebody, anybody. You either scream and swear at them or you physically hit somebody or something!”

#### **4.3.2.2 EMOTIONAL INDICATORS OF EXTREME STRESS/BURNOUT**

The following emotions were recorded by parents as indicators of extreme stress/burnout:

- A deep sense of utter frustration whereby “nothing gets done easily, everything is enormous, like you are all alone fighting against the whole world.”
- Resentment and extreme anger because of “what you have to endure, it’s so unfair.”
- Moodiness and weepiness. “Sometimes all I do is just lock my bedroom door and sit down and have a good cry.”
- “Nobody understands your situation, nobody listens to what you are saying. Everybody wants to tell you what and how you should be doing things because your way is wrong.”
- Depression – “I am currently on anti-depressants because it is the only way to cope for one day with my daughter, if not, I might have done something ‘very bad’ by now.”
- Helplessness. “Life gets harder and harder and I am not coping.” “Sometimes, it becomes so much, I just can’t care less.” “If the kids want to kill each other, let them. If the house resembles a pigsty, let it. If my husband comes home from work and there’s no supper and the kids and the house are a mess, too bad.”
- “Overly impatient because nothing gets done on time.”
- Inconsiderate to child’s needs because there are too many demands all at once.

- No time for yourself – “I have to worry about everything and everybody and that leaves no time to worry about me.”
- “I have lost my zest for life. It’s the same problems everyday, there’s nothing nice, good or new to look forward to. I don’t care how I look, what I eat or whether I get any rest, I don’t have the time for those kind of luxuries.”
- “There was a time when my emotions were so out of sync, I actually became hooked on drugs, just to get through each day.” “As a businessman, I endure enough stress at work, the added stress of a dysfunctional home was the last thing I needed. I started to consume vast amounts of alcohol. Eventually, it became too much for my wife. I am currently divorced, but I now belong to Alcoholics Anonymous.”
- A sense of helplessness and hopelessness. “Sometimes, I just feel like giving up, it all just becomes too much for me, but I don’t even have the time nor the energy to do even that.

### **4.3.3 SURVEY QUESTIONNAIRE ON EXTREME STRESS/BURNOUT**

Parents were required to answer either yes/no to the 25 items on the questionnaires (refer to Appendix 6). The data obtained from this questionnaire was analysed quantitatively using SPSS. Both descriptive and inferential statistics were used in this study. Frequencies were calculated for the total sample for all questions in this section. Inferential statistics were utilized to test for associations between gender and the variables on the questionnaire. The frequencies are reported as valid percentages and analysis of the data yielded the following results as indicated in Table 4.12, which reflects the frequency of parent responses to each question or statement on the questionnaire:

**Table 4.12 Profile of parents' responses on the burnout questionnaire**

		YES-%	NO-%
1	It is very difficult living with an ADHD child.	38	62
2	Their constant activity, noise, etc. is annoying.	51	49
3	Their short attention span is frustrating.	54	46
4	Their interrupting, calling out, and inappropriate/ potentially dangerous behaviour is upsetting.	51	49
5	Homework time is a struggle/battle.	62	38
6	You see how different your child's behaviour is when compared to other children of the same age.	64	36
7	Teachers complain about your child's classroom behaviour/incompletion of tasks.	51	49
8	Do you avoid contact with your child's teacher because you are tired of the endless complaints.	13.5	86.5
9	Neighbours call to tell you what your child did.	8	92
10	Your other children/relative's children are angry with the ADHD child and want you to "make him/her stop".	28	72
11	Your other children/relatives feel embarrassed to bring their friends home because the ADHD child will start acting out.	14	86
12	You feel lost because you also do not understand your child's behaviour.	24	76
13	You often get angry and frustrated with your ADHD child.	27	73
14	Do you and your spouse disagree on how to deal with your ADHD child, e.g. one favours punishment and the other is permissive and understanding.	31	69
15	Do you or your spouse try to withdraw from confronting these problems by using work as an excuse.	11	89
16	Do you or your spouse make excuses not to be home in the evenings.	0	100
17	Do you or your spouse blame each other for all the problems in your home.	12	88

		YES-%	NO-%
18	Do you or your spouse clash with each other unnecessarily.	29	71
19	Do you feel your family doctor who is treating your ADHD child, is not really helping.	14	86
20	Do other family members, e.g. grandparents, insist that you be more strict with your ADHD child.	22	78
21	Do you avoid social situations, e.g. shopping, restaurants, etc. because you do not want to be embarrassed by you ADHD child.	11	89
22	Do you feel everything is becoming too much and nobody understands, nor can they help you.	25	75
23	Is the cost of medication for your child's ADHD an added financial burden.	42	58
24	Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out.	28	72
25	Do you feel that you are not getting enough sleep or proper meals because of your ever-demanding ADHD child.	11	89

Table 4.12 indicates the parent responses to the burnout questionnaire. Question 2: “Their constant activity, noise, etc. is annoying” yielded a positive (‘yes’) response rate of 51% of the total sample. Fifty four percent of the respondents agreed with question 3: “Their short attention span is frustrating”, while 51% answered ‘yes’ to question 4: “Their interrupting, calling out and inappropriate/potentially dangerous behaviour is upsetting”.

Question 5: “Homework time is a struggle/battle”, indicates that 62% of the sample experienced this problem with their ADHD child. Sixty four percent of parents agreed with question 6: “You see how different your child’s behaviour is when compared to other children of the same age.”

Fifty one percent of the sample agreed with question 7: “Teachers complain about your child’s classroom behaviour/incompletion of tasks.”

Question 16: “Do you or your spouse make excuses not to be home in the evenings”, yielded a negative response rate of 100%.

#### 4.3.4 COMPARISON BETWEEN GENDER AND STRESS FACTORS

To answer the critical question on whether gender differences exist when responding to items on the questionnaire, comparison descriptive statistics was utilized. The results are indicated as valid percentages of responses to each item on the questionnaire, together with the gender frequencies (refer to Appendix 7).

By utilizing inferential statistics (Chi Square), the researcher was able to determine which specific variables on the questionnaire were affected by gender differences. All findings are reported in terms of the 95% level of confidence ( $p < .05$ ).

The results of the significant associations are represented in the following tables:

**Table 4.13 Profile of parent agreement/disagreement on dealing with ADHD children**

**Q14: Do you and your spouse disagree on how to deal with your ADHD child. \***  
**Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q14: Do you and your spouse disagree on how to deal with your ADHD child.	Yes	Count	6	5	11
		% of Total	16.7%	13.9%	30.6%
	No	Count	11	14	25
		% of Total	30.6%	38.9%	69.4%
Total	Count	17	19	36	
	% of Total	47.2%	52.8%	100.0%	

Table 4.13 indicates that on question 14: “Do you and your spouse disagree on how to deal with your ADHD child”, 16.7% of males answered “yes” compared to 13.9% of females that answered “yes”. The greater percentage of fathers indicating “yes” to this question implies that more fathers report differences regarding the parenting styles of mothers and fathers than mothers do. This reflects that fathers are quicker to realise that there are problems in a family than mothers are.

**Table 4.14 Profile of parents using work as an excuse to avoid confronting problems with ADHD child**

**Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse.	Yes	Count	2	2	4
		% of Total	5.6%	5.6%	11.1%
	No	Count	14	18	32
		% of Total	38.9%	50.0%	88.9%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Table 4.15 Profile of parents blaming each other for problems in the home**

**Q17 : Do you or spouse blame each other for all the problems in your home \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q17 : Do you or spouse blame each other for all the problems in your home	Yes	Count	2	2	4
		% of Total	6.1%	6.1%	12.1%
	No	Count	12	17	29
		% of Total	36.4%	51.5%	87.9%
Total		Count	14	19	33
		% of Total	42.4%	57.6%	100.0%

**Table 4.16 Profile of parents' agreement/disagreement on neglecting their health because of the demands of the ADHD child**

**Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child.	Yes	Count	2	2	4
		% of Total	5.7%	5.7%	11.4%
	No	Count	13	18	31
		% of Total	37.1%	51.4%	88.6%
Total		Count	15	20	35
		% of Total	42.9%	57.1%	100.0%

Table 4.14 indicates that on question 15: “Do you or your spouse try to withdraw from confronting these problems by using work as an excuse”, Table 4.15, question 17: “Do you or your spouse blame each other for all the problems in your home”, and Table 4.16, question 25: “Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child”, on these three questions on the burnout questionnaire, the frequencies of “yes” responses for males and females were equivalent.

Inferential statistics (Chi Square) examined all the item responses on the questionnaire in response to gender differences (refer to Appendix 8). Chi-Square test for independence is used to determine if two categorical variables are significantly related or not. This test is used when the researcher wishes to explore the relationship between two categorical variables. Each of these variables can have two or more categories. If you get Chi-Square significant values (p) of 0.05 or less, then those two variables are related and they are not independent. If the p value is more than 0.05, then those two variables are not significantly related and they are independent of each other.

Male and female respondents answered independently and differently from each other and their responses were not dependent on the other gender. The statistical analysis results revealed that there is no significant relationship between males and females

responding to the variables on the questionnaire because all Chi-Square p values are greater than 0.05 with the degree of freedom equal to one.

#### **4.3.5 QUALITATIVE ANALYSIS OF SEMI-STRUCTURED INTERVIEWS**

The questions that were formulated for the semi-structured interviews were based on the analysis of the responses from the questionnaires. The researcher identified 10 subjects from the sample to conduct semi-structured interviews with. The parents were selected on the basis of having obtained the highest scores on the survey questionnaire. Based on this, 5 mothers and 5 fathers who were identified as experiencing the highest levels of stress were chosen to participate in the semi-structured interviews.

The three categories formulated from the parents' responses to the items on the extreme stress/burnout questionnaire, together with an intensive literature review from past research studies on factors contributing to parental stress with ADHD children, which has already been stated in the literature review in Chapter 2, were used to guide the formulation of questions on the interview schedule.

The interview schedule comprised of 5 open-ended questions (refer to Appendix 9). The first question on the interview schedule, "You noticed how different your child's behaviour is when compared to other children of the same age. Please explain the differences in detail and explain how this makes you feel" was based on the category, "social problems of children with ADHD."

