

**Children with ADHD:
The Experience of Mothers**

Thesis submitted for the degree of Doctor of Clinical Psychology

to the Department of Psychology, University of Sheffield,

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July 1999

July 1999

Declaration

This work has not been submitted to any other institution for any other qualification.

Summary

There are three sections to this thesis;

1. A review of the literature pertaining to mothers of children with ADHD. Findings of studies in the following areas are summarised and critically discussed; parenting stress, family functioning, parental factors related to child antisocial behaviours and mother-child interactions. Some implications for further research and clinical practice are outlined.

2. A research report of a study which employed semi-structured interviews and Interpretational Phenomenological Analysis (IPA) to explore six mothers' experience of their sons' ADHD. Three themes emerged from the analysis of the interview transcripts; 1. The struggle to understand and explain the child. 2. Shouldering the burden. 3. The significance of diagnosis and treatment. The results are discussed in relation to relevant literature. Some clinical implications are considered.

3. A critical appraisal of the research project, giving an account of the project from its inception to completion of the thesis and including some reflections upon the impact of the research on the author.

Acknowledgements

I would like to thank Dr. Jonathan Smith for his helpful and encouraging supervision, Dr. Jacqueline Olurin-Lynch for her ideas early in the project and Dr. Daphne Keen for giving me access to her database to find participants for the study.

I am grateful to all the mothers and their children who agreed to take part in the project. It was a pleasure to spend time with them.

Thank you to all the friends and colleagues, especially Steph and Ellie, who have helped me on the way, and to Rebecca and Arne for the computer.

My special thanks go to Andrew and Shonagh, wonderful friends who gave me their love and support at a time when I needed it most.

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Literature Review

Mothers of children with ADHD:

A Review of the literature.

Word count: 8, 191

Abstract

Attention deficit hyperactivity disorder (ADHD) is a childhood disorder characterised by behaviour which is impulsive, overactive and/or inattentive to a degree which causes significant difficulties in important areas of the individual's life. Children with ADHD can pose a considerable challenge to the adults who care for them. Mothers tend to be the primary caregivers of these children and to be responsible for liaising with education and medical services on their behalf. This review considers some of the literature pertaining to mothers of children with ADHD. Findings of studies in the following areas are summarised and critically discussed; parenting stress, family functioning, parental factors related to child antisocial behaviours and mother-child interactions. Some implications for further research and clinical practice are outlined.

Accessing the Literature

A variety of strategies were employed to identify and obtain papers for this review. Searches were carried out on the following computer databases: Psychlit, BIDS, Medline and ERIC. Keywords used included; mothers, ADHD, hyperactivity and hyperkinetic disorder. Papers were also identified from reference lists in published literature.

Key to Abbreviations

ADHD - Attention Deficit Hyperactivity Disorder, ADD - Attention Deficit Disorder, ODD - Oppositional Defiant Disorder, CD - Conduct Disorder, PSI - Parenting Stress Index, CBCL - Child Behaviour Checklist, FES - Family Environment Scale, MMPI - Minnesota Multiphasic Personality Inventory.

Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a psychiatric diagnosis given to children when their behaviour can be characterised as impulsive, overactive and/or inattentive to a degree which is excessive for the individuals' developmental age, and when such behaviour appears to be causing them significant difficulties in important areas of their lives (Barkley, 1990). It is a developing concept covering a heterogenous set of problems which may not reflect a unitary disorder (British Psychological Society, 1995) and its use as a diagnostic category in the UK is on the increase (BPS, 1995).

Children with ADHD can pose a considerable challenge to the adults who care for them. The primary caregivers of children with ADHD are most often the childrens' mothers. Mothers are also the parents who tend to be responsible for liasing with educational and medical services on behalf of the child and for implementing any treatment options which may be offered (Harvey, 1988). The impact on mothers of parenting a child who has ADHD has been studied using a variety of approaches. This review will summarise and critically discuss a selection of more recent studies whose findings are relevant to mothers of children with ADHD. The following areas will be examined; parenting stress, family functioning, parental characteristics and antisocial behaviour in children with ADHD, and mother-child interaction. The main findings will be summarised and implications for clinical and future research work considered.

Parenting stress

A number of studies have investigated levels of parenting stress among the parents, usually the mothers, of children with ADHD. In these studies parenting stress has been measured using the Parenting Stress Index (PSI; Abidin, 1986). This is a 101 item questionnaire completed by the parent. It is based on a conceptualisation of stress within the parent-child relationship as multifaceted and influenced by parent, child and situational factors. Parental perceptions and appraisals of child characteristics are assessed on the subscales of the Child Domain. These are; Adaptability, Acceptance, Demandingness, Mood, Distractibility/Hyperactivity and Reinforces Parent. Parent characteristics and family context variables known to affect parenting are assessed on the subscales of the Parent Domain. These are; Depression, Attachment, Restriction of Role, Sense of Competence, Social Isolation, Relationship with Spouse, and Health. The PSI has been shown to possess adequate reliability and validity (Abidin, 1986).

Mash and Johnston (1983) employed an early version of the PSI in a study of parental perceptions of child behaviour problems, parenting self-esteem and mothers' reported parenting stress in younger and older hyperactive and normal children. The subjects were the parents of 16 "younger" (M age = 5 years 1 month) and 24 "older" hyperactive children (M age = 8 years 4 months) and the parents of 26 "younger" and 25 "older" control children. Hyperactivity was assessed using parent completed rating scales and parental perceptions of behaviour problems were assessed using the Child Behaviour Checklist (CBCL; Achenbach, 1978). Parenting self-esteem was measured using the

Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978) containing subscales reflecting 1. The Skill/Knowledge a parent feels they have acquired and 2. The Value/Comfort felt in the parenting role. Only mothers completed the PSI.

The results indicated that mothers of hyperactive children rated their children higher on measures of hyperactivity than did fathers. Mothers and fathers of hyperactive children saw themselves as less competent than parents of control children regarding both their parental skill and knowledge and the value and comfort derived from the parental role. Skill/knowledge self-esteem was age related, with parents of older hyperactive children reporting the lowest levels. Parenting self-esteem was inversely related to perceptions of child behaviour problems. The skill/knowledge and value/comfort self-esteem of mothers were correlated with the father's perceptions of the child as a problem, but fathers self-esteem was not related to mothers perceptions. Mothers of hyperactive children rated themselves as more stressed than mothers of controls on most PSI subscales, excepting marital relationships, health and situational characteristics. This was particularly so for child characteristics of degree of bother and distractibility, mother-child interaction, and mother characteristics of depression, sense of competence, social isolation, and self-blame, role restriction and attachment to the child. Correlations between mother's parental stress and mother and father ratings of their child's problems were highly positive.

There were a number of methodological limitations in this study. The limited sample size and consequent lack of power to detect potential relationships among variables meant that

the associations between specific child problems (including hyperactivity) and parent self-report measures could not be assessed. This and the absence of a non-hyperactive clinical control group render the findings inconclusive regarding the specificity of the relationships between self-esteem, maternal stress and hyperactivity. The assessment of the hyperactive status of the children relied heavily on parent report, with no other ratings (eg. teacher) or observational measures taken. It was reported that only mothers completed the PSI, but the reasons for this were not given. There was also a lack of information about the medication status of the children in the study. The study was correlational and the findings permit no conclusions regarding the direction of influence between parental perceptions of child problems and deficits in parental self-esteem and maternal stress.

As will be demonstrated, such methodological shortcomings recur throughout much of the research relevant to mothers of children with ADHD.

Some of these limitations were addressed in a study by Breen and Barkley (1988) which examined the extent to which 13 girls with ADDH differed from 13 ADDH boys, 13 non-ADDH clinic-referred girls and 13 normal girls in parent ratings of child psychopathology (using the CBCL) and of parenting stress, measured using the PSI and the Beck Depression Inventory (Beck, 1967). Assessment of ADHD status was thorough and involved interview with parents, behavioural observation of children during performance of academic work, delay and vigilance tasks and parent and teacher rating

scales. From the report of the results it appears that only mothers completed the various parent measures, although how or why this was the case is not made clear.

The main relevant findings were as follows. Mothers depression, CBCL and PSI scale scores did not differ for ADDH boys or girls. When the three groups of girls were compared on the Beck and CBCL measures, mothers of non-ADDH clinic referred girls were more depressed than either mothers of ADDH or normal girls. Mothers of ADDH and non-ADDH clinic referred girls were not significantly different on their PSI scale scores, but both had higher levels of stress on these scales than mothers of normal girls, with the exception of the parent domain scales of depression, relationship to spouse and health, on which only the mothers of non-ADDH clinic referred girls scored significantly higher than the controls.

These findings are in line with those of Mash and Johnston (1983), extending their conclusions to the mothers of girls with ADHD. However they also suggest that elevated levels of parenting stress in mothers are not specific to ADHD, but may be a general feature of mothers of children with behavioural and psychiatric problems, especially those involving aggressive or hyperactive behaviour. Again, various methodological limitations must be borne in mind. Sample sizes were small and may have precluded the detection of more subtle differences between the groups. The clinic control girls presented with a variety of psychiatric disorders and there was overlap between them and the ADHD girls in some of their clinical symptoms e.g. inattention, which may have obscured differences

which would have emerged between more distinct and homogeneous clinical diagnostic groups.

As has been pointed out, these studies, in common with much research in childhood psychopathology (Phares, 1992), rely solely on maternal reports of parenting stress. Baker (1994) addressed this imbalance by comparing reports of parenting stress (using the PSI) and child behaviour (using the CBCL) between mothers and fathers in 20 sets of parents of children with ADHD. Results showed that mothers perceived their child to be more stressful (on the Child Domain of the PSI) than did fathers and that on the Attachment subscale of the Parent Domain of the PSI fathers reported feeling less attached to their children than did mothers. There were no differences in other PSI scores. In contrast to the findings of Mash and Johnston (1983) there were no significant differences between mother and father reports of child behaviour on the CBCL. However the parents in the sample were white, married, middle to upperclass and seeking out parent training classes for ADHD, so the generalisability of the results may be limited. The children of these parents were also receiving various services, including 70% who were on psychostimulant medication and the small sample size made the impact of such provision on parenting stress difficult to evaluate.

In a more recent study Baker and McCal (1995) sought to clarify the relationship between types of child problem and mothers' parental stress in distinct diagnostic groups by comparing maternal reports of parenting stress (on the PSI) and child behaviour problems (on the CBCL) among 16 mothers of children with ADHD, 16 mothers of children with

learning disabilities and 16 mothers of children with no handicapping condition. They found that mothers of children with ADHD reported significantly higher parenting stress on the Child Domain than both the other groups. However, parenting stress on the Parent Domain did not differ among the groups.

Taken together, the results of all these studies suggest that mothers of children with ADHD have higher levels of parental stress than mothers of normal children and that this stress is related to the type and degree of their child's problems. Particular areas of stress include depression, sense of competence, social isolation, and self-blame, role restriction and attachment to the child. Parenting self-esteem in the areas of skill/competence and value/comfort in the parental role may also be lower in mothers of ADHD children compared with mothers of normal children. However there are a number of inconsistencies between the findings of the different studies and the various methodological shortcomings already discussed may account for this inconclusiveness. It should be noted that no clear distinction between mothers of ADHD children and mothers of children with other clinical problems can be made on the basis of these studies. Finally, the studies were all correlational and permit no conclusions to be made regarding the direction of influences between variables such as child behaviour and parental stress.

Family functioning

A broader, more systemic perspective is taken by those studies which have investigated the family functioning of families with ADHD children. Brown and Pacini (1989) examined perceptions of family functioning and levels of depression among the parents of

51 boys with ADD/H, 34 boys with a learning disability or developmental disorder and 34 non-disabled boys. Depression was measured using the Center for Epidemiological Studies-Depression Scale (CES-D: Radloff, 1977). Perceived family functioning was assessed using the Family Environment Scale (FES: Moos and Moos, 1981), a 90 true-false item instrument providing scores on ten dimensions in four general domains: interpersonal relationships, system maintenance, achievement and intellectual aspirations and activity aspirations. More mothers and fathers of ADD/H children reported themselves as depressed than the parents of either of the control groups. The parents of ADD/H children perceived their family environment as less supportive and more stressful than did either of the control groups, at least on the interpersonal relationships dimension, with specifically less expressiveness and less independence within their families. However scores on all the other scales and dimensions were not significantly different. Another interesting finding was that more parents in the ADD/H group were separated or divorced than in the other groups.

A number of methodological weaknesses should be borne in mind. There was a thorough assessment of the boys regarding ADD/H status but it was reported that 26% of the ADD/H group were designated as having ADD *without* hyperactivity. The presence of Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD) was not assessed in this group, although boys with either diagnosis were excluded from the clinical control group. The contribution of hyperactive behaviors or the non-compliant, aggressive behaviors etc. typical of CD and ODD to the pattern of results cannot therefore be determined.

Who completed the FES is not clear. At one point it is stated that the parent with primary responsibility for bringing the child to therapy sessions did so, at another the authors say that both parents were asked to complete the FES. This may be a serious shortcoming, in view of the fact that other researchers have found little agreement between parents of children with ADHD in views of their family functioning (Lewis-Abney, 1993).

In a more recent study of the correlates of family functioning when a child has ADHD, Lewis-Abney (1993) examined the relationship between selected demographic and psychosocial family characteristics and perceived family functioning. Although the children had previous diagnoses of either ADDH, ADD without hyperactivity or ADHD with conduct or oppositional problems, only parent ratings of behaviour were used in the analyses, which combined mother and father reports of child behaviour, parenting competence and family functioning. This lack of discrimination among child disorders and parent gender may have contributed to the paucity of significant findings in the study, with only age of the child being negatively related to levels of family functioning. Another limiting factor may have been the use of The Family Adaptability and Cohesion Evaluation Scales (FACES III: Olson, Portner and Lavee, 1985) which measures family functioning on only two dimensions, adaptability and cohesion. A broader assessment of family functioning may have yielded more significant findings.

Although it is not discussed in Lewis-Abney's report, it is clear from tables of the results that, for the mothers only, there was a significant negative correlation between the perceived levels of impulsivity and hyperactivity of the child and levels of family

functioning. As in the previous study by Mash and Johnston (1983) parenting self-esteem, measured on the PSOC (Gibaud-Wallston and Wandersman, 1978), was negatively related to perceptions of the hyperactive child as problematic.

An attempt to provide a broader and more discriminating picture of family functioning in families with ADHD and non-ADHD sons was made by Camparo, Christensen, Buhrmester and Hinshaw (1994). The subjects were 18 boys with ADHD and their mothers and fathers and 19 boys without ADHD and their parents. The criteria for inclusion in the ADHD group (a previous diagnosis of ADHD, parent interview and parent rating scales) were not particularly rigorous and this group also contained four boys who had been adopted, further compromising the homogeneity of the sample. Family functioning was assessed using mother and father completed questionnaires measuring marital satisfaction and the quality of the family system. The families were also videotaped engaging in a mother-father-son discussion about a childrearing concern selected from a list provided by the researchers. This triadic interaction was then scored by three raters blind to the research hypotheses and the ADHD status of the subjects. The coding system used provided scales pertaining to overall system function, marital system function and mother, father and son functionality.

Relevant findings from the observational and self-report data included no differences in family functionality, marital functionality, marital satisfaction or mother or father functionality between ADHD and non-ADHD families. The small sample size in this study increases the possibility that these results are artifactual, but they are in line with

some other studies which have found no differences in marital conflict between families with ADHD and families with normal children (Barkley, DuPaul & McMurray, 1990). Despite the small sample size some interesting differences did emerge between the groups. Both mothers and fathers of sons with ADHD independently reported that they spent more time discussing their sons' problems, blaming their sons for family problems, and that their sons' problems distracted them from other marital and family concerns more than did the parents of non-ADHD boys. That such distraction was not related to increased feelings of family unity or marital satisfaction among the mothers and fathers of boys with ADHD highlights the lack of information in this study regarding the nature of the discussions engaged in by mothers and fathers about their sons with ADHD (e.g. are they productive, leading to solution focused agreement?) and the concerns they were distracted from (which could be positive or negative, trivial or important). The artificial nature of the laboratory interaction situation and the lack, once again, of a non-ADHD clinical control group in this study further limits the generalisability and specificity of the findings.

As with the studies of parental stress discussed in the previous section, the sampling limitations of these studies of family functioning may explain some of the inconsistency in the various findings.

Parental characteristics and antisocial behaviours in children with ADHD

Most of the studies discussed so far do not adequately distinguish children with hyperactivity or aggression from those with co-existing hyperactivity and aggression or

externalising disorders involving aggression, such as Conduct Disorder (CD) or non-compliance, such as Oppositional Defiant Disorder (ODD), which may co-exist with ADHD in as many as 45 to 70 percent of cases (Barkley, 1990). This compromises the applicability of their findings. Jensen and colleagues (1993) go so far as to state that studies which do not clearly specify comorbid patterns of ADHD are not interpretable. This lack of discrimination between disorders may explain some of the inconsistency among the findings in this field. For example, Biederman, Munir and Knee (1987) found a greater prevalence of affective disorders in the first degree relatives of children with Attention Deficit Disorder, but failed to distinguish between Attention Deficit with and without Hyperactivity or, perhaps more importantly, between children with and without comorbid CD. When this was done in another study, (Lahey, Piacentini, McBurnett et al., 1987) ADD/H was not associated with any disorder in mothers or fathers, whereas CD and ADD/H with CD were linked with parental psychopathology. In a study investigating the personality characteristics of the mothers of children with disruptive behaviour disorders Lahey, Russo, Walker & Piacentini (1989) administered the Minnesota Multiphasic Personality Inventory (MMPI) to the biological mothers of 100 outpatient children aged 6-13 years. The children's diagnosis of ADHD was not significantly associated with any elevations of maternal MMPI scale scores, whereas mothers of children with diagnoses of conduct disorder had higher scores on MMPI scales reflecting antisocial behavior, histrionic behaviour and disturbed adjustment. Interactions of CD and ADHD were not significant for any MMPI scale, suggesting that CD may be linked to maternal personality disorder, but that ADHD is not.

