

Stress and Coping in Parents of Children with  
Attention Deficit Hyperactivity Disorder (ADHD)

By

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## ABSTRACT

This study examined stress and coping in parents of children with Attention Deficit Hyperactivity Disorder (ADHD). Specifically, the study examined differences in stress levels between parents of children with and without ADHD, stress based on parent gender, coping strategies used by parents of children with and without ADHD, coping strategies used by mothers and fathers, and finally, the impact of a child with ADHD on families.

Twenty-three parents of children with ADHD and 27 parents of children without ADHD were recruited through newspaper advertisements. Each group represented 15 children, 5-17 years old. Parents completed a Demographic Questionnaire, the short-form of the Conners' Parent Rating Scale – Revised (CPRS-R-SF) (Conners, 1998), the Questionnaire on Resources and Stress-Short Form (QRS-SF) (Friedrich, Greenberg, & Crinc, 1983), and the Ways of Coping Questionnaire (WOC) (Folkman & Lazarus, 1988). Ten parents of children with ADHD were interviewed about stress and coping. Interviews were recorded, transcribed, and coded using the constant comparative method.

Children with ADHD had an impact on their families. However, families appeared to be strengthened by focusing on child strengths, positive sibling relationships, teamwork and communication between spouses, and extended family interactions. Some parents felt better over time, others wished for more support. Marriages, siblings, and extended family interactions were negatively influenced by ADHD. One family's experience involved legal and social services.

Parents of children with ADHD reported more stress than parents of children without ADHD and no differences were found in stress based on parent gender. Both

findings are consistent with past research. Parent stresses included child behaviour, time demands, less time for relationships, health/diagnostic issues, finances, ADHD diagnosis, and changing stresses.

In the present study, parents coped with stress by using behaviour management, self-care, social support, focusing on positive aspects of life, seeking information, avoiding and not wishing away difficult situations. There were no parent gender or group differences based on problem- and emotion-focused strategies. Behaviour management and social support were considered effective, while losing one's temper and feel-good strategies were deemed ineffective. Only the lack of difference based on emotion-focused strategies was inconsistent with previous research.

Implications for designing family-based interventions include decreasing parent stress by improving parental coping, family relationships, social support systems, and providing individualized parent training. Despite limitations in the current study, future research must address design issues, elaborate on how parents of children with ADHD cope, and the developmental course of ADHD as it impacts families.

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## CHAPTER 1

*Introduction*

In this chapter, the concept of stress and coping will be introduced. After stress and coping are defined in general terms, Attention Deficit Hyperactivity Disorder (ADHD) will be described as the framework for stress and strain parents experience. A summary of stress research in parents of children with ADHD will be subsequently presented. In light of the limited research available on family coping with ADHD, research on coping and parents of children with other disabilities will follow. The introduction will conclude with issues and questions stemming from the reviewed literature.

The birth of a child is usually celebrated and considered a blessing. Yet, when that child is born with a disability, society, parents, and siblings may experience increased levels of stress and have difficulty coping or adjusting to the daily demands of the child. Despite the increasing research and public attention, which ADHD has received, little is known about how families are affected and cope with children with ADHD (Arcia & Fernandez, 1998).

The purpose of this study was to examine the impact on families of living with a child with ADHD. Three specific areas were examined. First, parental self-reported levels of stress were examined. The second part of the study focused on coping strategies parents used to manage stress. Lastly, the impact of a child with ADHD on their family was examined with the goal that the results on stress and coping patterns can be used to help design interventions for families that are finding adjustment to life with their child difficult.

### *Stress and Coping*

Stress had been recognized for centuries and, yet, formal research did not begin until it became important to the military during World War II and the Korean War (Lazarus & Folkman, 1984). Current definitions of stress emphasize the relationship between a person's characteristics and the characteristics of the environment. What constitutes stress is determined by the person involved (Lazarus & Folkman, 1984). Specifically, a situation is judged as stressful if the person perceives that situation as taxing or exceeding available resources.

Stress is a part of life but it is how an individual copes with it that determines human functioning (Lazarus & Folkman, 1984). Coping is defined as "constantly changing cognitive and behavioural efforts to manage specific and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping then refers to any attempt to manage stress regardless of how well it works.

Coping strategies can be problem-focused or emotion-focused. Problem-focused strategies involve actively problem-solving and seeking social support (Judge, 1998). The emphasis is on overt behaviour and dealing directly with the situation. In contrast, emotion-focused strategies may involve detachment from the situation, controlling one's feelings, wishing the problem away, and self-blame for the situation (Judge, 1998). Here the emphasis is on regulating emotion elicited by the situation. Research has found that those who consistently use problem-focused strategies, compared to emotion-focused strategies, experience less stress and psychological difficulties (Lazarus & Folkman, 1984).

Stress and coping in a general sense have been extensively researched. However, examining stress and coping within a family context is relatively new (McKenry & Price, 1994). The evolution from individual-focused research to family-focused research has been gradual (McKenry & Price, 1994). Similarly, family-focused research has emerged in the field of ADHD. Families have a variety of different coping strategies available to help them manage daily stressors (Judge, 1998). Some parents and families manage stress better than other families (Bright, Hayward, & Clements, 1997).

#### *ADHD as a Disability*

While the research on stress and coping in families of children with ADHD is limited, research on individuals with ADHD abounds. Although ADHD has received considerable attention in recent years, historically there have always been children who exhibit attention difficulties. Teachers and parents have long been aware that these children struggle at home, in school, and in society (Lerner, Lowenthal, & Lerner, 1995).

Children who can be characterized as hyperactive, unusually inattentive, and impulsive have been labelled with many terms since the 1940's. Previous labels have included 'minimal brain dysfunction,' 'brain-injured child syndrome,' 'hyperkinetic reaction of childhood,' and 'hyperactive child syndrome' (Barkley, 1998a). The current trend is to use the label, 'Attention Deficit Disorder with Hyperactivity' (Lerner et al., 1995). Barkley (1998) argues that the label changes reflect, at least to some degree, researchers' uncertainty regarding the underlying causes and diagnostic criteria for ADHD.

Presently, diagnosis of ADHD is normally based on criteria described in the American Psychiatric Association's Diagnostic and Statistical Manual IV (DSM-IV;

American Psychiatric Association [APA], 1994). The manual provides a grouped list of symptoms, of which the child must display six or more of the symptoms of inattention and/or six or more of the symptoms of hyperactivity and impulsivity (APA, 1994). Based on the DSM-IV, ADHD is divided into three subtypes: Primarily Inattentive type, Primarily Hyperactive-Impulsive type, and Combined type (APA, 1994). In addition to the symptoms, some other diagnostic criteria as follows must be met (APA, 1994):

- Symptoms must persist for at least six months at a level, which is maladaptive and inconsistent with the child's developmental level.
- Some symptoms must have been present prior to the age of seven and cause impairment in at least two settings.
- Symptoms must also be associated with significant impairment in social, academic or occupational performance.
- Diagnosis is only given when alternative causes or disorders are ruled out as the source of the symptoms.

#### *Stress Related to ADHD*

Several factors related to the nature of the ADHD itself place parents of children with ADHD under specific strain. First, impulsive behaviour, that is, acting without regard for consequences, can make it difficult for children to follow rules and learn from past experiences (Bender, 1997). Parents and other children in the family may find it difficult to understand why apparently disobedient behaviour continues to occur in the face of discipline.

Second, most children with ADHD display significant impairments in attention compared to children of the same developmental level (Runnheim, Frankenberger, &

Hazelkorn, 1996). The result is that children with ADHD do not always hear instructions or conversations, which in turn causes them to fail to respond or respond without regard to the context established by the conversation (Bender, 1997).

Third, the child's hyperactivity has the effect of creating an excessively busy environment. Parents and siblings can be annoyed by the child's behaviours (Bender, 1997). In addition, whether interacting with the overly active child or merely supervising him/her, parents become fatigued from the consistently high level of energy. Familial fatigue and annoyance may result in negative feedback, establishing a cycle where the child feels he/she cannot meet expectations (Falik, 1995).

While these factors may work to create stressful situations for families of children with ADHD, they are compounded by at least two other dimensions of the disorder. Symptoms appear to wax and wane (Fisher, 1998). Sometimes children with ADHD are able to concentrate and complete tasks quickly and correctly, yet at other times simply writing their name can take hours. This makes it very difficult for parents to set expectations for behaviour and school performance.

In addition to variations in symptomatology expression, ADHD is an invisible disorder. It is invisible in the sense that there are no physical markers indicating that an individual has a disability. Notably, individuals with ADHD may be less likely to experience negative stereotypes often associated with other disabilities, and, yet, based on appearance, would be more likely expected to pay attention and sit still like their peers. Failure to do so is attributed to a lack of motivation and effort, rather than to an innate disability. Teachers and, even parents, with limited understanding of ADHD may hold these attribution patterns.

Combined with the chronic disruptive nature of ADHD, the symptoms leave parents feeling emotionally and physically overwhelmed. The stress and strain is considerable. Parenting a child with ADHD requires continual adjustment and more skills compared to parenting a child without ADHD (Lewis-Abney, 1993). Researchers have found increased levels of stress in parents of children with ADHD, compared to parents of children without ADHD (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992; Mash & Johnston, 1983a; 1983b). Evidence also suggests that mothers report more stress than fathers do, although the difference may be small (Baker, 1994).

Child, parent, and environmental characteristics seem to be related to increased stress levels in parents of children with ADHD. Specifically, elevated levels of parental stress appear to be related to severe ADHD symptomatology and behaviour problems (Anastopoulos et al., 1992; Baldwin, Brown, & Milan, 1995). Increased parental stress also appears to be associated with psychological difficulty, poor health, alcoholism, and being a mother (Anastopoulos et al., 1992; Baker, 1994; Cantwell, 1972; Cunningham, Benness, & Siegel, 1988; Mash & Johnston, 1983a). Years married may act as a stress buffer but the results are not clear-cut (Befera & Barkley, 1985).

Finally, environmental characteristics such as informal and formal support services appear to reduce stress for parent of children with ADHD (Cunningham et al., 1988). Notably, parents may not perceive the support as helpful (Cunningham et al., 1988). Research has found mixed results regarding the role of socio-economic status (SES) and parental stress. For example, higher SES has been found to be related to increased (Baker, 1994) and decreased stress (Baldwin et al., 1995).

Several studies have also examined the impact of ADHD on family functioning (Anderson, Hindsaw, & Simmel, 1994; Fletcher, Fischer, Barkley, & Smallish, 1996; Gomez & Sanson, 1994; Johnston, 1996; Lewis-Abney, 1993). The research based on stress and associated variables or correlates as reported by parents of children with ADHD is also growing (Anastopoulos, Guevremont, Shelton, & DuPaul, 1993; Murphy & Barkley, 1996). However, few studies have considered how families cope or manage on a daily basis with the challenge of living with a child with ADHD (Kendall, 1998).

#### *Coping in the Disability Literature*

According to Lazarus and Folkman (1984) coping resources can be used to decrease a family's vulnerability to stress. However, due to the general lack of studies on children with ADHD and family coping, results from families with other disabilities will be used to gain a better understanding of coping.

Parents of children with disabilities seem to use the same number of problem solving or active strategies as parents of children without disabilities (Bright, et al., 1997). The difference appears to be in emotion-focused strategies where parents of children with disabilities use more emotion-focused strategies relative to parents of children without disabilities (Bright et al., 1997; Margalit & Ankonina, 1991). While these findings are not specific to ADHD, they suggest a pattern of results, which may fit a broad range of disabilities.

Gender differences in coping seem to have received little attention in terms of parents of children with disabilities. Mothers and fathers of children with chronic illnesses appear to use similar coping patterns (Hoekstra-Weebers, Jaspers, Kamps, & Klip, 1998; McCubbin, Nevin, Cauble, Comeau, & Patterson, 1982). Slightly different

behaviours were evident but general coping strategies were consistent across parents (Hoekstra-Weebers et al., 1998; McCubbin et al., 1982).

The use of problem-focused coping tends to be associated with lower levels of stress and better adjustment (Knussen & Sloper, 1992). In contrast, reliance on emotion-focused coping tends to be related to increased stress and poor family outcomes (Knussen & Sloper, 1992).

### *Issues to be Studied*

While the literature on stress in families of children with ADHD is far more exhaustive than the literature on coping, several holes remain. Specifically, several studies failed to include fathers (Breen & Barkley, 1988; Mash & Johnston, 1983a), use control groups (Anastopoulos et al., 1992; Baker, 1994; Baldwin et al., 1995), and focus specifically on one disability (Hanline & Daley, 1992; Judge, 1998).

Based on a review of stress and coping in families of children with ADHD, several questions remain unanswered. First, while several studies have examined stress levels in parents of children with and without ADHD, are the differences in stress levels replicable? Second, are there differences in reported stress levels for mothers and fathers? Third, do the coping strategies used by parents of children with and without ADHD differ? Fourth, are there differences in coping strategies used by mothers and fathers? And finally, how are families affected by a child with ADHD?

## CHAPTER 2

### *Review of Literature*

This chapter begins by reviewing ADHD as a disability at the individual and family levels. Stress theory is briefly reviewed as a backdrop for examining research on stress and coping in parents of children with ADHD. Correlation studies of stress involving child, parental, and environmental characteristics are examined. Next, research on differences in stress levels between parents of children with and without ADHD is presented. Also, differences in stress are considered relative to parent gender. Coping in parents of children with ADHD and other disabilities is discussed with attention to parent gender differences. As well, the relationship between stress and coping is reviewed. While noting limitations within the existing literature, the rationale, purpose, and research questions of the study are detailed.

#### *Stress and Parenting Children with Disabilities*

The effect of children on the psychological well-being of their parents has been investigated in numerous studies since the 1970's (Lavee, Sharlin, & Katz, 1996). Studies have consistently shown that parents with children living at home report more worries, distress, anxiety, depression, and less happiness or satisfaction compared to nonparents (McLanahan & Adams, 1989). However, if parenting is stressful in itself, how much more stressful is parenting a child with a disability?

A considerable body of literature has accumulated indicating that parents of children with disabilities experience increased levels of stress compared to parents of children without disabilities. Briefly, increased stress has been reported in parents of children with developmental disabilities (Boyce, Behl, Mortesen, & Akers, 1991),

Autism (Moes, Koegel, Schreiber, & Loos, 1992), externalizing behavior problems (Baker & Heller, 1996), learning disabilities (Dyson, 1996), and spina bifida (Kazac & Marvin, 1984).

### *ADHD as a Disability*

Recently, attention difficulties have become both recognized and accepted (Lerner et al., 1995). In fact, ADHD has become one of the most common diagnoses for children (Barkley, 1998b). Prevalence studies estimate that ADHD affects 3-7% of children (American Psychiatric Association; 2000; Barkley, 1998b). This prevalence rate translates into two children with ADHD behaviour patterns in each North American classroom (Barabasz & Barabasz, 1996). Many children with ADHD also have comorbid disorders such as conduct disorder, oppositional defiant disorder, learning disabilities, or central auditory processing disorder (Root & Resnick, 2003).

The etiology or cause of ADHD continues to be debated. The biological cause of ADHD remains unknown but appears to be considerably heritable (Galili-Weisstub & Segman, 2003). Reports suggest 25-33% of parents of children with ADHD have ADHD themselves (Barkley, 1998a). Some researchers believe that ADHD is caused by altered neuro-chemical activities and brain structures which control planning, organization, and self-regulation (Barabasz & Barabasz, 1996). Other researchers have proposed that ADHD results from a failure in behavioural inhibition (Barkley, 1998a). Attention Deficit Hyperactivity Disorder may arise when key brain circuits do not develop properly, perhaps because of an altered gene or genes. Other researchers consider the source of the disorder to be mismatches between the school environment/expectations and the manner

in which these children have previously learned meaningful behaviour and actions (Yelich & Salamone, 1994).

Despite the astounding speed at which genetic and biological research is developing, practitioners remain in the shadows about the underlying cause of ADHD. Yet in the mean time, the impact of ADHD on individuals has been well documented. The potentially negative impact of ADHD has prompted professionals to look beyond the individual to family and society for answers about how to help these individuals. The following section details the possible effect of ADHD on individuals.

*ADHD and the Individual.* At an individual level, children with ADHD typically have significant difficulties and impairments arising from the disorder in several settings. Academically, students with ADHD often have trouble organizing, studying, following changing class schedules, being self-reliant, and balancing social and school demands (Dielman & Franklin, 1998). Teachers rate students with ADHD as more stressful to teach than their classmates (Greene, Beszterczey, Katzenstein, Park, & Goring, 2002). Boredom, failure to attend to details, and failure to complete assignments are also problematic areas for many children with ADHD (Dielman & Franklin, 1998). This has far reaching consequences for later academic development (National Institutes of Health, 2000).