The hyperactive/impulsive and attention-deficit behaviours were further investigated by the researcher on the interview schedule. By asking the parents to describe the specific behaviours in detail and how they respond to them, the researcher was able to get more detailed information on the parents' subjective stress experiences with their ADHD children. The question on "school-related problems" related to how parents propose the ADHD child's school/teachers help decrease their extreme stress.

Together with these three categories, the researcher added on two further categories. Firstly, the critical question pertaining to gender differences helped formulate the question, “Do you think men and women respond/relate differently to parental stress? Explain further”. The aim of asking a question of this nature was to understand from the parents whether they believed that mothers and fathers responded differently to stress. The majority of the explanations from the parents pertained to their specific parenting styles with their ADHD child/children.

The final category of questions pertained to parent solutions. The researcher is of the opinion that if the solutions come from the parents of these ADHD children, then the people who are in a position to help, such as doctors, psychologists, teachers, spouses, other children and any other support systems, will know what to do and how to do it in order to assist parents with ADHD children to avoid extreme stress/burnout. Question 5 on the interview schedule asked the following questions of parents: “What do you think is the solution to your problems with parenting your ADHD child?”

These questions were used as guidelines within the context of the open-ended interviews (Appendix 9). Each question was related to a specific theme. The parents’ responses were then coded according to the following themes:

### **Hyperactive behaviours of ADHD children that contribute to parent stress**

Example of responses:

- My child is extremely loud, boisterous and over-talkative.
- My son cannot sit still, he is always dancing, uses lots of gestures, even while he is talking to me.
- My son cannot play with other children, cannot be part of a group. He’s always getting into trouble, hurting other kids. Sometimes he gets into arguments and then gets so frustrated that he will hit the other child.
- He is very much a loner because he does not know how to play with other kids and nobody wants to play with him.

- She is over-bearing. She must be on top of other children, even adults.
- Their behaviour is so inappropriate, it is described as being “naughty” by other parents who do not understand them.
- Very emotional. Will fight over toys, can’t accept “no”. When he becomes very frustrated, he will start hitting.
- Knows no limits, has no fear, has to be watched all the time. When playing a practical joke, she does not know when to stop, even if she is told to stop.
- Very attention-seeking. She always seems to want to take charge of a situation and she will disrupt a happy atmosphere to achieve this.
- Always untidy, very clumsy and destructive.
- In social situations, like visiting friends/family or going shopping, she will start playing-up and doing stupid things and embarrass the family.
- When she’s in a bad mood, she beats and punches us if we don’t pacify her.
- No patience. She cannot wait her turn and often throws tantrums if she can’t have her way.
- She always frustrates and annoys her siblings.

### **Attention-deficit behaviours of ADHD children that contribute to parent stress**

Examples of responses:

- Cannot complete any task. To get him dressed in the mornings for school is a mission and my greatest test of endurance. It takes him 10 minutes to put on one sock because he becomes distracted and forgets what he was doing.
- Many of our mornings end up with me yelling and eventually crying out of sheer frustration.
- My daughter cannot watch a movie because she cannot sit still for the duration of it, nor can she concentrate on the movie, she gets bored and starts talking or walking around, so going with her and my two boys to the movies is a nightmare.
- He cannot pay attention for more than 2 minutes, after that he’s in his own world and completely lost.

- He butts-in whilst I'm talking to someone, with the most irrelevant, inappropriate conversation and he will not wait his turn to speak.
- Because homework time is sheer torture and used to take hours to complete, I now ask the lady at aftercare to do it with him or I end up doing it by myself.

### **Coping styles of parents with their ADHD children**

Examples of responses:

- Instead of asking him to do anything, I end up doing it myself, even dressing him up in the mornings for school, just to avoid the stress and fighting.
- When my child misbehaves he knows the consequences. In our house we have a rule, first there are three verbal warnings, then there's no T.V.
- We avoid most social gatherings because we know that our child starts to play-up when he's with a crowd of people.
- Often I end up giving in to her impossible demands in order to keep the peace.
- Sometimes when my son is in one of "those" moods, I have to physically hold him down or he will hurt his sisters very badly.
- I try to give him the extra attention so that he won't try to seek it in negative ways.
- I try to correct my child by speaking to her but, it feels like I am continuously "nagging". It is difficult not to become permissive for the sake of your sanity.
- When everything becomes too much, I end up smacking him in order to stop him from driving me crazy.
- I try to be a calming influence on her by removing her or distracting her from a volatile situation, however, it is difficult to contain one's anger, especially if a level of frustration has built up over a period of time.

### **Gender differences and parental stress**

A comparison of mothers' and fathers' responses.

Examples of mothers' responses:

- It's hard for me to compare gender differences and stress in my family because ours is a very dysfunctional family with little communication.
- I think that stress reactions are not dependent on gender, but rather, on one's personality and how you deal with stress.
- Males get angry far more quickly and they don't have much patience, they cannot understand that their ADHD child has special needs and requires patience and understanding.
- My husband will leave the house and go for a drink when things are very stressful at home. I cannot walk away from my responsibility.
- Mothers are more tuned in to their children, they are more sensitive to their needs.

Examples of fathers' responses:

- Women tend to be far more emotionally involved and worried about their child's emotional health and state of mind.
- Of course there are differences because a mother sees more of her child than the father.
- Women shout and carry on like stupid things. Men handle it whichever way it comes.
- Men and women have different levels of tolerance. As a man I seem to "burst" when I've had a stressful day, whereas my wife shows her frustration by shouting.

### **School-related solutions from parents' perspectives**

Examples of responses:

- Schools need to work hand-in-hand with parents to assist them in this difficult situation, therefore there is a strong need for better communication between the school and the parents.
- Schools need to provide healthy foods at the tuck-shop and not junk foods that cause sugar spikes, resulting in extremely bad behaviours.

- Teachers need to understand what ADHD means and how it affects the child. It does not mean the child is lazy, stupid or naughty, but it is a disorder that my child has no control over. By teachers calling these kids names and labeling them, teachers are destroying what little self-esteem these children have left.
- Schools should help organize support groups, more talks and information evenings for parents with ADHD children on how to go about daily living with an ADHD child.
- Support for siblings of ADHD children is important as they tend to bear the “brunt of it”, although unintentionally.
- Schools, especially the teachers can help enforce correct, appropriate behaviours.

### **Personal solutions from parents of ADHD children**

Examples of responses:

- Accept your child and the disorder. Treat ADHD like an illness such as cancer or heart disease, and try treating it with medical assistance, don't treat it like a life sentence.
- Work hand-in-hand with the child's doctors, they usually know best.
- Avoid problem situations, such as huge crowds or visiting friends or family where there is something or someone that will set your child off.
- Discipline and structure at all times.
- Understand what having ADHD means so you won't be so hard on your child when he/she does something wrong. Get lots of information and advice so you know what to do in a problem situation.
- Persevere with teaching good behaviour and ensure your child eats healthy meals.
- Get help for yourself or you will soon be of little help to your child when you are completely burnt out. Join a support group for parents with ADHD children.
- Family therapy
- There are no straightforward, instant solutions but that does not mean we must give up because if you think about it, these kids only have us to protect them from the big, cruel world out there, so have hope.

- Try keeping your child constructively occupied.
- Be firm, but fair.

Chi Square analysis of the 25 items on the questionnaire with the variable gender, did not yield significant findings (refer to Appendix 8).

The results were presented in this chapter. The following chapter, **Chapter 5**, will engage in a discussion of the results.

## **CHAPTER 5**

### **DISCUSSION OF RESULTS**

This chapter discusses the results presented in Chapter 4. The aim of this study was to investigate factors that contributed to stress in parents of children diagnosed with ADHD. The aim of this chapter is to provide a discussion of the results by answering the following critical questions, which have guided this research and which have been previously stated:

- How do parents of ADHD children conceptualise extreme stress/burnout?
- What factors contribute to their burnout?
- Are there gender differences in terms of stress factors?

The respondents' biographical data is discussed first, followed by a discussion on the results yielded by the questionnaires and the semi-structured interviews.

#### **5.1 BIOGRAPHICAL DATA**

The biographical data of the 37 parents who participated in this study were analysed in Chapter 4 and the results were profiled in Tables 4.1 to 4.11. From the biographical data gathered, it appears that most of the respondents were in the 30-39 year age group, which is significant because it is indicative of maturity when dealing with problem situations with their ADHD children.

These results indicated that 54% of the sample were female while 46% were male. When a child has a learning disability, the entire family is affected. Mothers are often the ones who are most involved in the day-to-day issues. They are usually the ones who meet with the teachers, drive to the doctors, and consult with the specialists. Most often it is the mother who listens when the child is hurt, who intervenes when there are social problems and who acts as referee among the other family members.

It might be difficult for fathers to acknowledge that their child has a problem because many children have two behaviour patterns – one for when the mother is around, and another for when the father is there. Lots of times children are really horrendous to the parent who is with them all day. Dads tend to see them for much shorter periods of time. When fathers get directly involved in the process, they get a better understanding of the issues involved in educating a child with special needs (Tuttle and Paquette, 1994).

According to Kilcarr and Quinn in the 1997 edition of *Attention! Magazine*, fathers of children with ADHD have a special calling – to stand with their children during times of emotional or behavioural difficulties, to give their child hope and courage, and to provide opportunities so that their children might define themselves by their strengths rather than their weaknesses.

A child with ADHD needing his father's support is much like a person with a broken foot needing a crutch. He will not need to use the crutch permanently; however, in order to feel comfortable and go about his daily duties, he needs the broken foot and the crutch to work together to minimize discomfort. As the child with ADHD matures, he will need his father less for support, and more as an important sounding board and resource (Kilcarr and Quinn, 1997).

Results on Table 4.3 indicated that 68% of the respondents were married. This is significant because research on families with ADHD children have indicated that the majority of ADHD children come from families often characterized by marital dissatisfaction and separation of their parents. Divorced mothers of ADHD children have been described as being more impatient, power assertive, and less consistent and as experiencing more parental stress around child rearing than mothers of children without the disorder or married mothers (Mash and Johnston, 1983). When parents face issues together, parents can offer each other comfort and support. Everyone ends up feeling better about the possibilities for success (Tuttle and Paquette, 1994).