A few recent studies have set out to investigate the relationships between various parental characteristics and the aggressive and antisocial behaviours of children with and without ADHD. Stormont-Spurgin and Zentall (1995) examined the family characteristics of 29 male preschoolers with hyperactivity and aggression, 12 with hyperactivity, 7 with aggression and 15 normal controls. Both mother and teacher ratings were used for group classification. A battery of parent-completed instruments was administered. This included assessments of child activity levels, behaviour and temperament, demographic information, child rearing practices, parental depression, strategies used by parents in solving conflicts and social support. For reasons not clearly specified, fathers completed only the child rearing and child temperament and behaviour questionnaires. The children were also observed playing with toys and their behaviour rated using categories of physical negative, verbal negative, physical positive and verbal positive. At six months follow-up, child behaviour ratings were obtained from mothers, teachers and fathers.

Results relevant to this review showed that mothers of preschoolers with both hyperactivity and aggression reported more restrictiveness and control in their relationship with the child than mothers of preschoolers with pure aggression or with hyperactivity only. Maternal depression did not discriminate between groups. Mothers of hyperactive-aggressive preschoolers reported more incidents of physical aggression to their partners than did mothers of purely hyperactive boys. They also reported receiving more verbal aggression from partners during conflict than did mothers of purely hyperactive boys. Fathers' physical aggression was not significant when family income was partialled out of the analysis, however. Maternal depression and low family income

were significant in predicting continuing levels of child aggression (mother and teacher rated) at 6-month follow-up.

An important difference between this and other studies of families of children with ADHD is the nature of the samples, which were drawn from the general population rather than from clinical sources with possibly more severe disorders. It is possible that such samples may differ in important respects, such as the levels of variability among measures, leading to potential relationships remaining undetected.

Stormont-Spurgin and Zentall (1996) extended their exploration of parental factors by looking at child rearing practices associated with aggression in older children (7 to 11 years) with and without ADHD. Teacher ratings were used to assign children referred for attentional, learning and/or behavioural difficulties to one of three groups; ADHD only (7 children), ADHD and aggression (7 children) and a comparison group of 13 children without externalising disorders. The children were also observed playing with a friend. The 27 mothers and 15 of the fathers of the children completed a questionnaire measure of their child rearing practices in various categories including Indulgence/Permissiveness, Authoritarian Control, Protection, Physical Punishment and Non-physical Punishment. Relevant differences found among mothers included; mothers of both groups of children with ADHD were more likely than mothers of comparisons to use non-physical punishment, such as time outs, reasoning and taking away privileges. Mothers of children with both ADHD and aggression were less likely to keep their child away from harm, strangers and people with different values than were mothers of comparisons.

However, the authors claim to have assessed the child rearing practices used by the parents in this study may be overstated. The Child Rearing Practices Report (CRPR: Block, 1965) employed in this study has a number of limitations insofar as it relies on parents' reports of their own practice and that some of the items seem to evaluate beliefs about child rearing rather than actual practice. The physical punishment item used in this study, for example, requires the parent to indicate how much they "believe physical punishment to be the best way of disciplining". Some more objective measure of actual behaviour would have enabled more confident conclusions to be drawn.

Nigg and Hinshaw (1998) looked at parents' normal range personality traits and psychiatric diagnoses and their relationship to their child's antisocial diagnosis and naturalistically observed antisocial behaviours, in boys with and without ADHD. Subjects were 80 ADHD and 62 non-ADHD boys aged 6-12 and their parents (132 mothers and 93 fathers provided data). Assessment of ADHD was thorough, using four separate measures. ODD and CD were also assessed and the ADHD boys were put into ADHD only (31 boys) and ADHD with ODD/CD (49 boys) groups. Parent psychopathology was evaluated using a diagnostic interview. Parental personality assessment drew on the Five Factor model of personality and used self-report and spouse-report data to arrive at measures of Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness. Child overt antisocial behaviours (physical and verbal aggression and non-compliance) at play and in class were rated by trained observers using a brief time sampling procedure for 4 days a week for up to 15 days. Child covert antisocial

behaviours (stealing and property destruction) were assessed using a laboratory procedure developed by one of the researchers.

The key relevant findings of this study were; Mothers of boys with ADHD, regardless of comorbid diagnoses of ODD or CD, were more likely than comparison mothers to have had a major depressive episode and/or marked anxiety symptoms in the past year. Various maternal characteristics were related to child overt antisocial behaviours, maternal depression and anxiety being related to both aggression and non-compliance, higher maternal Neuroticism related to child aggression and lower maternal Conscientiousness associated with non-compliance. The relation of maternal Neuroticism to child aggression was stronger in the ADHD than the comparison group.

Differences between mothers and fathers were difficult to assess in this study however, as so many fathers did not fully participate and these fathers may have differed systematically on important variables from those who did take part. Only direct relationships between parent and child variables were evaluated, excluding the examination of possible mediators between such variables. Although ODD and CD were controlled, other common ADHD comorbid disorders, such as depression and learning disorders, were not and could have effected the results in a number of ways.

The findings of the studies considered in this section suggest that the presence of CD or ODD or antisocial behaviour in some children with ADHD may be associated with

important differences in various mother related variables, such as higher levels of depression and anxiety, more negative child rearing practices and greater parenting stress.

Mother-child interactions

Little of the research mentioned so far has made any attempt to independently observe the actual behaviour of mothers with their children who have ADHD. This has been the main focus of a number of studies over the past twenty years, the key findings of which will be briefly outlined here. This research has examined the ways in which the inattentive, overactive and impulsive behaviour of the children may affect their manner of interacting with their parents (usually, as in most of the work on ADHD, their mothers) and how the parents respond to them. For example, Barkley, Karlsson and Pollard (1985) examined the mother-child interactions of 60 ADD-H and 60 normal boys subdivided into age levels using a cross-sectional design. The procedures used for assessing the mother-child interactions were similar to those of other studies in this area. All mothers were observed with their children in a 20 minute free-play period followed by a 20 minute period in which the mother was given a list of 5 tasks to perform with her child. The videotaped interactions were then coded using the Response Class Matrix (Mash, Terdal & Anderson, 1974). This involves two coders scoring the mother's and the child's behaviours as antecedent and consequent using different categories for maternal and child behaviours. The results were in line with other studies in showing that children with ADHD are less compliant with parental commands, are less able to maintain compliance over time and request more parental encouragement and assistance during task performance than do normal or control groups of children (Campbell, 1975; Cunningham

& Barkley, 1979). The mothers in this study gave more commands and directions to their children, greater assistance in completing tasks and more reprimands and punishment than mothers of normal children. Other studies as well as this one have shown that these interactional conflicts are more likely to happen in situations where the child is assigned tasks to perform and that mothers seem to have greater difficulties during task-related interactions than do fathers of hyperactive children (Tallmadge & Barkley, 1983). Mothers have also been shown to experience more difficulties with their hyperactive children than their normal children in the same family (Tarver-Behring, Barkley & Karlsson, 1985).

All of these studies, however, suffer from the methodological inadequacy of not distinguishing between children with pure ADHD and children with comorbid disorders such as ODD or CD. Barkley, Fischer, Edelbrock & Smallish (1991) addressed this limitation in a study of mother-child interactions, family conflicts and maternal psychopathology in 100 hyperactive and 60 normal adolescents and their mothers, who had all taken part in a study of mother-child interaction 8 years earlier. Assessment of hyperactive status was rigorous and drew on information from a variety of sources. Mothers and/or adolescents completed a battery of questionnaires assessing various domains including communication and conflict in their interactions, frequency and degree of conflict about various topics, marital adjustment, maternal depression (using the BDI), maternal psychological maladjustment (using the SCL-90-R) and life events. Mother-adolescent interactions during discussion of neutral and previously identified conflictual topics were videotaped and coded using the Parent-Adolescent Interaction Coding System

(PAICS) into categories of; commands/put downs, defends/complains, problem solution, facilitates, defines/evaluates, and talks.

The observations of mother-adolescent interactions found that during the conflict discussion the mothers of the hyperactive adolescents used more commands and put downs, were more defensive and complaining, and used less general talking interactions with their teenagers than did mothers in the control group. Similar group differences had been observed in these interactions 8 years earlier. However, when the hyperactive adolescents were placed into subgroups according to the presence or absence of ODD, the comparisons indicated that most of the differences between hyperactive and normal children were attributable to the ADHD with ODD subgroup. Mothers of adolescents with ADHD only did not differ significantly from mothers of controls on ratings of interactional conflict. This suggests that it is the presence of ODD behaviours with ADHD that may increase mother-adolescent conflict. The results also showed that mothers of children with both ADHD and ODD reported greater and more varied types of psychological distress (including obsessive-compulsive symptoms, depression, interpersonal sensitivity, hostility and phobic anxiety on the SCL-R-90, and depression on the BDI) than mothers of ADHD only children, who did not differ significantly from normals on these measures. However, both mothers of ADHD/ODD and mothers of ADHD-only children reported less marital satisfaction and more life stress events than control mothers. Another interesting finding was that the interactional patterns of mothers and children had remained significantly stable over 8 years, with non-compliant children remaining more difficult as adolescents and eliciting more negative mother behaviour,

and less rewarding and facilitating mothers continuing to be so and eliciting more negative adolescent behaviours.

A further study by Barkley, Anastopoulos, Guevremont and Fletcher (1992) employed the same procedures and measures with groups of mothers and their adolescent children. The adolescents had ADHD alone (n=27), ADHD with ODD (n=56) or were in a community control group (n=77). The study also made use of an inventory of family beliefs to assess 10 types of distorted cognitions and unreasonable beliefs in parent-adolescent conflicts. For parents these concerned; ruination, obedience, perfectionism, approval, self-blame and malicious intent. For the adolescents they were ruination, autonomy, approval and unfairness.

An interesting pattern of results emerged from this study. Mothers of both groups of teenagers with ADHD reported more negative communication, more topics on which there was conflict and more angry conflicts with their children than mothers of controls. However, only mothers of adolescents with ADHD/ODD showed significantly more negative interactions (using more put downs and commands and less problem solves) during a neutral discussion, more extreme and unreasonable beliefs (predicting more ruinous consequences and attributing more malicious intent to their teenagers conduct) about their parent-teen relations, more personal psychological distress (more obsessive-compulsive, anxious and interpersonally hostile on the SCL-90-R and more depressed on the BDI) and less satisfaction in their marriages than controls. Most of the findings for the ADHD-only group placed them between the ADHD/ODD and control group, but not

differing significantly from either. The findings for the adolescents generally mirrored those of their mothers. Both the adolescents' ODD symptoms and maternal hostility (on the SCL-90-R) made unique contributions to the prediction of degree of conflict and anger in the mother-teenager relations of adolescents with ADHD. A finding inconsistent with those of previous studies was the absence of significant differences among the groups in mother-adolescent interaction during the conflict discussion.

The results of this and the other studies considered so far support a view of maternal characteristics and behaviours and child characteristics and behaviours in children with ADHD as reciprocally deterministic, with the child's challenging behaviour increasing the likelihood of the mother using negative attempts to control the child as well as increasing the chances of maternal psychopathology, such as depression or hostility. These maternal characteristics may also act to increase the child's problematic behaviour, and so on.

Two more recent studies have provided evidence in support of the existence of such reciprocal relationships between maternal and child characteristics in the development and maintenance of ADHD and comorbid antisocial behaviour. Anderson, Hinshaw and Simmel (1994) assessed the ability of negative maternal behaviour observed in mother-son interactions (using procedures similar to those in the Barkley, Karlsson and Pollard, 1985, study described earlier) to predict independently observed overt (non-compliance/disruption, verbal and physical aggression in classroom and playground situations) and covert (stealing in a laboratory situation) externalising behaviour in the

child, with both maternal symptomatology (on the SCL-90-R) and child negative behaviour during the interaction controlled. The subjects were 49 boys with ADHD and 37 normal boys, aged 6 to 12 years, and their mothers. Interestingly no differences were found between groups regarding levels of maternal psychiatric symptomatology. When hierarchical multiple regression analyses were carried out on the data, maternal negative behaviours predicted both non-compliance in class and play settings and stealing in the laboratory setting, even when maternal psychiatric symptomatology and negative child behaviour during interaction with the mother were partialled out. The prediction of non-compliance from maternal negativity was limited to the ADHD group, however, when Group by Predictor interaction terms were added into the regression equations. This might indicate that there are different processes underlying child noncompliance in the ADHD group, but there was lower variability in all the outcome measures in the control group and this may well have restricted the likelihood of predictability among the measures from this group.

All the studies of mother-child interaction discussed so far used absolute frequency counts or very brief event sequences of interactions to code and analyse. Fletcher, Fischer, Barkley and Smallish (1996) used a Markov chain model of sequential dependence to analyse the interactions of mothers and adolescents in neutral and conflict discussions. The goal of such analysis is to uncover identifiable patterns in longer sequences of data and to evaluate the effect of explanatory factors (such as group membership and who is speaking, in this study for example) on such patterns. In this study the influence of comorbid ODD on these patterns was also assessed. The subjects

were mothers and their teenage children who had ADHD only (n=21), ADHD/ODD (n=40) or were in a community control group (n=49). The findings relevant to this review were that diagnostic group membership was a major determinant of the nature of the parent-teenager exchange during neutral and conflict discussion. The mother-teen dyads in the ADHD/ODD group showed significantly higher rates of conflict than dyads in both the other groups on most measures. They were most likely to make negative comments and least likely to use positive or neutral behaviours. The mothers in the ADHD/ODD group responded in a similar manner to their teenagers (i.e. with greater negativity) than mothers in the other groups who tended to respond to their teenagers with positive or neutral comments. The authors claim that their findings show that the majority of conflict between children with ADHD and their parents may be due to comorbid ODD and that the results underscore the suggestion that ODD, or socially hostile behaviour, may be a characteristic of a family's interaction pattern, rather than a feature of an individual. Relatively small sample sizes and the fact that raters were not blind to the diagnostic status of participants may temper such interpretations of the results.

All the above studies of mother-child interaction employed a highly artificial laboratory procedure which may not have captured the important aspects of the normal day to day interactions of the participants. For example, it may be speculated that the mothers in the dyads might respond differently to the assessment situation than their children, especially when the children have ADHD, and be more motivated and able to moderate their behaviour while being observed.

The correlational nature of such studies also means that they cannot speak definitively to the direction of effects among the variables which are being examined. The extent to which maternal characteristics influence child characteristics or vice versa, or both, remains largely a matter of speculation.

Summary of main findings

Studies of parenting stress among the mothers of children with ADHD using the Parenting Stress Index (PSI: Abidin, 1986) have shown that such mothers report higher parental stress than non-clinical controls, especially on dimensions measuring self-blame, social isolation, depression, sense of competence, role restriction and attachment to the child (Mash and Johnston, 1983, Baker and McCal, 1995). Baker (1994) found few differences in levels of parental stress between mothers and fathers of children with ADHD, although mothers perceived their child with ADHD as more stressful than did the fathers. Other studies have found no differences in levels of parental stress in mothers of children with ADHD and mothers of children with other psychiatric disorders (Breen and Barkley, 1988).

When parenting self-esteem has been evaluated, mothers of children with ADHD have been shown to report lower levels of skill/knowledge and value/comfort in their role as parents than did mothers of normal controls (Mash and Johnston, 1983) and their levels of parenting self-esteem have been found to be negatively related to perceptions of the level of their child's problematic behaviour (Lewis-Abney 1993).

Research into levels of psychopathology among mothers of children with ADHD has not always yielded consistent results, with some studies showing no differences between mothers of children with ADHD and controls on various measures of psychopathology (Lahey et al, 1988, Lahey, Russo, Walker and Piacentini, 1989, Breen and Barkley, 1988, Anderson, Hinshaw and Simmel, 1994). However, a number of studies have reported elevated levels of depression among mothers of children with ADHD compared with normal controls (e.g. Mash and Johnston, 1983, Brown and Pacini, 1989) and Nigg and Hinshaw (1998) found that mothers of boys with ADHD were more likely to have had a major depressive episode and/or marked anxiety symptoms over the past year than mothers of normal boys. Other studies have shown that levels of maternal psychopathology, including depression, may be related to the presence of comorbid antisocial behaviors in some children with ADHD rather than to ADHD alone (Barkley, DuPaul and McMurray, 1990, Stormont-Spurgin and Zentall, 1995).

Research into broader family functioning is more sparse and findings have been equivocal. No differences in reported conflict in the spousal relationships of mothers of children with ADHD and those of mothers of normal controls were discovered in studies by Barkley, DuPaul and McMurray (1990) and Camparo, Christensen and Hinshaw (1994).

Investigations into the observed interactions of mothers and their children with ADHD have consistently demonstrated that such mothers relate more negatively to their child than mothers of normal children, using more commands and directions, giving greater

assistance with tasks and employing more reprimands and punishments. This difference is more marked in task rather than neutral situations (Barkley, Karlsson and Pollard, 1985) and mothers are more likely to display negative behaviours than fathers of children with ADHD (Tallmadge and Barkley, 1983). However, more recent studies have established that such maternal negative behaviours, and their counterparts in the children, are related to the presence of comorbid antisocial behaviours such as characterise conduct disorders in the children with ADHD (Barkley, Fischer, Edelbrock and Smallish, 1991) and that mothers of children with ADHD only may not differ significantly from normal controls on ratings of their interactional styles (Barkley, Anastopoulos, Guevremont and Fletcher, 1992, Fletcher, Fischer, Barkley and Smallish, 1996).

Critique of the research

The studies reviewed above all employ quantitative approaches to research, using objective measurement to examine relationships between variables which have been predetermined as relevant to the area of interest. It is possible that this may have led to important aspects of the experience of mothers of children with ADHD being overlooked. For example, much of the research relevant to mothers of children with ADHD has assessed variables hypothesised to be of some significance to *parenting* rather than *mothering*. The conceptual confusion this may reflect might also underly the lack of clarity in the sampling procedures regarding fathers and mothers in some of the studies which have already been discussed.

If it is the case, as some have argued (e.g. Ruddick, 1982, Richardson, 1993), that mothering and motherhood, as they are constructed in our society, offer very different challenges, opportunities and experiences to those offered by fatherhood as it is constructed, then research which does not address this possibility may not be able to do justice to the diversity of parenting experiences which men and women actually have. The point is that the issues which are significant for the experience of mothering may be very different from the issues central to the experience of fatherhood.