In addition, individuals are more likely to experience chronic school failure, negative peer relationships, loss of self-esteem, and alcohol and drug abuse (Barkley, 1998b). Many children with ADHD have difficulties with underachievement, learning disabilities, and long-term psychological problems. Many children with ADHD also have other behavioural problems like oppositional defiant disorder or conduct disorder

(Dielman & Franklin, 1998). These behavioural patterns may result in frequent dealings with law enforcement and social services. In brief, ADHD can have a long-term impact on academic, social, and emotional development (National Institutes of Health, 2000).

*ADHD and the Family.* Children live within family systems. These families are also affected by ADHD. For some time, researchers have acknowledged that parenting in itself is a stressful experience. Living with a child with disabilities produces unusual stressors, which require the family to make alterations to family routines (Singer, Irvin, Irvine, Hawkins, Hergeness, & Jackson, 1993). Parenting children with ADHD is no exception. Research has found that parents of children with ADHD experience substantially more stress than parents of children without ADHD (Anastopoulos et al., 1992; Sanger, MacLean, & Van Slyke, 1992).

Typical parenting styles are often ineffective for children with ADHD. If the child is the first child, parents may come to think they are bad parents (Lerner et al., 1995). On the other hand if there are older siblings, parents may begin to think the child is defective (Lerner et al., 1995). In either case, negative attributions begin to accumulate and will undoubtedly affect the child's and parent's emotional and social functioning.

Adding to the stress is the ongoing responsibility parents have. Unlike teachers and service providers, parents are responsible for their children with ADHD all day and every day (Lerner et al., 1995). In addition, because of the likely hereditary nature of ADHD, it is possible that some parents themselves have ADHD.

Children with ADHD also affect their siblings. Sibling interactions involving one child with ADHD are characterized by more conflict than normal sibling interactions (Mash & Johnston, 1983b). Siblings have also reported disruption in their lives resulting

from behaviours and symptoms related to ADHD (Kendall, 1999). This disruption creates feelings of victimization resulting from child aggression towards siblings, responsibility for care-taking involving protection, companionship, and supervision, and a sense of loss regarding the life they would never have (Kendall, 1999). Siblings may learn to cope by using aggressive retaliations, avoidance and accommodation. These coping behaviours represent a cause for concern and underline the necessity of a family approach to ADHD treatment programs, supporting the well-being of each member (Kendall, 1999).

Research suggests that these families experience increased levels of parental frustration, marital discord and divorce (National Institutes of Health, 2000). Despite the current emphasis on family-centred and ecologically oriented studies, surprisingly little is known about how families of children with ADHD adjust and manage challenges related to ADHD. Researchers are just beginning to examine family interactions in greater detail (Baker, 1994).

Relative to the history of research on stress and coping, theoretical and practical studies on family stress and coping is a relatively recent phenomenon (McCubbin, Cauble, & Patterson, 1982). The shift from individual to family-focused studies has been gradual within the general population (McKenry & Price, 1994). Notwithstanding the research attention ADHD has received, few studies have examined stress within a family context and even fewer studies have addressed coping and adaptation.

### *Stress Theory*

Research on stress and coping in families of children with disabilities fits within a larger body of research based on stress theory (McKenry & Price, 1994). One of the most common theoretical models of stress is that of Lazarus and Folkman (1984). The central

assumption of the theory is that what constitutes stress is determined by the individual (Knussen & Sloper, 1992). The stress relationship exists when demands tax or exceed an individual's resources (Lazarus, 1990). Stress involves an interaction between the individual (cognitive appraisal) and the environment (triggering event and available resources; Romano, 1992).

There are three forms of cognitive appraisal: primary, secondary, and reappraisal (Carlson, 1997). Primary appraisal determines if an event is irrelevant, positive, or stressful. If the individual perceives an event as stressful, secondary appraisals are utilized where the individual determines how to respond or cope. Additionally, secondary appraisals involve weighing the effectiveness of the coping strategy and perceived ability to implement the strategy (Carlson, 1997).

Lazarus and Folkman (1984) divide coping into two categories: active or problem-focused and emotion-focused strategies. Problem-focused coping includes active problem solving (e.g., defining the problem, evaluating alternatives, and implementing solutions) and seeking social support (Lazarus & Folkman, 1984). Problem-focused strategies tend to be associated with lower levels of stress and greater parental well-being (Knussen & Sloper, 1992).

Emotion-focused coping involves distancing oneself from the problem, self-blame, wishful thinking (that the problem would disappear), and controlling emotions (Lazarus & Folkman, 1984). These strategies are intended to reduce emotional distress, however, they are often associated with increased levels of stress and less well-being (Knussen & Sloper, 1992). However, whether or not a strategy is adaptive or maladaptive, depends on the situation (McKenry & Price, 1994). In fact, what may be

helpful in one situation could be detrimental in another situation (Knussen & Sloper, 1992). It is better to be able to access several strategies rather than rely solely on one type of response (Moos, 1986). Coping refers to what people actually do, not the resources or attributions available to them. Specifically, coping refers to efforts utilized to manage a stressor regardless of the effect (Lazarus & Folkman, 1984).

### *Stress and Coping in Parents with Children with ADHD*

Research on stress and coping in families of children with ADHD can be broadly divided into two groups. Studies on stress are primarily correlational, identifying correlates or variables related to high levels of stress. Within this group there are a variety of studies that focus on child, parental, and environmental variables. Child characteristics may include age, gender, and severity of behaviour problems. Parental characteristics may involve age, gender, marital status, use of alcohol, and health. Environmental variables involve family income, availability of information on ADHD, and availability of support services.

The second group, studies on coping, tends to be primarily correlational but there are qualitative studies. Correlational studies concentrate on identifying cognitive coping strategies associated with lower stress and better outcomes. Qualitative studies of coping provide rich descriptions of daily life from parents of children with ADHD. With this said, research on coping and ADHD is relatively rare. Many correlational studies on coping have been conducted, but to the best of my knowledge only two with families of children with ADHD. Qualitative research is also sparse and both qualitative studies were independently conducted in 1998. To gain a better understanding of family coping and

children with ADHD, studies will be reviewed from a variety of disability fields. The review begins with stress research, followed by coping literature.

### *Correlational Studies on Stress*

Studies will be reviewed according to child, parental, and environmental characteristics.

*Child Characteristics.* Specific characteristics of the child with ADHD appear to be related to increased levels of parental stress. Characteristics include the severity of the ADHD, behaviour problems, and gender. The greater the severity of the ADHD, or any disorder for that matter, the more stress parents seem to experience. Researchers have found that increased stress in mothers of children with hyperactivity was related to specific child characteristics such as distractibility and degree of bother (Mash & Johnston, 1983b).

Investigating the relationship between parenting stress and parent, child, and family-environmental variables, data from 104 mother-child pairs were analyzed by hierarchical multiple regression (Anastopoulos et al., 1992). Researchers found child characteristics of aggression, severity of ADHD, and health accounted for 43% of the variance in parenting stress while maternal characteristics of psychopathology and health status accounted for 13% of the variance in stress reported by mothers (Anastopoulos et al., 1992). Recently, Vitanza and Guarnaccia (1999) found parent stress was best predicted by how challenging child behaviours were perceived to be regardless of ADHD severity. Also, parents find children with multiple diagnoses as more stressful than children with a single diagnosis (Ross, Blanc, & McNeil, 1998; Weinstein, Apfel, & Weinstein, 1998).

In a study, which examined differences in stress between mothers and fathers of ADHD children, Baker (1994) found that there were no differences in reported child behaviours between parents, but problem behaviours did contribute significantly to parental stress. Similarly, Baldwin et al. (1995) reported the frequency of symptomatic ADHD behaviour accounted for a substantial part (18%) of overall stress reported by caregivers.

Possibly gender differences affect parent stress: mothers of girls with ADHD may report different levels of stress compared to mothers of boys with ADHD. Differences may be the result of variations in societal expectations for both the child and the parent. Due to an over representation of ADHD among boys, studies on gender differences are rare (on the child) primarily because of the difficulty in finding adequately large female samples. However, Breen and Barkley (1988) based on maternal reports detected no differences between stress levels for mothers of boys with ADHD and mothers of girls with ADHD (Breen & Barkley, 1988).

In brief, severity of ADHD symptomatology and behaviour problems (i.e., aggression, distractibility, and bother) appear to be related to higher levels of stress in mothers of children with ADHD. At this time, there do not appear to be differences in perceived stress as a result of the child's gender. The following section will address parental characteristics, which are associated with higher levels of stress in parents of ADHD children.

*Parent Characteristics.* Early in the 1970's researchers began to examine the characteristics of parents of children with ADHD. Parents of children with ADHD appeared to exhibit high levels of psychological difficulties. An early study that

compared 50 parents of boys (age 5 to 9 years old) with hyperactivity to 50 parents of boys without hyperactivity found a high rate of hysteria in mothers (Cantwell, 1972). Morrison (1980) reported similar results in a study of 140 children with hyperactivity and 91 children with psychological illnesses. Parents in both Cantwell's and Morrison's studies exhibited antisocial personalities and hysteria.

Mash and Johnston (1983a) examined stress in families of children with ADHD. Mothers of children with hyperactivity reported significantly more parenting related stress than mothers of children without hyperactivity, where higher stress was related to maternal depression, self-blame, and social isolation. Similarly, Anastopoulos et al., (1992) found psychopathology and health status accounted for 13% of the variance in stress reported by mothers. Taken together, some parents of children with ADHD experience psychological difficulty.

To further understand the impact of psychological health on stress, Cunningham et al. (1988) investigated differences between mothers and fathers of children with ADHD in terms of depression. Mothers of children with ADHD reported more depression compared to both groups of fathers and mothers of children without ADHD. Marital discord was also found to be higher in families of children with ADHD (Cunningham et al., 1988).

Some parents of children with ADHD also have problems with alcohol. As early as 1972, Cantwell reported higher alcoholism among fathers of children with hyperactivity compared to fathers of children without hyperactivity. Later, Morrison (1980) and Cunningham et al. (1988) found higher rates of alcoholism among parents of children with ADHD compared to control parents. Increased alcohol consumption has

consistently been associated with problem child behaviour for parents of children with ADHD (Pelham & Lang, 1999). Alcohol may offer temporary relief and or escape from frustrating situations and feelings of inadequacy related to parenting.

Mothers of children with disabilities often report greater stress related to parenting than fathers report. Similar patterns have been found in parents of children with ADHD. Baker (1994) looked specifically at the difference in stress reported by 20 sets of mothers and fathers of children with ADHD. Mothers of children with ADHD reported more stress compared to fathers. Nonetheless, the difference was small and accounted for little of the parenting stress variance. Fathers reported feeling less attached to their children than mothers did.

In addition, as the number of years married increased, reported parental stress decreased (Baker, 1994), suggesting that a stress buffer may develop as a result of a long-term marital relationship. However, an earlier study found more marital discord among parents of children with ADHD than parents of children without disabilities (Befera & Barkley, 1985). Yet other studies have failed to find increased discord (Cunningham et al., 1988). Further research is needed to clarify the effect of marriage on parenting stress.

Research thus suggests that parents of children with ADHD report more stress than parents of children without ADHD. Increased stress levels are associated with increased psychological difficulty, poor health, alcoholism, and being the mother. Years married may act as a stress buffer but more research is needed to clarify this finding.

*Environmental Characteristics.* Environmental conditions play a crucial role in the stress equation. Continual exposure to new or frustrating situations may use up available resources needed for daily management. In other cases the resources simply

never existed in the first place. Studies are just beginning to examine the impact of environmental variables on parental stress.

Economic resources provide families with means to secure extra services for their children. Services could include counselling, tutors, private schools, and parent training programs. Many of these services are not covered with standard health plans, so families must pay out of pocket. In some cases, families simply do not have the financial resources available and the children must go without these services. This is unfortunate because access to services has been found to decrease parental stress.

Interestingly, Baker (1994) found higher SES was related to increased parental stress. However, lower SES or financial strain has also been associated with increased parental stress (Baldwin et al., 1995). More research is needed to clarify the relationship between SES, families, and ADHD.

Besides access to formal services, parents may also access support informally through friends and family. Cunningham and colleagues (1988) examined parental stress in 52 two-parent families with and without children with ADHD. Parents of children with ADHD reported fewer contacts with extended family than parents of children without ADHD reported. Mothers of children with ADHD felt that contact experiences were less helpful than mothers of children without ADHD were.

In brief, parents are more likely to perceive increased stress when children are severely affected by ADHD and exhibit behaviour problems. Parent characteristics associated with increased stress include psychological difficulties, health problems, alcohol abuse, and being female. Evidence suggests that years married may reduce stress. Accessing formal and informal social service may decrease stress but is not always

viewed as helpful by parents. Increased stress has been associated with increased financial resources, which is contrary to most findings about SES.

*Differences in Stress Levels of Parents of Children with and without ADHD*

A direct causal link between parenting a child with ADHD and elevated stress levels has not been established (Anastopoulos et al., 1993). However, substantial correlational evidence suggests that the normal parenting process may be disrupted by the presence of a child with ADHD. A review of studies documenting differences in stress levels reported by parents of children with and without ADHD follows.

Two Canadian researchers, Mash and Johnston (1983a) examined stress in 40 families with a child with ADHD and 51 families with a child without ADHD. Mothers of children with ADHD reported significantly more stress than mothers of children without ADHD reported. Researchers found similar results in a second study examining parental stress and sibling interactions (Mash & Johnston, 1983b). Again, mothers of children with ADHD reported higher levels of stress related to parenting roles and skills compared to mothers of children without ADHD reported.

Similarly and recently, Swedish mothers of pre-schoolers with ADHD and ADHD with Oppositional Defiant Disorder reported more subjective, child rearing, attribution, and help expectation stresses compared with control mothers (Kadesjo, Stenlund, Wels, Gillberg, & Hagglof, 2002). Further, the Disruptive Behavior Stress Inventory (DBSI) distinguished not only increased stress in parents of children with ADHD compared to control parents but also increased stress in parents of children with ADHD-combined type compared to ADHD-inattentive type (Johnson & Reader, 2002).

Other studies provide indirect support of increased stress levels in parents of children with ADHD compared to parents of children without ADHD. For example, while Anastopoulos et al. (1992) failed to employ a control group for their comprehensive study examining stress in parents of children with ADHD, the stress scores on the Parent Stress Index ranged from 144 to 396 (mean=276.1, SD=47.2). These values indicate a remarkably high level of stress falling above the 90<sup>th</sup> percentile compared to norms reported by Abidin (as cited in Anastopoulos et al., 1992).

#### *Differences in Levels of Stress of Mothers Compared to Fathers*

Intuitively, information about differences in perceived stress between mothers and fathers comes from a closer examination of family roles. Traditionally, mothers have stayed at home and assumed greater responsibility for childcare (Dyson, 1997). Dyson found that typically, mothers of children with disabilities also assumed this role. However, more women are working outside the home and having fewer babies and fathers are spending more time with their children (Allen & Barber, 1994; Meyers, 1993). As a result, new family roles are being formed (Meyers, 1993).

Despite increasing interest in the role of fathers over the past twenty years there continues to be a paucity of research about fathers of children with disabilities (Young & Roopnarine, 1994). Not surprisingly, one of the major limitations of research on stress and ADHD is the blatant failure to include fathers as informants. In fact, many studies, which address the impact of having a child with ADHD on parents, typically include only mothers as informants (Mash & Johnston, 1983a). However, a few exceptions exist.

Baker (1994) examined differences in reported stress in mothers and fathers of children with ADHD. He found a small yet significant difference between maternal and

paternal self-reported stress levels. Specifically, in Baker's study mothers reported parenting their children with ADHD to be more stressful than did fathers. Baker's regression analyses suggested that parent gender contributed little to parenting stress (6%) while the child's problem behaviour, years married, and SES accounted for 45% of the variance in parent stress. Notably, Baker found that fathers reported feeling less attached to their child with ADHD compared to mothers.

Additional information comes from Mash and Johnston (1983a). They found that fathers, when compared to mothers, tended to view their child's problem behavior as less severe. It is possible, that by viewing their child's behavior as less problematic, fathers also experience less stress. Unfortunately, "due to practical limitations, only mothers" completed the questionnaire on stress (Mash & Johnston, 1983a).

Further information regarding differences between maternal and paternal stress comes from the literature on disability. Baker and Heller (1996) compared perceived stress in mothers and fathers of children with externalizing behavior problems. Baker and Heller found elevated levels of stress for mothers and fathers, yet mothers reported more stress and a need for help when externalizing behaviours were moderate and high while fathers reported increased stress and a need for help only when the child's externalizing behaviours were high. Webster-Stratton (1988) also found mothers reported more stress than did fathers in a study of children with conduct disorders.