The important findings reported in Table 4.4 indicated that 38% of parents reported having two children and 35% of parents reported having three children in their families. These findings are significant when addressing the problems associated with the siblings of ADHD children. It is also difficult for the brother or sister of the ADHD child. They just don't understand why parents have to spend so much time with one child. Often they are jealous. Occasionally they are embarrassed. Sometimes they must explain to friends why their brother or sister has such a hard time learning. Sometimes they are frightened it could happen to them (Silver, 1999). These factors can only make parents lives even more stressful.

The results in Table 4.5 indicated that 76% of parents were employed. In a study by Etaugh and Folger (1998) on how others perceive the potential stress experienced by those who occupy multiple roles, it was found that full-time employees who spent more time in family caregiving were perceived by others as experiencing more stress than those who spent less time in family caregiving.

From the biographical data gathered, it is indicated that the average family income of majority of parents was between R3000-R5000 (35%) and 30% of parents reported a family income of R5000-R10 000. This implies that the sample falls in the average – above average socio-economic status.

Results from Table 4.7 indicated that 78% of parents had matric as their minimum level of education, of this, 40% have degrees and diplomas. Three parents indicated special standard eight as their highest level of education. These three parents, although they do not represent a significant number, they do provide information that they also experienced learning difficulties.

Eighty six percent of parents reported that their children take either herbal or ADHD medication and 57% of parents reported being on a medical aid scheme (Tables 4.8 and 4.9).

The results from Table 4.10 indicated that 59% of parents reported being diagnosed with ADHD/Learning Disorder and in Table 4.11, 32% of parents reported having two children diagnosed with ADHD. The genetic theory of ADHD postulates that the possibility of a genetic cause to ADHD is supported by the fact that ADHD appears to run in families. Between 10 and 35 percent of children with ADHD have a first-degree relative with past or present ADHD. Approximately half of parents who have been diagnosed with ADHD themselves, will have a child with the disorder (Zametkin, et al., 2000).

People respond to stress differently depending on different factors, however, one's biographical background can make people more vulnerable to the effects of stress. Studies indicate that the following biographical factors are important predictors to how a person responds to stress:

- Older adults. As people age, the ability to achieve a relaxation response after a stressful event becomes more difficult. Aging may simply wear out the systems in the brain that respond to stress, so that they become inefficient. The elderly too are very often exposed to major stressors. No one is immune to stress, however, it may simply go unnoticed in the very old and in the very young.
- Women in general and working mothers specifically. Working mothers, regardless of whether they are married or single, face higher stress levels and possibly adverse health effects, most likely because they bear a greater and more diffuse workload than men or other women. Such stress may also have a domino effect on their children.
- Less educated individuals.
- Divorced or widowed individuals (A number of studies indicate that unmarried people generally do not live as long as their married contemporaries).
- Anyone experiencing financial strain, particularly long-term unemployment and those without medical aid.
- Isolated individuals.
- People who are targets of racial or sexual discrimination.
- People who live in cities.

## **5.2 PARENTS' PERCEPTIONS OF EXTREME STRESS/BURNOUT**

The results from the survey questionnaire on extreme stress/burnout have indicated that the parents in this study conceptualized stress/burnout in terms of physical and emotional symptoms. The physical symptoms included extreme exhaustion, depletion of energy, lack of rest, not coping with the demands of work and home and aches and pains in the muscles of the neck, the back and terrible headaches. The emotional indicators included frustration and extreme anger, resentment, moodiness and weepiness, not being understood, depression, helplessness, impatience, being inconsiderate, feeling neglected, and having no zest for life.

The body tries to tell us through signs such as rapid heartbeat, dizzy spells, tight muscles or various body aches that something is wrong. When a person feels out of control or under intense pressure, he or she may experience the physical, emotional or relational symptoms brought on by extreme stress. Remember, however, that the body and mind are not separate entities. Past research studies on the signs and symptoms of stress listed some of the following symptoms and signs:

### **Physical symptoms**

- Sleep disturbances
- Back, shoulder or neck pain
- Tension or migraine headaches
- Muscle tension
- Fatigue

### **Emotional symptoms**

Like physical signs, emotional symptoms such as anxiety or depression can mask conditions other than stress. The following emotional symptoms are uncomfortable and can affect your performance at work or your relationships with others:

- Nervousness
- Anxiety
- Depression

- Irritability
- Moodiness
- Frustration
- Over-reactions

**Relational symptoms:**

The anti-social behaviours displayed in stressful situations can cause the rapid deterioration of relationships with family, friends and co-workers. These symptoms include:

- Increased arguments
- Isolation from social activities
- Road rage
- Conflict with co-workers or employers
- Over-reactions

Given the above symptoms of stress as found in past research studies, the perceptions of extreme stress/burnout perceived by the parents in this study is indicative of the presence of stress in their lives with their ADHD child.

**5.3 SURVEY QUESTIONNAIRE ON EXTREME STRESS/BURNOUT**

The aim of the questionnaire was to investigate which specific factors were contributing to stress in parents with their ADHD children. The data was analysed quantitatively using the SPSS computer programme.

Results on Table 4.12 indicated that the following questions on the survey questionnaire yielded significant results:

- Question 6: “You see how different your child’s behaviour is when compared to other children of the same age”. Sixty four percent of the sample answered “yes”.
- Question 5: “Homework time is a struggle”. Sixty two percent of the parents agreed.

- Question 3: “Their short attention span is frustrating”. From the sample of parents, 54% answered “yes”.
- Question 2: “Their constant activity, noise, etc. is annoying”. Fifty one percent of parents agreed.
- Question 4: “Their interrupting, calling out, and inappropriate/potentially dangerous behaviour is upsetting”. Fifty one percent of the respondents agreed.
- Question 7: “Teachers complain about your child’s classroom behaviour/incompletion of tasks”. Again, 51% of parents answered “yes”.

The above significant responses by the parents on the survey questionnaire were clustered by the researcher into 3 primary categories of parental stressors, namely social problems of children with ADHD, school-related problems, and hyperactive-impulsive and attention-deficit behaviours that serve as sources of immense stress for parents. The category “social problems” was based on the high frequency of respondents to the question: “You see how different your child’s behaviour is when compared to other children of the same age”. This item on the questionnaire had the highest frequency, 64% of parents found this to be a significant factor contributing to their stress.

The items on question 5: “homework time is a struggle/battle” and question 7: “Teachers complain about your child’s classroom behaviour/incompletion of tasks” also scored significantly on the questionnaire. Both these factors are about the child’s school-life, therefore the researcher grouped these two factors into the category “school-related problems”.

The majority of parents also rated their ADHD children’s short attention span as frustrating, their constant activity, noise, etc. as annoying and their interrupting, calling out, and inappropriate/potentially dangerous behaviour as upsetting. Given the literature on the symptoms of ADHD, the researcher was able to cluster these behaviours according to the DSM-IV classification system of ADHD children with hyperactive/impulsive and attention-deficit behaviours which parents rated as causes of stress in their lives.

## **5.4 ANALYSIS AND DISCUSSION OF THE SEMI-STRUCTURED INTERVIEWS WITH PARENTS**

Data from the semi-structured interviews were analysed as indicated in Chapter 4, yielding a qualitative description of the subjective stress experiences of these parents with ADHD children. Since the researcher was interested in the descriptive information yielded from the data analysed in this study, themes identified as essential and common for the subjects were extracted and thereafter integrated into central themes for the purpose of understanding the information from the semi-structured interviews.

It's hard to miss ADHD children. They are the whirlwinds of frenzied activity that seem to have 12 flailing arms and two high-speed legs. The ADHD children leave messes, throw tantrums, start fights, act obstinate and destroy property. The ADHD children are the ones who find themselves in trouble at school, can't finish a game and often have trouble keeping friends.

By understanding the problems associated with parenting an ADHD child, one can then understand why the lives of these parents are so stressful and sometimes out of control.

### **5.4.1 SOCIAL PROBLEMS WITH ADHD CHILDREN**

The majority of the parents stated that their ADHD child's interactions in social situations, such as with peers and adults always end up in trouble. Parents observed their children in group situations and noticed that they cannot play with other children because they always end up getting into arguments with them or they get so frustrated that they end up hitting the other children.

They are also prone to emotional outbursts. Parents mentioned their children fighting over toys and not being able to accept "no" for an answer. This makes them become very frustrated and they start lashing out at others. Their behaviours with others were described as "over-bearing", jumping and climbing on top of other children, even adults. When other parents watched these ADHD children playing, their behaviour was so

inappropriate and strange that they are described as being “naughty” by other parents who do not understand them and do not wish for their children to associate with them.

Due to these above reasons, most ADHD children are described as “loners” because their parents believe that they do not know how to play with other children and nobody wants to play with them. Other reasons that were given by many parents were related to their ADHD children’s lack of fear. Parents stated that these children have to be watched constantly because once they are out of sight, they are up to something dangerous because to them it is normal, due to their lack of fear. They are also described as having “no limits” and an example of this given by several parents related to when they play a practical joke on somebody, they never know when to stop, even when they are told to do so.

Their own parents described them as always being untidy, very clumsy and destructive, not qualities people admire. In social situations, like visiting friends/family or even going shopping was a huge task for parents with ADHD children because parents reported that their children would start playing-up and doing stupid things to embarrass the family.

In keeping with the above findings, Silver (1999) discovered that children and adolescents with ADHD often do not relate well to peers and may not be accepted by them. Their inappropriate behaviour leads to social rejection and exacerbates their inability to relate to others appropriately.

Developing healthy peer relationships is critical for the normal development of a child. Peer relationships have been found to be an important predictor of positive adult adjustment and behaviour. Difficulty in finding friends leads to feelings of low self-esteem and these feelings usually continue in adulthood. ADHD children are socially inept and are frequently disliked by their peers. ADHD children are less often chosen by peers to be best friends, partners in activities, or to sit next to in class. It is difficult to determine all the factors that make a child unpopular, but children who frequently display aggressive or negative behaviours tend to be rejected by their peers (Kane, 2001).

Many ADHD children are aware that they are socially inept. Children who are anxious or fearful about peer relationships are unlikely to behave in an effective manner. These children withdraw from peer interactions and, in this way, limit their ability to gain acceptance and friendship. Children tend to encounter social rejection when they are perceived to be dissimilar from their peers. Similarity fosters social acceptance. Given the fact that ADHD children do not learn social clues as well as other children, they tend to be viewed as different (Whalen and Henker, 1985).