One way to begin to address such possibilities may be through the use of research methods which allow a focus on the idiosyncratic subjective experience of participants, on the meaning of particular phenomena to the participants and on their individual historic accounts of the development of perceptions and processes. It has been argued (e.g, by King, 1994) that such a focus is best served using qualitative research interviews and analyses.

Clinical implications

Assessment of children who may have ADHD should involve not only a focus on the child's behaviour and psychological condition, but also on the psychological well-being of parents and on relationships within the family.

Empathy and understanding are vital when assessing the possible separate contributions of child and parent characteristics and their interactions to the problems the family are

experiencing. The potential for reinforcing existing patterns of blame and shame should be carefully considered.

Where a child's ADHD coexists with ODD or CD a more intensive and long-term approach to treatment may be necessary in order to prevent the escalation of negative interaction within the family. Approaches which engage the whole family and tackle the behaviours of all its members may be the most effective. Targets for appropriate intervention might include parental cognitions, communication skills, psychological disturbance and habitual patterns of interrelationship within the family.

Future research

Two main directions for future research are suggested.

1. Longitudinal studies with large samples, to enable the evaluation of a variety of important variables including child characteristics (such as type and level of behaviours) and parent (mother and father) characteristics (such as psychopathology, personality traits, child rearing behaviours and beliefs) and the relationships between these as they unfold over time.
2. The use of qualitative interviews and analysis to explore the experience of mothers whose children have been diagnosed with ADHD and have received treatment such as the prescription of stimulant medication. The aim would be to enable a focus on the development of perceptions and processes important to the individual and on individual historic accounts of experience.

References

- Abidin, R. R. (1986) *Parenting stress index*. Charlottesville, V. A: Pediatric Psychology Press.
- Achenbach, T. M. (1978) The Child Behaviour Profile. I: Boys aged 6-11. *Journal of Consulting and Clinical Psychology*, **46**, 759-776.
- Anastopoulos, A. D., Shelton, T. L., DuPaul, G. J., & Guevremont, D. C. (1993) Parent training for attention-deficit hyperactivity disorder: Its impact on parent functioning. *Journal of Abnormal Child Psychology*, **21**, 581-596.
- Anderson, C. A., Hinshaw, S. P., & Simmel, C. (1994) Mother-child interactions in ADHD and comparison boys: Relationships with overt and covert externalising behaviour. *Journal of Abnormal Child Psychology*, **22**, 247-265.
- Arnold, E. H., O'Leary, S. G., & Edwards, G. H. (1997) Father involvement and self-reported parenting of children with attention deficit-hyperactivity disorder. *Journal of Consulting and Clinical Psychology*, **65**, 337-342.
- Baker, D. B. (1994) Parenting stress and ADHD: A comparison of mothers and fathers. *Journal of Emotional and Behavioural Disorders*, **2**, 46-50.

Baker, D. B., & McCal, M. S. (1995) Parenting stress in parents of children with attention-deficit hyperactivity disorder and parents of children with learning disabilities.

Journal of Child and Family Studies, 4, 57-68.

Barkley, R. A. (1990) *Attention deficit hyperactivity disorder: a handbook for diagnosis and treatment*. New York: Guilford Press.

Barkley, R. A., Anastopoulos, A. D., Guevremont, D. C., & Fletcher, K. E. (1992) Adolescents with attention deficit hyperactivity disorder: Mother-adolescent interactions, family beliefs and conflicts, and maternal psychopathology. *Journal of Abnormal Child Psychology*, 20, 263-288.

Barkley, R. A., DuPaul, G. J., & McMurray, M. B. (1990) Comprehensive evaluation of attention deficit disorder with and without hyperactivity as defined by research criteria. *Journal of Consulting and Clinical Psychology*, 58, 775-789.

Barkley, R. A., Fischer, M. Edelbrock, C., & Smallish, L. (1991) The adolescent outcome of hyperactive children diagnosed by research criteria-III. Mother-child interactions, family conflicts and maternal psychopathology. *Journal of Child Psychology and Psychiatry*, 32, 233-255.

Barkley, R. A., Karlsson, J., & Pollard, S. (1985) Effects of age on the mother-child interactions of ADD-H and normal boys. *Journal of Abnormal Child Psychology*, **13**, 631-637.

Beck, A. T. (1967) *Depression: Causes and treatment*. Philadelphia: University of Philadelphia Press.

Biederman, J., Munir, K., & Knee, D. (1987) High rate of affective disorders in probands with attention deficit disorder and in their relatives: a controlled family study. *American Journal of Psychiatry*, **144**, 330-333.

Block, J. H. (1965) *The child-rearing practice report (CRPR): A set of Q items for the description of parental socialisation attitudes and values*. Berkley: University of California Institute of Human Development.

Breen, M. J., & Barkley, R. A. (1988) Child psychopathology and parenting stress in girls and boys having attention deficit disorder with hyperactivity. *Journal of Pediatric Psychology*, **13**, 265-280.

Brown, R. T., & Pacini, J. N. (1989) Perceived family functioning, marital status, and depression in parents of boys with attention deficit disorder. *Journal of Learning Disabilities*, **22**, 581-587.

Byrne, J. M., DeWolfe, N. A., & Bawden, H. N. (1998) Assessment of attention-deficit hyperactivity disorder in pre-schoolers. *Child Neuropsychology*, 4, 49-66.

Campbell, S. B. (1975) Mother-child interaction: a comparison of hyperactive, learning disabled, and normal boys. *American Journal of Orthopsychiatry*, 45, 51-57.

Camparo, L., Christensen, A., Burhmester, D., & Hinshaw, S. (1994) System functioning in families with ADHD and non-ADHD sons. *Personal Relationships*, 1, 301-308.

Cunningham, C. E., & Barkley, R. A. (1979) the interactions of hyperactive and normal children with their mothers during free play and structured task. *Child Development*, 50, 217-224.

Fletcher, K. E., Fischer, M., Barkley, R. A., & Smallish, L. (1996) A sequential analysis of the mother-adolescent interactions of ADHD, ADHD/ODD, and normal teenagers during neutral and conflict discussions. *Journal of Abnormal Child Psychology*, 24, 271-297.

Gibaud-Wallston, J. & Wandersman, I. P. (1978) *Development and utility of the Parenting Sense of Competence Scale*. Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Harvey, E. (1998) Parental employment and conduct problems among children with attention-deficit/hyperactivity disorder: An examination of child care workload and parenting well-being as mediating variables. *Journal of Social and Clinical Psychology*, **17**, 476-490.

Jensen, P. S., Koeretz, D., Locke, B. Z., Schneider, S., Radke-Yarrow, M., Richters, J. E., & Rumsey, J. M. (1993) Child and adolescent psychopathology research: problems and prospects for the 1990s. *Journal of Abnormal Child Psychology*, **21**, 551-580.

Kottman, T., Robert, R., & Baker, D. (1995) Parental perspectives on Attention-deficit/Hyperactivity Disorder: How school counselors can help. *The School Counselor*, **43**, 142-150.

Lahey, B. B., Russo, M. F., Walker, J. L., & Piacentini, J. C. (1989) Personality characteristics of the mothers of children with disruptive behaviour disorders. *Journal of Consulting and Clinical Psychology*, **57**, 512-515.

Lewis-Abney, K. (1993) Correlates of family functioning when a child has attention deficit disorder. *Issues in Comprehensive Pediatric Nursing*, **16**, 175-190.

Mash, E. J., & Johnston, C (1983) Parental perceptions of child behaviour problems, parenting self-esteem, and mothers' reported stress in younger and older hyperactive and normal children. *Journal of Consulting and Clinical Psychology*, **51**, 86-99.

Mash, E. J., Terdal, L., & Anderson, K. (1974) The Response Class Matrix: A procedure for recording parent-child interactions. *Journal of Consulting and Clinical Psychology*, 40, 163-164.

Moos, R. H. and Moos, B. S. (1981) *Family environment scale manual*. Palo Alto, CA: Consulting Psychologists Press.

Nigg, J. T., & Hinshaw, S. P. (1998) Parent personality traits and psychopathology associated with antisocial behaviours in childhood attention-deficit hyperactivity disorder. *Journal of Child Psychology and Psychiatry*, 39, 145-159.

Phares, V. (1992) Where's Poppa? *American Psychologist*, 47, 652-664.

Radloff, L. (1977) The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.

Stormont-Spurgin, M., & Zentall, S. S. (1995) Contributing factors in the manifestation of aggression in preschoolers with hyperactivity. *Journal of Child Psychology and Psychiatry*, 36, 491-509.

Stormont-Spurgin, M., & Zentall, S. S. (1996) Child-rearing practices associated with Aggression in youth with and without ADHD: An exploratory study. *International Journal of Disability, Development and Education*, 43, 135-146.

Tarver-Behring, S., Barkley, R., & Karlsson, J. (1985) The mother-child interactions of hyperactive boys and their normal siblings. *American Journal of Orthopsychiatry*, 55, 202-209.

Drug treatment for children with ADHD:

The experience of mothers.

Word count: 18, 000

Abstract

Attention Deficit Hyperactivity Disorder (ADHD) is a psychiatric diagnosis applied to children who present with significant difficulties in their lives as a result of behaviour which is impulsive, overactive and/or inattentive. Children with ADHD can pose considerable challenges for the adults who care for them. Mothers tend to be the primary caregivers for these children and to be responsible for liaising with education and medical services on their behalf. The current study employed semi-structured interviews and Interpretational Phenomenological Analysis (IPA) to explore the experience of six mothers whose sons (aged between 9 and 11 years) had received a diagnosis of ADHD and were being treated with stimulant medication. Three main themes emerged from the analysis of the interview transcripts; 1. The struggle to understand and explain the child. 2. Shouldering the burden. 3. The significance of diagnosis and treatment. These themes are discussed in relation to relevant literature and some clinical implications are considered.

Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a psychiatric diagnosis applied to children (and adults) who present with significant difficulties in important areas of their lives (e.g. education, social relationships, work) when these difficulties can be understood as the result of behaviour which is impulsive, overactive and/or inattentive to a degree excessive for the individuals developmental age (Barkley, 1990). ADHD is the latest in a long line of diagnostic categories which have attempted to validly differentiate such clusters of behaviour from those characteristic of other disorders (Anastopoulos, Barkley and Shelton, 1995). It is a developing concept covering a heterogeneous collection of problems which may not reflect a unitary disorder (British Psychological Society, 1996). Indeed DSM-IV allows for recognition of three subtypes of ADHD, depending on whether individuals display all primary features, are predominantly inattentive or predominantly hyperactive/impulsive (American Psychiatric Association, 1994) and there is some evidence that such differences may even reflect distinct disorders (Barkley, 1990).

Critiques of the ADHD concept focus on issues of reliability and validity, including problems with differential diagnosis, reliable identification and finding convincing evidence of biological aetiology (e.g. Reid, Maag and Vasa, 1993). The neglect of the socio-cultural foundations of ADHD has also been highlighted (Ideus 1995).

Notwithstanding the controversial nature of the ADHD concept, its use as a diagnostic category in the UK is on the increase (BPS, 1996). Once diagnosed, a variety of interventions may be employed. These may include the use of behavioural and cognitive management techniques, the evidence for the effectiveness of which is uncertain and contradictory (Fiore, Becker and Nero, 1993), school-based interventions, which are not specifically applicable to ADHD, and medication, most commonly a stimulant such as Methylphenidate (Ritalin).

There is considerable evidence that, in the short-term, stimulant medication can have many beneficial effects (Swanson, McBurnett, Wigal, Pfiffner et al, 1993). These include increased self-control, concentration, cooperation and academic productivity and decreased hostility and behaviour problems. Academic achievement, antisocial behaviour and depression may be unaffected. Positive effects may not persist when medication is discontinued and in the long term it is important to combine medication with psychosocial interventions (BPS, 1996). A substantial subgroup of children do not appear to benefit from medication (Swanson et al 1993).

Children with ADHD can pose a considerable challenge to the adults who care for them. The primary caregivers of children with ADHD tend to be their mothers. Mothers are also the parents who tend to be responsible for liaising with educational and medical services on behalf of the child and for implementing any treatment options which may be offered (Harvey, 1988). The impact on mothers of parenting a child who has ADHD has been

studied using a variety of approaches. Some of the findings will be briefly summarised here.

Studies of parenting stress among the mothers of children with ADHD using the Parenting Stress Index (PSI: Abidin, 1986) have shown that such mothers report higher parental stress than non-clinical controls, especially on dimensions measuring self-blame, social isolation, depression, sense of competence, role restriction and attachment to the child (Mash and Johnston, 1983, Baker and McCal, 1995). Baker (1994) found few differences in levels of parental stress between mothers and fathers of children with ADHD, although mothers perceived their child with ADHD as more stressful than did the fathers. Other studies have found no differences in levels of parental stress in mothers of children with ADHD and mothers of children with other psychiatric disorders (Breen and Barkley, 1988).

When parenting self-esteem has been evaluated, mothers of children with ADHD have been shown to report lower levels of skill/knowledge and value/comfort in their role as parents than did mothers of normal controls (Mash and Johnston, 1983) and their levels of parenting self-esteem have been found to be negatively related to perceptions of the level of their child's problematic behaviour (Lewis-Abney 1993).

Research into levels of psychopathology among mothers of children with ADHD has not always yielded consistent results, with some studies showing no differences between mothers of children with ADHD and controls on various measures of psychopathology

(Lahey et al, 1988, Lahey, Russo, Walker and Piacentini, 1989, Breen and Barkley, 1988, Anderson, Hinshaw and Simmel, 1994). However, a number of studies have reported elevated levels of depression among mothers of children with ADHD compared with normal controls (e.g. Mash and Johnston, 1983, Brown and Pacini, 1989) and Nigg and Hinshaw (1998) found that mothers of boys with ADHD were more likely to have had a major depressive episode and/or marked anxiety symptoms over the past year than mothers of normal boys. Other studies have shown that levels of maternal psychopathology, including depression, may be related to the presence of comorbid antisocial behaviours in some children with ADHD rather than to ADHD alone (Barkley, DuPaul and McMurray, 1990, Stormont-Spurgin and Zentall, 1995).

Research into broader family functioning is more sparse and findings have been equivocal. No differences in reported conflict in the spousal relationships of mothers of children with ADHD and those of mothers of normal controls were discovered in studies by Barkley, DuPaul and McMurray (1990) and Camparo, Christensen and Hinshaw (1994).

Investigations into the observed interactions of mothers and their children with ADHD have consistently demonstrated that such mothers relate more negatively to their child than mothers of normal children, using more commands and directions, giving greater assistance with tasks and employing more reprimands and punishments. This difference is more marked in task rather than neutral situations (Barkley, Karlsson and Pollard, 1985) and mothers are more likely to display negative behaviours than fathers of children with

ADHD (Tallmadge and Barkley, 1983). However, more recent studies have established that such maternal negative behaviours, and their counterparts in the children, are related to the presence of comorbid antisocial behaviours such as characterise conduct disorders in the children with ADHD (Barkley, Fischer, Edelbrock and Smallish, 1991) and that mothers of children with ADHD only may not differ significantly from normal controls on ratings of their interactional styles (Barkley, Anastopoulos, Guevremont and Fletcher, 1992, Fletcher, Fischer, Barkley and Smallish, 1996).

There have been few investigations into the cognitions of mothers of children with ADHD, although in one study such mothers saw the causes of their child's noncompliance as more unstable and uncontrollable on an analogue measure than did mothers of controls (Sobol, Ashbourne, Earn and Cunningham, 1989). Mothers' attributions for inattentive-overactive and prosocial behaviours have also been shown to vary with the presence or absence of oppositional-defiant behaviours (Freeman, Johnston and Barth, 1997). The expectations for their child's development held by mothers of children with ADHD have been found to be less positive than those of control mothers, even in areas of development unaffected by the presence of ADHD (Sonuga-Barke and Goldfoot, 1995).

All of the studies described above adopt quantitative approaches to research. They employ objective measures to scrutinise the relationships between predetermined variables deemed relevant to the area of interest. This may lead to important aspects of participants' experience being overlooked. For example, most of the research relevant to

mothers of children with ADHD has measured variables hypothesised to be of some significance to *parenting* rather than *mothering*. If it is the case, as some have argued (e.g. Ruddick, 1982, Richardson, 1993), that mothering and motherhood, as they are constructed in our society, offer very different challenges, opportunities and experiences to those offered by fatherhood, then research which does not address this possibility may not be able to do justice to the diversity of parenting experiences which men and women actually have. One way to begin to address such possibilities may be through the use of research methods which allow a focus on participants' idiosyncratic subjective experience, on the meaning of particular phenomena to the participants and on their individual historic accounts of the development of perceptions and processes. It has been argued (e.g, by King, 1994) that such a focus is best served using qualitative research interviews and analyses.

There has been one study which has employed such methods to examine the development of Cuban mothers' ADHD schemas and help seeking behaviour (Arcia and Fernandez, 1998). The findings suggested that these mothers lacked a cultural model for ADHD and held a cultural model of normal behaviour which hampered the development of an ADHD schema, which was eventually motivated by perplexity at the child's behaviour and a high degree of concern for academic achievement. While this study did privilege the participants individual accounts of their experience, it adopted a rather narrow focus on a particular aspect of that experience, the development of schemas of ADHD and their relation to help seeking.

The present study aims to employ semi-structured interviews and qualitative analysis to examine the experience of mothers whose sons have been diagnosed with ADHD and treated using methylphenidate (Ritalin). The approach adopted is Interpretative Phenomenological Analysis, as described by Smith (1995). This approach has been chosen over other qualitative methods due to its acceptance of and concern with the links between individuals accounts, cognitions, physical states and behaviour, an acceptance which is questioned by some other qualitative approaches, such as discourse analysis (Smith, 1996).