Dyson (1997) examined parental stress, family functioning, and social support in mothers and fathers of children with and without disabilities. Dyson found that fathers of children with disabilities reported as much stress as mothers reported

In brief, to date, only limited evidence directly related to differences in stress reported by parents of children with ADHD is available. It appears that both parents typically experience stress related to their child but further research is needed to clarify differences between parents on reported stress.

### *Coping*

It has been suggested that other factors such as coping strategies and resources act as stress mediators. Coping resources are used to decrease a family's vulnerability to stress. According to Lazarus and Folkman (1984), resources may include health, problem-solving skills, perceptions of the situation, family relationships, and social support networks.

Unlike the numerous studies dealing specifically with stress in families with ADHD, the literature examining how families cope and adjust to living with a child with ADHD is sparse. In fact, only two qualitative studies (Arcia & Fernandez, 1998; Kendall, 1998), one pilot study (Bailey, Barton, & Vignola, 1999) and one study using coping as a general measure (Kadesjo et al., 2002), have been found. This dearth suggests an obvious and important area of research is awaiting exploration.

### *Coping in Parents of Children with ADHD*

A brief summary of the two studies on coping related to parenting a child with ADHD is presently provided. A pilot study, focused on maternal coping for children with ADHD found that compared to controls, mothers of children with ADHD were more likely to use indirect coping (Bailey et al., 1999). No differences in aggressive/confrontive or rational coping were found. This represents a starting point for research in this area despite the small sample size, reliance on questionnaire data, and

exclusion of fathers. More recently, Kadesjo et al. (2002) reported differences in coping for Swedish mothers of preschoolers with ADHD and ADHD-ODD relative to controls. Coping was used as a general category involving items such as 'occasional conflicts,' and 'can't handle the situation.' Coping scores were significantly higher for ADHD groups but no further analysis of types of coping was conducted.

Given the lack of literature and specific details dealing with coping in families with ADHD, a general review of coping in families with disabilities, used to guide the present research design, is provided.

#### *Differences in Coping of Parents of Children With and Without Disabilities*

As discussed in the introduction, use of problem-focused coping strategies (e.g., problem solving and seeking social support) seem to be related to better outcomes, while emotion-focused strategies (e.g., minimizing, wishful thinking, self-blame, and distancing) appear to be associated with poor outcomes. This pattern seems to hold for parents of children with disabilities.

For example, recently Judge (1998) examined the relationship between parental coping strategies and family strengths in 69 families with young children with disabilities. Family strengths referred to a sense of control over life events, seeing change as beneficial, and active management in the face of stress (Judge, 1998). Judge found that parents used a variety of coping strategies, the most common being problem-focused strategies involving seeking social support, actively solving the problem, and maintaining a positive outlook on life. In addition, social support, whether emotional or informational, was positively associated with increased family strengths. Wishful thinking, self-blame,

distancing, and self-control were negatively related to family strength. Interestingly, positive reappraisal did not predict family strengths.

The previous study is limited in that it primarily included only mothers and no control group. Interestingly, a similar study was conducted which also investigated the relationship between coping strategies and family strength in Hispanic, African-American, and Caucasian families with toddlers with and without disabilities (Hanline & Daley, 1992). Results indicated that the use of internal coping strategies (e.g., reframing and minimizing reactivity) tended to be more predictive of family strengths than social support from outside the immediate family for all three ethnic groups. No differences were found in coping strategies and family strengths for Hispanic families of children with or without disabilities. The difference between African-American families was that families of children with disabilities were more likely to access community resources than families of children without disabilities. In contrast, there were many differences between the two groups of Caucasian families. Specifically, Caucasian families of children with disabilities used more coping strategies to acquire help from the community than Caucasian families of children without disabilities. Despite the increase in coping strategies, these mothers reported less pride and accord. The strength of this study lies in its use of control groups.

Margalit and Ankonina (1991) examined 71 parent-couples with a child with disabilities and 77 parent-couples with a child without disabilities in the Tel Aviv area. Not surprisingly, the parents of children with disabilities reported more stress. What was interesting was the fact that these families had higher levels of negative affect (e.g., feeling upset, distressed, nervous, guilty, or tense), used more avoidant coping strategies,

less supportive relationships and occasions for personal growth. Neither positive affect (e.g., zest for life, active, excited, strong, energetic) nor active coping differed between the two groups.

A British study found that mothers of children with 'learning difficulties' who were single and had low self-esteem were more likely to use 'poor' coping strategies and rate program services as poor compared to mothers who were married and had higher self-esteem (Bright et al., 1997). Interestingly, all mothers used the same proportion of 'good' coping strategies. The most common 'poor' coping strategies were denying the problems, wishing away problems, and distraction techniques like alcohol use (Bright et al., 1997). Unfortunately, the authors failed to delineate what the good coping strategies were.

In sum, parents of children with disabilities seem to use the same number of problem solving or active strategies as parents of children without disabilities. However, parents of children with disabilities appear to use more emotion-focused strategies than parents of children without disabilities. With only preliminary findings related to ADHD, extrapolation from a broader pattern of results from a broad range of disabilities may be possible.

#### *Differences in Coping of Mothers Compared to Fathers*

In terms of problem- and emotion-focused coping, no differences were found in mothers and fathers of children with paediatric cancer over a one-year period (Hoekstra-Weebers et al., 1998). While the literature suggests that, in general men prefer active, problem-focused coping (Vergrugge, 1985), Folkman and Lazarus (1980) found that gender differences in coping were minimal if sources of stress (health, home, and work)

were controlled. Hoekstra-Weebers et al. (1998) found that following the severe stress of diagnosis of childhood cancer, gender differences between parents do not exist for coping strategies. However, it is important to note that a high level of emotional coping in fathers was associated with increased marital dissatisfaction. Similar patterns of coping in mothers and fathers were also reported in parents of children with cerebral palsy (McCubbin et al., 1982).

Based on the above research, it seems that at least for families of children with chronic illness, there do not appear to be gender differences in coping patterns. However, as McCubbin et al. (1982) reported, specific behaviours, which are deemed most helpful for coping, may differ for mothers and fathers.

#### *Qualitative Studies on Coping*

Many of the correlational studies on coping and stress are very well designed and have resulted in significant discoveries and contributions to the emerging field of coping in families of children with ADHD. However,

“Many paradigms involve such a complex interaction of variables that they elude quantitative techniques which reduce disparate observed phenomena to the homogeneity of traits or types” (Stenhouse, 1988).

This suggests the need for an analysis based on interviews and observations, which will provide access to global pictures of coping. Coping undoubtedly is a complicated construct or paradigm. In keeping with the philosophy of multiple sources, the present study has been designed in an attempt to validate quantitative results while adding a qualitative perspective to the coping and resiliency literature.

One qualitative study involved Cuban mothers of children with ADHD. Arcia and Fernandez (1998) interviewed seven mothers about their child's symptoms, identification, diagnosis, and school performance and the mother's relationship with school personnel, behaviour management techniques, and help-seeking behaviour. The focus of the study is on practical, every day ways of coping with ADHD.

In terms of coping strategies related to academic performance, most mothers supervised homework, employed tutors, initiated school transfers, and provided books and phonics programs (Arcia & Fernandez, 1998). Discipline or management strategies used by some mothers included behavioural strategies (token economies, time-out, and behaviour contingencies) as recommended by the diagnosing child psychologist. Other mothers tried to avoid physical punishment by providing incentives, scolding, sweet-talking, withholding privileges, shouting, and warning of impending consequences by counting. Mothers who did not rely on behaviour management strategies did not appear to have developed strategies specific to managing problems related to ADHD.

Culture played a significant role in this study of Cuban mothers. Mothers were reluctant to praise children when desirable behaviour occurred. This reluctance stems from a cultural belief that talking about it could reverse the trend and yet is diametrically opposed to behaviour principles (Arcia & Fernandez, 1998).

Medication is a common strategy used in helping parents/teachers/children cope with ADHD (Runnheim et al., 1996). Reports of medication rates for children with ADHD range from 52 to 75 % with methylphenidate as the most common drug (Harel & Brown, 2003; Robison, Sclar, Skaer, & Garlin, 1999). In the study on Cuban mothers of children with ADHD, most of the children were on, had been on, or were soon going to

be on medication (Arcia & Fernandez, 1998). The mothers had generally positive attitudes towards medication, which was sustained by teacher reported improvements.

Cuban mothers did not actively seek help until their schemas of ADHD had developed (Arcia & Fernandez, 1998). Once mothers felt their child's behaviour was not normal, they sought expert help. In several cases, services were paid out of pocket when health insurance did not cover the needed service. Mothers respected and valued the opinions of the experts but did not implement interventions, which was considered to be the job of the experts. Experts included teachers who were strict, had a plan, and gave clear suggestions for what to do at home. Teachers without plans were considered irritations.

The mother's role was to ensure that the correct experts were available and resources allotted. Cuban mothers chose to pursue expert help for the child rather than seek parental support through classes or support groups (Arcia & Fernandez, 1998). This preference for child-centred interventions has also been found in the general population (Wilson & Jennings, 1996). However, there are several types of parent-centred practices designed to help parents of children with ADHD. These include parent training, counselling, and home management (Bender, 1997).

The other qualitative study by Kendall (1998), on coping in parents of children with ADHD, interviewed 15 families. This study differs from the previous study in that it discusses coping as a cognitive process. Kendall (1998) found that parents were able to cope with ADHD by use of three processes of reinvesting. Making sense is the first process. It involved coming to understand that something was different about their child, temporary relief when the diagnosis was made, believing that if they worked hard their

child could resume normal development, becoming worn out from continual frustration/recharging cycles, and by finally relinquishing the idea that normal development was possible (Kendall, 1998).

The second process parents used was recasting biography (Kendall, 1998). It involved coming to understand their own lives and, for many parents, remembering what it was like to grow up with ADHD. Parents grieved for their child's frustrations and their own past frustrations. Many felt guilty about what they did to cause the ADHD. Initially, parents, especially mothers, were enmeshed in their children's lives. Gradually, parents were able to separate themselves and begin the process of restoring themselves.

Relinquishing the good ending is the third process parents went through in adjusting to having a child with ADHD (Kendall, 1998). Letting go of the good ending involved the belief that the child with ADHD was just like everyone else. Parents had to adjust goals they had set for their children. This varied according to values and customs of individual families. To let go parents had to let go of their biases about ADHD and put things in perspective. These processes allowed parents to come to terms with ADHD and enabled them to reinvest in their 'real' child.

The two qualitative studies on parenting children with ADHD provide a glimpse of the daily problems parents face. There is a clear sense of how difficult parenting can be and yet a sense of hope also emerges. Parents have adjusted to the demands life has thrown at them.

In brief, the qualitative studies support the use of problem-focused strategies over emotion-focused strategies in adjusting to the demands of parenting a child with ADHD.

When quantitative correlational information is combined with the rich description of the qualitative studies, a fuller picture of stress and coping in parents of ADHD emerges.

### *Relationship Between Stress and Coping*

According to stress theory (Lazarus & Folkman, 1984), coping is generally divided into active or problem-focused and emotion-focused strategies. Problem-focused strategies are usually related to lower levels of stress and well-being while emotion-focused strategies are usually related to higher levels of stress and less well-being (Knussen & Sloper, 1992). Findings from specific studies are reviewed below.

In a study of 147 mothers of adult children with developmental delays, Cameron and colleagues (Cameron, Armstrong-Stassen, Orr, & Luckas, 1991) attempted to identify coping resources and behaviours associated with lower levels of stress. They found that as the number of behaviour problems increased, maternal stress increased. Yet the severity of the handicapping condition was not related to stress. In addition, mothers with a good sense of mastery, good physical and emotional health, and financial security reported less stress. Reframing and acquiring social support were negatively related to stress. Thus, mothers who were able to reappraise the situation and secure social support reported less stress.

Similarly, in a study of mothers and fathers of children with severe physical disabilities, low levels of wishful thinking and high levels of support-seeking from informal networks was related to better outcomes for mothers (Sloper & Turner, 1993). Yet none of the coping strategies was significant predictors of paternal outcomes (e.g., life satisfaction, parental distress, and adaptation to child).

Frey, Greenberg, and Fewell (1989) found that for mothers and fathers of children with disabilities (e.g., Down's syndrome, cerebral palsy, and sensory impairments), those who were highly problem-focused, low in avoidance, and low in wishful thinking were related to positive outcomes. For mothers, positive outcomes were also related to high levels of seeking social support and low self-blame. Focusing specifically on parents of children with Down's syndrome, results suggest positive outcomes for mothers are related to high practical coping and for fathers related to low passive acceptance (Sloper, Knussen, Turner, & Cunningham, 1991).

In sum, these studies support the notion that problem-focused strategies are associated with lower levels of stress and better adjustment in parents of children with disabilities. In addition, emotion-focused strategies seem to be related to increased stress and poor family outcomes. However, it is important to note that restricted access to information and support services may limit active coping in parents (Knussen & Sloper, 1992).

#### *Limitations of the Existing Literature*

Based on the previous review, several limitations in the literature emerge: namely, the lack of control groups, paternal input, and failure to distinguish different types of disabilities. Ironically, despite the current emphasis on studying the family, many researchers continue to focus on mothers as informants.

Research on families with children with ADHD seems to be abundant (Anastopoulos et al., 1992; Baker, 1994; Breen & Barkley, 1988; Cantwell, 1972; Cunningham, Benness, & Siegel, 1988; Mash & Johnston, 1983a; 1983b; Morrison, 1980), yet many studies fail to include control groups (Anastopoulos et al., 1992; Baker,

1994; Baldwin et al., 1995). Inclusion of control groups is paramount in ascertaining whether the results represent typical or unique adaptation patterns for families of children with disabilities (Dyson, 1997).

Much of the research investigating the impact of ADHD on the family has used mothers as primary informants (Breen & Barkley, 1998; Mash & Johnston, 1983a). The neglect is so extensive that Fischer (1990) urged researchers to include fathers in future investigations. This maternal focus is not unique to the ADHD literature, rather it is found throughout the literature on children with various disabilities (Phares, 1992).

It is essential that paternal perspectives be included in studies of the family. Because each participant in research brings his/her own set of understanding and experiences to the research encounter, it is important to gather information from all possible sources. Given this obvious dearth in the literature, one of the purposes of this study will be to examine stress and coping in both mothers and fathers of children with ADHD.

In addition to the limitation in the research caused by the lack of studies on coping in families of children with ADHD, several of the studies group different types of disabilities together. For example, in a study by Judge (1998), parents of children with speech/language delays, developmentally at risk, cerebral palsy, physical/sensory impairments, and developmental delays were all grouped together to form the sample of parents of children with disabilities. Hanline and Daley (1992) used similar grouping, where children with disabilities included those with neurological impairments, genetic anomalies, sensory impairments, physical disabilities, and developmental delays. In

another case, parents of children with learning disabilities, mental retardation, and emotional/behavioural disorders were grouped together (Margalit & Ankonina, 1991).

Taking these limitations into consideration, this study will include data from both mothers and fathers of children with and without a disability. In addition, the study will address issues specifically related to only one disability, namely ADHD. Finally, the design will incorporate both quantitative and qualitative approaches during data collection and analyses.

#### *Purpose of the Study*

This study examined stress and coping in parents of children with and without ADHD. Differences in stress levels and coping were compared between groups of parents and mothers and fathers. Additionally, the family impact of a child with ADHD was explored.

#### *Importance of the Study*

The rationale behind the study is fourfold. First, based on the prevalence rates of ADHD (Barkley, 1998b) and the well documented increased stress associated with parenting children with disabilities (Baker & Heller, 1996; Boyce et al., 1991; Dyson, 1996; Kazac & Marvin, 1984; Moes et al., 1992), stress in parents of children with ADHD appears to be a widespread issue in our society. Second, perhaps for parents of children with ADHD, even understanding that their stress and coping patterns are typical of families in their situation may help to reduce some stress. Third, through understanding stress and coping better, parent-training programs may be designed or improved to meet the needs of parents, related to stress and coping. Finally, through a

better understanding of stress and coping, intervention programs for children with ADHD could specifically address issues related to parental stress.

### *Research Questions*

The study will examine stress and coping in families of children with and without ADHD. Both between- and within-group comparisons will be made. Specifically, this study will address five questions:

1. What differences, if any, are there in reported stress levels of parents of children with ADHD, compared to parents of children without ADHD?
2. What differences, if any, are there in reported stress levels of mothers, compared to fathers?
3. What differences, if any, are there in reported coping strategies of parents of children with ADHD, compared to parents of children without ADHD?
4. What differences, if any, are there in reported coping strategies of mothers, compared to fathers?
5. What, if any, is the impact of a child with ADHD upon a family as a unit?