In addition, some of these children feel so out of control that they will try to dominate their environment. When among their peers, they need to control what is done and how it is done. They can be bossy and demanding. For others, their frustration may result in anger and aggressive behaviours (Pelham and Bender, 1982).

#### **5.4.2 HYPERACTIVE/IMPULSIVE AND ATTENTION-DEFICIT BEHAVIOURS OF ADHD CHILDREN**

Parents stated that their children are extremely loud, boisterous and over-talkative regardless of where they were. They cannot sit still, they are always moving around and dancing, even while talking to people due to their hyperactivity. Their attention-seeking behaviours include always wanting to take charge of a situation even if it means total chaos, not having any patience and not being able to wait their turn even when their parents are talking to other adults, they just butt-in with the most irrelevant conversation. They often must have things their way, if not, they throw tantrums, frustrate and annoy siblings or even physically abuse their parents and siblings.

Their attention-deficit behaviours are also a great source of discomfort for their parents. These children are incapable of concentrating and focusing long enough in order to complete any task. The problems associated with attention-deficit behaviours included not completing their homework, not dressing-up by themselves for school in the mornings and not being able to sit still and watch a movie. They often become distracted

or bored whilst doing something and then they become totally lost as to what they were supposed to be doing.

According to the numerous studies conducted on ADHD children, the following results are common to all research studies on ADHD children and are in keeping with the parents' problems relating to the hyperactive/impulsive and attention-deficit behaviours of ADHD children

ADHD symptoms often include aggressive behaviour, constant activity, easy distractibility, impulsiveness and/or the inability to concentrate. These ADHD symptoms may include fidgeting or constant movement, excessive talking and difficulty participating in "quiet" activities like reading. They often fidget with their hands or feet or squirm in their seat and run about excessively in situations where it is inappropriate. They are constantly "on the go" and act as if "driven by a motor". They also talk excessively and blurt out answers before hearing the entire question. They cannot wait their turn and often interrupt or intrude on others at home or at school. They often feel or act restless.

#### **5.4.3 SCHOOL-RELATED PROBLEMS OF ADHD CHILDREN AND POSSIBLE SOLUTIONS**

The two areas relating to the child's school that serve as factors that contribute to parent stress with ADHD children on the survey questionnaire include homework and teachers complaining about the child's classroom behaviour. Parents regarded completing homework as sheer torture, taking hours to complete. To avoid this battle, most parents reported asking the people at aftercare to complete the child's homework with him or her. Alternatively, parents also reported completing the homework themselves instead of going through the problems with their child. They described it as being far "easier" for the sake of peace.

Activities that cause normal stress in most homes cause an extraordinary level of stress in homes of children with learning disabilities. Homework is a stressful issue in most

families, but when your child is learning disabled, the simplest assignment can become a nightmare (Tuttle and Paquette, 1994).

Another stress factor for parents with ADHD children relates to the teachers' numerous complaints. What follows is a brief summary of school-related problems with ADHD children. In the classroom, those with ADHD tend to engage in more inappropriate behaviour, including annoying peers and disrupting ongoing classroom activities, and becoming involved in aggressive interactions with others (Whalen and Henker, 1985). Children who cannot engage themselves with classroom work assignments often disrupt and irritate their peers. ADHD children become bored more easily than other children and as a result they create problems in the classroom (Kane, 2001).

ADHD children tend to be more impulsive and aggressive than other children. Teachers observe that the social interactions of ADHD children more often involve fighting and interrupting others. These children are more intense than others and behave inappropriately in social contexts. For example, ADHD children are more likely to yell, run around and talk at unsuitable times. They also tend to want to dominate play, engage in off-task behaviours and engage in more teasing and physical jostling of peers. This sets up a process of peer rejection (Kane, 2001).

Interactions with teachers tend to be characterized by more negative affect and poor compliance on the part of children. Constant or repetitious annoying behaviours of ADHD children make teachers and their peers react negatively. Teachers seem to have had it by the end of the school year with ADHD children.

Comments by teachers such as, "Why can't they ever get anything ever turned in on time?," "Why does it take so long to start?," "Their constant interruptions are so annoying!," "And why the heck can't they just sit down and stay there for one whole period?" By this stage the teacher has used up all of his or her patience with the ADHD child and is feeling frustrated and angry, also, by this time, the ADHD child has been reprimanded, criticized, has failed in academics and/or in social situations, and is fast

losing his or her self-esteem. His or her attitude is probably going downhill, as well (Stubbs, 1997).

These school-related problems are evident in most parents' reports of their ADHD child's problems at school. In the semi-structured interviews parents were also asked to provide possible solutions for the school to make the lives of the ADHD child and their parents a little easier. Parents stressed the importance of better communication between the school and the ADHD child's parents so both teachers and parents can work together to assist the child.

Teachers also need to have a sound knowledge and understanding of ADHD and how this impacts and affects the child's school and home life. They can assist parents by not labeling the child as lazy, stupid or naughty because these children have no control over this disorder. By calling them names, they are destroying what little self-esteem they have left.

Parents are of the opinion that one way in which schools can really assist them with their ADHD children is by setting-up support groups for these parents and another one for the siblings of these children. Not only are these parents battling with these ADHD children, so too are the siblings. The parents strongly believe that by gaining more knowledge about this disorder is the only tool to fight this disease. By being surrounded by people who are in a similar situation, parents feel that they can support and assist each other through trying times.

Providing parents with an opportunity to discuss their frustrations associated with their child, and how this was affecting the entire family, can be enormously helpful. Parents in support groups soon realize that their experience is by no means an isolated experience. Perhaps developing a way to address these issues may prove to be useful to teachers and parents of ADHD children (Breggin and Breggin, 1995).

Teachers are also encouraged by parents to help enforce correct, appropriate behaviours, in an acceptable manner, including providing healthy foods at the tuck-shop at school and not junk foods that cause sugar spikes, resulting in extremely bad behaviours which only makes the classroom situation “hell” for the ADHD child, the teachers and other learners.

#### **5.4.4 GENDER AND PARENTAL STRESS**

This question was included in the semi-structured interview even though the Chi Square analysis of cross-tabulations between gender and all 25 items on the questionnaire did not produce significant results. The researcher still wanted to investigate from parents whether they believed that the factors that contribute to stress could be affected by their gender. The question that parents had to answer was, “Do women and men respond differently to parental stress? Explain further.”

Most parents believed that men and women do react differently to stress and the reasons they gave for this included: mothers spend more time with their children and therefore are more in-tuned to their needs, and may therefore not be easily upset by their demands. Women are more emotionally involved and more concerned about their children’s mental health than men are. Men and women have different tolerance levels, men get angry more quickly and have far less patience than women. Women, on the other hand, will not get angry and storm out the house when things are too stressful, they cannot walk away from their ADHD child.

One father was of the opinion that women experience extreme stress when they shout inappropriately and he believed that men handle stress “whichever way it comes”. Another parent felt that stress reactions are not dependent on gender, but rather, on one’s personality and their ability to deal with stress. One parent communicated that it was impossible to respond to this question as their family was a very dysfunctional one with little communication. From these parents’ responses, it is indicated that the majority of parents are of the opinion that gender differences plays a significant role when it comes to the way a person responds to parental stress.

According to the available literature on gender and stress studies, many factors affect this relationship, such as, the increasing number of women in the workplace and the fact that past research studies on this phenomena tend to focus on mothers only. Another significant finding is the paucity of research on the impact of family and work conflicts on men (Nelson and Burke, 2002). In a study which looks at how parents with an ADHD child feel that things are going in the family (Kendall, 1998), for all four groups of children in the study, the parent who responded to the questionnaire items were always the mother.

Gender differences are apparent in most aspects of marriage and family life, including marital communication, the division of household labour, and parenthood (Finken and Amato, 1993). In relation to parenting, it is usually assumed that motherhood is a more central role to women than fatherhood is to men. Consistent with this assumption, some research has shown that stress in the parental role has a more detrimental impact on the well being of mothers than on fathers.

A large portion of the literature points to the fact that many women have strong psychological ties to the role of being a mother. Many women view the role of parenthood as necessary for the fulfillment of their life values and central to their sense of self-worth. In contrast, men tend to have more of their identity invested in the “breadwinner” role than in parenthood.

Identity theory holds that strains that threaten to disrupt an individual’s most salient role identities are most psychologically damaging than strains that threaten to disrupt less salient role identities. Due to a woman’s identity being closely tied to her role as parent, perceived failure as a parent is likely to threaten a woman’s identity and therefore lower her self-esteem. On the other hand, because a man’s identity may be more closely tied to his occupational role, failure in the parental role may be less threatening to men than to women and may impact less on their self-esteem (Shelton, 1998).

Research on problems with parenting yields differing results. Some indicate gender differences do exist whilst others point to a lack of gender differences. The fact that there exists an absence of mother-father differences may reflect a societal trend toward greater equality of parents in child rearing and the sharing of the stress and strain of parenthood.

Another study on gender, work and stress points to the fact that Type A behaviour could be related more significantly to stress than one's gender. Recent research on the Type A behaviour patterns, however, suggests that an individual's hostility is the toxic component of Type A, and includes anger such as hostility and defensiveness. It is also indicated that people with Type A behaviour are more vulnerable to stress (Low, 2003).

The above summary on some of the existing literature that is available on stress and gender does agree with the parents' responses. Some studies point to gender differences whilst others talk about personality/behaviour types affecting stress.

#### **5.4.5 SOLUTIONS FROM PARENTS OF ADHD CHILDREN**

From parents' responses to this question it is indicated that parents have lots of ideas but require assistance from significant others to put these solutions into operation. This section will first take note of parents' current coping styles and then look at parents' proposed solutions.

Parents described permissive behaviour on their part as being the easiest way to cope with difficult situations with their ADHD child. These include often giving in to their child's impossible demands in order to keep the "peace". When it comes to completing tasks, parents would rather complete it themselves instead of going through another argument or fight with their ADHD child. Some parents use behaviour modification techniques such as "no T.V.", whilst others avoid social situations.