Method

Participants

The participants were six mothers of boys aged between nine and eleven years. All the participants were white. The boys had all been diagnosed with ADHD and had been receiving methylphenidate (Ritalin) for at least six months. They were all attending mainstream schools, had no specific learning disabilities and had no other diagnoses, such as Conduct Disorder or Oppositional Defiant Disorder. The boys were selected from a database of 56 children diagnosed with ADHD compiled by a Consultant Community Paediatrician. All parents of the 19 children meeting the above criteria on the database were contacted by letter and asked if they would be interested in taking part in the study. Of the 10 parents who replied and were then contacted by telephone, one decided not to take part in the study and two others were excluded as their sons were no longer taking Ritalin for ADHD. One further mother was excluded at interview when it became clear that her son had ceased to take any medication for ADHD some time ago. Demographic information about the participants is given in Table 1.

PSEUDONYM	AGE	MARITAL STATUS	CHILD'S PSEUDONYM AND AGE
Val	38	Married	Tom - 10
Sharon	40	Married	Sam - 9
Pat	45	Divorced	Liam - 10
Jane	43	Divorced	John - 11
Liz	29	Single	Jack - 10
Ann	37	Married	Lee - 9

Table 1. Demographic characteristics of the participants.

Ethical considerations

The research proposal for this study was accepted by the ethics committee of the Doncaster Royal Infirmary. The anonymity of the participants has been protected by changing all names and identifying details in the interview transcripts.

Researcher

The researcher is a thirty-seven year old white middle-class male with experience of interviewing adults and children in a clinical setting. He is the father of a ten year old boy.

Collecting the data

Data were collected using semi-structured interviews which were recorded and transcribed ready for analysis.

Constructing the schedule

An interview schedule was constructed with predetermined questions to use with each participant, following the approaches outlined in Smith (1995) and Kvale (1996). This then acted as a guide and a reminder during the interview, but was not followed rigidly, the researcher remaining free to enquire more deeply into particular areas and to follow the priorities and concerns of the interviewee, who could introduce topics the researcher had not thought of. The aim was to give the participant, as the expert on the subject, the best possible opportunity to tell their story. The schedule used with the mothers covered three broad areas; the experience of diagnosis and treatment, the experience of self and others and the experience of understanding and dealing with ADHD. Specific questions to address relevant facets of each area were devised, along with prompts which could usefully follow on from the kind of answers that might be given. The aim was to construct questions which were specific enough to encourage the respondent to talk about the topic and general enough to encourage them to do it in their own way, from their own perspective and with their own emphasis. Once complete the schedule was memorised, to facilitate its use as a framework and checklist for the actual interviews (See Appendix A.)

Conducting the interviews

The interviews with the mothers took place in the participants' own homes and lasted approximately one and a half hours.

Recording the interviews

All the interviews were audio-taped. Four interviews were transcribed by professional audio-typists, the transcripts being checked against the recordings by the researcher. The remaining interviews were transcribed by the researcher. The aim of transcription was to reproduce word for word all that the participant and the interviewer said during the interview, recording significant non-verbal events such as laughter, pauses etc., in a manner which was easy to read. If any part of the recording was unintelligible this was clearly marked in the text.

Analysing the data

The transcripts were analysed using IPA methods described by Smith (1995) and Smith, Osborn and Jarman (1998). The procedure was as follows;

The first transcript was read several times to ensure familiarity with the participants account. The tape recording was also listened to, so that important non-verbal aspects of the interview were not disregarded.

At each reading the left hand margin of the text was used to make a note of anything which seemed interesting about what the participant was saying in the interview. These notes included preliminary summaries and interpretations of the material, attempts to make links with other aspects of the participants account or sometimes simply represented associations and speculations which occurred to the researcher (See Appendix B).

The transcript was then re-read and the right hand margin used to write down emerging preliminary themes, that is, words or phrases which seemed to capture the gist or essence of what was being said by the participant. There was no requirement at this stage for these theme “labels” to be conclusive or very general. All of the transcript was analysed in this manner, with no prioritising or omission of particular aspects at this point (see Appendix B).

When the transcript had been worked through in this way, a complete list of the emergent themes at this “first level” was compiled. The location of each occurrence of each theme was given by adding the relevant page number to the theme label (see Appendix B).

The next stage of analysis involved looking for connections and similarities among the first level themes. Some themes were near repetitions of the same content. Others could be linked by more general, overarching themes. Those themes which seemed to belong together were gathered into groups. Each group was then given a label which appeared to capture the thematic essence of the group. Each label was numbered to facilitate identification (see Appendix B).

A further list of these group labels or “second level” themes was then compiled and the process of looking for connections and groupings among this list was repeated. In this way a final list of “third level” themes or master themes for the interview emerged, the constituent themes and examples of which could be readily traced back through the analytic process to their occurrence in the text (see Appendix B).

The process of analysis described above for the first interview was then repeated for each of the participants' transcripts in turn. A list of all the master themes from each of the transcripts was then compiled. These master themes were in turn clustered together and from these groupings superordinate themes were derived which captured important shared aspects of experience described across the individual transcripts (see Appendix B). The mothers' transcripts and the sons' transcripts were analysed as separate groups.

Once derived the group themes were used as lenses for a reviewing of each transcript to check that the themes were significantly present in each account. At this stage, and throughout the process of writing up the results, there was further revision and enrichment of interpretation.

Validity

The ways in which the validity of qualitative research can be demonstrated may differ from those employed in quantitative approaches, reflecting the different philosophical and epistemological foundations of these modes of augmenting knowledge. Various means for establishing and scrutinising the soundness of qualitative research have been suggested (Henwood & Pigeon, 1992, Streubert, 1994, Smith, 1996). Informed by these suggestions, the following procedures for ensuring appropriate standards of validity were adopted;

- During the interviews participants responses were reflected back to them, paraphrased and summarised, to check the participant's meaning and the researcher's understanding and interpretations. Streubert (1994) describes this as "data credibility".
- Each stage of analysis, from initial thoughts and speculations to final group themes and write up of the results was clearly documented. The chains of inference and interpretation leading from transcript to results are therefore open to audit.
- The transcripts and each level of analysis as well as the write up of the results were scrutinised by an experienced qualitative researcher. This is described by Streubert (1994) as "data auditability".
- In the final report of the results the reader is provided with sufficient raw data to assess the validity of conclusions drawn.
- The generalisability of the findings is addressed by discussing them in the context of relevant research literature.

Results

From the analysis of the mothers' interview transcripts the following significant group themes emerged;

- 1. The struggle to understand and explain the child.**
- 2. Shouldering the burden.**
- 3. The significance of diagnosis and treatment.**

These are described in detail in the following section. In the quotations which illustrate the explication of the themes the following conventions are used; Square brackets [...] denote repetitive, tangential or otherwise irrelevant text which has been omitted for the sake of clarity. A series of dots, , denotes a pause in speech.

1. The struggle to understand and explain the child

The child's perplexing behaviour

All the participants spent some time describing what it was about their son's behaviour in the past that had caused them concern. The cataloguing of illustrative incidents as well as more general characterisations were employed to establish the challenging and negative nature of the child's behaviour:

He just wanted to gatecrash and destroy everything...he was being aggressive to other kids...pulling their hair and slapping them...he'd got no sense of danger neither, I couldn't keep him away from the cooker, and he never seemed to learn, even if he'd got himself hurt. (PAT)

He was always on the go, he couldn't sit still...you could never concentrate him, he was always fidgeting. (SHARON)

He was a complete whirlwind, never sat still for a second. Always breaking things, his toys, his sister's toys, other kids' toys. He never looked at you when you was trying to tell him something, it was in one ear and out the other. (VAL)

While the mothers were clear that the child's behaviour could be challenging and negative, they also found it perplexing, often seeming to have difficulty describing it and sometimes speaking of their difficulty in adequately describing it:

I do find it difficult explaining the things that he does. Y'know you've got to watch him and he doesn't act in the same way with, like, other people[...]It's like you could just do with a video camera just watching his movements and what he does [...]I just find it hard, y' know, explaining. He sits there squealing and making these funny noises and being cheeky without being...(pause).(PAT)

I mentioned it to the nursery teachers and y'know, yes, they did agree with me that he quite, I wouldn't say naughty, his work seemed to lack a lot of enthusiasm, there wasn't, it's hard to describe. If he was asked to do a picture at school, some days he was fine, he'd do a picture, y'know the scenario that all children go through. But then on the other hand if it was another day he'd just use one particular colour and just colour the paper in that colour...Um, that wasn't seen as naughtiness, but the climbing and, er, um, basically the fidgeting and they told him to listen to the story, he just wasn't able.(ANN)

But what Lee tends to do again is - again, he's intimidating. He'll, well, I don't know, he winds the other kids up in a sense of, well not threatening behaviour, not bullying behaviour, because he's not a bully, I'd find, y'know, that the other kids were bullying him.(ANN)

Part of their difficulty seemed to arise from the puzzling inconsistency of the child's behaviour and the fact that it varied from situation to situation:

...yet he'd sit and watch a video from start to finish and you'd think well, if he can concentrate on that, why can't he concentrate on his school work.(SHARON)

He wouldn't be destructive or go out of his way to be awkward with my mum and dad, but he would with us.(ANN)

The thing was, sometimes he'd be fine, you wouldn't know it was the same kid. People would think, well there's nothing up with him is there? (VAL)

Another aspect of the difficulty was that the constellation of behaviours the mothers perceived in their sons did not seem to fit any of the categories they had for describing children and their behaviour:

Well, I mean how do you put a name on something...bad behaviour...well it isn't bad behaviour, it's just different behaviour. It's just not accepted, it's not bad, because it isn't always bad, like I say, it's not always destructive or malicious, or...it's just strange. (PAT)

It wasn't like anything I'd come across. Y'know, like was he a bad lad, well, yes and no, he wasn't really naughty, he did daft things, yes, but he didn't seem to be aware, so not naughty exactly. You couldn't really pigeon hole him. (VAL)

Other peoples' views of the child were sometimes very different from those of the mothers and this added to the confusion:

His grandparents, they'd say he was fine, just a bit lively maybe, a bit of go in him. It was like, as though they saw a different kid from the one I saw. They didn't see as much of him as me, but I thought, how come he seems so different to other people? (JANE)

The accounts of the child's behaviour given by the mother's could themselves be inconsistent and contradictory. Pat for example, who described her son Liam as both boisterous and incessantly active and also subdued and inert:

He was so boisterous...always charging around, and so loud!

...he was forever running out and up and down the stairs [...] he was up and down all the time. You could hear him banging things...he'd be running round, tearing round like an idiot...

Liam has always been quite subdued, you know just sitting around, yeah, subdued....he would just sit doing nothing for hours on end. (PAT)

Within the generally perplexing and negative account of the child the mothers occasionally seemed to struggle to include more positive aspects:

But he wasn't, y'know, a completely terrible child, an absolute monster. He could have his moments of, y'know, well...it's hard to think of any actually, but he wasn't all bad...maybe he seemed that way, but it wasn't like all there was. (VAL)

Don't get me wrong. He could be really nice sometimes. It's just there weren't that many of them sort of times. (LIZ)

Ann was explicit about the effort it could take to hold on to more positive views of her son:

He could be wonderful sometimes. Kind and thoughtful, lovely. But it was so hard to remember that side of him when he had you tearing your hair out most of the time. (ANN)

When describing their feelings towards their child in the past the participants also spoke in terms of having to contain or make sense of different and apparently conflicting emotions and of feeling ambivalent towards him;

Well I loved him, but there was no bond between me and Liam. (PAT)

I always said I love my son but I don't like him. (JANE)

It got to the point where I really began to resent him. He was my son and I loved him and I could feel for him, feel sorry 'cos he seemed to be turning everyone against him, but at the same time, I was...I could almost, I could hate him at times. (LIZ)

In trying to make sense of their bewildering child the mothers looked to other children and drew comparisons. These were rarely in their own child's favour and led some of the mothers to consideration of what was "normal" and whether their own child was abnormal in some way:

Where other kids would be just getting on with it, playing quietly and that, and our Liam, he'd be wizzing around...in the playground you'd see him, on his own, on top of the wall balancing or something. He just couldn't be like other kids. (PAT)

Even at that early age I'd look at other children and I'd look at him and I'd think what's up with him, because he didn't seem normal. I wished he could be! (laughs) 'Cos those children didn't seem to give their mums half the bother he gave me. (JANE)

Search for a cause

Faced with the perplexing behaviour of their child, and a sense that that something was wrong, the mothers began to actively search for explanations, especially causal formulations which implied some remedy or means of dealing effectively with their child. Each mother had considered a number of possible explanations for their son's difficulties. These candidate theories were often tested empirically by trying out the treatment/management strategies which followed logically from them. Different explanations were offered by various professionals and when this was the case acceptance of the explanation, however provisional, might be seen as part of the process of trying to get help.

Liz described this search for an explanation, with associated solutions and support, as "going down every avenue". As she put it "If I'm going to get help for him and it's an avenue I've got to go down, then I've got to take it..." The gazetteer of explanatory avenues she had explored was particularly extensive, but not unrepresentative of the

searches of the other mothers, all of whom had considered some of these causal explanations.

All the participants reported that they had at some stage explored the possible influence of diet, especially food colourings and additives, on their son's behaviour and that this was an avenue which received expert professional support:

He was also being investigated into food allergies and was under the dietician [...] trying to sort his diet out...I did go into that. I had to keep a food diary for the dietician [...] his food allergies varied from setting him off, to aggravating his hyperactivity. (LIZ)

...I started checking out the food colourings and trying to eliminate some...and I went through all the diet and things like that. (JANE)

Other candidate causes included learning or developmental difficulties:

I was told then they thought he was dyslexic. Spatial dyslexia or something. (LIZ)

...and I did think maybe he wasn't understanding people, y'know, when I told him not to do something, that he was slow or something, that he had a learning problem. (VAL)

Childhood experiences were also considered:

I wasn't sure at the time if it had anything to do with his dad, 'cos his dad went when he was six months old, his dad was very violent.(LIZ)

I quite often looked back and wondered if it was 'cos he more or less lived there, with his grandparents, for nearly one year of his life.(PAT)

Sometimes naughtiness or manipulation were seen as possible causes:

I used to think he was naughty, that he had a bit of a devil in him.(JANE)

He'd do things basically to distract your attention...I thought he was just being destructive to get attention from me daughter.(ANN)

A number of the mothers had also explored the possibility that physical problems might underly their child's behaviour:

I went down every avenue first. He got brain scans, chromosome tests, blood tests.(LIZ)

So I thought maybe it's his eyesight [...] Then I thought, he's not understanding what I'm saying, you know, like a language barrier or something.(LIZ)

I thought maybe it's his hearing, he's not hearing me when I shouted at him, that would explain, I couldn't understand why I couldn't get through to him.(VAL)

I thought I just had a child that didn't sleep.(SHARON)

These various causal explanations often implied or brought with them possible solutions to the problem of the child's behaviour. All the mothers spoke of their attempts to put such solutions into practice and of the disappointing results which they obtained:

We started checking out food colourings. Keeping him off certain things. It seemed for a bit like it was having an effect.(JANE)

You couldn't alter his behaviour by saying that's very good, 'cos it didn't have any effect...he thought you was lying to him. Parenting power, all these ways to handle behaviour and I've tried everything. It was just not working. (LIZ)

Mother as cause

The assumption that dealing with a difficult child was a mother's job seemed to feed the participants' concern to clarify the degree to which they were personally responsible for the development of their son's problematic behaviour, an important issue for each of the mothers. They had all wondered at some point whether they might have been the cause of their child's difficulties or had in some way exacerbated them:

Was it something I was doing that made him behave like thatbecause all of my friends, none of their children are the same as him.(LIZ)

....when you've searched everything else, you know, you think, well is it my fault? What have I done to him or what aren't I doing with him? Should I be spending more time? Should I be trying harder?.(SHARON)

You think you are doing something wrong. You feel its down to you.(JANE)

Associated with this was a heightened awareness of themselves as parents, good, bad or average, which often involved comparison with other parents:

....you seem to become very aware of what you're doing yourself, and you're looking at yourself as a person and am I doing the right things?....I went through every situation I could think of, how I was treated as a child, how basically other people dealt with situations....like when you talk to work colleagues, you get told stories that they say about their own children...it was, I don't know, it was like checking myself out.(ANN)

....if there is something wrong with a child or you are having problems, it does make you think well am I a good parent?...I suppose that's a natural feeling that "is it something I've done?" You know "am I a good parent?".....How do you really know if you're a good parent or...you don't do you? You don't, you just do the best for your kids, although

some parents don't, do they? They're just happy to , you know, let them get on with it....I mean, our Sam's friend, that's how his mother thinks. I thought our Sam had got problems but his friend is even worse, but I don't think his mother tries. Some people don't though do they?(SHARON)

An important element of this heightened awareness was the experience of other people being critical, judging their parenting negatively as a result of their child's behaviour:

I've always felt as though I've been criticised. I mean my dad, my own father's turned round and said he needs a good hiding now and again. "You wouldn't do that if you were me" and "you should do this and you should do that" and so on....most people just think I'm not in control of him. My own doctor thinks so, relatives see me as not being in control...that I've not done my job properly.(JANE)

This neighbour was standing there saying I was a terrible mother and I should learn to control my child and children wouldn't behave like that if I brought him up properly.(LIZ)

For others their attempts to seek help exposed them to the dismissive and disbelieving attitudes of unhelpful professionals:

I think he was just dismissed really...go and see how he goes on...yeah, I think I was brushed off. It was as though I was complaining over nothing.(JANE)

School weren't very helpful when I used to ask what could be done, "try this, try that, be more firm with him, use a reward chart" I'd tried it all and it didn't work, but they seemed to think it was all down to me. My GP wasn't any better. When I took a book on ADHD that I'd found he didn't even look at it. He just pushed it to one side and told me that I shouldn't be reading stuff like this, that I wasn't qualified to be deciding what was what from a book.(VAL)

Such experiences could encourage the growth of self-doubt:

I didn't think about it until I saw a psychiatrist and she was saying things like, you know, when I'd told her like, "well you know he has lived with his grandparents for a while and you didn't breastfeed him, why did you not breastfeed him like you breastfed your daughter?" and things like that. You get to the point where you think "I was to blame", you actually question yourself.(PAT)