### *Hypotheses*

It is predicted that parents of children with ADHD will report more stress than will parents of children without ADHD. The prediction is based on previous research that found elevated levels of stress in parents of children with ADHD (Anastopoulos et al., 1992; Mash & Johnston, 1983a; 1983b). Further, it is predicted that mothers will report more stress than will fathers of children with ADHD (Baker, 1994).

In terms of coping, parents of children with disabilities seem to use the same number of problem-focused but more emotion-focused coping strategies as parents of

children without disabilities (Bright et al., 1997; Margalit & Ankonina, 1991). Thus, it is predicted that parents of children with ADHD will use more emotion-focused coping strategies but similar levels of problem-focused coping strategies when compared to parents of children without ADHD. Based on the reviewed research (Hoekstra-Weebers et al., 1998; McCubbin et al., 1982), it is predicted that mothers and fathers will report similar coping patterns.

In holding with the nature of the qualitative research, no predictions will be made regarding the parents description of the impact of a child with ADHD on the family, rather, emergent themes will be identified to describe the nature of family experience with a child with ADHD.

## CHAPTER 3

*Method*

This chapter presents information regarding the participants, procedures, and instrumentation. Participants are described in terms of relevant demographic information. Procedures detail participant recruitment, data collection, and interview protocol. Instrumentation identifies the questionnaires employed and interview questions.

*Participants*

Mothers and fathers of children with ADHD and children without ADHD took part and the distribution is presented in Table 1. A total of 50 parents were included and divided into two groups: group with a child with ADHD (ADHD) and group with a child without ADHD (control). The ADHD group had 23 parents, 15 mothers and 8 fathers. The control group had 27 parents, 14 mothers and 13 fathers. Each group represented 15 children. Recruited families had a child with ADHD or a child without ADHD between 5 and 17-years-old. Participants resided in a town or city in Ontario between May 2000 and May 2002.

*Table 1*

Participants by Group and Gender

Parent	Group	
	Parents of Children with ADHD	Parents of Children without ADHD
Mothers	15	14
Fathers	8	13
Total	23	27

Table 2 summarises categorical demographic data for parents and their children. Parent data collected involved ADHD diagnosis, ADHD-like behaviour or symptoms, education, current employment status, ethnicity, marital status, and parent relationship to the child. Child data collection included additional diagnoses, ethnicity, gender, medical conditions, siblings diagnosed with ADHD, and siblings diagnoses with ADHD-like behaviour. The groups appear well matched across variables with the exception of parent and sibling related ADHD-like behaviour, and siblings with ADHD diagnosis, and additional child diagnoses. A few parents chose not to provide some demographic information, as a result not all variables equal group totals. Detailed analyses will be presented in the results section.

*Table 2*

Categorical Demographic Information on Parents and their Children

		Group ( <i>n</i> )		
Variable		Category	ADHD	Control
Parent	ADHD Diagnosis	Yes	2	0
		No	20	27
		Missing data	1	0
	ADHD-like Behaviour	Yes	9	0
		No	10	16
		Missing data	4	11
	Education	Public School/High School	10	7
		College/Technical	6	9

	Undergraduate Degree	3	3
	Graduate Degree	3	6
	Missing data	1	0
Employment	Full-time Employment	14	13
	Part-time Employment	1	4
	Self-Employed	2	4
	Stay at Home Parent	5	6
	Student	1	0
Ethnicity	Asian	0	1
	Caucasian	21	21
	Native Canadian	1	5
	Missing data	1	0
Marital status	Common law	1	0
	Divorced	1	1
	Married	16	25
	Remarried	0	1
	Separated	3	0
	Single	1	0
	Missing data	1	0
Relationship to child	Adopted	3	0
	Biological	19	26
	Boy/Girlfriend	1	0
	Step-Parent	0	1

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Child	Additional Diagnoses	Yes	12	1
		No	2	14
		Missing data	1	0
	Ethnicity	Asian	0	1
		Caucasian	13	11
		Native Canadian	2	3
	Gender	Female	4	4
		Male	11	11
	Medical Conditions	Yes	4	2
		No	10	13
		Missing data	1	0
	Siblings ADHD Diagnosis	Yes	4	0
		No	10	15
		Data Missing	1	0
	Siblings ADHD-like	Yes	4	0
Behaviour	No	9	14	
	Missing data	2	1	

Additional quantifiable data is presented in Table 3, detailing the means and standard deviations for parent and child age expressed in months, number of children in each family and the family income. Further analyses of all demographic variables will be presented in the “Results” chapter.

*Table 3*

## Descriptive Statistics for ADHD and Control Groups

Variable	ADHD			Control		
	M	SD	N	M	SD	N
Parent age (months)	508.65	83.41	23	470.78	77.10	27
Child age (months)	134.53	41.40	15	113.07	39.60	15
Number of children	2.67	1.18	15	2.87	1.30	15
Family income	62416.67	48404.47	12	60583.33	22952.36	12

*Procedure*

Parents were contacted through advertisements in the local newspapers (Guelph Mercury and Kitchener-Waterloo Record), local community information locations, and University of Guelph bulletin boards (Appendix A). Parents who indicated an interest in the study were given a brief introduction to the study over the telephone. The introductory letter, consent forms, and questionnaires were mailed to interested participants, in a self-addressed envelope. Families of children with ADHD were asked whether they were also interested in participating in an interview in order to gain more detailed information about their experiences with stress and coping. Families who failed to return their packages within two weeks were called and encouraged to complete the package. If necessary, new packages were sent.

Interviewed parents were chosen by purposive sampling to add to the understanding of the experience of parents, rather than representativeness as per other research paradigms. The results provide insight, ideas, and strategies and are not intended

to be generalizable. It is anticipated that this research will stimulate further testing of interview results.

Ten parents of children with ADHD agreed to an interview to provide greater detail about their experiences with stress and coping. One mother and one father were asked to participate as parents of a child with ADHD who was of primary, elementary, and high school age, resulting in six parents. Four additional mothers volunteered to be interviewed and were included. The purpose of the interviews was to tap into the thoughts and feelings of parents, specifically, living with a child with ADHD through intense description. Thus, the inclusion of a control group was deemed irrelevant.

Interviews were arranged at the convenience of the parents, either at the family's home or at the University of Guelph. Parents were presented with an introductory letter (Appendix B) and a consent form (Appendix C) upon arrival. Most interviews were approximately one hour. A token gift certificate (\$5) was given to parents who completed the questionnaires and the interview, to show appreciation for their time and effort.

Interviews were audio recorded. Audiotapes were transcribed verbatim and checked for accuracy by an experienced administrative assistant unfamiliar with the purpose of the study. Transcripts were coded according to themes and sub-themes. Parents received their interview transcript in a self-addressed stamped envelope. Parents had the opportunity to make adjustments or follow up with comments where necessary. Descriptions and themes were modified reflecting changes parents indicated.

#### *Instrumentation*

Parents completed a Demographic Questionnaire, the short-form of the *Conners' Parent Rating Scale – Revised* (CPRS-R-SF) (Conners, 1998), the *Questionnaire on*

*Resources and Stress-Short Form* (QRS-SF) (Friedrich, Greenberg, & Crinc, 1983), and the *Ways of Coping Questionnaire* (WOC) (Folkman & Lazarus, 1988). Ten parents of children with ADHD completed an interview on stress and coping. The ADHD group provided additional information regarding diagnosis, diagnosing professional, and date of diagnosis.

*Demographic Questionnaire.* Parents completed the Demographic Questionnaire to collect information about the family and child (Appendix D).

*Conners' Parent Rating Scale – Revised – Short Form.* The CPRS-R-SF (Conners, 1997) provided a comprehensive measure of symptoms of ADHD (Conners, Sitarenios, Parker, & Epstein, 1998). Behavior sub-scales include oppositional, cognitive problems, hyperactivity-impulsivity, anxious/shy, perfectionism, social problems, and psychosomatic. This revised scale has demonstrated good internal reliability coefficients, high test-retest reliability, and effective discriminatory power (Conners et al., 1998). Normative data was collected in Canada and the United States (Conners et al. 1998).

*Questionnaire on Resources and Stress – Short Form.* Stress and care demands were measured by the QRS-SF (Friedrich et al., 1983). The 52-item questionnaire is based on Holroyd's (1974) Questionnaire on Resources and Stress. The QRS-SF provides measures on parent and family problems, pessimism, child characteristics, and family problems. The higher the overall score, the higher the level of stress. The Kuder-Richardson-20 reliability correlation is .95. Although the QRS-SF was designed for families of children with disabilities, it has also been found reliable for families of children without disabilities (Scott, Sexton, Thompson, & Wood, 1989). Dyson (1993; 1997) has used the QRS-SF successfully in Canadian studies.

*Ways of Coping Questionnaire.* The WOC (Folkman & Lazarus, 1988) is designed to measure a range of parental coping strategies in response to difficult situations. Participants indicate on a 4-point Likert scale (e.g., 0=not used; 1=somewhat used; 2=used quite a bit; or 3=used a great deal) how often they use each coping strategy. The eight sub-scales include the following strategies: confrontive, distancing, self-controlling, seeking social support, self-blame, planned problem solving, wishful thinking, and positive reappraisal. The WOC has been used successfully in studies of parental coping in families of children with disabilities (Bright et al., 1997; Judge, 1998).

*Interview Questions.* In order to assess some of the problems and emotions in greater depth, parents were asked to discuss their experiences with stress and coping related to parenting. Wilgosh (1990) supports the combining of qualitative and quantitative techniques to better understand families of children with special needs.

Interviews took approximately one hour to complete. Parents were allowed to tell their stories in their own way, in keeping with the assumptions of qualitative research (Arcia & Fernandez, 1998). The interviewer asked each parent four standard questions (Appendix E) and prompted the parent only when necessary. Questions addressed issues of stress, coping, and the effectiveness of coping strategies in reducing stress.

This chapter summarises demographic information for the participants, procedures of recruitment, data collection, and interviewing, and describes the instruments administered. The next chapter will outline the results stemming from the analyses.

## CHAPTER 4

*Results**Data Analyses*

The results are divided into three sections: demographic data, stress and coping data, and interview data. Differences in stress between parent groups are presented, followed by analyses of reported parent coping strategies. Using interview data from parents of children with ADHD, a thematic summary of perceived parental stress, coping strategies, efficacy of coping strategies and family impact were developed.

*Demographic Information*

A wide array of demographic information was collected from families involved in the study. Quantitative data including demographic, stress and coping data were analysed with SPSS 11.0.

Pearson Chi-Square tests indicated no significant differences between groups based on parent gender, parent education level, parent ethnicity, marital status, employment status, parent relationship to child, and parents formally diagnosed with ADHD (see Table 4). Notably, there was a significant difference between groups in parents reporting ADHD-like difficulties where  $\chi^2(1, N = 35) = 10.20, p > .05$ . Nine of 19 parents of children with ADHD reported experiencing similar difficulties as their child did. No parents in the control group reported ADHD-like symptoms. Additionally, parents of children with ADHD were slightly older ( $M = 508.65$  months,  $SD = 83.41$ ) than parents of children without ADHD ( $M = 470.78$  months,  $SD = 77.10$ ) but the difference was not significant  $t(48) = 1.67, p > .05$ .

Table 4

## Chi-Square Tests of Differences between Groups on Parent's Characteristics

Demographic Characteristic	<i>n</i>	Chi Value	<i>df</i>	<i>p</i> (2-sided)
Gender of parent respondent	50	0.91	1	.34
Parent education	47	5.38	5	.37
Parent ethnicity	49	3.19	2	.20
Marital status	49	8.10	5	.15
Parent employment status	50	3.30	4	.51
Parent relationship to child	50	5.81	3	.12
Parents with ADHD	49	2.56	1	.11
Parents with ADHD-like difficulties	35	10.20	1	<.01*

\*  $p < .05$ .

Analyses of family data for each group indicated no significant differences between groups based on child ethnicity, gender, additional diagnoses, medical conditions, grade, and birth order (see Table 5). However, parents of a child with ADHD reported significantly more siblings with ADHD-like behaviour ( $\chi^2(1, N = 27) = 5.06, p > .05$ ) and ADHD diagnosis ( $\chi^2(1, N = 29) = 4.97, p > .05$ ), compared to the control parents. Further, the children with ADHD were significantly more likely to have other diagnosis in addition to ADHD ( $\chi^2(1, N = 30) = 16.43, p > .05$ ).

Independent sample 2-tailed t-tests indicated there were no significant differences between groups based on family income, number of children per family, or the age of the target child (see Table 6). Children with ADHD were slightly older ( $M = 134.53$  months,

$SD = 41.40$ ) than children without ADHD ( $M = 113.07$  months,  $SD = 39.60$ ) but the difference was not significant.

*Table 5*

Chi-Square Tests of Difference for Family Demographic Characteristics

Demographic Characteristic	<i>n</i>	Chi Value	<i>df</i>	<i>p</i> (2-sided)
Child ethnicity	30	1.37	2	.51
Child gender	30	0.00	1	1.00
Child with additional diagnoses	30	16.43	1	<.01*
Child with medical conditions	29	1.03	1	.31
Child grade	30	9.67	10	.47
Child birth order	27	2.48	4	.65
Siblings diagnosed with ADHD	29	4.97	1	.03*
Siblings with ADHD-like behaviour	27	5.06	1	.03*

\*  $p < .05$ .

*Table 6*

T-test for the Groups on Family Demographic Characteristics

Demographic Characteristic	<i>n</i>	T-value	<i>df</i>	<i>p</i>
Number of children	30	.44	28	.07
Family income	24	-.12	22	.91
Child chronological age	30	1.45	28	.16

\*  $p < .05$ .

In terms of medication, 11 of 15 (73 %) parents of children with ADHD reported their children currently taking medication to manage their ADHD symptoms. Detailed

analysis indicated that eight children were taking Ritalin/Methylphenidate, one was taking Wellbutrin, one was taking Risperidol, and one was using natural remedies.

Table 7 presents the ADHD Index scores from the CPRS-R-SF for each child in the study. The ADHD Index score for children with ADHD ( $M = 75.50, SD = 9.31$ ) was significantly higher  $t(46) = -9.19, p < .05$  than the ADHD Index score for children without ADHD ( $M = 52.54, SD = 8.14$ ).

### *Family Stress and Coping*

Parental stress was measured by the QRS and Table 8 presents the resultant total and the sub-scale scores for mothers and fathers by group. To investigate whether mothers' and fathers' perceived stress was related, I used Pearson product-moment correlation coefficients to measure the strength of association for the QRS total score. Mothers' and fathers' scores for both groups were not related on QRS total score.

Parents of children with ADHD reported more stress compared to parents of children without ADHD. The multi-variate analysis of variance (MANOVA) of QRS total score pointed to a significant main effect of group for stress,  $F(1, 46) = 61.56, p < 0.001$  with the parents of children with ADHD reporting higher stress. There was no significant interaction, between gender and group,  $F(1, 46) = 2.91, p > 0.05$  or main effect of gender,  $F(1, 46) = 1.22, p > 0.05$ . However, the mothers of children with ADHD tended to report more stress than fathers of children with ADHD but there was considerable variation for both parents.

Analysis of the sub-scales found significant group effects for parent and family problems ( $F(1, 46) = 28.05, p < 0.001$ ), pessimism ( $F(1, 46) = 65.83, p < 0.001$ ), and child characteristics ( $F(1, 46) = 35.71, p < 0.001$ ), with parents of children with ADHD

reporting more stress on these sub-scales. There was no significant group effect for physical incapacitation ( $F(1, 46) = 0.64, p > 0.05$ ). There was no significant interaction or main effect of gender for the sub-scales.

*Table 7*

ADHD Index Scores from the CPRS-R-SF for Children with and without ADHD

Child with ADHD		Child without ADHD	
Case	ADHD Index	Case	ADHD Index
1	82	16	44
2	76	17	50
3	70	18	54
4	71	19	40
5	74	20	63
6	63	21	49
7	86	22	49
8	87	23	71
9	76	24	45
10	89	25	40
11	56	26	57
12	72	27	46
13	72	28	47
14	75	29	58
15	86	30	47



Raw scores for the WOC sub-scales were computed and converted to relative scores in accordance with standard scoring procedures for the WOC. Relative scores were used as they control for unequal numbers of items within the scales and for individual differences in responding. Where data points were incomplete, the scores were prorated. Table 9 presents the means (*M*) and standard deviations (*SD*) for the WOC scales. The MANOVA of the mean relative scores of the WOC scales found no significant interaction or effect of group or gender. Visual analysis of the means and standard deviations confirm relatively flat trends in the data.