Giving the child extra attention seems to work for some parents whilst others try explaining the inappropriateness of their behaviour to their child. When all else fails,

some parents resolve to smacking their children, especially when the parent can no longer contain their anger and frustration.

The possible solutions described by parents in the semi-structured interviews include: accepting the child along with the disorder and dealing with it. Dealing with ADHD and treating it is seen as a collaborative approach between parents, doctors and teachers. The ADHD child requires structure and discipline at all times. Parents believe that by getting as much information and understanding as possible, they will be better able to cope with their child. Family therapy for the whole family and support groups for parents and siblings were strongly agreed upon by all parents in the sample.

If anyone thinks being an ADHD child is difficult, try parenting one. For as out of control as ADHD children act, their parents often feel equally out of control in their ability to tame the ADHD symptoms. The usual methods of discipline don't work with ADHD children, mostly because ADHD children do not work like their non-ADHD counterparts.

As long as the list is on the problems parents experience with their ADHD child, so too is the list of endless solutions. Several research articles have invested in the most practical solutions for parents with ADHD children. What follows is a brief summary of some of the most effective and practical solutions that the researcher identified, which is closely related to the parents' proposed solutions. It is noted that, firstly, ADHD children need training to better conduct themselves, so do parents of ADHD children. Therapists can equip parents with tools and techniques for managing their child's behaviour. Positive parenting alone cannot cure ADHD children but it goes a long way in encouraging positive behaviour and relieving ADHD symptoms.

ADHD children often have difficulty focusing on large-range tasks or multi-faceted tasks. Simply telling the ADHD child to "clean the room" may not produce the desired results the parent expects. Clearly listing the expectations: "make your bed, put the dirty clothes in the washing basket and then put your toys back on the shelf", can often yield better results. Along with clearly outlining the expectations, parents can offer rewards for tasks

completed: “when you are finished cleaning your room, we can read a book (go for a walk, have a snack, etc.) (Silver, 1999). “Time out” when the child becomes too unruly or out of control often works well for ADHD children.

Another highly effective way to modify the behaviour of ADHD children is through a system of praise and rewards. A comment as simple as: “I really appreciate the way you asked for the toy instead of grabbing it” highlights success instead of failures. The more positive responses from successes that ADHD children can experience, the more likely they will put an extra effort into repeating that desired behaviour.

Parents can also structure situations to allow their child to succeed. This may include allowing only one or two playmates at a time to avoid over-stimulation. Parents can divide large tasks into smaller steps if the child has trouble completing tasks, then praise the child as each step is completed. If, at all possible, parents should try to place their ADHD children in smaller classroom settings to allow for more individualized attention.

Parents can also learn stress management methods so that they can respond more calmly to their child’s behaviour. Meditation, relaxation techniques and exercise all work to decrease frustration. Sometimes it might be necessary for parents to enter couples therapy or for the family to start family therapy. Find a support group or just another parent with an ADHD child and talk periodically as this will provide you with helpful information and various resources. Sports and other high-energy activities help channel excess energy which ADHD children seem to have an abundance of.

Organisation helps everyone involved with the ADHD child. These children function best when their lives are structured and their parents’ responses are predictable. Family members and teachers respond most positively when they understand the effects of ADHD and can anticipate the reactions and behaviours of the ADHD child. A structured, co-operative environment can make home a safe, nurturing and non-competitive place for an ADHD child and that environment can have a positive effect on the entire family (Silver, 1999).

The following chapter, **Chapter 6**, concludes the study, indicating the limitations and implications of this study and makes recommendations for future research.

## CHAPTER 6

### CONCLUSION, LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

The quantitative analysis of the survey questionnaire and the qualitative analysis of the semi-structured interviews in this study, provided information on the factors contributing to stress in parents of children diagnosed with ADHD. The biographical information was compiled from the profiles of the thirty-seven parents who participated in this study. In this chapter, a general summary of the conclusions, limitations, implications of the study and recommendations for further research are discussed.

#### 6.1 CONCLUSION

The main purpose of this study investigated the factors contributing to stress in parents of children diagnosed with ADHD.

The critical questions that guided this research were:

- How do parents of ADHD children conceptualise extreme stress/burnout?
- Which factors contribute to parental stress/burnout with ADHD children?
- Are there gender differences in terms of stress factors?

The results of this study have indicated that generally parents perceive extreme stress/burnout in terms of physical and emotional symptoms. The physical symptoms included extreme exhaustion, depletion of energy, lack of rest, bodily aches and pains and not being able to cope with the demands of work and home. The emotional symptoms indicated by parents included frustration, anger, resentment, moodiness and weepiness, being misunderstood, depression, helplessness, impatience, being inconsiderate, feeling neglected and a sense of hopelessness.

The very fact that these parents described most of the physical and emotional symptoms of extreme stress indicates that at some point or another in their lives with their ADHD

children, they have felt stressed. It was also observed by the researcher that because these parents do not experience single stressful events, occurring randomly, but rather, their lives are constantly enveloped by the stress of parenting their ADHD children, therefore, they do not even take notice of it because they do not have the time for themselves and the only time they realize that something is wrong is when their health is affected and they require medical attention.

Given the fact that parenting is a stressful job by itself, parenting an ADHD child is even more demanding, however, not all aspects of parenting ADHD children contribute equally to extreme stress in parents. From the results of this study, it would appear that some aspects of parenting ADHD children are rated as extremely stressful whilst other factors appeared manageable by parents. The factors contributing to extreme stress appeared to be associated with social problems with ADHD children, especially their lack of social skills, their inappropriate hyperactive/impulsive and attention-deficit behaviours and their school-related problems.

Parents indicated many possible solutions to their problems with their ADHD children, however, they also indicated that in order to realize these solutions, they require assistance and support from significant others, such as spouses, family members, doctors, teachers and therapists. Support groups for parents and siblings of ADHD children were also requested. Parents were of the opinion that this was one area where the schools can really assist these families, considering the large number of ADHD children attending the school. More knowledge and information for all those associated with the ADHD child was reported as another important solution. Parents believed that by better understanding ADHD as a disorder, parents, family members, close family friends and teachers would be better able to understand the nature of ADHD and the ADHD child and this in turn could reduce tension and stress.

Although the results of the statistical analysis revealed that there is no significant relationship between males and females responding to the variables on the questionnaire, parents of ADHD children indicated that gender differences do affect one's stress

responses. They believed that women generally have more stressful encounters with their ADHD child because they are more sensitive and emotional. It was also indicated that mothers spend more time with their children than fathers do. Generally, men were portrayed as getting angry more quickly and having far less patience than women. According to Tuttle and Paquette (1994), fathers find it difficult to acknowledge that their child has a problem and, instead of accepting it and dealing with it, they often are in denial. Only when fathers become directly involved in the process, do they get a better understanding of the issues involved in parenting a child with ADHD. Mothers are usually the ones involved with the day-to-day issues with the ADHD child, mothers are also the ones who report far more stress in their role as parent to the ADHD child.

Given the above findings, it can be concluded that certain factors associated with parenting an ADHD child does serve as sources of immense stress for parents. Schools are described as one agency that can assist parents with their difficulties. The role of parenting an ADHD child is different for mothers and fathers, however, as long as these differences persist, it would be virtually impossible to create peace and harmony in the homes of families with ADHD children.

## **6.2. LIMITATIONS OF THE STUDY**

As a novice researcher, whilst the questionnaire was refined a number of times, questionnaires by their very nature always have limitations. However, every precaution was taken to control the variables that may affect the answering of questionnaires. In addition, the researcher had no control over the respondents' completion of the questionnaires. Due to the sensitive nature of the study, parents might have given socially appropriate responses, thus, their responses may not have been a true reflection of the stress associated with parenting their ADHD child.

The sample was small and consisted of parents whose children attend the same school, a school for long-term remediation. This school also had a high percentage of ADHD learners. This could have compromised the generalisability of the results. The population

of these ADHD learners attending this special school was not a true reflection of the population at most mainstream schools. This school appears to have a higher white learner ratio and an average classroom size of 14 learners. Therefore, care must be taken with the generalisability of the results from this study.

Another problem faced by the researcher in conducting this research was the lack of research based on the local context. Research in this area is virtually non-existent in South Africa and theorists have been reduced to extrapolating conclusions from the international literature.

### **6.3. IMPLICATIONS OF THE FINDINGS**

ADHD is a life disability, affecting all aspects of life. For many, ADHD is a lifetime disability as well. Like other chronic developmental disorders, the consequences of not recognizing, diagnosing and fully treating ADHD can be extensive. Each stage of psychological and social development can be affected, as can academic success, self-esteem, and positive peer interactions. The resulting emotional, social and family problems can become as great a disability for the entire family, especially the parents.

With ADHD children, so much of time, energy and attention is focused on the child that often the parents of these children who are just as needy of support and assistance are overlooked. Parents often find themselves being burnt out by the demands of their ADHD child, leaving little or no time for themselves.

Family stress theory sets forward acute stressors which when accumulated could lead to family crises, including physical, emotional or relational crises (McDonald, 2003). However, their impact can be muted or buffered with protective factors which help families to survive multiple contextual stressors, and to continue to competently parent despite chronic and acute stressors. These protective factors buffer the impact of the stressors, and one includes social relationships and the other includes perceptions. Social relationships are further distinguished as being within family variables, such as,

attachment, positive family bonds, effective communication, as well as across family variables, such as, social isolation vs. informal and formal social support networks; perceptions, which include the range in cognitions and attitudes between hope and personal effectiveness vs. despair and helplessness.

Professor Reuben Hill's theory of family stress (1947,1959 and 1983 in McDonald, 2003) states that internal and external family resources and social support available to the family would significantly minimise the impact of multiple stresses on the family functioning. This is in keeping with what the participants in this research study proposed, the need to formulate a network of support structures for families with ADHD children. In order to decrease the impact of parent stress on the family functioning, each of the following relationships need to be systematically altered so as to improve communication and provide help to those parents who are experiencing extreme stress as a result of parenting an ADHD child:

- ADHD child and parent bond.
- The family unit.
- Parent-to-parent relationships.
- Parent-school relationship.
- Parent-self - help group bonds.
- Parent-community treatment/counseling agencies.

“You did then what you knew how to do. When you knew better, you did better.”