The idea that their son's behaviour was a reflection of their mothering and could be a public sign of their own inability as parents aroused feelings of embarrassment and shame in a number of situations:

People do look at you and people do think "hmm, look at that woman, she can't control her kids" and to me that matters. I don't like people...I wouldn't like people to be saying that about me...I didn't like it 'cos it...I was embarrassed..(SHARON)

Guilty feelings resulted from the belief that they could have done differently, or done more, as parents:

You think, I should be spending more time with him, trying harder with him, helping him more, with his reading and so on. So there's quite a lot of guilt there.(VAL)

You do question yourself as to if you're a good parent and is it what you've done. You do question yourself, you do...you're always saying, if only you'd done this, if only you'd done that. Everything's "if only".(SHARON)

For Liz such emotions fed her reluctance to admit that she was having difficulty coping:

We did go back to the Children's Hospital again and they just said "come back if you can't cope". I felt what's the point in going? Because being told to go back when you can't cope is like admitting that you can't manage your own child and I wouldn't admit that.(LIZ)

2. Shouldering the burden

Demands on mother's resources

For all these mothers, having a son with ADHD was seen as a significant source of additional demands upon their resources as a parent, at least before a diagnosis was made and treatment begun. An important part of this sense of an extra burden was the stress and strain of dealing with the child's challenging behaviour, for example the exhausting level of vigilance and involvement required to keep their sons safe and out of trouble:

He was hard work, very hard work. Not sleeping at all, which means I can't sleep. He was in hospital 'cos he jumped off the shed. Split his head, there was blood everywhere. I caught him hanging out of his bedroom window. He'd tried to jump out of the window and got stuck on the window fastenings.....It's very tiring. I've got to constantly keep my eye on him, 'cos he gets himself into dangerous situations he's just not aware of.(LIZ)

To be honest he'd wear me out. He was always up to something. Like one time I caught him pushing straws into the gas fire. Playing with electric appliances, smashing his toys and his sisters toys, you name it. He was always up to some mischief, it never let up. So you had to watch him constantly, you know, watch him like a hawk. And like I said It'd wear me out.(VAL)

I used to like him to play in the garden, but as soon as my back was turned, he'd climb over the fence.....he was a compulsive wanderer. He'd just take off....It's very stressful, especially when you've padlocked the gate and he's climbed over the fence.(ANN)

For Jane the demands on her attention began from the first few months of her son's life:

.....right from being a baby, right from the day he was born, he was always a whingey baby.....he was constantly needing the attention, if you like.....you had to be picking him up or cuddling him or carrying him or doing something, occupying him, or again there'd be this constant whining.(JANE)

Jane, Val and Pat each described the effort to deal with their child's behaviour as a battle with few if any peaceful interludes:

Taking him on holiday and things like that weren't right nice.....We'd be sat at the airport and he'd be running around, tearing round like....and then you'd be worn out because you'd be so on edge all the time. What's he going to do? Where's he going to go?.....For all them years it seemed such a battle, such a battle.(PAT)

A battle which could be made all the more debilitating by having to balance the needs of other children:

And I was also having to please another child at the same time. Because with him being like that she got left out quite a lot....because I was trying to please him....and that made it harder. I was torn between them.(PAT)

You'd be trying, you know, trying to deal with him, anything that might help, and that meant the others got like left out. Or you'd spend time with them and he'd be all over the place. It was a right juggling act (laughs)...a nightmare.(VAL)

Isolation

The burden of mothering their challenging child was one which the participants often felt they carried alone, with little or no support from others including husbands/partners:

It went on for such a long time, such a long time. The thing was as well, my husband worked away quite a bit, so I was landed with him nearly all the time. On me own.(PAT)

You feel alone, because you don't know who to turn to or who to speak to. When I spoke to my husband about it he just said "Oh, he's just a lad".(ANN)

Yes it was painful and at that time I had to deal with it alone because my ex-husband wasn't around and I dealt with it alone and it was very painful.(JANE)

The child's behaviour could make it difficult to maintain supportive relationships with family and friends:

I tried not to visit friends because I knew that as soon as we got there he'd cause some riot....I think they thought that he was this mad creature....I'd ring up and say is it all right if I come to see youand I'd find out that sometimes they'd make an excuse that they were going out....they didn't want me to go because I was taking Lee....it was all right for me to go when I was on my own....For a long time I did feel isolated from friends.(ANN)

A lot of my friends couldn't cope with him....I used to get too embarrassed to take him to anyone's house and things like that. So we were becoming very secluded.(LIZ)

Other avenues of support were also cut off due to the challenging nature of their son's behaviour:

It really tied us down. We couldn't get baby-sitters to go out because he was so disruptive.(PAT)

It meant I could never get a baby sitter.(LIZ)

I'd got this little job, just a couple of hours a day, and this friend of mine offered to have him and she only had him for a week, a fortnight, if that, before she said "I can't do it".(JANE)

This sense of isolation could be intensified by the perceived indifference of professionals involved with the child including school staff and GPs:

School didn't want to know, doctor didn't want to know, no one seemed to give a toss, frankly.(VAL)

Conflict with others

Related to the participants' sense of isolation, of being alone with the problems associated with their child, was the experience of conflict with others engendered by their sons behaviour. This could range from disagreements over the nature and extent of the child's problem and how to manage his behaviour to dealing with negative attitudes and complaints from family, friends, school and neighbours:

My mum and dad they just wouldn't see it, Oh he's just a naughty boy, he's a lively, naughty lad, give him a smack....we had rows over it and we weren't speaking for a while it used to get to me that much.(VAL)

It caused a big strain on my marriage....it caused a lot of problems in the marriage. Because I had a set way of dealing with him and then my husband would say well I think you should be a bit more firm and do this with him and so we'd end up arguing then over who was doing the right thing.(PAT)

I used to dread going up to school because I knew what would be coming and then the teacher would come out and, you know....you've got teachers on your back saying "Sam's a naughty boy"....and I'd say "I know he's been naughty"....it just used to get to me.(SHARON)

The trouble that Lee has got into has been phenomenal...I've always tried to make it a routine that I don't argue with people...you were always getting the knock on the door and thinking what has he done again?...people saying "Oh if that were my son I'd give him a good crack...and yes I've had to bite my lip at times and think, well don't respond..(ANN)

The participants often seemed to be caught in something of a dilemma. They were the one living with their child, trying to cope with his challenging behaviour, struggling to get recognition and support both for his difficulties and for their own attempts to manage them; on the other hand they also had to adopt a more protective role, dealing with the complaints and soaking up the antagonism of less understanding others, acting as a defender or advocate for their child:

I don't know if I were being overprotective, I mean when people were shouting at him...I didn't like it. Even now I don't like anyone calling him anything...I've had more arguments and verbal battles with people over it than anything.(LIZ)

But if anyone came round complaining, or if they had a go when we were out, I wouldn't stand there without having my say, because some people...they don't have the right to be nasty and I wouldn't stand for that, especially when its just a little kid.(VAL)

For some of the mothers the responses of others had the intensity of intimidation and aggression, as in the following incident recalled by Ann, which illustrates the tension which could exist between the desire to get help for the child (and the isolated self) and the need to protect the child (and the self) from perceived attack:

I'd got to go into school on this particular day and see a gentleman, he's from...they used to call them the naughty boy's home ...he's the headmaster...I was absolutely petrified and horrified that he stood and shouted in the Headmistress' office...this guy's voice was quite overwhelming. He was shouting about Lee. You know, that if he continued as he was....I said "excuse me, I'm sorry, this is not the way that this should be dealt with". He said "he is coming to my school and I will make him a better person". I said "no you won't. I'm sorry, I won't give my consent for him to come to your school"...The aggression filled the office....I felt angry, I felt tearful. Very isolated and very vulnerable that there was no one there as protection for me.(ANN)

A mother's job

It was interesting that however great the the burden these mothers shouldered as a result of having a child with ADHD and however isolated they felt carrying this burden, they all seemed to accept or assume that the burden somehow belonged to them, that it was their

job as mothers to carry it. While the lack of support from others might be keenly felt there seemed to be little expectation that bringing up their son could be a team effort, a partnership with husbands, family, school or other professionals. The expectation seemed to be that, as mothers, child rearing was their business and any problems which arose in connection with this should be solved by their own efforts:

When it comes down to it you're the mum, it's down to you, it's my job and no one's going to do it for me. (LIZ)

Only when this proved impossible would the help of others be sought, and when this was done it was difficult for the mothers and, as they perceived it, those they sought help from, not to see the need to seek help as evidence of a falling short, a lack of commitment to or a deficiency in the skills of the mothering/parenting which was their allotted task and responsibility:

I mean when Dr. Patel said about these parenting lessons, y'know you think, I've got this far, why do I suddenly need all this parenting, y'know...I take things very personally anyway and it always seemed to be a reflection on me as a parent and how I do things, but I think I have got fairly high standards and fairly high morals and values and things like that. (JANE)

Sharon was the only participant who spoke of parenting as a "team effort" with her husband, who she described as a supportive partner. However she was still clear that

parenting was first and foremost her domain and responsibility and that her husband supported her in this role by not criticising her efforts and by “having a go” himself only when she was not succeeding:

We talk about everything, you know. I mean he were as fed up as me but it were always me that had to do...like it were my suggestion to take him to the doctors. It were me that took him to the doctors which is what most mothers would do anyway but it were always me.....you know , men are at work...he's out working. I can take him to the doctors 'cos I'm home, you know, this, that and the other, and I said to him “well what if we try this, what if we try that?”. It were my idea to take him to the doctor and my idea to take him off food colourings and everything and what have you...We've a fine relationship really...Steve's never got to a point where he said “Oh God, do summat wi' Sam, he's getting on me nerves”, you know, or owt like that....If I couldn't do nothing with him Steve would try.(SHARON)

For some of the participants their struggle and burden was not lightened or made worthwhile by the compensations of more positive moments with their son. Indeed the lack of a rewarding relationship with the child was highlighted by most of the mothers.

Nothing you did for him, nothing you wanted to do would please him. You got nothing back from him, no feedback at all, nothing. (VAL)

To be honest we didn't have such a good relationship anyway, because he was never a child to show any affection whatsoever. So I felt he pushed me to one side anyway...I always offered the affection but he never took it...he wasn't a child that would come and sit on your knee, even from being a toddler.(PAT)

Getting to the end of your tether

All the mothers had at some stage reached the point of feeling that they could no longer meet the challenges posed by their son, that their resources were spent and there was no more they could give or do to cope:

I'd tried everything...from looking at his diet to y'know all the ways, different things to try and get him to behave. Going up to school, seeing the doctor. None of it worked and I suppose I got to thinking there's no point, I can't cope, there's nothing more I can do, y'know, chucking the towel in sort of thing.(VAL)

I got to the point where I broke down...I said (to the GP) well you're either going to have to give me or Liam something because I just can't cope anymore.(PAT)

With the growing exhaustion, the sense of being at the end of their tether and of losing the battle to cope with or control their child, the search for help seemed increasingly urgent and the difficulties in getting help increasingly desperate:

No one seemed to want to do anything. Nobody seemed to want to help....I just wanted somebody to take an interest in him....you just get to the end of your tether and, oh God, you know, "do something with this child of mine", you know, "somebody help me".(SHARON)

As related by the participants, the cumulative effects of being alone with this burdensome problem, of being disbelieved, criticised and blamed, of feeling responsible, guilty and ashamed, unable to do anything to change things for the better, led to a sense of failure and helplessness:

Over the years you get to the point where you thought, well, this is just not working. All these things they were asking me to do were just not working [...]You get to the point where you think "Is it me? Is it the way I brought him up? Have I done something wrong?...I just felt like this, what can I do? If I can't control him? Yeah, I felt like, a sort of...useless parent.(PAT)

It also led, in varying degrees, to the experience of depression. This ranged in depth and intensity from Sharon's experience of upset and despondency, through Val's more pervasive feelings of hopelessness and to the experience of Jane and Liz, who had each received treatment for clinical depression.

I'd go home and basically cried and cried because I used to get to the end of my tether, wondering what I'd done wrong....(SHARON)

I just felt down all the time, like no energy, what's the point sort of thing. I just couldn't see anyway out...looking back I was probably depressed or something...(VAL)

The following extract illustrates how Liz experienced criticism and condemnation from significant others, leading to self-blame and a sense of being unable to cope. The treatment she received for her feelings of helplessness and depression added to her difficulties and intensified her sense of being trapped in an intolerable situation;

My mum said I was a bad parent...that it was what I was doing wrong why his behaviour was like it was...I just got to the stage where I just said it's not right, it's not normal and if it is because I'm a bad parent then I accept that I'm a bad parent and he'd be better off without me. I couldn't cope with him...I started on a very big downward spiral. The doctor put me on anti-depressants which knocked me out, when I was sleepy, that's when he was running around....I just got to the stage where I wanted to leave him, emigrate. I thought if I ever did that, then I wouldn't be able to face myself.(LIZ)

Other participants also spoke of feeling trapped in a dreadful situation by their obligations as a mother:

You feel stuck, you and this awful child who won't...but he's your child so you're stuck with it. But there's nowhere to go, no one to turn to...a nightmare, it really was.(ANN)

3. The significance of diagnosis and treatment

In each of these mothers accounts of their experience of their son's ADHD the giving of the diagnosis and commencement of treatment with Ritalin was a watershed moment, such that the participants often spoke in terms of "before" or "since" diagnosis and treatment. However there was a clear difference in the meanings which the diagnosis and the treatment held for the participants and they will be considered separately here.

Diagnosis

The bestowing of the diagnosis was a powerful moment with considerable emotional impact for all the mothers. They experienced profound relief when given the diagnosis, a number of aspects of which were identified as being particularly important. The diagnosis provided a label and an explanation for their sons' various perplexing behaviours, which now became, as Sharon put it, "classic symptoms" of ADHD, "a recognised illness". It was also taken as a clear vindication of their own concerns and their efforts over the years to have these concerns taken seriously. At last they were believed, they hadn't made it up, misperceived or imagined it all:

...it gave me the satisfaction that yes something had been identified, I'd got a diagnosis...I'd said all along that there was something wrong, but nobody believed you. It was as though, y'know, everything I said was, it's a fabrication. And suddenly I got this diagnosis and it made me feel a lot better.(ANN)

Somebody out there actually understood what I was saying. That it wasn't all in me head...it was as though everybody seemed to suddenly agree with what I was saying.(JANE)

The diagnosis also served to lift the blame from mother and child, supplying a cause, a route for attributions regarding the child's challenging behaviour, which exonerated the parent and absolved the child:

Once you've got a diagnosis, you know, you know its not you thats done it. It were just nice to know that I haven't made him as he was.(SHARON)

...and as well as me feeling better, because like it wasn't anything that I'd done wrong that caused it all, it was nice for Tom. He wasn't doing it on purpose, you know, being naughty, he wasn't just a naughty boy, it was ADHD.(VAL)

It was not only the mothers who saw the child differently:

...when I told his sisters, you know, that Sam had got this ADHD and explained it in a way that they could understand, they actually felt sorry for him really. Yeah. They actually help him now with his homework on a night time.(SHARON)

This exoneration was seen as instrumental in improving the mothers psychological well-being and their ability to cope with their sons' behaviour, independently of any effect the subsequent medication might have. Pat's account of the importance of the diagnosis exemplifies such themes:

PAT: ...we saw Dr. Smith and she asked him some questions and she explained about how she saw him and said there's no doubt I diagnose him as ADHD...everything she asked him on the scoring thing that he...I said it's the first time he's come top in a test (laughs). I think he scored about eighteen out of these twenty questions. What Liam had was ADHD...I cried, yeah I cried. Just a sense of relief, yeah, yeah, such a relief. And at that time there was no mention of any medication or anything. It was just a case of yes I diagnose him as ADHD. I didn't care about what medication he was going to be on, or if there was any, or anything...the only thing that was stuck in my mind was yes we've got an answer, why he's like this...It was just a sense of relief and hope for me and hope for him. Hope for all the family really...

INT: From the diagnosis? Getting the label or getting the medication?

PAT: From the label.

INT: So what difference did it make?

PAT: I'd got a reason...because all through them years I honestly thought it was my fault...I felt a lot happier after, I feel a lot happier when I just sit and think about it...as time went on I thought I'd got a bit more patience with him, or I tried harder. It was in the back of my mind then, if he did something I'd think it's not because he's naughty it's because he's got a problem...there was a big weight off me shoulders.