Table 9

Means (*M*) and Standard Deviations (*SD*) for WOC Scales by Group

	ADHD						Control					
	Mother		Father		Total		Mother		Father		Total	
	<i>n</i> =15		<i>n</i> = 8		<i>n</i> =23		<i>n</i> =14		<i>n</i> =13		<i>n</i> =27	
Coping Scales	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Confrontive	.12	.07	.13	.08	.12	.07	.09	.06	.11	.06	.10	.06
Distancing	.09	.07	.10	.04	.10	.06	.08	.05	.12	.05	.10	.05
Self-control	.15	.05	.18	.05	.16	.05	.16	.06	.16	.04	.16	.05
Seek Social	.15	.06	.14	.07	.15	.06	.15	.09	.12	.06	.14	.07
Responsibility	.08	.08	.08	.05	.08	.07	.10	.08	.09	.06	.09	.07
Escape-avoid	.10	.06	.07	.06	.09	.06	.07	.06	.08	.04	.07	.05
Problem solve	.17	.07	.20	.07	.18	.07	.22	.16	.18	.05	.20	.12
Reappraisal	.13	.08	.10	.07	.12	.08	.13	.07	.14	.09	.14	.08

*Analysis of Interview Data*

Qualitative data were analysed by the constant comparative method (Glaser, 1976, 1993; Glaser & Strauss, 1967). Using this method, each meaningful expression in the interview, a word, phrase, or sentence constituted a unit of analysis, which was then labelled and described. The coding process involved comparing data as the parent defined their experience according to similarities and differences. The units of analysis were coded according to sub-themes, which were then grouped according to major themes. This process was repeated until final major themes became crystallised. The author of the study conducted the coding and categorizing of 204 pages of interviews. Detailed researcher notes were kept to delineate thematic decisions.

Two coders, naive to the purposes of the study coded 30% each of the original interview data and all categories. Coder one was chosen due to her experience and sensitivity to individuals with disabilities; she has taught elementary public school for eight years and has special education training. Coder two was chosen because of limited experience with psychology and education jargon; she was a retail associate with three years of sales experience.

Point by point agreement between the author and both coders were calculated on the themes. Coders read the interviews and were permitted to ask questions regarding relationships of people within the interviews, as identifying information had been removed. For example, 'K-' was identified as the mother, 'J-' as the child and so forth. No further information was provided to coders. Next, coders were instructed to use the author's themes to categorize the interviews.

Point by point agreement between the author and both coders were good. In order, reliabilities on interview questions 1 through 4, for coder one were 71%, 91%, 88%, and 83% and coder two were 88%, 87%, 100%, and 80%.

Several themes emerged from the analysis of qualitative data. The themes are presented as follows: types of stress, coping strategies, effective and ineffective coping strategies, and the impact of ADHD on the family. Parent identification numbers (ID#) and their child's gender and age are in parenthesis following the quotes.

*Types of Stress.* In order to better understand the impact of ADHD on families, parents were asked to, 'Discuss what stresses if any, you experience related to parenting your child.' If necessary, the interviewer prompted discussion regarding child behaviour, health/diagnostic-related issues, time demands, financial strain, and/or school experiences. Parents identified several types of stress as indicted in Table 10. Stress was related to their child's behaviour, extra time demands, less time for other relationships, health related stress, finances, getting a diagnosis, changes in stress over time, and some miscellaneous issues.

Stress related to child behaviour included verbal outburst, aggressive behaviour and the effect of medication on behaviour. One parent said, "Ah, the issues at school were anything from violent outbursts to, you know, disturbing the class" (ID#3, male, age 16). Another said:

There are a few times where they forgot his medication at school ... Because when I get home from work, uhm, I would have 10 calls on there from parents and teachers, only on the days where they forgot to give him his medication. ... And

there are times like even when he is on medication that I get calls but not nearly as many (ID#5, male, age 11).

Specifically, 9 of 10 parents found their child's behaviour to be a source of stress.

*Table 10*

Types of Stress and Frequencies Identified by Parents of a Child with ADHD

Type of Stress	Frequency (n <sup>a</sup> )
Child's behaviour (verbal, aggressive, effect of medication)	9
Time demands (homework, appointments, volunteering at school)	8
Less time for other relationships (marriage/other children)	6
Health related stress (mother or child)	6
Financial stress	3
Initial diagnosis	6
Stress changes with development (i.e., relationships with teachers)	5
Miscellaneous (coping strategies)	5

<sup>a</sup> Parents could report more than one category.

Parents emphasised stress related to extra time demands. This involved one-on-one help with homework, doctor and school appointments, and regular school volunteering. Eight of ten parents reported stresses due to increased time demands. For example:

She needs more as far as, uhm, schoolwork and getting her to sit down and, and do it definitely. More so than, than B- did or, or C- did or, she definitely needs more time.... She has a real problem with her hands going everywhere so what I do is when she does her homework, I make the one hand stay. So it steadies her paper and steadies her, more focused and at the same time, writing.... "A- your

hand. A- your hand. No, no- you can't have a drink 'til this is done. No you can't go to the bathroom. Finish this mark, this question." Because it's all, if she gets, uhm, unfocused, then you'll lose her. And I - I don't allow her to get unfocused and ... her time is much more demanding whereas I can help B- with her homework at the same time as I'm making supper. You know, with A- it's one-on-one sit down (ID#1, female, age 8).

Notably within this group of parents, seven reported regular volunteering and active involvement in their local school.

Parents were also concerned by less time for other relationships. This meant less time for their other children or partner. For example, one mother said:

I enjoyed the time with him [at school] but it meant that I also had to spend t- more time at work and that would mean more time away from my other son who really suffered for J-, for J-'s sake, his ADHD. It was quite noticeable on that. He resented the time because I would coach J-'s team but I would also coach K-'s team, have to be there, say "Ok, J- focus, you look at me, now what is it we're going to do next?" And it's like "Gee, Mom you spend so much time with him." (ID#10, male, age 16).

Six parents reported less available time for relationships with other people.

Additional Health/diagnostic issues also caused stress. Parent health issues consisted of ulcerative colitis (ID#8, male, age 8), multiple sclerosis (ID#5, male, age 11), general fatigue and tension (ID#3, male, age 16) and depression (ID#6, female, age 6); child conditions consisted of allergies (ID#5, male, age 11); and sibling diagnoses such as ADHD (ID#9, female, age 17). Six parents reported health/diagnostic stresses

though three reported no health-related stress while the remaining parent made no comment.

In terms of finances, six parents claimed no financial strain associated with ADHD. One mother said, “Uhm, well we both have good jobs so a portion of it was covered through our work. We’re very fortunate; however, uhm, for those people that don’t have coverage it can be tough. It’s about a \$1000 for the assessment. Uhm, so that’s, that’s a little pricey” (ID#2, male, age 10). However, three parents did report financial strain. One family decided the best option for their son was to put him into a private school. The mother said,

Yes, putting him into private schools was very expensive. Ah, the last private school was \$35, 000 a year.... And you know you have to mortgage your house a few times over to, to do that. I mean, yes, we live in a nice house now, ah, but it’s, you know, it belongs to the school right now, uhm, yeah (ID#10, male, age 16).

Parents who were not stressed about money tended to have medical coverage through their employer while families worried about costs associated with ADHD had no coverage or made education choices resulting in increased expenses.

Not surprisingly, some stress resulted from obtaining a diagnosis of ADHD for their child. One mother illustrated her frustrations:

The stress that I encountered was mainly with not being able to get D-diagnosed.... And, no one could figure out what was wrong with him.... They had said it was bad parenting – they, that I was too lenient or else then they told me I was too strict. Ah, they told me my child ate too much junk food and I asked them to come in and view my house, to say, “Find junk food.” I never have

refined sugar in my house. I never had white flour in my house. My children were allergic to dairy products so they drank goat's milk. Uhm, they weren't allowed cookies, or pop, anything. So, I asked them how they felt that I – it was poor dieting. And that was very stressful. Because I - I don't think anybody believed me (ID#10, male, age 16).

She was not alone as 6 of 10 parents reported similar experiences.

Parent stress seemed to change over time, focusing primarily on changes in teachers as the child moved from grade to grade. One father explained how the stresses changed related to his child's school experience:

His Grade 1 teacher thought he was a disciplinary problem. Never even gave any, any credence to anything other than this, this is a bad kid and you know.... His Grade 2 teacher.... She managed to regiment his days 'cause you need that planning and the structure with an ADHD kid. But he hates her for it but he doesn't know how much she really helped him in formulating some of ... the basis for, you know, ah behavioural, in the classroom, behavioural things. And then we, we got to Grade 3.... She listened to his stories and you know she, she was just so compliant with everything that he needed and helped him with everything and, and he just loved it, you know. This year, ah, the teacher that he got, uhm, uhm, we just, ah, somehow the whole thing got off on the wrong foot. Communication died.... I'm glad that Grade 4 is over. And as F- said we're, we're going to, we're going to, ah, re-structure Grade 5 differently. Four has been, four has been a great year because of Ritalin and what he's, what he's achieved academically you know and his ability to concentrate.... So Grade 5 will be

different, hopefully. He's coming along. We have to take our, our academic successes in small steps but it's, it's coming (ID#4, male, age 10).

Five parents discussed the changing nature of stresses related to school relationships.

Parents reported both very positive and very stressful relationships with the school.

The remaining miscellaneous comments involved coping strategies, which are discussed in the ensuing section. One parent began the interview, "Uhm, I don't think there's any real, uhm, difference in stress level whether she's ADHD or uhm, it's just hard parenting children nowadays anyway. I don't really notice any, any big difference. More frustration than stress" (ID#1, female, age 8). Yet, she then discussed several stresses she experienced related to ADHD.

Thus, parents described in detail the stresses they experienced related to parenting a child with ADHD. Stresses were related to child behaviour, time demands, less time for relationships, health/diagnostic issues, finances, and getting the ADHD diagnosis. Parents also discussed the changing nature of stress as children interacted with different teachers.

*Coping Strategies.* Second, parents were asked to discuss how they coped with stress related to parenting their child with ADHD. Parents disclosed a wide range of coping strategies including behavioural management strategies and cognitive strategies (see Table 11). Cognitive strategies involved looking after themselves, social support, positive appraisal, seeking information, avoidance or wishing away, and not wishing away. Parents reported decreased stress over time and some miscellaneous minor events.

Behaviour management strategies were reported as being used by 8 of 10 parents. These strategies included prompts, monitoring behaviour, monitoring academic progress, reinforcing behaviour, and providing routines. One mother used creative prompting,

Table 11

## Coping Strategies and Frequencies Identified by Parents of a Child with ADHD

Coping Strategy	Frequency (n <sup>a</sup> )
Behavior management strategies:	
Prompting, monitoring behaviour, monitoring academic progress, providing reinforcement, providing routines	8
Cognitive strategies:	
Looking after self	9
Seeking social support	8
Using positive appraisal	7
Seeking information	5
Avoiding/wishing away	5
Not wishing away	4
Decreasing stress over time	3
Struggling with organisation	2
Miscellaneous	8

<sup>a</sup> Parents could report more than one category.

I don't say, "Are you getting dressed?" I say, "Were you able to find your socks?" "Oh, yeah." You know by his tone he's going, "Right, get the socks." Or I'll say, "Did I remember to put your pants in the drawer or are they in the basket on the floor." "Uhm, I'll check." ... It's those kinds of cues that I will give him to work up his body. "You now have socks on. How about some pants?" You know this kind of thing, and then he'll come out and he'll say, 'May I watch TV?', and I'll say, 'I can see that you brushed your teeth but, your hair, you're

having a bad hair day.’ You know, or we’ll flip it around and he’ll go ‘Ah, right, I forgot my hair.’ And back he’ll go. You know, things like that. Uhm, that, that’s what I will do to deal with the stress of knowing that he is going to forget what he is supposed to do or get distracted (ID#8, male, age 8).

Another mother coped by providing consequences for school behaviour. “She knows the consequences when she does come home that if you are out of line at school, you go to bed with no books or you don’t get to watch TV or you know things like that and she was told this” (ID#6, female, age 6). Parents used multiple components of behaviour management strategies.

The most common coping strategy used by 9 of 10 parents was to look after themselves. For some it meant time at sports or the gym (ID#8, male, age 8; ID#10, male age 16), alone (ID#2, male, age 10; ID#3, male, age 16; ID#4, male, age 10), to gain control over anger (ID#7, female, age 6), or medication (ID#9, female, age 17). One mother recognised self-care as important without specifying how or if she did (ID#5, male, age 11). Another mother felt more time with her spouse was a way to look after herself (ID#6, female, age 6). Self-care ideas were unique but the common element was time and space away from child-related stress.

Social support was also widely drawn on by parents. Eight parents found support in professionals (i.e. counsellors, psychologists, or medical doctors) and friends. As illustrated by one father,

I mean we - we went for family counselling as, as, as a family unit all four of us would go. Ah, you know we had individual counselling. We would talk to people.... Talk to our own doctors about it. We’d talk to psychologists. Uhm,

other people that we know, ah, that are involved in sort of children's programs, ah other, other parents that have had the same experience. That was one of the good things about the military academy was the fact that, ah, 85% of the kids that were going to that school had some form of ADD or ADHD.... Some kids were, had more trouble with the law, some were into hard drugs, some weren't. But basically the stories were very, very similar about the not knowing what to do and, and what worked this week didn't work next week.... Just confirmation that you know we're really not that, we're not that bad parents.... I found it helpful to focus on those other parents not in the sense of making me feel better about what I was doing, but the fact that you know some of these people just - they didn't know where to turn. And, and I found it a relief for me to go to them and say, "Yeah, we had the same problems. And, and it's not going to help the fact that it worked last week and - and you know grounding him for a week was great but next week that's not going to work" (ID#3, male, age 16).

Social support appeared to help parents feel less alone and to act as a source of confirmation of parenting ability and strategies.

Parents used positive appraisal to cope with their stress. A father commented, "call him down here right now he's going to give you all the major league scores from this afternoon.... But D-'s pretty good with, ah, one-on-one adult thing you know. He holds his own pretty good" (ID#4, male, age 10). Seven parents used positive appraisal. They focused on child accomplishments and/or strengths rather than areas of difficulty.

Half the parents sought information about ADHD. They read books and searched the Internet.

I looked everywhere for information.... I searched libraries.... I needed something current because I also needed to know what was wrong with him. Ah, but I needed know, to know, I needed to know more information, because for me knowledge is power. The more knowledge I had, even the pros and cons, the better I was able to deal with J- (ID#10, male, age 16).

Thorough searches armed this mother with information, which helped her understand her son's behaviour and equipped her to help him.

Some parents avoided or wished away stress. "And then I started picking her up at the, uhm, the side of the school there. I would just park on the road and she would come up because I had gotten to the point where I'm just really fed up with this and I don't want to hear any more" (ID#6, female, age 6). This mother avoided daily school reports on her daughter. In all, five parents used avoidance or wished away stressful encounters. Interestingly, some parents said they never wished away stressful situations. These four parents accepted responsibility and dealt directly with ADHD related issues.

Uhm, I guess there's days that I may have said, "What would it be like if he didn't have ADHD?" Uhm, but I don't ever say, "I'm not going to school because I don't feel like it." He's my drive. He's my ambition. Uhm, I can't give up because I'd be giving up on him and for that... (ID#2, male age 10).

This mother admits wondering about life without ADHD and although she gets tired, she always tries to deal directly with the situation. Parent feelings may be similar to those in the avoid/wish away group but these parents appeared focused on addressing stressful issues.

A few parents reported stress decreased gradually over time. One mother noted that, “But she’s just sort of coming out of it now where she is, she is having better days” (ID#6, female, age 6). While ADHD created a lot of stress for this family, the mother felt they were making progress and improving. Two other parents felt stress declined over time.

Two mothers recognised that they themselves had difficulty with organisation. They recognised the importance of organisation in helping their child manage but struggled to keep on top of it, as illustrated by:

And knowing that I have to buy five of everything so I can find one. Kind of demanding.... Like, like, I’m for myself like it’s a I - that’s why like I didn’t have you over at my house to do the survey, my house is a mess. I just can’t keep up with it. I can’t keep things organized (ID#9, female age 17).

Creating order and structure was identified as a good strategy, but one which they struggled to implement.

Additionally, miscellaneous comments from this section focused on stress or unique coping strategies. In summary, parents employed a range of coping strategies including behaviour management strategies, looking after themselves, seeking social support, focusing on positives, seeking information, avoidance/wish away, and not wishing away difficult situations. A few parents also reported decreased stress over time and difficulty staying organized. The next section focuses on parent perception of the effectiveness of the coping strategies.