(Maya Angelou)

While conflicts and differences are a part of all relationships, particularly when there are children around, a crucial factor in parenting an ADHD child is the ability of the adults involved to work together in a consistent way. Working together means supporting and agreeing with each other as well as sharing the responsibilities of parenting the ADHD child. By parents identifying what specific factors associated to parenting their ADHD

child is causing extreme stress to them, then with the necessary support structures in place and available to them, these can be worked through and resolved.

#### **6.4 RECOMMENDATIONS**

Given the importance of proper communication between the school and the parents of ADHD children, it is recommended that further research in South Africa be conducted into establishing ways in which better communication can be established, whereby, parents and teachers work together, forming a partnership, to help each other with the problems associated with teaching and parenting ADHD children. The sample selected for this study expressed a strong desire for support groups. These special schools have therapists, medical personnel and psychologists at their disposal. These interventionists, together with the teachers and parents of ADHD children would definitely benefit by setting up support groups to assist each other.

Considering the field of education is moving towards the inclusion of learners with special needs into mainstream, more in-service training programmes accessing information about the management of learners diagnosed with ADHD should be provided to mainstream educators so as to provide them with the knowledge and skills to deal with the problems learners with ADHD might experience in the mainstream classroom environment (Reid, Maag, Vassa and Wright, 1994).

Little is known about ADHD on the African continent because of the lack of resources, problems in access and communication and political strife. The recognition of culture and ethnicity are extremely important in the development of ADHD, as culture shapes the environment in which behaviour is defined as inappropriate (Madu, 2003).

Hopefully, clinicians will soon join the researchers in developing adequate and appropriate methods of diagnosis and intervention for our specific South African context. In order for this to become a reality, involvement of educational and health care

institutions are of paramount importance. The monetary investment will by far outweigh the eventual cost to society.

Traditional family roles, in which mothers do all the nurturing and fathers withdraw into outside work activities, leave mothers overly responsible for the emotional health of all members of the family. Many family researchers recommend sharing the role of nurturing, as it leads to healthier and happier families. Researchers have found that traditional roles contribute to dysfunction due to the alienation of the father in the emotional life of the family and the over-functioning of the mother in an impossible attempt to make everyone happy.

Fathers are encouraged to be more responsible and involved with the nurturing of their ADHD child as well. They are encouraged to attend school meetings, doctors' appointments and support groups. There also appears to be a paucity of research between stress and gender even in the international environment, especially on men and stress. A further recommendation of this study is the future research of this phenomenon in the South African context.

Although the focus of this study was the parents of ADHD children, it is still important to bear in mind the daily struggles and problems that the ADHD child has to endure. This is captured very nicely in the following poem from an ADHD child:

### **THE ADHD CHILD'S BILL OF RIGHTS**

“Help me to focus  
Please teach me through my sense of touch  
I need hands on and body movement  
I need to know what comes next  
Please give me a structured environment where there is a dependable routine.

Give me an advanced warning if there will be changes.

Wait for me, I'm still thinking

Please allow me to go at my own pace.

If I rush I get confused and upset

I'm stuck, I can't do it!

Please offer me options for problem-solving.

I need to know the detours when the road is blocked.

Is it right? I need to know now!

Please give me rich and immediate feedback on how I'm doing.

I didn't forget, I didn't hear it in the first place!

Please give me directions one step at a time and ask me to say back what I think you said.

I didn't know I wasn't in my seat.

Please remind me to stop, think and act.

Am I almost done now?

Please give me short work periods with short-term goals.

What?

Please don't say: "I've already told you that!"

Tell me again in different words.

Give me a signal, draw me a symbol.

I know, it's all wrong isn't it?

Please give me praise for partial success.

Reward me for self-improvement, not just for perfection.

But why do I always get yelled at?

Please catch me doing something right and praise me for my specific positive behaviour.

Remind me and yourself about my good points, when I'm or you're having a bad day.

I may be hard to live with, and I have ADHD, but I still have feelings and would have never chosen to behave like I do sometimes.”

(Author Unknown)

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**APPENDIX 1**

ENQUIRIES: P.T. ZUNGU  
IMIBUZO:  
NAVRAE:

REFERENCE: Permission: Research  
INKOMBA:  
VERWYSING:

DATE: 03 August 2004  
USUKU:  
DATUM:

RE: APPROVAL TO CONDUCT RESEARCH

**TO WHOM IT MAY CONCERN**

This is to serve as a notice that **Ms Y. Privithirajh** has been granted permission to conduct research with the following terms and conditions:

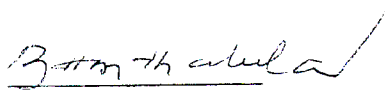
- That as a researcher, she/he **must** present a copy of the written approval from the Department to the Head of the Institution concerned before any research may be undertaken at a departmental institution.
- Attached is the list of schools she/he has been granted permission to conduct research in. however, it must be noted that the schools are not obligated to participate in the research if it is not a KZNDEC project.
- **Ms Y. Privithirajh** has been granted special permission to conduct her/his research during official contact times, as it is believed that her/his presence would not interrupt **education programmes**. Should education programmes be interrupted, she/he must, therefore, conduct his/her research during nonofficial contact times.
- No school is expected to participate in the research during the fourth school term, as this is the critical period for schools to focus on their exams.

Comments: \_\_\_\_\_



**Thandiwe Zungu**  
Deputy Director: Research, Strategy and Policy Development

Comments: \_\_\_\_\_



**B H Mthabela**  
Director: Research, Strategy Development and ECMIS

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**APPENDIX 2**

**DATE:** 6 August 2004

**OUR REF:** I CUNARD/a0  
PSYCHUNIVKZN04

**Dr Z Naidoo  
Department of Educational Studies  
University of KZN  
WESTVILLE  
3630**

Dear Dr Naidoo

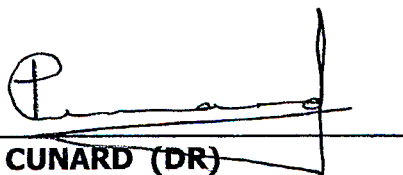
**REQUEST TO CONDUCT RESEARCH AT THE BROWNS' SCHOOL:  
MS. Y. PRITHIVIRAJH**

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This request has been approved by the KZN Department of Education.

On behalf of The Browns' School, it is also approved by us.

Yours sincerely,



**I. CUNARD (DR)  
HEAD OF DEPARTMENT: PSYCHOLOGY**



**T. M. WOODS  
Acting PRINCIPAL**

**BIOGRAPHICAL QUESTIONNAIRE**  
(Confidential information)

**APPENDIX 3**

**NAME** \_\_\_\_\_

**AGE** \_\_\_\_\_

**GENDER** \_\_\_\_\_

**MARITAL STATUS** \_\_\_\_\_

**NAMES AND AGES OF CHILDREN** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOW ARE YOU RELATED TO THE ADHD CHILD?** \_\_\_\_\_

**EMPLOYMENT STATUS** \_\_\_\_\_

**MONTHLY HOUSEHOLD INCOME** \_\_\_\_\_

**HIGHEST LEVEL OF EDUCATION** \_\_\_\_\_

**MEDICAL AID/CASH PATIENT** \_\_\_\_\_

**IS YOUR ADHD CHILD ON MEDICATION?** \_\_\_\_\_

**WERE YOU EVER DIAGNOSED AS ADHD/LEARNING DISORDERED**  
\_\_\_\_\_

**HOW MANY OF YOUR CHILDREN ARE ADHD?** \_\_\_\_\_

**CONTACT TELEPHONE NOS. HOME:** \_\_\_\_\_

**WORK:** \_\_\_\_\_

**CELL:** \_\_\_\_\_

**BURNOUT QUESTIONNAIRE**

**APPENDIX 4**

**NAME** \_\_\_\_\_

**GENDER** \_\_\_\_\_

**DATE** \_\_\_\_\_

When you think critically about yourself, have you seen yourself change from a motivated individual to an impatient, detached creature, entirely dismissive of other people and their concerns?

Burnout, the result of working to reach unrealistic goals, is a trap more and more people are falling into. Simply put, no soul can survive striving to reach a goal, knowing it is in vain, without becoming tired and frustrated. Burnout can happen to anyone. You may be striving to be all things to all people and end up exhausting yourself in the effort to satisfy everyone.

Parents of ADHD children often find themselves trying to burn the candle at both ends. It seems the stresses and strains they endure on a daily basis go far beyond what most people are capable of coping with.

Given the above, do you experience extreme stress/burnout when it comes to parenting your ADHD child?

\_\_\_\_\_

What does extreme stress/burnout mean to you? Describe it.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please complete the following questionnaire. The answers you give on this form will be used to help therapists and psychologists to design and implement more effective interventions to help parents deal with their associated stress. Please do the best you can to answer all the questions.

Thank you for helping in this important study.

**INSTRUCTIONS: PLEASE ANSWER THE FOLLOWING QUESTIONS BY PLACING AN X IN THE APPROPRIATE COLUMN.**

**APPENDIX 5**

	YES	NO
1. It is very difficult living with an ADHD child.		
2. Their constant activity, noise, etc. is annoying.		
3. Their short attention span is frustrating.		
4. Their interrupting, calling out, and inappropriate/potentially dangerous behaviour is upsetting.		
5. Homework time is a struggle/battle.		
6. You see how different your child's behaviour is when compared to other children of the same age.		
7. Teachers complain about your child's classroom behaviour/ incompleteness of tasks.		
8. Do you avoid contact with your child's teacher because you are tired of the endless complaints.		
9. Neighbours call to tell you what your child did.		
10. Your other children/relative's children are angry with the ADHD child and want you to "make him/her stop".		
11. Your other children/relatives feel embarrassed to bring their friends home because the ADHD child will start acting out.		
12. You feel lost because you also do not understand your child's behaviour.		
13. You often get angry and frustrated with your ADHD child.		
14. Do you and your spouse disagree on how to deal with your ADHD child, e.g. one favours punishment and the other is permissive and understanding.		