Reaction to the diagnosis was not straightforwardly positive for all the mothers however. Val and Ann experienced moments of concern alongside the relief, the diagnosis raising questions as well as answering them:

I did find myself thinking OK, so we've got this diagnosis and there was a bit of a, a worry maybe that...what was it going to mean sort of thing, like does it get worse, will he grow out of it, that kind of thing.(VAL)

I wasn't sure of the diagnosis, where it was going to lead...was it treatable? I didn't know anything about it. Was it going to go away, or was it something that he was going to have for the rest of his life? And basically how it was going to affect my life. And am I going to have to guide him throughout every goal and every step that he's taking?.(ANN)

While the personal significance of the diagnosis was considerable for them all, the participants understanding of the ADHD diagnosis was not uniformly consistent:

...because it's attention deficit it means they're lacking in attention, doesn't it? But it isn't attention deficit. I feel its the wrong words if you like. Because people do show him attention. Its attention seeking more than attention deficit.(JANE)

When the doctor explained it, went into detail and that, well it was hard to...it all went a bit over my head, to be...I still have trouble, you know, telling other people what it actually is, what ADHD is. But all that doesn't matter really, 'cos its what our Tom has got and that's why he's like he is, and there's a name for it, and he's getting help and that's what's important.(VAL)

...even though I've got these sheets of paper explaining what it is, like, you know, that's what it is, I still don't really understand what it is really. I suppose it's different because it's not a disease sort of thing.(PAT)

Despite these uncertainties and the difficulties some of the mothers experienced in understanding the diagnosis, it seemed to provide them with a means of explaining their son's behaviour to other people in a way which acted as a bulwark, protecting them against the judgement and hostility of others:

So now I can say it's ADHD, its a recognised disorder and he can't help it. Some people still say, Oh its just another name for a naughty boy, but I can ignore them, they're just ignorant.(JANE)

Scepticism and criticism were still encountered from a number of sources but it appeared that this could now be dealt with by the mothers in terms of the ignorance of other people faced with a little known, complex and difficult to understand clinical entity:

Me mum and dad weren't all too impressed about it and even now they say, y'know, he's all right, what's up with him? They said O. K. he's a lad and he's a bit aggressive and a bit angry, we all get like that at times. But I don't let it bother me. (PAT)

I've told friends, but they don't understand it. They don't understand it. "He looks normal". Yes he is normal. What do you expect him to look like? Has he got a big head or pointy ears? "What is this thing he's supposed to have got?" I've tried to explain to them it's like a chemical imbalance, sort of thing, and through basically...medication things can improve. (ANN)

...but even now people don't understand. Because...there is not really enough said or done about it. Y'know so people still don't know, they can't understand what it's like. (JANE)

Another positive effect of the diagnosis was to provide the mothers with a different and apparently more appropriate frame of reference with which to make social comparisons, their son becoming "not bad for a boy with ADHD" and themselves better mothers than some were in similar circumstances:

Meeting other people with children with ADHD I sort of think, well Lee's not half as bad as what their children are...I've been able to identify that Lee's not quite as bad...which has been good. (ANN)

I've got to know that some other kids have got it too, and their mothers...well it makes me think I haven't been doing such a bad job really. (VAL)

Treatment

When it came to discussing the treatment for their sons ADHD the mothers' accounts were more complex. The positive effects of Ritalin in a number of areas were clearly and unanimously acknowledged. The changes in the child's behaviour were described as immediate and dramatic:

...it were brilliant, you know, 'cos you knew when he'd had a tablet, within ten, fifteen minutes, he'd be a different person...in a few days it was like having a different son, like somebody swapped the old Sam for a new one. (SHARON)

Within twenty minutes of him having his tablets everything was calm. (PAT)

He was completely different, it was as though, well, like someone had waved a magic wand on him or something. It was amazing. (VAL)

The perceived improvements included positive changes in the child's ability to concentrate, a reduction in restlessness, improvements in behaviour at school, improvements in academic work and enhanced relationships with siblings and peers:

He became a lot quieter...the concentration was there. He was able to sit and concentrate at school...he was able to work in a group at school, whereas I found before he wasn't interested in working in a group. He started playing football...In school, yeah, he's improved in a lot of things. (ANN)

...he was actually more focused and more concentrated...He were able to write things and draw things and actually get through a lesson without being told off. He'd sit still. Stop moving around the classroom.(JANE)

Children will play with him a bit more now...they must see him differently because they do play with him.(PAT)

People started to like him more.[...] I did notice that he started to talk about certain individuals more as though he was actually building a relationship with certain people ...he seemed to be having somebody round more often, being able to go to other people.(JANE)

The effects of this upon the mothers ranged from getting positive feedback about their child to feeling that it was now possible to start enjoying some kind of social life:

His teachers they'll say he's well mannered, he's polite, he always has his things ready. I think "is that my son they're talking of?" because you can't believe somebody's actually talking nice about him because like in the first four/five years of school, it was "Oh, Sam's a naughty boy", so it was really nice and still is nice to hear 'em say nice things about him.(SHARON)

The Open evening was really, it was lovely. It was really pleasant...I were really pleased, really pleased. It was so pleasant to come home with that sort of feeling. At last. We're getting somewhere.(JANE)

...through medication things can improve. You can have a social life with your child with ADHD and you can go out and enjoy yourselves.(ANN)

An important aspect of the changes post-Ritalin was the increased love, affection and rewardingness in the relationship with their child which the mothers were enjoying:

Before, when I wanted to give him a love, it were like you're not allowed to love him...there was something there always stopping him and yet now he's started taking the tablets and he is a lot calmer, you can do it...he's a very tactile child, very loving.(LIZ)

Well there's a little bit of affection there from him, because we have a laugh and a kiss like...that's different from before. Yeah. He'll still push me away, but I fight him, y'know, whereas before I wouldn't've attempted to have gone near him.(PAT)

It were a nice change 'cos he was so calm and you could talk to him and he'd sit and listen to you and he'd look at you when you were talking to him and he'd sit and have a nice conversation with you.(SHARON)

The view that Ritalin made the child “normal” was a common one and could be linked to the opportunity for the mothers to have what they saw as a normal life once more. In the following extract Ann relates this to the experience of no longer being shamed by the challenge of dealing with her son's extreme behaviour:

You can go out now and now that, well for my peace of mind, I can think, well them on that table there are not looking at me, you know. You're more relaxed in yourself as well. I mean, we went to the pub for a meal John (husband), Sam and myself, and it were lovely. He sat good as gold. He ate his tea. He weren't laughing and he weren't giggling. It weren't that silly giggle, you know what I mean, he were just normal (laughs). It were lovely, really nice to just take him out and know that he's not going to make a show of you and you're not going to show yourselves up by shouting at him. It were lovely, it really was.(ANN)

There was, however, some uncertainty regarding the nature of the medication and the way it worked. This was an area where the mothers continued to judge themselves, asking was it the right thing to do?

Well I had me doubts, like I thought should I be doing this? I looked upon them as being like a sedative, and I thought like I don't really want to change him to the point where he's going to be dopey or withdrawn.(PAT)

I mean every tablets got it's side effects but this seemed to me...it just seemed to jump off the page and you think "Oh god, look at these side effects" and then it said it were a controlled drug as well and "Oh god what am I giving my son", you know, and do I really want him to take tablets.(SHARON)

I'd heard about Ritalin and I thought, well I don't think I like the idea of Ritalin. I'd seen a documentary on T.V. and it just sort of highlighted that it wasn't a very good drug and continues to be used. But I'd also heard it had been used as a slimming drug so I thought is this the right pathway that I should be going down.(ANN)

It's made my life more manageable to a certain degree. There's still, I still find myself, sort of judging meself still. Am I doing the right thing by giving him the medication.(ANN)

It was a little bit frightening because I say, it was the drugs, he might be on this for a long, long time. I'm not one to be taking tablets if I've got a headache, so for John to

actually take something for just an ordinary behavioural thing, it didn't seem actually right..it still doesn't feel right that he should be taking drugs, but I know when he hasn't.(JANE)

Alongside this a number of concerns were raised about the possible negative effects of the drug:

Me mum and dad say that he is too quiet on medication.(PAT)

I mean sometimes when he's had a tablet, it looks as though he's going to burst into tears, that's one of the side effects as well. They can make him not depressed exactly but really quiet, like today, this morning, when he's had his tablet, I had to keep asking him if he's alright because he looks as if he's going to burst into tears.(SHARON)

He lost a lot of weight, so of course that worried me. It still does, but he seems OK now. But you have to wonder about it, don't you?(JANE)

There was some uncertainty regarding appropriate expectations for improvement and domains of change on Ritalin:

I was telling my brother how much better X was, how good he was, and he was at the kitchen window and he says, "well, if he's so good, tell me why he's walking away with

next doors' rockery". And he'd dismantled the rockery, took it up...There's still a lot of problems. I still can't take him places. I can't take him for a meal. (LIZ)

I don't want an angel. I don't want a perfect child. But I still think there's room for improvement. You don't know how far it's going to get us though. (ANN)

It could also be difficult to separate ADHD from non-ADHD behaviour, the disorder from "sheer naughtiness":

Some people say it's just an excuse for a naughty child, but it's not, but on the other hand sometimes he does seem to just...for instance he'll ignore you when it suits him and how do you know that isn't simply being naughty? (VAL)

An important aspect of the mothers' uncertainty around the issue of medication was the realisation that the drug was effective mainly during school hours, leading to some disappointment and resentment regarding who benefited from the treatment. On the one hand pleasure and a reduction of stress consequent on the child's less troubled school career, on the other a sense that mother was still having to cope with the problematic business:

I wish it could be like an implant where he just gets a feed every so often in a way, because I'm not getting the benefit of his Ritalin, just his school...I suppose in a way I've got to a point with the Ritalin in him not taking it, if he can do well at school he has got a

future, he doesn't necessarily need to have that sort of future at home, does he? I feel I can cope.(JANE)

The tension between the different needs of the various parties and the question of who the Ritalin was for/was benefiting was evident:

I still think he should take a tablet over the weekend just to keep the edge, if you like, off his behaviour...I don't want him to be unhappy. I don't want him to be unhappy but I need a little bit of peace that it gives me.(JANE)

The mothers also had to deal with the attitudes of others, ignorant, hostile, dismissive, toward the diagnosis and treatment, experienced as stigmatising by some:

A lot of people were quite negative about it. You know feeding kids of his age with tablets like....I suppose people thought , Oh it didn't seem right this, its almost sedating him, and there is a stigma about sedation, and you think...I ignore it because I think well I see him a lot more than they do.(PAT)

The issue of continuing management and control loomed larger for some mothers than for others. Jane, for instance, was beginning to experience something of a struggle with her son regarding his medication:

He says he doesn't want to take all his tablets and I've had to fight with him to make sure he has them, 'cos for a while at school he tried to get away without taking them all. But he needs to take them, I need him to have them. Without them I just can't control him.

(JANE)

Uncertainty regarding the future

When discussing what the future might bring the participants expressed with varying degrees of tentativeness and uncertainty the hope that their sons would mature and grow out of ADHD and its attendant problems or that they would learn to deal with these problems more effectively:

I'm hoping that, sort of , going along from like now up to adulthood that his behaviour does like cool off...Basically I hope he'll settle down.(ANN)

I were talking to the Doctor about it and she said sometimes they're fine when they get to, you know, 15 and 16. Something just snaps and that's it, you know. They're fine from then on because they're more adult, they're more grown up and they learn to cope with itso I'm hoping that Sam's going to be one of them when he does get older.(SHARON)

They were even more vague and uncertain about for how long their sons would be taking Ritalin:

Well if he needs it I suppose he'll have to have it, but saying that I'm not sure how long they do actually keep them on it and anyway when he's an adult he might see things differently, like whether he thinks he needs it, although maybe he'll manage without when he is older in any case.(VAL)

Alongside the tentative hope more pessimistic prospects were contemplated and these opposing strains of hope and fear were often uneasily blended:

I can't see him being much. I get a negative view and I think what's he going to be like when he's sixteen. I get a negative sort of feeling about him....I'm hoping I'm wrong but I can't see him doing much for his self. I can't see him going very far. I'll be happy if he leaves school and gets a job and he's fine, but at the back of me mind I don't think that'll happen....I'm frightened to death for him, because I don't know how he's going to handle it.(PAT)

There was a strong sense during the interviews that it was difficult for these women to look to the future and when they did it had a vague, murky quality. Some of them stated explicitly that they avoided thinking about it, preferring to take each day as it comes:

I tend not to look too far into the future because you take every day as it is, you know what I mean. We do have some good days and some bad days and we take it day by day and assume this is what he'll be like until he's off Ritalin or whatever.(SHARON)

If this was true regarding their sons it was even more the case when they were invited to comment on their own futures:

To be honest I never think about what it'll be like for me when he's grown up, left home, if he ever does go! I just take it one day at a time.(LIZ)

Discussion

A brief summary of the results will be provided and they will then be discussed in relation to existing research in a number of relevant areas. Some limitations of the study will be outlined and the potential clinical implications of the findings considered. Possible areas for future research will be briefly explored.

Summary of results

From the analysis of the mothers' accounts three clear themes emerged. These themes appeared to capture and organise a good deal of the significant material common to all of the accounts. Each theme will be summarised in turn.

1. The struggle to understand and explain the child.

The challenging and negative behaviours of their child in the past were emphasised by the mothers. The perplexing nature of this behaviour seemed to be equally significant. The inconsistency and contradiction the mothers perceived in their sons' behaviour was reflected in their own accounts and they also struggled to include their more positive views of the child and to contain the apparently conflicting or ambivalent feelings they held towards him. Comparison with other children was an important part of the process of questioning their child's normality. All of the above factors provided the background to and seemed to motivate the mothers' search for causal explanations and associated solutions to the problem of their child's behaviour. With the failure of such solutions the mothers increasingly wondered whether they were the cause of the problem. A heightened

awareness of themselves as parents was sharpened by the experience of others being judgemental, critical, dismissive and disbelieving. This fed the self-doubt of the mothers and they spoke of their feelings of shame regarding their sons' behaviour as a reflection of their mothering and their feelings of guilt connected with their sense that they could have done more and done better for their child. This shame and guilt seemed to add to the burden which is the focus of the second theme.

2. Shouldering the burden.

Here the emphasis was on the child as a source of additional demands on the participants' resources as parents, the stress and strain of coping with the child being described as a constant battle with no respite. The mothers felt that they often had to cope alone with little or no support from others. The child's challenging behaviour was seen as instrumental in enforcing this isolation, making it difficult to maintain supportive relationships with friends or babysitters, for example. The child's behaviour also led to the experience of conflict with others and here the mothers were faced with the dilemma of defending their child while trying to get recognition for his problems, sometimes in the face of aggression and attack. The participants appeared to accept the burden of coping with their difficult son as theirs alone, with no expectation that the job could or should be shared with anybody else. They also highlighted the lack of any compensating rewards in their relationship with their child.

The participants also described a process of getting to the end of their tether, reaching a point where they felt drained and exhausted, unable to do more. Their search for help

became more desperate and was met with what they experienced as disbelief, criticism, and blame. Feeling alone with a burden they were to blame for, guilty, ashamed and seemingly unable to change things for the better, the participants began to see themselves as failures, helpless and trapped in an intolerable situation. Looking back, they all felt they had experienced some level of depression. These circumstances provide the context for the participants' accounts of the significance, to them, of the diagnosis and treatment of their sons' ADHD.

3. The significance of diagnosis and treatment

The diagnosis of ADHD and the treatment using Ritalin had different meanings for the participants. Receiving the diagnosis was a powerful event for these mothers. It provided a label, a descriptive and explanatory framework to help them understand their son's previously baffling behaviour. It also vindicated the mothers' longstanding concerns and their search for an answer. The diagnosis also lifted the blame for the child's behaviour from the mother and from her son. The mothers felt that this had increased their psychological well-being and their ability to cope with their child, independently of any effect the treatment might have had. The ADHD diagnosis gave them a means of explanation, a defence against the perceived criticism of hostile others. It also introduced a new, more appropriate reference group for social comparison. However, the mothers expressed some uncertainties regarding the diagnosis and some difficulty understanding it.

Attitudes towards treatment were more complex. The immediate and dramatic positive effects on their sons' behaviours were readily acknowledged, along with the positive effect this had on the mothers' lives, including a more rewarding relationship with their son and the experience of "normality" as a parent. The mothers were at the same time quite uncertain about the nature of the medication and expressed concern regarding its possible negative effects. They continued to judge themselves around this issue, asking if they were doing the right thing. This dilemma was sharpened by the fact that most of the medication effects were perceived as happening at school and the question of who the medication was for loomed large. Looking to the future was difficult for the participants, who were unsure how long their sons would need medication or what their sons' prospects might be.

Discussion of results

Many studies have found that parents of children with ADHD view their child's behaviour as negative and challenging (e.g. Mash & Johnston, 1983, Breen & Barkley, 1988, Baker & McCal, 1995) and that mothers' views in this respect are more extreme than those of fathers (Mash & Johnston, 1983, Baker, 1994). The mothers in this study were no exception. However, the confusion and perplexity which were important aspects of their accounts have not been reported in the quantitative research in this area. This contrasts with the results from a qualitative study of Cuban American mothers of children with ADHD (Arcia & Fernandez, 1988), where similar themes of perplexity and bewilderment regarding their child's behaviour were noted. That the mothers' difficulties in accounting for the child's behaviour in both that study and the present one may be a

common experience shared by other mothers of ADHD children is supported by a study which found an average of 24 months time lag between the time mothers of children with ADHD from the general population first noted the initial symptoms of ADHD and the moment when they were sure that a problem existed (Sullivan, Kelso and Stewart, 1990).

That ADHD is a difficult condition to explain is clear from the many reformulations it has gone through as a psychiatric diagnosis (BPS, 1996). The difficulty of the mothers in the present study seemed to be compounded by the tendency they share with parents of normal children to interpret behaviour as willed and intentional (Dix, Ruble, Grusec, & Nixon, 1986).

Weiner (1985) and others (e.g. Hewstone, 1989) have provided evidence that in situations where achievement is important people typically seek out explanations for outcomes. Such explanations and attributions are reflective of the achievement history of the individual and can be located along dimensions of locus (of the cause), stability (of the cause over time) and controllability (of the cause). The preoccupation of the mothers in the current study with searching for causal explanations was striking, and parallels the experience of the Cuban women in Arcia and Fernandez's (1998) sample. There are some important differences in the type of explanations considered however. For example, the mothers in the present study had all contemplated the possibility that dietary factors might be responsible for their child's behaviour. This is in line with the findings of Sonuga-Barke and Balding (1993) that among British parents poor diet is considered a likely cause of symptoms of hyperactivity, but this did not figure in the explanations pursued by the mothers in Arcia and Fernandez's 1998 study and may reflect their different cultural

context. A more important difference is that the mothers in the present study had, after “trying out” various explanations and associated solutions, come to think that they themselves might be the cause of their child’s problems, whereas this did not figure in the experience of the Cuban mothers. The findings for the mothers in the present sample are in line with increased tendency to self-blame found among mothers of children with ADHD compared with mothers of normal children in studies of parental stress in these groups (Mash and Johnston, 1983, Breen and Barkley, 1988). This might represent a tendency on the part of such mothers to make internal locus attributions (to themselves) for their child’s behaviour. However the few studies of mothers’ attributions for the behaviour of their child with ADHD have found that their attributions (for child noncompliance, for example) tend to be more external as well as more unstable and uncontrollable than those of fathers and of mothers of normal children (Sobol, Ashbourne, Earn & Cunningham, 1989, Freeman, Johnston & Barth, 1997). The apparent discrepancy between these findings and the salience of self-blame in the accounts of the mothers in the present study might be explained by the fact that the attributions elicited in the above studies were for particular incidents of child behaviour. It may be that while the mothers would not consider themselves responsible for such individual behaviours of their child and see such behaviour as unchangeable, they can still develop self-blaming beliefs that they as mothers are the ultimate and more pervasive cause of their child’s problems.