*Effective and Ineffective coping Strategies.* Next, parents discussed, “In your experience are some coping strategies, if any, more effective or better than others are at

reducing stress?” Parents identified two groups of effective coping strategies: behavioural management strategies and seeking social support. Two groups of ineffective coping strategies consisted of losing your temper and emotional/feel-good strategies. Table 12 presents a summary of effective and ineffective coping strategies.

Most parents (90%) reported behavioural management strategies to be effective. This included breaking down tasks, prompting, ignoring undesired behaviour, reinforcing desired behaviour, removing desired item, and choosing enforceable goals. Parents provided many examples of implemented behavioural strategies. For instance, “He gets timed, timeout. He does respond to that. That’s only because you’ve taken him away from the bad situation. Now he can get his brain wrapped around things, calm himself down and start all over again” (ID#2, male, age 10). Some parents adjusted their approach to be age-appropriate as illustrated by this mother,

I was counting. One, two, three.... You know like, I thought at that point he was outgrowing that because he’s gonna be 12. So what I say is uhm, chill, chill, chill. So he knows by that that uhm, I am counting and that he's not really being centred out in front of his, his buddies (ID#5, male, age 11).

Parents generally mentioned using several elements of behaviour strategy.

Social support was the other coping strategy parents contended was effective. As expressed by this mother, “Okay, the most helpful was, was talking to people.... Because the information was there and if I didn’t understand what I, what I got, or else I did understand it and it scared me, I could talk to people about it” (ID#10, male, age 16).

Three parents found discussing ADHD an effective means of coping with stress.

Table 12

Effective and Ineffective Coping Strategies and Frequencies Identified by Parents of a Child with ADHD

<i>Coping Strategies</i>	Frequency (n <sup>a</sup> )
Effective – using behavioural management strategies:	9
Chunking, ignoring undesired behaviour, removing reinforcement opportunities, removing desired items, prompting/supporting success, choosing enforceable goals	
Effective – seeking social support	3
Ineffective – losing temper	4
Ineffective – using emotional/feel good strategies:	4
Siblings helping with homework, talking, being nice, providing choices	
Miscellaneous	6

<sup>a</sup>Parents could report more than one category.

Parents also discussed ineffective coping strategies. Four parents found getting angry or losing their temper as ineffective. One mother explained,

As much as you want to, you know as much as you want to yell sometimes, what you gonna do? It's not going to help them, it's not going to change that. It might make you feel better and I've been there, done that. And it only makes me feel better so that's kind of useless (ID#2, male, age 10).

Parents recognised they did yell, in some cases hurting the child's feelings, yet creating no change in child behaviour, and thereby deemed yelling ineffective. Another ineffective coping strategy consisted of emotional or feel-good strategies. This involved

getting siblings to help with homework (ID#1, female, age 8), talking to the child (ID#5, male, age 11), being nice (ID#9, female, age 17) and providing choices (ID no 10, male, age 16). On the surface, these strategies appeared 'nice' but they did not reduce stress.

Interestingly, while parents reported using many coping strategies, they reported only behaviour management strategies and social support to be effective. Losing one's temper and feel-good strategies were found ineffective by some parents and were not reported as coping strategies in the previous section of the interview. Three parents had difficulty thinking of ineffective strategies they had used and did not comment.

*The Impact of ADHD on Families.* Parents discussed how their child with ADHD impacted their family. Discussion separated broadly into two overarching themes, those which acted to strengthen their family and those which caused parents concern (Table 13).

*The Impact of ADHD on Families: Strengths.* Parents discussed five main themes that supported their family. These involved focusing on child strengths, parents feeling better over time, positive sibling relationships, marriage commitment to communication and teamwork, and extended family involvement.

Parents clearly emphasised their child's strengths. Six parents saw and concentrated on the gifts their children brought to their family and social setting. This is clearly illustrated by two fathers, "She loves to read so, which is promising.... She likes reading more than anything." (ID#7, female, age 6) and,

Table 13

## Family Impact Themes and Frequencies Identified by Parents of a Child with ADHD

Family Impact	Frequency (n <sup>a</sup> )
<b>Strengths:</b>	
Focus on child strengths	6
Parents feel better over time	6
Positive sibling relationship	5
Marriage commitment and teamwork	5
Extended family involvement	4
<b>Concerns:</b>	
Negative effect on marriage (e.g., initial stress, less time, unsupportive marriage)	6
Negative effect on siblings (e.g., conflict, less time, extra responsibility)	6
Limited extended family involvement	5
More general support desired	5
Complicated negative effects (e.g., move & law)	2
Miscellaneous	5

<sup>a</sup> Parents could report more than one category

The gift syndrome too as well. You know I mean you can look at things as being, a, you know, a detriment but it's, it's been a, it's been a boon to the family – it pulls everybody together, and you act- as a common cause and all that nonsense.... But he's creative and you know just, just entertaining and nice to be

around. You know. He's, he's so appreciative.... He responds to, you know, ah, he understands what we're all up against and you know he responds to that so. It's like being rewarded everyday that that he's here you know. He's, he just personally rewards you for all your effort you know (ID#4, male, age 10).

Parents definitely focused on the positive strengths of their children.

Gradually parents began to feel better, as shared by six parents. One mother thought that, "it's gotten better, not worse just because of the way we deal with it and we don't make it stressful. He's certainly our joy; he really is" (ID#2, male, age 10). Child behaviour showed some improvements, effective routines were implemented, and parents used their knowledge gained from other parents, increasing a sense of successful coping.

The lives of siblings are also impacted by ADHD. Five parents reported good sibling relationships (two parents had an only child). One father explained:

They get along really, really well.... His comprehension, his life skills and things like that they're, they're advanced for nine. You know his size is advanced for nine, too, as well. So that's helped nip the four-year difference between the two. And of course E-'s [sibling] just one of those calm laid-back kids and, ah, you know it's just been a perfect combination of you know one off setting the other kinda thing (ID#4, male, age 10).

Parents were encouraged by and proud of positive sibling relationships.

Marriage relationships appeared supportive at the time of the interviews. This is clearly demonstrated in the supportive interactions between a divorced couple:

There are times when I talk to him on the phone and he's had a bad day with E- and, and you know, I console him. You know just try to be, you know, calm down

and there are a lot of times, you know, where he says to me, you know, where, where he can, uhm, be consoling to me, like it's, you know, a, we're very amicable that way where, you know, we do realise that our son does require a little bit more (ID#5, male, age 11).

Five parents spoke of commitment to communication and teamwork.

Finally, in terms of strength, some families found support in their extended family interactions. Four parents reported similar assistance and involvement as this family:

Uhm, it's very hard on my mom.... She used to baby-sit for K- and I when we would be able to go away.... My brother was really good. He understood J-....

My younger sister is a teacher. She was wonderful with J- (ID#10, male, age 16).

Parents identified five family strengthening themes. Parents concentrated on their child's abilities and gifts rather than shortfalls. Parents in this study felt better over time, giving hope to other parents of children with ADHD. Families were further strengthened through positive sibling relationships, commitment between spouses to communication and teamwork, and interaction with extended family.

*The Impact of ADHD on Families: Concerns.* Parents expressed concern about several areas of their family-life as a result of ADHD. Notably, parents appeared concerned but not alarmed or panicked about these issues. Concerns centred around the negative effects on the marriage relationship, negative effects on siblings, wishing for more support, limited extended family involvement, and complicated negative effects.

Some parents felt ADHD impacted them by creating strain on their marital relationships. Initially during early stages of dealing with their child's ADHD, three parents felt increased stress on their marriage. One mother commented, "And then when

she came along it was like very difficult for us in the beginning but now, no, we've been married like 13 years. So it's, we, we get along well, we get along really well" (ID#6, female, age 6). Additional time demands on parents, stemming from helping their child with ADHD, left a few parents wishing for more time to spend with their spouse. One mother shared that both she and her husband were "tired and stressed about the children," (ID#8, male, age 8) and she wished for more time with her husband. Strikingly and encouragingly, except for one case of a totally non-supportive ex-spouse relationship (ID#10, male, age 16), parent relationships appeared positive having survived initial stresses and presently focused on communication and teamwork, with a wish for more time with their spouse.

Parents also worried about sibling relationships. Conflicts occurred in the form of arguments, teasing, and frustration. For example, one mother worried about how the child-sibling relationships were faring because "when he is angry and, and you know when he picks on them ... he doesn't always let something go" (ID#8, male, age 8). Undoubtedly, repeated conflicts beyond that of typical sibling difficulty could potentially damage the sibling relationship. Extra sibling responsibilities also concerned parents.

Uhm, but it's been a big responsibility for him [the sibling]. He's felt responsible for him at school. We didn't put that on him, he kind of took that on himself.

Uhm, and there are times when if we're kind of stressed we'll ask C- to hang with him [the child] for a while or you know go outside with him. But I think it's, it's probably played a pretty big impact on C- (ID#2, male, age 10).

Further, two parents were troubled by having less time for their other children resulting from increased time demands associated with parenting a child with ADHD. One mother

felt the impact was “pretty major. I feel very bad because I think it has taken our time away from C- although C-'s very well adjusted. Uhm, didn't need the extra attention, didn't need the extra support for homework. Uhm. We're very, very fortunate” (ID#2, male, age 10). In short, although parents reported good relationships among siblings there was some conflict. Parental apprehension also included extra sibling responsibility and available parent-sibling time.

In terms of extended family, five parents reported little or minimal involvement. One mother illustrated,

Well, I never had really the support of my family as far as once he started walking. Uhm, I've never had them to baby-sit or whatever because they could never deal with that. Uhm. Ah, uhm I think, I think they may, bas - basically just confirmed that B- was different somehow but not in a way that they have been uhm, uhm, supportive. I guess they basically kind of left me alone with my problem (ID#5, male, age 11).

Interestingly, none of the parents reporting little extended family involvement expressed a desire for more interaction with their extended family. However, half the parents wished for more support in general. The source of support appeared unimportant. Although some parents reported receiving some social support, a sense of aloneness was evident. “Yeah, I think I - I have felt all alone with it for the longest time but then I realised that I'm his mother and if I do not do it for him, who is?” (ID#5, male, age 11). While a few desired social support, others wished for support in the form of clearer information throughout the journey for themselves and for other parents as well.

While the previous four thematic concerns must be taken seriously, unfortunately some family experiences are cause for alarm rather than concern. For one family, the mother and father faced several serious family crises as a consequence of their son's actions. Their sixteen-year-old son was involved with alcohol, drugs, and problems with law enforcement.

I mean has C- had a, a negative effect on the family? Yes. Uhm, the fact that C- has needed so much attention has had an effect on our family as a whole.... More recently with ah C- rebelling and leaving home and getting involved with drugs and stuff like that, yeah, I mean that's had a real psychological impact on, on, on everybody. Uhm, to the point where last year, ah, I mean 'cause we'd had the house broken into and all this kind of stuff where E- said, "We have to move. We have to get out of here." ... We ended up with, you know, unlisted numbers and all this kind of stuff and, uhm, C- was in detention (ID#3, male, age 16).

Consequently, the child no longer lived at home and the parents wrote letters, which were delivered through the probation officer. At the time of the study, these parents had moved from the 'alarm' stage to 'concern' where there remained hope for help through drug counselling and community support services.

Finally, there were a variety of comments, which did not fit any pattern or theme. These involved a range of topics such as receiving the diagnosis helped a parent understand child behaviour (ID#1, female, age 8), desire for a normal life for their child (ID#5, male, age 11), concerns regarding child friendships (ID#7, female, age 6), and how their faith brought them through (ID#10, male, age 16).

Briefly, parent concerns focused on their strained marital relationship, negative interactions between siblings, a lack of support from extended family, and a desire for more general support. One family shared their experience of a very difficult journey with their son involving legal and social services.

The impact of a child with ADHD on their family is undoubted. Families were strengthened by focusing on their child's abilities and skills, understanding sibling relationships, commitment and teamwork within their marriages, and extended family involvement. Other parents beginning their journey with ADHD can take encouragement from the fact that over time parents reported feeling better. Parents were concerned but not alarmed by the negative role ADHD appeared to play in sibling relationships in terms of conflict, less parent-sibling time, and extra responsibilities. Some parents, after surviving initial stresses, wished for more time with their spouse. Some families experienced limited contact with extended family. One family encountered serious negative events related to their child with ADHD. Parents wished for more support. The complex and interactive nature of families is clear.

#### *Chapter Summary*

In summary, quantitative and qualitative results suggest families are impacted by ADHD, resulting in parental stress and use of coping strategies. More stress was reported by parents of children with ADHD compared to parents of children without ADHD but no differences in coping were found based on parent group or gender. In terms of family impact, parents felt families were strengthened by focusing on their child's abilities, understanding sibling relationships, spouses committed to communication and teamwork, and extended family involvement. Encouragingly, parents claimed to feel better over

time. Parents were concerned by the negative impact ADHD had on marriage, sibling interactions, and extended family involvement, creating a desire for more support. One family experienced a more intense level of concern involving legal and social services. Specific parent stresses pertained to child behaviour, time demands, less time for relationships, health/diagnostic issues, finances, getting the ADHD diagnosis, and the changing nature of their situation. Parent coping strategies included behaviour management strategies, looking after themselves, seeking social support, using positive appraisals, seeking information, avoidance/wish away, and not wishing away difficult situations. For a few parents stress decreased over time but some had difficulty organizing themselves. While many coping strategies were identified, parents indicated only behaviour management strategies and social support as effective. Although difficult to identify, ineffective strategies were losing one's temper and feel-good strategies.

## CHAPTER 5

*Discussion*

To reiterate, the purpose of this study was to examine stress and coping in parents of children with and without ADHD. Additionally, the impact of a child with ADHD on the family was investigated through qualitative interviews. Parents of children with ADHD have consistently reported high levels of stress (Baker, 1994) which, when combined with an understanding of how these parents cope with stress, may lead to improved family-based interventions. This chapter begins by examining the quantitative differences in stress and coping. Discussion of the qualitative parental reports of stresses, coping strategies and effectiveness, and the affect of a child with ADHD on the family unit follows. Subsequently, possible applications are suggested, concluding with limitations and suggestions for future research.

*Quantitative Results: Stress*

According to Lazarus and Folkman (1984; 1990), stress exists when an individual perceives that demands exceed resources. For families with a child with ADHD, triggering events appear more frequently and sometimes exceed available resources. Group and gender differences in parent-reported stresses are discussed as they relate to earlier research.

*Group Differences in Stress.* It was hypothesized that parents of children with ADHD would report more stress compared to parents of children without ADHD. Consistent with the hypothesis for this study, parents of children with ADHD reported more stress than parents of children without ADHD. Not only are these results consistent with reports of increased stress among parents of children with a variety of disabilities

(Baker & Heller, 1996; Boyce et al., 1991; Dyson, 1996; Kazac & Marvin, 1984; Moes et al., 1992) but they are also congruent with the finding that parents of children with ADHD reported more stress than parents of children without ADHD and normative samples (Anastopoulos et al., 1992; Breen & Barkley, 1988; Johnson & Reader, 2002; Mash & Johnston, 1983a).

More detailed analyses of present stress scores revealed that parents of children with ADHD reported elevated stress related to parent and family problems, pessimism, and child characteristics. Present results are similar to past research showing increased stress related to greater parental and family issues of depression, self-blame, social isolation, help expectations, and poor parenting skills as well as child characteristics such as distractibility, degree of bother, oppositional-defiant behaviour, and ADHD sub-types (Anastopoulos et al., 1992; Baldwin et al., 1995; Breen & Barkley, 1988; Kadesjo et al., 2002; Johnson & Reader, 2002; Mash & Johnston, 1983a).

The sub-scale physical incapacitation did not differentiate parent groups. This was anticipated given ADHD is not associated with physical disability.

*Parent Gender Differences in Stress.* Another purpose of this study was to learn more about paternal experience in view of the fact that much of the research on stress and ADHD has neglected fathers (Baker, 1994). An attempt was made to explore paternal and maternal roles as they related to stress and ADHD. It was hypothesized that mothers would report more stress than would fathers of children with ADHD (Baker). Although not significant in this investigation, mothers of children with ADHD tended to report more stress than fathers of children with ADHD but there was considerable variation for both parents. There were no significant gender differences for control parents either, with

practically equal stress reported by both parents, but there were large variations. Baker found a small but significant difference between mothers and fathers of children with ADHD, with mothers reporting higher levels of stress. Failure in the present study to find gender differences in stress may be due to the small sample size.