	YES	NO
15. Do you or your spouse try to withdraw from confronting these problems by using work as an excuse.		
16. Do you or your spouse make excuses not to be home in the evenings.		
17. Do you or your spouse blame each other for all the problems in your home.		
18. Do you or your spouse clash with each other unnecessarily.		
19. Do you feel your family doctor who is treating your ADHD child, is not really helping.		
20. Do other family members, eg. grandparents, insist that you be more strict with your ADHD child.		
21. Do you avoid social situations, eg. shopping, restaurants, etc. because you do not want to be embarrassed by your ADHD child.		
22. Do you feel everything is becoming too much and nobody understands, nor can they help you.		
23. Is the cost of medication for your child's ADHD an added financial burden.		
24. Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out.		
25. Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child.		

**Respondent Gender**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	17	45.9	45.9	45.9
	Female	20	54.1	54.1	100.0
	Total	37	100.0	100.0	

**Q1 : It is very difficult living with an ADHD child**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	14	37.8	37.8	37.8
	No	23	62.2	62.2	100.0
	Total	37	100.0	100.0	

**Q2 : Their constant activity ,noice,etc is annoying**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	51.4	51.4	51.4
	No	18	48.6	48.6	100.0
	Total	37	100.0	100.0	

**Q3: Their short attention span is frustrating**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	20	54.1	54.1	54.1
	No	17	45.9	45.9	100.0
	Total	37	100.0	100.0	

**Q4: their interrupting calling out and inappropriate /potentially dangerous behaviour is upsetting**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	51.4	51.4	51.4
	No	18	48.6	48.6	100.0
	Total	37	100.0	100.0	

**Q5 : Homework time is a struggle / battle**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	62.2	62.2	62.2
	No	14	37.8	37.8	100.0
	Total	37	100.0	100.0	

**Q6 : You see how different your child's behaviour is when compared to other children of the same age.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	62.2	63.9	63.9
	No	13	35.1	36.1	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q7 : Teachers complain about your child's classroom behaviour / incompletion of tasks**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	51.4	51.4	51.4
	No	18	48.6	48.6	100.0
	Total	37	100.0	100.0	

**Q8 : Do you avoid contact with your child's teacher because you are tired of the endless complaints**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	13.5	13.5	13.5
	No	32	86.5	86.5	100.0
	Total	37	100.0	100.0	

**Q9 : Neighbours call to tell you what your child did**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	3	8.1	8.3	8.3
	No	33	89.2	91.7	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q10 : Your other children / relative's children are angry with the ADHD child and want you to "make him/ her stop"**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	27.0	27.8	27.8
	No	26	70.3	72.2	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q11: Your other children / relatives feel embarrassed to bring their friends home because the ADHD child will start acting out.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	13.5	13.9	13.9
	No	31	83.8	86.1	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q12 : You feel lost because you also do not understand your child's behaviour.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	24.3	24.3	24.3
	No	28	75.7	75.7	100.0
	Total	37	100.0	100.0	

**Q13: You often get angry and frustrated with your ADHD child.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	27.0	27.0	27.0
	No	27	73.0	73.0	100.0
	Total	37	100.0	100.0	

**Q14: Do you and your spouse disagree on how to deal with your ADHD child.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	29.7	30.6	30.6
	No	25	67.6	69.4	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	10.8	11.1	11.1
	No	32	86.5	88.9	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q16: Do you or your spouse make excuses not to be home in the evenings.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	32	86.5	100.0	100.0
Missing	System	5	13.5		
Total		37	100.0		

**Q17 : Do you or spouse blame each other for all the problems in your home**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	10.8	12.1	12.1
	No	29	78.4	87.9	100.0
	Total	33	89.2	100.0	
Missing	System	4	10.8		
Total		37	100.0		

**Q18 : Do you or your spouse clash with each other unnecessarily .**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	27.0	29.4	29.4
	No	24	64.9	70.6	100.0
	Total	34	91.9	100.0	
Missing	System	3	8.1		
Total		37	100.0		

**Q19 : Do you feel your family doctor who is treating your ADHD child, is not really helping .**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	13.5	14.3	14.3
	No	30	81.1	85.7	100.0
	Total	35	94.6	100.0	
Missing	System	2	5.4		
Total		37	100.0		

**Q20 : Do other family members eg, grandparents, insist that you be more strict with your ADHD child.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	21.6	22.2	22.2
	No	28	75.7	77.8	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q21: Do you avoid social situations eg: shopping, restaurants.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	10.8	11.4	11.4
	No	31	83.8	88.6	100.0
	Total	35	94.6	100.0	
Missing	System	2	5.4		
Total		37	100.0		

**Q22: Do you feel everything is becoming too much and nobody understand, nor can they help you.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	24.3	25.0	25.0
	No	27	73.0	75.0	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q23: Is the cost of medication for your child's ADHD an added financial burden.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	40.5	41.7	41.7
	No	21	56.8	58.3	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q24 : Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	27.0	27.8	27.8
	No	26	70.3	72.2	100.0
	Total	36	97.3	100.0	
Missing	System	1	2.7		
Total		37	100.0		

**Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child.**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	10.8	11.4	11.4
	No	31	83.8	88.6	100.0
	Total	35	94.6	100.0	
Missing	System	2	5.4		
Total		37	100.0		

## Comparison Descriptive Stats

## APPENDIX 7

### 1 : It is very difficult living with an ADHD child \* Respondent Gender Crosstabulation

			Respondent Gender		Total
			Male	Female	
Q1 : It is very difficult living with an ADHD child	Yes	Count	6	8	14
		% of Total	16.2%	21.6%	37.8%
	No	Count	11	12	23
		% of Total	29.7%	32.4%	62.2%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

### Q2 : Their constant activity ,noise,etc is annoying \* Respondent Gender Crosstabulation

			Respondent Gender		Total
			Male	Female	
Q2 : Their constant activity ,noise,etc is annoying	Yes	Count	7	12	19
		% of Total	18.9%	32.4%	51.4%
	No	Count	10	8	18
		% of Total	27.0%	21.6%	48.6%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

### Q3: Their short attention span is frustrating \* Respondent Gender Crosstabulation

			Respondent Gender		Total
			Male	Female	
Q3: Their short attention span is frustrating	Yes	Count	7	13	20
		% of Total	18.9%	35.1%	54.1%
	No	Count	10	7	17
		% of Total	27.0%	18.9%	45.9%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

**Q4: their interrupting calling out and inappropriate /potentially dangerous behaviour is upsetting \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q4: their interrupting calling out and inappropriate /potentially dangerous behaviour is upsetting	Yes	Count	7	12	19
		% of Total	18.9%	32.4%	51.4%
	No	Count	10	8	18
		% of Total	27.0%	21.6%	48.6%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

**Q5 : Homework time is a struggle / battle \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q5 : Homework time is a struggle / battle	Yes	Count	10	13	23
		% of Total	27.0%	35.1%	62.2%
	No	Count	7	7	14
		% of Total	18.9%	18.9%	37.8%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

**Q6 : You see how different your child's behaviour is when compared to other children of the same age. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q6 : You see how different your child's behaviour is when compared to other children of the same age.	Yes	Count	10	13	23
		% of Total	27.8%	36.1%	63.9%
	No	Count	6	7	13
		% of Total	16.7%	19.4%	36.1%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q7 : Teachers complain about your child's classroom behaviour / incompleteness of tasks \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q7 : Teachers complain about your child's classroom behaviour / incompleteness of tasks	Yes	Count	8	11	19
		% of Total	21.6%	29.7%	51.4%
	No	Count	9	9	18
		% of Total	24.3%	24.3%	48.6%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

**Q8 : Do you avoid contact with your child's teacher because you are tired of the endless complaints \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q8 : Do you avoid contact with your child's teacher because you are tired of the endless complaints	Yes	Count	2	3	5
		% of Total	5.4%	8.1%	13.5%
	No	Count	15	17	32
		% of Total	40.5%	45.9%	86.5%
Total		Count	17	20	37
		% of Total	45.9%	54.1%	100.0%

**Q9 : Neighbours call to tell you what your child did \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q9 : Neighbours call to tell you what your child did	Yes	Count	1	2	3
		% of Total	2.8%	5.6%	8.3%
	No	Count	16	17	33
		% of Total	44.4%	47.2%	91.7%
Total		Count	17	19	36
		% of Total	47.2%	52.8%	100.0%

**Q10 : Your other children / relative's children are angry with the ADHD child and want you to "make him/ her stop" \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q10 : Your other children / relative's children are angry with the ADHD child and want you to "make him/ her stop"	Yes	Count	4	6	10
		% of Total	11.1%	16.7%	27.8%
	No	Count	12	14	26
		% of Total	33.3%	38.9%	72.2%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q11: Your other children / relatives feel embarrassed to bring their friends home because the ADHD child will start acting out. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q11: Your other children / relatives feel embarrassed to bring their friends home because the ADHD child will start acting out.	Yes	Count	2	3	5
		% of Total	5.6%	8.3%	13.9%
	No	Count	14	17	31
		% of Total	38.9%	47.2%	86.1%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q12 : You feel lost because you also do not understand your child's behaviour. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q12 : You feel lost because you also do not understand your child's behaviour.	Yes	Count	4	5	9
		% of Total	10.8%	13.5%	24.3%
	No	Count	13	15	28
		% of Total	35.1%	40.5%	75.7%
Total	Count	17	20	37	
	% of Total	45.9%	54.1%	100.0%	

**Q13: You often get angry and frustrated with your ADHD child. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q13: You often get angry and frustrated with your ADHD child.	Yes	Count	3	7	10
		% of Total	8.1%	18.9%	27.0%
	No	Count	14	13	27
		% of Total	37.8%	35.1%	73.0%
Total	Count	17	20	37	
	% of Total	45.9%	54.1%	100.0%	

**Q14: Do you and your spouse disagree on how to deal with your ADHD child. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q14: Do you and your spouse disagree on how to deal with your ADHD child.	Yes	Count	6	5	11
		% of Total	16.7%	13.9%	30.6%
	No	Count	11	14	25
		% of Total	30.6%	38.9%	69.4%
Total	Count	17	19	36	
	% of Total	47.2%	52.8%	100.0%	

**Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse.	Yes	Count	2	2	4
		% of Total	5.6%	5.6%	11.1%
	No	Count	14	18	32
		% of Total	38.9%	50.0%	88.9%
Total	Count	16	20	36	
	% of Total	44.4%	55.6%	100.0%	