Associated with the notion that they were to blame for the child’s difficulties were the mothers’ experiences of shame and guilt connected with the performance of their role as a

mother. There is evidence that the experience of shame and/or guilt may be implicated in the development and maintenance of depression (Gilbert, 1992, Gilbert, Pehl & Allan, 1994, Gilbert, Allan & Goss, 1996). In the current study the contribution that shame and guilt made to the mother's burden, including experiences of depression, was explicitly acknowledged by them.

A number of other factors identified as important to the sense of burden shared by the participants have also emerged as characteristic of mothers with ADHD children in various studies. The social isolation and lack of support which the participants describe was also reported to be more extreme for mothers of children with ADHD than for controls in studies by Mash and Johnston (1983), Breen and Barkley (1988) and Baker and McCal (1995). Brown and Pacini (1989) also cite evidence that the parents of children with ADHD participate in fewer social activities than parents of controls. Such isolation and the lack of a supportive relationship with a partner, which the participants also highlighted, have been identified in various studies as vulnerability factors in the development of depression among women (Brown and Harris, 1978, Brown, 1989).

Alongside the role of shame, guilt, isolation and lack of social support the mothers gave an account of the development of helplessness, hopelessness and depression that has much in common with the learned helplessness/hopelessness model of depression (Abramson, Seligman and Teasdale, 1978). Thus, in the face of uncontrollable events (in the case of these mothers their inability to manage or change their sons' challenging behaviour) an attributional style involving the making of internal, personal and stable

attributions for the failure to control events (as was the case in the mothers' accounts of their experiences) leads to decreased self-esteem and a hopeless view of the future. The mothers' blaming themselves for their helplessness would, within this model as in the accounts of the mothers, be central to the development and/or maintenance of depression (Gilbert, 1992).

Various authors have argued that mothering and the social conditions surrounding that role require resilience and strength if they are to be successfully coped with (Ruddick, 1982, Richardson, 1993). A number of factors may support such resilience and strength. The mothers in this study spoke clearly about the way their various supports were curtailed through the long struggle to cope with the difficulties presented by their sons, including support which might have been derived from their relationship with him. In a study of the construction of depression in mothers Lewis (1995) reports that several mothers said their children were rewarding companions and that this, provided they were emotionally supported by a partner or friends, helped them overcome much of the negative experience of routine childcare. For the mothers in the present study there was no such relationship with their child, who was experienced as unrewarding. This has been shown to be the case in other studies of children with ADHD (e.g. Byrne, DeWolfe, & Bawden, 1998). It was also a significant element in the accounts given of their sense of burden by the mothers in this study.

Feminist writers examining the construction of motherhood in a patriarchal society have emphasised the subordination and oppression of women in their everyday lives as mothers

(Dally, 1982, Oakley, 1984, Nicholson and Usher, 1992, Richardson, 1993). They have pointed out that in western societies motherhood is on the one hand idealised and on the other trivialised and undervalued. To bear and rear children is often a fundamental part of a woman's life and one which is surrounded by cultural myths and stereotypes regarding the instinctual pleasures and satisfactions to be derived from it. At the same time to be a mother is to occupy a low status place in our society. Jelabi (1993) argues that it is the difficulty in reconciling these paradoxical positions that creates feelings of confusion and inadequacy in women when they become mothers. Ruddick (1982) maintains that being a mother and engaging in the culturally prescribed practices needed to nurture a child in our society leads to the evolution of distinctive ways of seeing and being. This often involves adopting styles of "humility" and "cheerfulness" to cope with the priority activities of mothering. However, in our society these virtues develop in conditions of subordination and are difficult to credit and celebrate, easy to denigrate and devalue. Ruddick also points out that it can be very difficult to explicitly recognise the strengths necessary for mothers to maintain a sense of their own identity, fulfil some of their own needs and negotiate their way through the social subordination associated with the exacting tasks their role demands.

From perspectives such as these many aspects of the experience of the participants in this study can be seen to arise from conditions of subordination and oppression shared, to some degree, by all women in a patriarchal society. This might be particularly relevant for an understanding of the participants' view that dealing with their sons challenging behaviour was in some way their job alone and that they were uniquely responsible if

anything went wrong. It may also illuminate the participants' tendency to measure themselves against an idealised standard of how they should perform and experience their role as mothers. The difficulties the participants experienced in getting recognition and respect for their strengths, achievements and commitment as mothers, both from others and from themselves, could also be understood as a feature of a wider social subordination.

Some authors have argued that a feminist consciousness and analysis of motherhood would help make the strengths of such women explicit and support them as they cope with the challenges of that role (Apter, 1993). Other writers might argue that sharing their experiences with a male researcher would influence the participants' accounts, shaping their narratives in ways which emphasised a conventional, stereotyped view of motherhood and excluded aspects of experience which did not accord with this (Roberts, 1981).

The experience of one of the participants in the current study is worth considering in more depth at this point because it seemed to differ in some important respects from the accounts given by the other mothers around the theme of their burden. It may therefore illuminate some of the central elements of those accounts.

Sharon did not appear to have experienced the same degree of isolation as the other participants and was alone in describing a supportive relationship with her husband. She also seemed to have been able to find various aspects of her relationship with her son to

be rewarding, fostering a sense of specialness through his difficulties and her attempts to deal with them. It is interesting that, although she shared the view of extra burden and the experiences of being at times at the end of her tether and struggling to get help from professionals, her account of the effects of all this were much less suggestive of a depressive response than the other mothers. Sharon was also unique in being able to frame her experience of coping with her son's ADHD as a positive learning opportunity. She was also more protective of her son, resisting some negative views of his behaviour and questioning notions of normality and naughtiness.

In the context of the participants' narratives regarding their experience of burden and helplessness, the impact of the diagnosis of their child's ADHD can be understood to derive from the shift in attributions, from internal to external, which it enabled, allowing the mothers to reassess their responsibility for the difficulties they had experienced with their son and to construct a different, more positive story about their struggles with ADHD. The treatment with medication reinforced this attributional shift and instigated some sense of control in the mothers' relationship with their sons. The clinical implications of this shift are discussed below.

Limitations of the study

None of the children of these mothers had diagnoses of ODD or CD. This may be a reflection of a number of possible parent and/or child characteristics including the psychological adjustment of the mothers and relative mildness of the challenges posed by

their children (Nigg & Hinshaw, 1998). The experience of these mothers may therefore be very different from mothers whose children have received a diagnosis of ODD or CD.

While the sample size was sufficient to enable the emergence of rich and varied description within clearly shared themes, a larger sample might have entailed some loss of contact with the unique individual accounts of the participants, but could have helped clarify and amplify the most salient aspects of common themes.

The preoccupations and concerns of the mothers may reflect in some degree the limited age range of their children (9 to 11). Mothers of older and younger children may have provided different accounts, yielding other themes. For example there is some evidence that mothers may find parenting their children with ADHD less stressful as the children get older (Barkley, Karlsson & Pollard, 1984, Barkley et al, 1991).

The socio-economic status (SES) of the participants was not assessed. None of the mothers seemed to be middle class, unlike many of the subjects in previous research involving parents of children with ADHD. As SES has been shown in some studies to be related to a number of variables including family, parent, and child characteristics (Barkley, 1990), it could be that the experience of the mothers in this study may in part reflect their SES and not be salient for mothers of different SES. The interview schedule did not explicitly raise issues pertinent to socio-economic status and this may have contributed to the mothers not addressing such issues during the interviews.

The participants who agreed to take part in research of this nature may differ systematically from those mothers who were contacted and declined to take part. For example, their experience of services might have been more positive or more negative.

The results of the analyses were not presented to the participants for them to comment upon and criticise, either individually or as a group. This would have enriched the findings of this study and enhanced their validity.

Although the interview schedule and the interview itself were intended to encourage the participants to give accounts from their own perspective and reflecting their own priorities, the focus on ADHD, its diagnosis and treatment may have meant that the interviews had a “problem” focus and this may have discouraged the mothers from describing and giving priority to less problematic and more success related aspects of their experience relevant to the issues being considered, in the area of mothering for example.

Clinical implications

The assessment of ADHD children should, wherever possible, involve some consideration of their mother’s emotional and psychological well-being, in particular the degree to which depressive symptoms may be present.

Great care must be taken to make explanations of the ADHD diagnosis as clear and understandable as possible. Similarly, the nature, mechanisms and effects of medication

should be carefully explained in a simple and clear fashion. Time should be taken to check the understanding of all those involved in the care of the child. Printed information regarding these issues should also be made available to all parents of children with ADHD diagnoses.

All professionals who have contact with mothers of children who present with ADHD should be aware of the potential for such encounters to raise issues of shame and guilt in these mothers. Every effort should be made to empathise with and understand the mother's best efforts to cope with their child's behaviour. The possibility that advice and encouragement may be interpreted as blaming should be borne in mind.

A framework for integrating medical and psychological treatments for ADHD may be provided by those therapies which take a narrative approach to helping families with problems (e.g. White and Epston, 1990). As the mothers in this study describe it, an important part of the positive impact of receiving the diagnosis of ADHD lies in the way it provides an alternative set of attributions which lift the blame for their son's problematic behaviour from both themselves and their child and place it squarely on the shoulders of "ADHD". This process is similar to the use of externalising metaphors in narrative therapies. Here the deliberate construction of such a metaphor helps place the problem (e.g. soiling, temper tantrums) outside of the individual child and allows child and family to become allies and collaborate in devising ways to limit the power that the problem has had over their lives. The therapy then supports the family as they develop

alternative solution-focused narratives which enable them to successfully improvise and creatively alter their ways of dealing with this and other problems.

Usual treatment approaches to ADHD using medication as well as more psychological approaches such as parent training have not been well integrated. Conceptualising diagnosis as an externalisation of the problem within a narrative framework would enable the use of drugs such as Ritalin to take their place as one of any number of strategies leading towards solution which the child and the family might use as the work to limit and overcome the disruptive power of “ADHD” over their lives.

Such an approach might also have the advantage of supporting families as they deal with their problems in a way which avoids increasing the shame, guilt and defensiveness of the mothers of children with ADHD. It could also be useful in helping these mothers deal with the ambivalence they feel towards medication when it is presented as the only effective answer to the problems they are experiencing with their child.

The development of support and self-help groups might be particularly useful for mothers such as those in the present study. Such groups could help alleviate a number of the stressful factors identified by these mothers as contributing to their difficulties. This might be especially the case regarding the sense of isolation the mothers experienced, as well as their perceptions that other people misunderstood, judged and blamed them as mothers for the behaviour of their children.

Future Research

A number of potential directions for future research may be suggested by the results of this study, including;

Studies which investigate the relationships between the various factors identified by the participants as playing some role in the development of their experiences of depression. These factors could include isolation and lack of social support, guilt and shame, the role of causal attributions and self-blame, the experience of failure as a mother and helplessness and entrapment.

Longitudinal studies which can evaluate the ongoing relationships between such variables and the psychological adjustment of the child.

Studies which examine the impact of diagnosis compared to treatment on variables such as mother's self-esteem, parenting stress, attributions and expectancies, and relationships with the child and significant others.

Qualitative studies of children's experience of ADHD, diagnosis and treatment, and of the experience of their fathers.

Further qualitative studies of the experience of mothers with children of different ages who have a diagnosis of ADHD.

References

Abidin, R. R. (1986) *Parenting stress index*. Charlottesville, V. A: Pediatric Psychology Press.

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978) Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 87, 49-74.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th ed. revised)*. Washinton D. C.

Anastopoulos, A. D., Barkley, R. A., and Shelton, T. L. (1995) The history and diagnosis of Attention-Deficict Hyperactivity Disorder. In P. Cooper and K. Ideus (eds.) *ADHD. Educational, Medical and Cultural Issues*. Maidstone, Kent: The Association of Workers for Children with Emotional and Behavioral Difficulties.

Anderson, C. A., Hinshaw, S. P., & Simmel, C. (1994) Mother-child interactions in ADHD and comparison boys: Relationships with overt and covert externalising behaviour. *Journal of Abnormal Child Psychology*, 22, 247-265.

Apter, T. (1993) *Professional Progress: Why Women Still Don't Have Wives*. London: Macmillan.

Arcia, E., & Fernandez, M. C. (1998) Cuban mothers' schemas of ADHD: Development, characteristics, and help seeking behaviour. *Journal of Child and Family Studies*, 7, 333-352.

Baker, D. B. (1994) Parenting stress and ADHD: A comparison of mothers and fathers. *Journal of Emotional and Behavioural Disorders*, 2, 46-50.

Baker, D. B., & McCal, M. S. (1995) Parenting stress in parents of children with attention-deficit hyperactivity disorder and parents of children with learning disabilities. *Journal of Child and Family Studies*, 4, 57-68.

Barkley, R. A. (1990) *Attention Deficit Hyperactivity Disorder*. New York: Guilford Press.

Barkley, R. A., Anastopoulos, A. D., Guevremont, D. C., & Fletcher, K. E. (1992) Adolescents with attention deficit hyperactivity disorder: Mother-adolescent interactions, family beliefs and conflicts, and maternal psychopathology. *Journal of Abnormal Child Psychology*, 20, 263-288.

Barkley, R. A., Fischer, M. Edelbrock, C., & Smallish, L. (1991) The adolescent outcome of hyperactive children diagnosed by research criteria-III. Mother-child interactions, family conflicts and maternal psychopathology. *Journal of Child Psychology and Psychiatry*, *32*, 233-255.

Barkley, R. A., Karlsson, J., & Pollard, S. (1985) Effects of age on the mother-child interactions of ADD-H and normal boys. *Journal of Abnormal Child Psychology*, *13*, 631-637.

Breen, M. J., & Barkley, R. A. (1988) Child psychopathology and parenting stress in girls and boys having attention deficit disorder with hyperactivity. *Journal of Pediatric Psychology*, *13*, 265-280.

British Psychological Society (1996) *ADHD: A Psychological Response to an Evolving Concept*. Leicester. BPS.

Brown, G. W. (1989) Depression: A Radical Social Perspective. In K. Herbst & E. Paykel (Eds.), *Depression: an Interactive Approach*. Oxford: Heineman Medical Books.

Brown, G. W., & Harris, T. O. (1978) *The Social Origins of Depression*. London: Tavistock.

Brown, R. T., & Pacini, J. N. (1989) Perceived family functioning, marital status, and depression in parents of boys with attention deficit disorder. *Journal of Learning Disabilities, 22*, 581-587.

Byrne, J. M., DeWolfe, N. A., & Bawden, H. N. (1998) Assessment of attention-deficit hyperactivity disorder in preschoolers. *Child Neuropsychology, 4*, 49-66.

Camparo, L., Christensen, A., Burhmester, D., & Hinshaw, S. (1994) System functioning in families with ADHD and non-ADHD sons. *Personal Relationships, 1*, 301-308.

Dally, A. (1982) *Inventing Motherhood*. London: Burnett.

Dix, T., Ruble, D. N., Grusec, J. E. , & Nixon, S. (1986) Social cognition in parents: Inferential and affective with children of three age levels. *Child Development, 57*, 879-94.

Fiore, T. A., Becker, E. A., and Nero, R. C. (1993) *Research Synthesis on Education Interventions for Students with ADD*. North Carolina; Research Triangle Institute.

Fletcher, K. E., Fischer, M., Barkley, R. A., & Smallish, L. (1996) A sequential analysis of the mother-adolescent interactions of ADHD, ADHD/ODD, and normal teenagers during neutral and conflict discussions. *Journal of Abnormal Child Psychology, 24*, 271-297.

Freeman, W. S., Johnston, C., & Barth, F. M. (1997) Parent attributions for inattentive-overactive, oppositional-defiant, and prosocial behaviours in children with attention deficit hyperactivity disorder. *Canadian Journal of Behavioural Science*, 29, 239-248.

Gilbert, P. (1992) *Depression: The Evolution of Powerlessness*. Hove: LEA.

Gilbert, P., Allan, S., & Goss, K. (1996) Parental representations, shame, interpersonal problems, and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy*, 3, 23-34.

Gilbert, P., Pehl, J., & Allan, S. (1994) The phenomenology of shame and guilt: An empirical investigation. *British Journal of Medical Psychology*, 67, 23-36.

Harvey, E. (1998) Parental employment and conduct problems among children with attention-deficit/hyperactivity disorder: An examination of child care workload and parenting well-being as mediating variables. *Journal of Social and Clinical Psychology*, 17, 476-490.

Henwood, K. L., & Pigeon, N. F. (1992) Qualitative Research and Psychological Theorizing. *British Journal of Psychology*, 83, 97-111.

Hewstone, M. (1989) *Causal Attribution: From Cognitive Processes to Collective Beliefs*. Oxford: Blackwell.

Ideus, K. (1995) Cultural foundations of ADHD: a sociological analysis. In P. Cooper and K. Ideus (eds.) *ADHD: Educational, Medical and Cultural Issues*. Maidstone, Kent. The Association of Workers for Children with Emotional and Behavioural Difficulties.

Jebali, C. (1993) A feminist perspective on postnatal depression. *Health Visitor*, 66, 59-60.

King, N. (1994) The qualitative research interview. In C. Cassell and G. Symon (eds) *Qualitative Methods in Organisational Research*. London: Sage.

Lahey, B. B., Russo, M. F., Walker, J. L., & Piacentini, J. C. (1989) Personality characteristics of the mothers of children with disruptive behaviour disorders. *Journal of Consulting and Clinical Psychology*, 57, 512-515.

Lewis-Abney, K. (1993) Correlates of family functioning when a child has attention deficit disorder. *Issues in Comprehensive Pediatric Nursing*, 16, 175-190.

Lewis, S. (1995) *The Social Construction of Depression*. Unpublished PhD manuscript: University of Sheffield.

Mash, E. J., & Johnston, C (1983) Parental perceptions of child behaviour problems, parenting self-esteem, and mothers' reported stress in younger and older hyperactive and normal children. *Journal of Consulting and Clinical Psychology, 51*, 86-99.

Nicholson, P. (1990) Understanding postnatal depression: a mother-centred approach. *Journal of Advanced Nursing, 15*, 689-695.