Thus, an elevated level of stress in parents of children with ADHD found in this study is consistent with past research. Significant gender differences were not identified in the present sample but tended in a direction similar to Baker's (1994) results.

The next section provides a detailed discussion of the coping strategies used by parents of children with ADHD.

#### *Quantitative Results: Coping*

Concerning coping, problem-focused coping strategies appear related to better outcomes while emotion-focused coping strategies appear to be linked to poor outcomes. The pattern seems true for parents of children with disabilities. Regardless of the focus on parental stress and ADHD, less attention has addressed how parents manage increased stress. Next, group and gender differences in parental coping are compared to prior research.

*Group Differences in Coping.* It was hypothesized that parents of children with ADHD would utilize more emotion-focused coping strategies but similar levels of problem-focused coping strategies when compared to parents of children without ADHD. In this study, no significant differences were found for interaction, group or gender on any of the eight WOC sub-scales. Moreover, visual analysis of the means and standard deviations verified a flat trend across the data, conceivably accounted for by missing data and small sample size. To the best of the author's knowledge, two studies on coping in

parents of children with ADHD preliminarily suggest that some differences in coping between groups of parents may exist (Bailey et al., 1999; Kadesjo et al., 2002). However, Kadesjo et al. failed to analyse in detail the differences in coping and Bailey et al. examined only three types of coping.

Research on parents of children with other disabilities provides necessary clarification. There are two main results. First, compared to control parents, parents of children with other disabilities use more emotion-focused strategies such as negative affect and avoidance, have less supportive relationships, and have fewer opportunities for personal growth (Margalit & Ankonina, 1991). Also, in a multicultural study, Hanline and Daley (1992) found significant differences between Caucasian parents of children with and without disabilities yet few differences in groups of parents from Hispanic and African American cultures. Second, all parents appear to use the same proportion of 'good' coping strategies such as positive affect and active coping (Bright et al., 1997; Margalit & Ankonina, 1991).

Comparing the present results to past research, the finding of no differences between parent groups in problem-focused strategies are consistent with prior research while the finding of no differences in emotion-focused strategies are not consistent with previous research.

*Parent Gender Differences.* Some preference in men for active, problem-focused coping has been documented (Vergrugge, 1985) although when sources of stress are controlled, gender difference appears to be minimal (Folkman & Lazarus, 1980). It was predicted that mothers and fathers would report similar coping patterns. The present study did not find differences in coping based on parent gender, which is consistent with

studies of children with paediatric cancer (Hoekstra-Weebers et al., 1998) and cerebral palsy (McCubbin et al., 1982). Thus, given the consistency between current results and previous research there seem to be no differences in coping based on gender for parents of children with disabilities.

In sum, the lack of gender differences is congruent with prior research, as is the lack of group difference for problem-focused strategies. Nonetheless, previous research suggests differences in emotion-focused strategies between parents of children with disabilities and parents of children without disabilities, which was not seen in this study.

Next, emergent themes from interviews with parents of children with ADHD are explored.

#### *Qualitative Data from Interviews*

The final aim of the study was to gain a better understanding of the impact of a child with ADHD on the family unit. Parents discussed stresses, coping strategies, effectiveness of coping strategies, and how his/her child with ADHD affected the family unit. Given the exploratory nature of this question no predictions were made but the results are related to previous research as follows.

*Types of stress.* Parents in this study reported stress related to child behaviour, extra time demands, less time for other relationships, health issues, finances, initial diagnosis, and changes over time.

Most parents in this study identified child behaviour (such as verbal outbursts, aggression, and effect of medication) as stressful. Previously, severity of ADHD symptomatology and behaviour problems (i.e., aggression, distractibility, and bother) has been related to higher levels of stress in parents of children with ADHD (Anastopoulos et

al., 1992; Baker, 1994; Baldwin et al., 1995; Mash & Johnston, 1983b; Vitanza & Guarnaccia, 1999). Evidence also indicates parents of children with multiple diagnoses experience more stress than mothers of children with a single diagnosis (Ross et al., 1998; Weinstein et al., 1998).

Most parents in this study reported increased stress due to extra time demands. This involved one-on-one homework time, appointments, and regularly volunteering at their child's school. These comments directly align with work by Arcia and Fernandez (1998), who found that most mothers supervised homework, employed tutors, initiated school transfers, provided books, and phonics programs.

With these additional time demands, present parents were consequently also stressed by having less time for relationships with other children, spouses, and friends. Less time available for social interaction decreases the opportunities for support, which is a concern, given the vital role social support plays in coping with stress (Judge, 1998). Social support is discussed in greater detail as a coping mechanism in the following section.

Health and diagnostic issues acted as additional stressors regardless of whether they affected the parent or child. Psychological distress (e.g., anti-social behaviour, depression, and social isolation) and health issues seem related to elevated parental stress (Anastopoulos et al., 1992; Cantwell, 1972; Mash & Johnston, 1983a; Morrison, 1980). Parents did not discuss alcoholism in this study, which was raised in other studies as a concern (Cantwell, 1972; Cunningham et al., 1988; Morrison, 1980; Pelham & Lang, 1999). This may have been due to the interview format. Although one father disclosed that alcohol was a problem prior to his family life, he had subsequently been to

counselling which had changed his life. Parents seemed comfortable with the interview process, evident in the disclosure of other personal details.

Some parents reported financial stress. Either they did not have medical plans through their employment or chose private education options. Remaining parents reported no financial stress. Mixed results with respect to finances have been reported elsewhere. Baker (1994) found higher SES related to increased stress but Baldwin et al. (1995) found that lower SES was related to increased stress. Further information is needed to understand the relationship between SES, families, and ADHD.

Parents found that the diagnosis process was stressful. Unfortunately, this is a common experience as parents try to make sense of their child's behaviour (Arcia & Fernandez, 1998) and put support plans into motion. Once the diagnosis is obtained, there appears to be a period of relief (Kendall, 1998).

Stress changed over time. Not surprisingly, as children attained new developmental and academic milestones parents faced new stresses. New phases also introduced new professionals, with whom new relationships needed to be formed. Viewing ADHD in terms of developmental process is hardly new but there appears to be limited understanding regarding underlying developmental mechanisms and pathways (Johnston & Mash, 2001).

In the present study parents detailed stresses they experienced related to parenting a child with ADHD. Stresses related to child behaviour, time demands, less time for relationships, health/diagnostic issues, and getting the ADHD diagnosis are congruent with previous research. Nonetheless, evidence points to the need for further research

attention with respect to the changing nature of stress, the role of finances, and child health issues. Next, parents identified a range of coping strategies they employed.

*Types of Coping Strategies.* Coping strategies and resources are used to reduce or moderate stress. The present sample of parents identified many behavioural management and cognitive strategies including social support, self-care, positive appraisal, seeking information, avoidance, and not wishing away.

In terms of behavior management, Arcia and Fernandez (1998) found that mothers of children with ADHD used components of behavioural strategies. This is not surprising given the prevalence of behavior-based interventions for children with ADHD and their well-documented efficacy (Root & Resnick, 2003). Thus, behavioural components are likely to be part of any clinician's treatment recommendations. Two parents in the study admitted that they were having difficulty with their own organization and were concerned that their disorganization affected their child's ability to manage. Given the hereditary nature of ADHD (Galili-Weisstub & Segman, 2003), it is to be expected that some parents will struggle with ADHD symptoms, such as disorganization, thus making it difficult for that parent to provide organized, structured interventions for his or her child.

Most children (73%) in this study used medication to manage their ADHD. Their parents vigilantly monitored medication effectiveness and side effects. Specifically, eight children took Ritalin/Methylphenidate, one took Wellbutrin, one took Risperidol, and one received natural remedies. These results are consistent with past studies reporting 52-75% of children with ADHD receive medication, mostly methylphenidate (Harel & Brown, 2003; Robison et al., 1999).

In the present study, parent self-care meant time and space away from child-related stress. Kendall (1998) found that, over time, parents became less enmeshed with their children. Seeing oneself as an individual with corresponding needs separate from the child may be the first step in learning to look after themselves as parents.

Social support involves seeking out and maintaining contact with friends and professionals. In the current study, parents found peers, relatives, plus a range of professionals to be supportive. Several parents repeated this theme as the interviews concluded and expressed a desire for more social support. Social support acted to combat loneliness and confirmed parenting strategies.

Positive appraisal refers to how parents frame their experiences. As noted earlier, current parents focused on child strengths and accomplishments. Kendall (1998) suggests accepting a child with ADHD means parents must adjust goals and perspectives. Applied to the present study, the constant focus on positive accomplishments suggests that parents had accepted their child with ADHD.

Avoidance and wishing away permit temporary emotional escape from issues at hand. Half the parents in this study avoided while the other half embraced stress. Within some contexts, avoiding or denial is a healthy strategy, permitting some level of functioning until resources are available to deal with the situation. However, long-term use may have dire consequences.

A similar overall pattern of coping was found in the study by Judge (1998) in which parents used a variety of coping strategies, the most common being problem-focused strategies involving seeking social support, actively problem solving, and maintaining a positive outlook. Also, Judge reported that social support, whether

emotional or informational, was positively associated with increased family strengths while wishful thinking, self-blame, distancing, and self-control were negatively related to family strength.

Thus similar to previous research, in the present study parent-reported coping strategies included behavioural management and cognitive strategies of social support, self-care, positive appraisal, seeking information and avoidance. During interviews, parents appraised the effectiveness of various coping strategies in the following manner.

*Effective/Ineffective Coping strategies.* Research points to a pattern where problem-focused coping strategies (e.g., problem solving and seeking social support) are related to better outcomes and emotion-focused strategies (e.g., minimizing, wishful thinking, self-blame, and distancing) are associated with poor outcomes. Notably, the present sample of parents evaluated behavioural management strategies and seeking social support as effective and losing temper and emotional/feel good strategies as ineffective coping strategies.

Evidence suggests that problem-focused strategies are linked to better family outcomes (Frey et al., 1989; Sloper et al., 1991). Behaviour management and social support were reported as effective coping strategies by parents in this study. Clearly, behaviour management represents a specific problem-focused strategy for dealing with problematic behaviour. Also, Arcia and Fernandez (1998) found that mothers who did not use behaviour management did not appear to have developed strategies for dealing with ADHD. Social support has also been associated with better outcomes in prior research (Cameron et al., 1991; Frey et al., 1989; Judge, 1998; Sloper & Turner, 1993). Social support provides parents with emotional and informational support. Taken together, the

finding that problem-focused strategies of behaviour management and social support are effective coping mechanisms is consistent with previous research.

In general, emotion-focused strategies are related to higher levels of stress and less well-being or poorer outcomes (Knussen & Sloper, 1992). More specifically, good outcomes appear related to less reliance on emotion-focused strategies such as wishful thinking, self-blame, distancing, and self-control (Frey et al., 1989; Judge, 1998; Sloper & Turner, 1993). In this study, parents felt losing one's temper and emotional strategies were ineffective which is congruent with previous research.

Remarks made by present parents align with prior research that while problem-focused strategies are effective, emotion-focused strategies are ineffective in managing stress. Parents concluded by discussing the impact of his/her child on the family unit.

*Family Impact.* Families in this study talked about the impact their child with ADHD had on their family. These parents discussed how their families were strengthened by focusing on child strengths, positive sibling relationships, extended family involvement, and marriages committed to communication and teamwork. Further, parents in this study reported feeling better as time went by. Negative impacts were also recounted. Present parents were concerned by strain on marriages, conflict in sibling relationships, limited extended family involvement, and wished for more support. Unfortunately, one family had dealt with more complicated negative sequelae related to ADHD. A discussion of how these results fit within previous research follows.

Present parents emphasized child strengths and accomplishments, even reiterating this theme throughout the interview, thereby highlighting its salience. Kendall (1998) found parents go through the process of adjusting goals and putting things in perspective.

Kendall suggests the resulting acceptance of the 'real' child involves an endpoint focusing on the child's strengths and accomplishments. Applied to the present sample of parents, the declarations of his or her child's abilities suggest that parents had accepted their child.

Extended family interactions were reported as strengthening by some of the current parents yet other parents reported minimal involvement with extended family. Prior research suggests families of children with ADHD have fewer contacts with extended family and less helpful interactions than families of children without ADHD (Cunningham et al., 1988). Further exploration of the role of extended family related to ADHD is needed, since the present group of families encountered a range of support.

Half of the parents interviewed reported good sibling relationships, yet conflict also occurred. Existing literature suggests sibling interaction involving one child with ADHD involves more conflict than normal sibling interactions (Mash & Johnston, 1983b). Parents may be unaware of the seriousness of the conflicts/aggression or downplay its significance (Kendall, 1999). Kendall found that siblings felt victimized, responsible for care taking, and loss of the life they would never have. Notably, a few parents in the present study were concerned about being less available for other children and extra sibling responsibilities. Recognizing the impact on siblings is a beginning point, but parents and professionals must go beyond and provide actual support for siblings, which may take the form of one-on-one time, counselling, or sibling support groups.

In this study, each parent discussed marriage. Specifically, a few talked about an initial stress on their marriage resulting from their struggles with ADHD but half were committed to communication and team work, wishing for more spouse time.

Interestingly, only one participant in the study reported a totally unsalvageable and non-supportive marriage. However, the finding of generally positive marital relationships in this sample is similar to results reported by Cunningham et al. (1988), which failed to find increased marital discord in parents of children with ADHD. Other researchers have found frustration, increased marital discord, and divorce among families of children with ADHD (Befera & Barkley, 1985; National Institutes of Health, 2000). For present parents, there were reports of increased frustration but no elevated levels of marital discord or divorce.

Though the tone of the interviews was positive, two parents stood out in terms of the impact ADHD had on their family. The parents did not describe their experience as particularly negative but the events are serious. Their child was involved in alcohol and drug abuse, school delinquency and frequent run-ins with law enforcement. As a result major family events included school changes, home break-ins, moving, calls from police, incarcerated child, and eventually severed relationships. Having ADHD increases the likelihood of chronic school failure, negative peer relationships, loss of self-esteem, substance abuse, and co-comittant disorders like ODD or CD (Barkley, 1998b; Dielman & Franklin, 1998). The ‘correlates’ of ADHD are frequently spouted but it is not until they touch lives in a real way that the true impact of the struggle of the individual and family can be understood. It is the reason passionate professionals strive to develop effective family interventions.

Some parents, in this study, reported feeling better over time. It is impossible at this point to determine how and why this may happen. Possible explanations include increased parenting ability, increased tolerance for stress, decreased child problematic

behaviour, and increased supports. Further, it is unclear why some families fared better over time while others did not. This highlights how important it is to understand the developmental trajectory of ADHD in children and its impact on parents.

In the course of discussing family impact, it is apparent that families are strengthened by some experiences and stressed by others. Overall family impact results from this study are consistent with and fit the pattern of prior research (Judge, 1998). Specifically, focusing on child strengths, positive sibling interactions, extended family involvement, and marriages committed to communication and teamwork strengthened families in the present study. Also, some parents felt better over time. Further, in this study, negative family impacts involved strained marriages, conflicted sibling relationships, limited extended family involvement, and wished for more support. Rich description by two parents detailed how lives are affected by ADHD and its related factors. Clearly, like all families, those with a child with ADHD are dynamic, complex and interactive.

In this study, parents of children with ADHD reported increased stress compared to parents of children without ADHD and stress was not associated with parent gender. In terms of coping strategies there were no parent gender or group differences based on problem- or emotion-focused strategies. Present parents identified a variety of stresses and used a range of coping strategies. Moreover, parents appeared to be good judges of the effectiveness of coping strategies. Clearly, a child with ADHD influences family dynamics. All these results are supported by past research other than the lack of differences based on emotion-focused strategies.

*Implications, Limitations, and Future Directions for Practitioners and Researchers*

The utility of the present study is evident when applied to intervention planning. Despite limitations in the current study, it points to essential issues requiring in depth investigation.

*Implications.* Results from this study have implications for intervention planning.

Interventions must address and include the following program elements:

- a) Aid mothers and fathers in identifying personal stress and coping strategies.
- b) Train parents to rely increasingly on effective coping strategies and less on ineffective coping strategies.
- c) Support and strengthen spousal relationships.
- d) Teach families how to access and foster formal (e.g., community professionals, respite services) and informal (e.g., extended family, friends) social supports.
- e) Assist parents in recognizing problematic sibling dynamics and fostering positive sibling relationships.
- f) Identify and assess essential parent skill sets and provide necessary training (e.g., anger management, organization skills).

Practitioners must also understand that sustained, elevated stress creates neediness in families of children with ADHD where parents become demanding and willing to try any treatment (Kaplan, Crawford, Fisher, & Dewey, 1998). Given the stress, the families' neediness is understandable. Creating effective individualized family-based interventions remains paramount.