**Q16: Do you or your spouse make excuses not to be home in the evenings. \***  
**Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q16: Do you or your spouse make excuses not to be home in the evenings.	No	Count	14	18	32
		% of Total	43.8%	56.3%	100.0%
Total		Count	14	18	32
		% of Total	43.8%	56.3%	100.0%

**Q17 : Do you or spouse blame each other for all the problems in your home \***  
**Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q17 : Do you or spouse blame each other for all the problems in your home	Yes	Count	2	2	4
		% of Total	6.1%	6.1%	12.1%
	No	Count	12	17	29
		% of Total	36.4%	51.5%	87.9%
Total		Count	14	19	33
		% of Total	42.4%	57.6%	100.0%

**Q18 : Do you or your spouse clash with each other unnecessarily . \*** Respondent Gender Crosstabulation

			Respondent Gender		Total
			Male	Female	
Q18 : Do you or your spouse clash with each other unnecessarily .	Yes	Count	4	6	10
		% of Total	11.8%	17.6%	29.4%
	No	Count	11	13	24
		% of Total	32.4%	38.2%	70.6%
Total		Count	15	19	34
		% of Total	44.1%	55.9%	100.0%

**Q19 : Do you feel your family doctor who is treating your ADHD child, is not really helping . \*** Respondent Gender Crosstabulation

			Respondent Gender		Total
			Male	Female	
Q19 : Do you feel your family doctor who is treating your ADHD child, is not really helping .	Yes	Count	2	3	5
		% of Total	5.7%	8.6%	14.3%
	No	Count	14	16	30
		% of Total	40.0%	45.7%	85.7%
Total		Count	16	19	35
		% of Total	45.7%	54.3%	100.0%

**Q20 : Do other family members eg, grandparents, insist that you be more strict with your ADHD child. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q20 : Do other family members eg, grandparents, insist that you be more strict with your ADHD child.	Yes	Count	3	5	8
		% of Total	8.3%	13.9%	22.2%
	No	Count	13	15	28
		% of Total	36.1%	41.7%	77.8%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q21: Do you avoid social situations eg: shopping, restaurants. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q21: Do you avoid social situations eg: shopping, restaurants.	Yes	Count	1	3	4
		% of Total	2.9%	8.6%	11.4%
	No	Count	15	16	31
		% of Total	42.9%	45.7%	88.6%
Total		Count	16	19	35
		% of Total	45.7%	54.3%	100.0%

**Q22: Do you feel everything is becoming too much and nobody understand, nor can they help you. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q22: Do you feel everything is becoming too much and nobody understand, nor can they help you.	Yes	Count	3	6	9
		% of Total	8.3%	16.7%	25.0%
	No	Count	13	14	27
		% of Total	36.1%	38.9%	75.0%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q23: Is the cost of medication for your child's ADHD an added financial burden. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q23: Is the cost of medication for your child's ADHD an added financial burden.	Yes	Count	5	10	15
		% of Total	13.9%	27.8%	41.7%
	No	Count	11	10	21
		% of Total	30.6%	27.8%	58.3%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q24 : Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q24 : Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out.	Yes	Count	2	8	10
		% of Total	5.6%	22.2%	27.8%
	No	Count	14	12	26
		% of Total	38.9%	33.3%	72.2%
Total		Count	16	20	36
		% of Total	44.4%	55.6%	100.0%

**Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child. \* Respondent Gender Crosstabulation**

			Respondent Gender		Total
			Male	Female	
Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child.	Yes	Count	2	2	4
		% of Total	5.7%	5.7%	11.4%
	No	Count	13	18	31
		% of Total	37.1%	51.4%	88.6%
Total		Count	15	20	35
		% of Total	42.9%	57.1%	100.0%

## Chi-Square test for Independence

APPENDIX 8

**Q1 : It is very difficult living with an ADHD child \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.087	1	.769
Continuity Correction	.000	1	1.000
Likelihood Ratio	.087	1	.768
Linear-by-Linear Association	.084	1	.772
N of Valid Cases	37		

**Q2 : Their constant activity ,noise, etc is annoying \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.303	1	.254
Continuity Correction	.659	1	.417
Likelihood Ratio	1.311	1	.252
Linear-by-Linear Association	1.268	1	.260
N of Valid Cases	37		

**Q3: Their short attention span is frustrating \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.100	1	.147
Continuity Correction	1.250	1	.264
Likelihood Ratio	2.117	1	.146
Linear-by-Linear Association	2.043	1	.153
N of Valid Cases	37		

**Q4: their interrupting calling out and inappropriate /potentially dangerous behaviour is upsetting \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.303	1	.254
Continuity Correction	.659	1	.417
Likelihood Ratio	1.311	1	.252
Linear-by-Linear Association	1.268	1	.260
N of Valid Cases	37		

**Q5 : Homework time is a struggle / battle \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.149	1	.699
Continuity Correction	.002	1	.963
Likelihood Ratio	.149	1	.700
Linear-by-Linear Association	.145	1	.703
N of Valid Cases	37		

**Q6 : You see how different your child's behaviour is when compared to other children of the same age. \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.024 <sup>b</sup>	1	.877
Continuity Correction <sup>a</sup>	.000	1	1.000
Likelihood Ratio	.024	1	.877
Linear-by-Linear Association	.023	1	.878
N of Valid Cases	36		

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.78.

**Q7 : Teachers complain about your child's classroom behaviour / incompletion of tasks \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.232	1	.630
Continuity Correction	.023	1	.879
Likelihood Ratio	.232	1	.630
Linear-by-Linear Association	.226	1	.635
N of Valid Cases	37		

**Q8 : Do you avoid contact with your child's teacher because you are tired of the endless complaints \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.082	1	.774
Continuity Correction	.000	1	1.000
Likelihood Ratio	.083	1	.773
Linear-by-Linear Association	.080	1	.777
N of Valid Cases	37		

**Q9 : Neighbours call to tell you what your child did \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.253	1	.615
Continuity Correction	.000	1	1.000
Likelihood Ratio	.259	1	.611
Linear-by-Linear Association	.246	1	.620
N of Valid Cases	36		

**Q10 : Your other children / relative's children are angry with the ADHD child and want you to "make him/ her stop" \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.111	1	.739
Continuity Correction	.000	1	1.000
Likelihood Ratio	.111	1	.739
Linear-by-Linear Association	.108	1	.743
N of Valid Cases	36		

**Q11: Your other children / relatives feel embarrassed to bring their friends home because the ADHD child will start acting out. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.046	1	.829
Continuity Correction	.000	1	1.000
Likelihood Ratio	.047	1	.829
Linear-by-Linear Association	.045	1	.832
N of Valid Cases	36		

**Q12 : You feel lost because you also do not understand your child's behaviour. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.011	1	.917
Continuity Correction	.000	1	1.000
Likelihood Ratio	.011	1	.917
Linear-by-Linear Association	.011	1	.918
N of Valid Cases	37		

**Q13: You often get angry and frustrated with your ADHD child. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.403	1	.236
Continuity Correction	.661	1	.416
Likelihood Ratio	1.439	1	.230
Linear-by-Linear Association	1.365	1	.243
N of Valid Cases	37		

**Q14: Do you and your spouse disagree on how to deal with your ADHD child. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.341	1	.559
Continuity Correction	.049	1	.825
Likelihood Ratio	.341	1	.559
Linear-by-Linear Association	.331	1	.565
N of Valid Cases	36		

**Q15: Do you or your spouse try to withdraw from confronting these problems by using work as an excuse. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.056	1	.813
Continuity Correction	.000	1	1.000
Likelihood Ratio	.056	1	.813
Linear-by-Linear Association	.055	1	.815
N of Valid Cases	36		

**Q16: Do you or your spouse make excuses not to be home in the evenings. \* Respondent Gender**

**Q17 : Do you or spouse blame each other for all the problems in your home \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.107 <sup>b</sup>	1	.744
Continuity Correction <sup>a</sup>	.000	1	1.000
Likelihood Ratio	.106	1	.745
Linear-by-Linear Association	.104	1	.747
N of Valid Cases	33		

a. Computed only for a 2x2 table

b. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.70.

**Q18 : Do you or your spouse clash with each other unnecessarily . \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.097	1	.755
Continuity Correction	.000	1	1.000
Likelihood Ratio	.098	1	.754
Linear-by-Linear Association	.095	1	.758
N of Valid Cases	34		

**Q19 : Do you feel your family doctor who is treating your ADHD child, is not really helping . \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.077	1	.782
Continuity Correction	.000	1	1.000
Likelihood Ratio	.077	1	.781
Linear-by-Linear Association	.075	1	.785
N of Valid Cases	35		

**Q20 : Do other family members eg, grandparents, insist that you be more strict with your ADHD child. \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.201	1	.654
Continuity Correction	.002	1	.964
Likelihood Ratio	.203	1	.652
Linear-by-Linear Association	.195	1	.659
N of Valid Cases	36		

**Q21: Do you avoid social situations eg: shopping, restaurants. \* Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.781	1	.377
Continuity Correction	.123	1	.726
Likelihood Ratio	.821	1	.365
Linear-by-Linear Association	.759	1	.384
N of Valid Cases	35		

**Q22: Do you feel everything is becoming too much and nobody understand, nor can they help you. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.600	1	.439
Continuity Correction	.150	1	.699
Likelihood Ratio	.611	1	.434
Linear-by-Linear Association	.583	1	.445
N of Valid Cases	36		

**Q23: Is the cost of medication for your child's ADHD an added financial burden. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.286	1	.257
Continuity Correction	.630	1	.427
Likelihood Ratio	1.301	1	.254
Linear-by-Linear Association	1.250	1	.264
N of Valid Cases	36		

**Q24 : Has your entire life been turned upside down because of your ADHD child and you feel that you sometimes need some time-out. \* Respondent Gender**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.351	1	.067
Continuity Correction	2.120	1	.145
Likelihood Ratio	3.564	1	.059
Linear-by-Linear Association	3.258	1	.071
N of Valid Cases	36		

**Q25 : Do you feel that you are not getting enough sleep or proper meals because of your ever demanding ADHD child. \***  
**Respondent Gender**

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.094	1	.759
Continuity Correction	.000	1	1.000
Likelihood Ratio	.093	1	.760
Linear-by-Linear Association	.091	1	.762
N of Valid Cases	35		