Nicholson, P., & Usher, J. (1992) *The Psychology of Women's Health and Healthcare*. London: Macmillan.

Nigg, J. T., & Hinshaw, S. P. (1998) Parent personality traits and psychopathology associated with antisocial behaviours in childhood attention-deficit hyperactivity disorder. *Journal of Child Psychology and Psychiatry, 39*, 145-159.

Oakley, A. (1984) *The Captured Womb*. Oxford: Blackwell.

Reid, R., Maag, J. W., and Vasa, S.F. (1993) Attention Deficit Hyperactivity Disorder as a disability category: a critique. *Exceptional Children, 60*, 198-214.

Richardson, D. (1993) *Women, Motherhood and Childrearing*. London: Macmillan.

Roberts, H. (1981) *Doing Feminist Research*. London: Routledge.

Ruddick, S. (1982) Maternal thinking. In B. Thorne and M. Yalom (eds) *Rethinking the Family: Some Feminist Questions*. London: Longman.

Smith, J. A. (1995) Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre and L. V. Langenhove (eds.) *Rethinking Methods in Psychology*. London: Sage.

Smith, J. A. (1996) Evolving issues for qualitative psychology. In J. Richardson (Ed.) *Handbook of Qualitative Research Methods for Psychology and the Social Sciences*. Leicester: BPS.

Sobol, M. P., Ashbourne, D. T., Earn, B. M. & Cunningham, C. E. (1989) Parent's attributions for achieving compliance from attention-deficit-disordered children. *Journal of abnormal child psychology*, *17*, 359-369.

Sonuga-Barke, E. J. S., & Balding, J. (1993) British parents beliefs about the causes of three forms of childhood psychological disturbance. *Journal of Abnormal Child Psychology*, *21*, 367-376.

Sonuga-Barke, E. J. S., & Goldfoot, M. T. (1995) The effect of child hyperactivity on mother's expectations for development. *Child: Care, Health and Development*, *21*, 17-29.

Stormont-Spurgin, M., & Zentall, S. S. (1995) Contributing factors in the manifestation of aggression in preschoolers with hyperactivity. *Journal of Child Psychology and Psychiatry, 36*, 491-509.

Stormont-Spurgin, M., & Zentall, S. S. (1996) Child-rearing practices associated with Aggression in youth with and without ADHD: An exploratory study. *International Journal of Disability, Development and Education, 43*, 135-146.

Streubert, H. J. (1994) Evaluating the qualitative research report. In G. Lobiondo-Wood & J. Haber (Eds.) *Nursing Research: Methods, Critical Appraisal and Utilisation*. St. Louis: Mosby.

Sullivan, A., Kelso, J., & Stewart, M. (1990) Mothers' views on the ages of onset for four childhood disorders. *Child Psychiatry and Human Development, 20*, 269-278.

Swanson, J. M., McBurnett, K., Wigal, T., Pfiffner, L. J. et al (1993) Effect of stimulant medication on children with attention deficit disorder: a "review of reviews". *Exceptional Children, 60*, 154-162.

Weiner, B. (1985) An attributional theory of achievement motivation and emotion. *Psychological Review, 92*, 548-573.

White, M., & Epston, D. (1990) *Narrative Means to Therapeutic Ends*. New York: W. W. Norton.

Critical Appraisal

Word count: 1,700

Writers on ADHD are fond of quoting part of a nineteenth century rhyme concerning,

Fidgety Phil

Who wouldn't sit still

They may hope in this way to suggest a respectable maturity for the concept they are constructing, but I am always reminded that Fidgety Phil was one of a number of variously awkward, intransigent and disobedient children who feature in Struwwelpeter's grim collection of cautionary tales for young people. Each of these children refuse in some way to buckle under and accept the dictates of the adult world they are being socialised into. Each of them meets an exemplary and gruesome end as a result. Conrad for instance, who persists in sucking his thumbs despite being warned that if he doesn't stop, the Scissor Man will come calling. Persists that is, until the Scissor Man does indeed pay him a visit and cuts off his thumbs, as a result of which Conrad bleeds to death.

Fidgety Phil's crime is his restlessness, or more precisely his refusal to curb this restlessness even in situations where it undermines and disrupts the rigorous order imposed by social etiquette. It is his hyperactivity at the dinner table which seals his fate. His fidgeting results in the table being upended, food and crockery scattered everywhere, sharp knives and forks sent flying, flying straight into Phil's restless little body. He too bleeds to death.

For me the Struwwelpeter stories are a grisly articulation of some of the repressions children and childhood are subject to in our society. I enjoy them because the violence of these repressions, our awareness of which is itself often repressed, is here hilariously exposed. I was a rebellious child, overflowing with anger at the adults who, with my best interests at heart, seemed intent on wielding their authority and power to crush my liveliness and constrain my energy. My defiance was important to me and I remained receptive to those whose ideas help to expose the power relations between adults and young people and the abuse and oppression they give rise to. It is not hard for me to identify with the Phils of this world at their most fidgety. For example, when I read studies of the adult outcomes for children with ADHD, reports that such children as adults have more car accidents than normal individuals remind me of Phil's fate at the dinner table and that it the creation of cars (polluting death dealers) as much as the individuals' ADHD which is responsible for that outcome.

My point is that these childrens' difference is difficult to accomodate in an increasingly ordered and demanding society and that instead of searching for ways in which this difference may be respected and celebrated, effort is devoted to devising ever more sophisticated and powerful means to constrain and subdue it, through diagnoses, behavioural interventions and drug treatment, for example.

I felt that research in this area could attempt to join with and empower those children labelled as problematic and diagnosed with this disorder, the validity of which seemed to

me still provisional and uncertain. The aim would be to somehow help give a voice to a relatively unheard group, whose story was yet to be told from their own point of view.

Some practical teaching sessions by Jonathan Smith on using Interpersonal Phenomenological Analysis enthused me and convinced me that this approach would be a good way to explore such questions and to give a voice to the children involved.

I had other ideas for possible projects. What clinched it for the ADHD option was a discussion with the psychologist who became my NHS supervisor. She told me that the Consultant Paediatrician she worked with had a database of all the children receiving treatment for ADHD in her area, a register of over eighty potential participants. At the same time I read the BPS report on ADHD which recommended among other things that more research be undertaken on the impact of the ADHD diagnosis on children's understanding of self and behaviour.

Progress with the project once my proposal had been accepted was painfully slower than I had hoped. Gaining ethics approval was a cumbersome, repetitive process and I will take greater account of this in the planning of any future research.

The next stage, of gathering a group of participants, had its own difficulties and disappointments. The application of my exclusion criteria to the children on the consultant's data base left only twenty suitable participants. Once contacted, only ten agreed to take part, four of these being excluded at a later stage.

The interviews with the first two children were very disappointing and the resulting data far from rich. A second interview with each child did not add a great deal to the data from the first. It was at this point that the decision to definitely include the mothers in the study was taken. Their interviews went much more smoothly and produced interesting accounts. The rest of the children had more to say than the first two and some fascinating material was collected, but the focus of the study had by this time moved towards the accounts of the mothers.

The decision not to try and complete the analysis and writing up of the study for the first deadline enabled me to enjoy and get more out of the rest of my third year of training, especially my clinical work on placement. This gave me an enthusiasm and confidence on starting my first job which I might otherwise not have had. However finding the time and energy to concentrate on the research while getting to grips with the demands of a new job were much harder than I anticipated.

As I began to write up the results of my analyses it became clear that I had enough material for two studies and that it would be difficult to do justice to the children and their

mothers within the constraints on length imposed by the nature of the assignment and the time I had available. After discussing the options with my academic supervisor I decided to concentrate on the mother's accounts, as these were fuller and more complete than the children's. My intention is to develop the study of the children's experience by interviewing more children and writing up the analyses for a separate paper.

What I learned/personal impact

One of the aspects of the qualitative approach which impressed me most was the flexibility which allowed me to adapt the study in response to the challenges and opportunities I encountered as I proceeded with the project. This and the overlap of clinical and research skills necessary in conducting fruitful interviews convinced me that room for qualitative research could be found even among the pressures of a clinical workload.

In the process of carrying out this research my views of ADHD and the families of children diagnosed with it have changed considerably. If I began as a self-styled champion of children labelled with ADHD, with the aim of amplifying their voice among the clamour of parents, the education system and the medical profession, then I arrived at a more complex position. The experience of listening to the accounts of the committed and caring mothers who have struggled to do the best for their child in the face of considerable challenge and to the children whose lives have, in their view, been changed

somewhat for the better through recognition and treatment of some of their difficulties has I hope altered my simplistic approach to these issues irrevocably.

I am aware that there were other directions the work might have taken (and still might). For example, when these mothers talk about their experience of ADHD they tell a certain type of story, construct a narrative of a particular genre. As they tell it, theirs is the story of a quest and as such it seems to have many features in common with other, more literary, quest narratives (such as Homer's *Odyssey*, *The Grail* narratives, Spenser's *Faerie Queen* etc.) *The Pilgrim's Progress* is a useful comparison because it uses quest conventions to allegorise, as a journey, the individual's struggle to achieve spiritual salvation.

Aspects of this quest story which can be found in the mothers' accounts include; a blighted situation/something not right before the start of the journey. a focus on a lone protagonist. The search for an answer/salvation/etc. Helps and hindrances on the way. Conflict with various antagonists. Episodes of despair. Reaching the goal.

If the mothers make sense of their personal history in this way and map a quest pattern onto their experience, where does this leave them if diagnosis/treatment is the goal/destination/salvation? For, unlike *Pilgrim* or *Ulysses*, their story is not ended and there is a conspicuous gap between the closure they imply in their narrative and the continuing complexity and uncertainty they are experiencing as caring mothers of pathologised sons.

I am also interested in Michel Foucault's ideas about the relationship between power and knowledge, that they are importantly equivalent, and his notion of dominant discourses, that at any historical moment there are certain dominant ways of seeing and speaking about the world, of constructing and wielding knowledge/power and that alternative, illegitimate, discourses are repressed/suppressed.

Michael White suggests that the therapeutic endeavour is to help people to tell alternative, empowering stories about themselves and their lives and that this is a political act of resistance to and rebellion against dominant discourses which make such alternative narratives untellable, unhearable.

From such a perspective this research project may be limited ethically and politically. The participants were invited to tell their stories by a researcher representing the status quo, as though such an encounter could be neutral vis a vis dominant power relations/structures.

A different approach to the co-construction of these stories, as in some practices of community psychology and in the work of narrative therapists might have empowered the participants to create new narratives of success and possibility. Returning to the participants to share the results of the analyses with them, perhaps as a group, might be

one way to do some of that work. Making contact with support groups etc. could be another. It may be that the project is not yet ended.

Appendices

A. Interview schedule: mother's experience of ADHD.

A. *Diagnosis and treatment.*

1. Can you describe your son's problem, as you see it, from its beginnings to diagnosis and treatment commencing?
2. What were your thoughts when the diagnosis was made?
3. What did you feel?
4. What do you think about your son taking Ritalin?
5. What are your feelings about your son's treatment?
6. In what ways does taking Ritalin affect your son's life?
Prompt; school, friendships, family, activities.
7. How does your son's treatment affect your life?
Prompt; work, family, relationships, interests.

B. *Self and others.*

1. How do you see your son?
Prompt; what sort of person is he? what are his most important characteristics?
2. How has this changed, if at all, since taking Ritalin?
3. How do others see and behave towards your son?
Prompt: other children, family, teachers, other adults.
4. How has this changed, if at all, since he began treatment?
5. How does your son see and behave towards others?
6. How has this changed, if at all, since he started taking Ritalin?
7. How do you see yourself?
8. How has this changed, if at all, since diagnosis and treatment of your son?
9. How do others see and behave towards you?
10. How has this changed, if at all, since your son began treatment?
11. How does you see and behave towards others?
12. How has this changed, if at all, since your son started taking Ritalin?

C. *Understanding and dealing with ADHD.*

1. What does ADHD mean to you personally?
2. How do you deal with ADHD?
Prompt; do you have particular ways of coping? Practical methods? Emotional?
3. How do you see the future for your son?
4. How do you imagine your own future?

B. Examples of stages of analysis

The participant, Pat, is describing her experience of an initial interview with a Family Therapy Team.

Previous experience of not being heard.

Hope that will be listened to, unburdened.

Defensiveness?

Questions seen as hostile, irrelevant?

Advice seen as controlling, unwanted, unsympathetic, unrealistic.

Child as the problem.

Feeling blamed.

Well the thing is I'd had this from the doctor anyway, and I thought I'm coming here now and I'm going to be able to get it all off me chest and somebody's going to listen to me, but I took an instant dislike to her anyway because of her attitude, she, I don't.... We had conversation: about was the marriage stable, um, did you ever hit him, um, well the things she was asking me to do and the things she was telling me what I should be doing well I didn't agree with. I got the impression from her that yes I could do that if he was an ideal child. It was as though I was getting the blame. That was the feeling I got from her.

The themes which were identified in this section of Pat's account were as follows;

Well the thing is I'd had this from the doctor anyway, and I thought I'm coming here now and I'm going to be able to get it all off me chest and somebody's going to listen to me, but I took an instant dislike to her anyway because of her attitude, she, I don't.... We had conversation about was the marriage stable, um, did you ever hit him, um, well the things she was asking me to do and the things she was telling me what I should be doing well I didn't agree with. I got the impression from her that yes I could do that if he was an ideal child. It was as though I was getting the blame. That was the feeling I got from her.

Desire to be understood

Getting advice

Feeling blamed

To illustrate this process further here is another section of the transcript, showing first the preliminary notes and then the initial themes:

Pat unsure how teachers view D.
Seeing D as naughty obscures nature of his difficulties? Pat's struggle with school. Pat does get response from teachers. Overwhelmed by advice? Did she try all these things? Was she expected to do it all? Time and effort. These "things" not working.

Helplessness. Need to feel able to control D. Uselessness. Feeling a failure as a parent. Self-doubt and self-blame.

Pat: I don't know if the teachers just looked upon him as a naughty child. So I pushed and pushed and pushed at school. Well it was just a case of er, try this and try that, try a rewarding system Over the years you get to the point where you think, well this is just not working. All these things they were asking me to do were just not working.

Interviewer: They were asking you to try different things and you didn't have any success.

Pat: No I didn't. No.

Interviewer: How did that make you feel? At the time?

Pat: At the time (sighs). Well basically I just felt like, what can I do? I can't control him. Yeah . . . felt like a, sort of a useless parent. You get to the point where you think "is it me? Is it the way I brought him up? Have I done something wrong?"

The themes identified in this passage and noted down in the right hand margin were;

Pat: I don't know if the teachers just looked upon him as a naughty child. So I pushed and pushed and pushed at school. Well it was just a case of er, try this and try that, try a rewarding system Over the years you get to the point where you think, well this is just not working. All these things they were asking me to do were just not working. Interviewer: They were asking you to try different things and you didn't have any success. Pat: No I didn't. No.

Different views of son

Pat's struggle

Advice

Failure

Interviewer: How did that make you feel? At the time?

Pat: At the time (sighs). Well basically I just feel like, what can I do? I can't control him. Yeah . . . felt like a, sort of a useless parent. You get to the point where you think "is it me? Is it the way I brought him up? Have I done something wrong?"

Helplessness

Control of son

Failure as parent

Blaming self

When the transcript had been worked through in this way, a complete list of the emergent themes at this "first level" was compiled. Some themes appeared a number of times throughout the transcript. The location of each occurrence of each theme was given by adding the relevant page number to the theme label. From the transcript of Pat's interview a total of two hundred and forty five different themes at this first level were identified.

An extract from the grouping of first level themes from the analysis of Pat's transcript is given below.

26. Pat criticised, put down

Husband criticises Pat p5, p13

Others criticising Pat p4

Getting advice p3, p9

Negative experience with psychologist p9

Feeling blamed p9, p11

Pat "put down" p8

Desire to be understood p9

27. Pat Rejected by GP

Rejected by GP p8

GP dismissive p5, p8

28. Pat isolated, unsupported

Pat avoids others due to son p6

Isolation p3

Absent husband p13

Lack of support p3

Support not given p2

No support for Pat p5

No response from professionals p6

GP unhelpful p8

Lack of progress p2

The table of master themes derived from the transcript of Pat's interview is reproduced below. For brevity's sake the relevant second level sub-themes are given for only two of the master themes.

Pat (P). Analysis of transcript.

Master (third level) Themes

1. Sense of responsibility

- 22. Different views of son (from P's).
- 26. P criticised/put down.
- 27. P rejected by GP.
- 33. P helpless/a failure.
- 34. P depressed.
- 36. P's guilt/responsibility.
- 37. Differences re: parenting
- 32. Battle to control son.
- 18. Son blamed for lack of bond with P.
- 17. Early separation P and son.
- 23. P's contradictory views of grandparents relationship with son.
- 19. Son OK when little.
- 20. P senses problem early on.
- 21. Developmental changes.

2. Mother's burden

- 25. Conflict in marriage due to son.
- 28. P isolated, unsupported.
- 29. Burden on P.
- 30. P's needs.
- 31. Difficulty balancing needs of children.
- 32. Battle to control P.
- 35. P's struggle to get help.

3. Negative and contradictory views of son

4. Explaining her son

5. Support

6. Significance of diagnosis

7. Significance of Ritalin (more complex)

8. Uncertain future

The final table of group themes derived from the list of master themes from each of the mothers interview transcripts is reproduced below. Constituent master themes from the individual interview transcripts are only given for the group themes *Mother's sense of responsibility* and *Mother's burden*.

Group Themes

1. Mother's sense of responsibility

M takes it personally (Ann)

M's sense of responsibility (Liz)

M's sense of responsibility (Pat)

M's sense of responsibility (Sharon)

Taking it personally (Jane)

M's sense of responsibility (Val)

2. Mother's burden

Burden on L (Liz)

Burden (Pat)

A's burden and struggle (Ann)

S's burden (Sharon)

Burden on V (Val)

Support (Pat)

3. Contradictions in the view/account of the child

4. The struggle to understand and explain the child

5. Uncertainty regarding the future

6. The significance of diagnosis and treatment