*Limitations.* By identifying limitations, future research endeavours on stress and coping in parents of children with ADHD will be better designed and more relevant. The current study was limited by a small volunteer sample with a wide age range (5-17 years), reliance on self-reported stress and coping, missing data, and checklist confirmation of ADHD diagnosis.

Although parent groups were well-matched on demographic features and family variables, a few significant group differences emerged which may confound the present results. First, parents and siblings of a child with ADHD were more likely than controls to also experience ADHD-like difficulties. Additionally, children with ADHD were more likely than control children in the study to have additional diagnoses. It is possible that present parents of children with ADHD would experience more stress as a result of their own struggle with ADHD, increased stress resulting from parenting more than one child with ADHD-like difficulties, and/or parenting a child with multiple diagnoses. These limitations need to be addressed in future research on family stress and coping.

Future studies could attempt to recruit parents with ADHD who have children with and without ADHD while controlling for additional diagnoses. This type of project would require extensive commitments of funding and time. However, it is the author's contention that, given the familial pattern of ADHD (Galili-Weisstub & Segman, 2003) and high co-morbidity rate of ADHD (Root & Resnick, 2003), the results retain relevance for parents of children with ADHD.

*Future Research Directions.* Future research should pay careful attention to design, expanding knowledge of how parents of children with ADHD cope, the developmental process of ADHD, and family impact. More specifically:

- a) Incorporate multiple sources of information (e.g., teacher, friend) and multiple measures of stress and coping (e.g., parent tabulations, direct observation).
- b) Identify which coping strategies reduce stress in a timely manner.
- c) Large-scale investigation to determine whether gender differences in coping exist for parents of children with ADHD.
- d) Examine qualitative differences in stress and coping between parents of children with ADHD and without ADHD.
- e) Validate and replicate whether parents act as good judges of coping efficacy.
- f) Recruit sufficient participants to permit meaningful analysis of possible differences in stress and coping based on child age, for example children could be recruited and grouped according to preschool, elementary, and high school ages.
- g) Identify the developmental pathway of ADHD and its impact on families over time.

Despite some limitations, the present study suggests that family-based interventions should incorporate research on stress and coping while supporting marriage and sibling relationships, increasing social support, and providing parent specific training. Issues for further study involve methodological design, clarification on how parents of children with ADHD cope, representation of the developmental progression of ADHD and its corresponding effect on families.

*Final Summary*

To summarize, consistent with prior research, in this study, parents of children with ADHD reported increased stress compared to parents of children without ADHD and no difference in stress based on parent gender. No group or gender differences in coping strategies were found in this study. Similar coping, apart from differences in emotion-focused coping results, have been reported previously.

Types of parent stress included child behaviour, time demands, less time for relationships, health/diagnostic issues, finances, getting the ADHD diagnosis, and the dynamic nature of stresses. Coping strategies such as behaviour management, self-care, seeking social support, focusing on positives, seeking information, avoidance and not wishing away difficult situations were utilized. For some, parent stress decreased with time and some parents struggled with organization. Only behaviour management and social support were effective, while losing one's temper and feel-good strategies were ineffective.

Parents reported that their families were impacted by ADHD. Focusing on child strengths, positive sibling relationships, teamwork and communication between spouses, and extended family involvement strengthened this group of families. Over time, these parents felt better. Reportedly, ADHD negatively affected marriage, sibling, and extended family interactions. Parents wished for more support. One family's experiences brought them in contact with the law and social services.

Implications of this study involve designing family-based interventions that are aimed at reducing stress by improving parental coping, family relationships, social support systems, and individualized parent training. Despite limitations in the current

study, future research must address design issues, elaborate on how parents of children with ADHD cope, and describe the developmental course of ADHD as it impacts families.

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*Appendix A*

*Advertisements*

# **Does your Child have ADHD?**

**Would you be interested in talking about your experience as a parent of a child with ADHD?**



**We are doing research at the University of Victoria to better understand stress and coping in mothers and fathers of children with ADHD. We are focusing on parents with children aged 5 to 13.**

If you are interested in participating in this project

please contact Amanda Langley at:

**(519)-766-0832**

## **Do you have Children aged 5-13?**



Would you be interested in talking about your experience as a parent?

**We are doing research at the University of Victoria to better understand stress and coping in mothers and fathers of children. We are focusing on parents with children aged 5 to13.**

If you are interested in participating in this project

please contact Amanda Langley at:

**(519)-766-0832**

*Appendix B**Introductory Letter**Stress and Coping in Parents of Children with Attention Deficit Hyperactivity Disorder*

Dear Parents,

You are invited to participate in the study on Stress and Coping in Parents of Children with ADHD and without ADHD by Amanda Langley. Amanda is a graduate student in the Department of Educational Psychology & Leadership Studies at the University of Victoria. This research is part of requirements for a degree in Educational Psychology and is being supervised by Dr. Lily Dyson. The study will be conducted from March 2000 - April 2002.

The purpose is to explore stress and coping in families of children with ADHD and without ADHD. Specific questions include: what differences, if any, are there in stress levels and coping strategies in parents of children with ADHD compared to parents of children without ADHD, what differences, if any, are there in stress levels and coping strategies in mothers compared to fathers, and what is the relationship between coping strategies and stress levels. This research is important because ADHD affects 5% of school children and parenting a child with disabilities is consistently related to elevated stress levels. Possibly knowing other parents experience similar stress may help reduce stress. Results about stress and coping can be used in programs for parents and children.

You are invited to participate in the study because you replied to the project's advertisement, and are a parent of a child age 5-13. If you agree to voluntarily participate in this research, you will be asked to answer questionnaires, which should take about 1 hour to complete in your home. Questionnaires measure child behaviours and parental stress and coping related to children. Ten mothers and fathers will randomly be selected for an interview. Interviews will be recorded and arranged at your convenience (home/University office). Interviews will last ½ hour and it will take ¼ hour to read, verify, and mail the interview summary.

There are no known or anticipated risks to you by participating in this research. Potential benefits of your involvement in this research include a study summary, which may help you to understand how other parents experience stress and coping. The project has the potential to increase the knowledge base of parental stress and coping related to children with ADHD and guide programs for parents and children.

As a way to compensate you for any inconvenience related to your participation, you will be given a small gift certificate for completing the questionnaires and interview. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or explanation. Withdrawal will not affect your relationship with the University of Victoria. If you withdraw from the study your data will not be used and will be immediately destroyed.

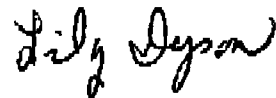
If interviewed, parents will be given another consent form. You will be reminded that participation is voluntary, and refusing or withdrawing approval at any time will have no negative affect for you or your family.

In terms of protecting your anonymity, names and addresses will be needed to contact parents for interviews. Yet, pseudonyms will be assigned to all participants to protect the anonymity of parents, family members, and others that may be identifiable. Conducting all interviews in private, safe, comfortable settings (home/University office) will protect your confidentiality and confidentiality of the data. Materials will be secured in a locked filing cabinet in Amanda's home.

Data from the study will be destroyed after five years to allow for possible publication. Under the supervision of Dr. Dyson, Amanda will retain and dispose the data. After five years, tape recordings will be erased and transcripts and other documents will be shredded. It is anticipated that the results of this study will be used and shared with others in my thesis, possibly journal articles, and presentations at meetings.

If you have any questions about the study please contact Amanda or Dr. Dyson. Also, you may verify the ethical approval of this study or raise any concerns by contacting the Associate Vice President Research at the University of Victoria (250)-721-7968. Others associated with study include Dr. Kerns, Dr. Roberts and Lori McLeod. Thank you for your time and consideration.

Sincerely,



Amanda Langley  
Graduate Researcher  
519-766-0832 or [alangley@uvic.ca](mailto:alangley@uvic.ca)

Dr. Lily Dyson  
Professor  
250-721-7816 or [ldyson@uvic.ca](mailto:ldyson@uvic.ca)

## *Appendix C*

### *Consent Form*

The purpose of this study is to look at stress and coping in families of children with ADHD and without ADHD. Specific questions include: what differences, if any, are there in stress levels and coping strategies in parents of children with ADHD compared to parents of children without ADHD, what differences if any are there in stress levels and coping strategies in mothers compared to fathers, and what is the relationship between coping strategies and stress levels. This research is important because ADHD affects 5% of all school children and parenting a child with disabilities has consistently been associated with elevated stress levels. Possibly, knowing other parents experience similar stress may help to reduce stress. Results about stress and coping can be used in training programs for parents and children.

*Having read the attached information letter, I understand that:*

- My participation in this study is entirely voluntary.
- I am invited to participate because I replied to the project's advertisement and am a parent of a child aged 5-13.
- I will be asked to answer questionnaires (Demographic Questionnaire, Conners' Parent Rating Scale, Questionnaire on Resources & Stress, and Ways of Coping Questionnaire) that should take 1 hour to complete in my home. I may be randomly selected for a ½ hour recorded interview. Interviews will be arranged at my convenience (home/University office). It should take ¼ hour to read, verify, and mail the interview summary.
- There are no known or anticipated risks to me by participating in this research.
- Potential benefits of my participation in this research include a study summary. It may help me understand how other parents experience stress and coping, which may help to reduce stress levels. This project has the potential to increase understanding of parental stress and coping related to children with ADHD. This may be used to in training programs for parents and children.
- I will receive a small gift certificate (\$5) for completing questionnaires and the interview, as compensation for inconvenience related my participation (my time). As a research participant, it is unethical to receive undue compensation or inducements and, if I agree to participate in this study, the certificate must not be coercive. If I would not choose to participate if the certificate was not offered, then I will decline to participate.
- I may withdraw at any time without any consequences or any explanation. If I withdraw from the study my data will not be used in the study and will be immediately destroyed.
- If interviewed, I will be given another consent form and reminded that my participation is voluntary and refusing to participate or withdrawal will have no negative affect on my family or myself.
- Contact information will be needed to send questionnaires and arrange interviews. Yet, any future use of the data will use pseudonyms to protect the anonymity of participants, family members, and others that may be identifiable. Conducting all interviews in private, safe, comfortable settings (home/University office) will protect my confidentiality and confidentiality of the data. All materials will be secured in a locked filing cabinet in Amanda's home.
- Data will be disposed of after five years to allow for possible publication. Under Dr. Lily Dyson's supervision, Amanda will retain and dispose the data. After five years, all data will be destroyed. It is anticipated that the results will be used and shared with others in a thesis, possibly journal articles, and presentations at meetings.
- I may verify the ethical approval of this study, or raise any concerns I have, by contacting the Associate Vice President Research at the University of Victoria (250)-721-7968. Other individuals associated with the study include Dr. Kerns, Dr. Roberts, and Valerie Langley.

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#### *Approval for Participation in the Study*

My signature below indicates that I understand the above conditions of participation in this study and that I have had the opportunity to have my questions answered by the researchers.

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Participant Signature

Date

Graduate Researcher Signature

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL BE TAKEN BY THE RESEARCHER

*Appendix D*

*Demographic Questionnaire*

Instructions: Please complete the following questionnaire.

Child's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Birthday: \_\_\_\_\_

Gender:

- Male       Female

Grade:

- K     1     2     3     4     5     6     7     8

Other, please specify: \_\_\_\_\_

Ethnicity:

- Caucasian    Asian       Native Canadian    African-Canadian

Hispanic     Other, please specify: \_\_\_\_\_

Describe your child's current living situation (e.g., lives with both biological parents 100% of the time, lives with biological mother and step-father, sees biological father every other weekend etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child been diagnosed with ADHD?    Yes / No

Who provided the child's diagnosis of ADHD?

\_\_\_\_\_

Diagnosis was given by a:

Medical Doctor     Mental Health Worker     Psychiatrist

Psychologist     School-based Team

Other, please specify: \_\_\_\_\_

Date of initial ADHD diagnosis: \_\_\_\_\_

Has your child received other diagnoses?: Yes / No

If yes,  Conduct Disorder  Oppositional Defiant Disorder

Depression     Manic-depressive Disorder

Anxiety Disorder     Learning disabilities

Other, please specify: \_\_\_\_\_

Does your child have any medical conditions?

Epilepsy     Diabetes     Other, please specify: \_\_\_\_\_

\_\_\_\_\_

Is your child currently taking medication for ADHD symptoms? Yes / No

If yes, Name of drug: \_\_\_\_\_

Dose: \_\_\_\_\_

Times/day: \_\_\_\_\_

Side effects? \_\_\_\_\_

If no, has your child ever taken medication for ADHD symptoms? Yes / No

Name of drug: \_\_\_\_\_

Dose: \_\_\_\_\_

Times/day: \_\_\_\_\_

Side effects? \_\_\_\_\_

Why were medications discontinued? \_\_\_\_\_

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

Has your child taken other medications for ADHD symptoms?      Yes / No

If yes, Name of drug: \_\_\_\_\_

Dose: \_\_\_\_\_

Times/day: \_\_\_\_\_

Side effects? \_\_\_\_\_

Why were medications changed? \_\_\_\_\_

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

Is your child currently taking any other medications?      Yes / No

If yes, Purpose of drug: \_\_\_\_\_

Name of drug: \_\_\_\_\_

Dose: \_\_\_\_\_

Times/day: \_\_\_\_\_

Side effects? \_\_\_\_\_

If there are other medications being taken please explain on reverse. →

## Maternal Information

Mother's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Ethnicity:

 Caucasian  Asian  Native Canadian  African-Canadian Hispanic  Other, please specify: \_\_\_\_\_

Highest level of Education Completed:

 High school  College  Technical/trade  Undergraduate Graduate  Post Graduate

Employed:

 Full-time  Part-time  Stay at home parent

Marital status:

 Married  Divorced  Separated  Remarried  Common law Single  Other, please specify: \_\_\_\_\_

Mother's Relationship to child:

 Biological  Step  Adopted  Foster  Legal Guardian Other, please specify: \_\_\_\_\_

Have you (mother) ever been diagnosed with ADHD? Yes / No

If yes, Who provided the diagnosis? \_\_\_\_\_

When were you (mother) diagnosed? \_\_\_\_\_

If no, do you struggle with some of the same difficulties as your child? Yes / No

Please explain. \_\_\_\_\_

## Paternal Information

Father's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Ethnicity:

 Caucasian  Asian  Native Canadian  African-Canadian Hispanic  Other, please specify: \_\_\_\_\_

Highest level of Education Completed:

 High school  College  Technical/trade  Undergraduate Graduate  Post Graduate

Employed:

 Full-time  Part-time  Stay at home parent

Marital status:

 Married  Divorced  Separated  Remarried  Common law Single  Other, please specify: \_\_\_\_\_

Father's Relationship to child:

 Biological  Step  Adopted  Foster  Legal Guardian Other, please specify: \_\_\_\_\_

Have you (father) ever been diagnosed with ADHD? Yes / No

If yes, Who provided the diagnosis? \_\_\_\_\_

When were you (father) diagnosed? \_\_\_\_\_

If no, do you struggle with some of the same difficulties as your child? Yes / No

Please explain. \_\_\_\_\_

\_\_\_\_\_

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Please list all your child's brothers and sisters:

<i>Name</i>	<i>Age</i>	<i>Gender</i>	<i>Relationship</i>	<i>ADHD Diagnosis</i>
		Male / Female	Biological / Step	Yes / No
		Male / Female	Biological / Step	Yes / No
		Male / Female	Biological / Step	Yes / No
		Male / Female	Biological / Step	Yes / No
		Male / Female	Biological / Step	Yes / No
		Male / Female	Biological / Step	Yes / No

Although, siblings may not have been diagnosed with ADHD, in your opinion, do they display some similar behaviours as your child with ADHD? Yes / No

If yes, please explain: \_\_\_\_\_

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Birth order of child with ADHD (e.g., 2<sup>nd</sup> of 3): \_\_\_\_\_

Family's Yearly Income: \_\_\_\_\_

Please include your mailing address if you would like to receive a summary of the study once completed.

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*Appendix E*

*Parent Interview*

1. Discuss what stresses if any, you experience related to parenting your child.

Prompt: Your child's behaviour? Health? Time demands? Financial strain?  
School experiences?

2. Discuss how you cope with stress related to parenting your child

Prompt: Seeking information? Seeking social support (talking to spouse/friend)?  
Wishing the problem away? Avoiding the situation? Looking for the good in a  
situation? Blaming self?

3. In your experience are some coping strategies, if any more effective or better than others at reducing stress?

Prompt: Can you tell me an example of a coping strategy that is really effective  
and a time when you used it? Can you tell me an example of a coping strategy  
you have tried but you found to be ineffective?

4. How has your child impacted your family?

Prompt: Siblings? Spouse? Extended family? Marriage?