Effects of ADHD on the Family

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Abstract

This integrative paper looks not only at my internship experience overall, strengths and weaknesses and plans for future professional development, but also examines my experiences dealing with ADHD in the context of therapy. This paper also reviews some of the research about the impacts on a family when one of the children is diagnosed with ADHD and the impact of an adult family member with a diagnosis of ADHD.
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Introduction

In a 2001 review of literature about families of children with ADHD, Johnston and Mash pointed out that while there has been a shift of interest away from Attention Deficit/Hyperactivity Disorder (ADHD), many unanswered questions still remain, such as the degree of difficulty associated with family relationships and parental adjustment. Since more energy has been put toward identifying symptoms of ADHD rather than identifying impacts on the well-being of the symptom carrier, much work still remains in this regard (Klassen, Miller, & Fine, 2004).

Other questions also exist. For example, to what extent can a family’s difficulties be directly related to the fact that one or more family members is diagnosed with ADHD versus other factors that may be involved (Johnston & Mash, 2001)? If some of the etiology of ADHD is not biological or genetic in origin, but somehow dynamically rooted in the family environment, then how is the family’s psychosocial health impacting the child with the ADHD symptoms – and possibly exacerbating those symptoms?

The understanding of the ways a person with ADHD affects his or her family has changed as the understanding of ADHD’s etiology and symptomology has changed. Generally, these studies
point to a correlation between the severity of symptoms of ADHD and negative impact on the family system, on the mothers, and to a lesser extent on the fathers in the family system. Additionally, the marital relationship of a husband and wife can suffer negatively as a result of having one or more ADHD children in the family. Parents report lower levels of parenting satisfaction (Edwards, Barkley, Laneri, Fletcher, & Metevia, 2001), lower self-esteem (Mash & Johnston, 1983; Vitanza & Guarnaccia, 1999) and higher levels of negative parenting behavior (Edwards et al., 2001).

While much research has been done on ADHD in children and adolescents, and on its impact on families, less research has been done on the impact on the family of an adult family member with ADHD. As might be expected, having a spouse with ADHD has significant negative impact on the marital relationship. It also negatively impacts the child-rearing efforts of the parents, and by inference, impacts the children (Eakin, Minde, Hechtman, Ochs, Krane, Bouffard, Greenfield & Looper, 2004).

**ADHD Described**

**Diagnostic Criteria for ADHD**

ADHD is defined by a persistent pattern of inattention and/or hyperactivity/impulsivity that is elevated above levels normally observed in persons of the same developmental age and
for a period longer than six months (American Psychiatric Association [APA], 2000).

There are three types of ADHD, Predominantly Inattentive Type, the Predominantly Hyperactive-Impulsive Type, and Attention-Deficit/Hyperactivity Disorder, Combined Type.

The inattentive type is described by numerous characteristics, including failing to give attention to details in chores or schoolwork, difficulty sustaining attention, not seeming to listen or hear when spoken to, failure to follow through and finish chores and/or schoolwork. Other characteristics include difficulty organizing tasks and activities, avoiding or disliking tasks that require sustained mental effort - such as homework, often losing things, often easily distracted by extraneous stimuli, or often forgetful in daily activities (APA, 2000).

The Hyperactive/Impulsive Subtype is characterized by some or all of the following symptoms: frequent fidgeting, often leaving one’s seat in classroom or during normally seated times, running or climbing excessively and inappropriately, often having difficulty playing quietly, often on the go or acting as if they can’t stop moving, often talking excessively (APA, 2000). Impulsivity is characterized by blurting out answers, having difficulty waiting his/her turn, physically making sudden motions that are disruptive or interrupting others.
The third subtype of ADHD is the Combined Type. This subtype should be used if six or more symptoms of both the inattentive type and the hyperactive type have persisted for more than six months (APA, 2000).

In order to be diagnosed with ADHD, a person must have sufficient numbers of either hyperactive/impulsive subtype symptoms or the inattentive subtype symptoms. The combined subtype requires that the person must have at least six of the symptoms from each subtype to be identified as having the combined subtype.

For every subtype these symptoms must have persisted for at least six months and some of them must have been present before the age of seven. There must be clear evidence of significant impairment in at least one realm of functioning (APA, 2000).

It is worth noting that the current diagnostic criteria are categorical in nature. That is, they measure to what degree a person exhibits the symptoms that categorize the three subtypes of ADHD. The goal is diagnosis. There are as yet no biological tests that confirm the presence of ADHD (Staller & Faraone, 2006).

**Impaired Executive Functioning**

Executive functions (EFs) are also referred to as higher-level functions, control processes, control functions or execu-
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tive processes. EFs are known to be impaired in children who have been diagnosed with ADHD, although research has produced mixed results. Sometimes the research shows impaired executive functioning in ADHD children and sometimes it does not (Fuggetta, G., 2006).

Neurophysiological studies suggest frontal lobe dysfunction in persons with ADHD. Frontal lobe dysfunction impacts attentional components, impulsiveness, planning, and problem solving, all of which are descriptive of various symptoms of ADHD. Using neuropsychological tests such as the Wisconsin Card Sorting Test (WCST), the Go/No-Go test, and the Stroop Color and Word test, researchers have attempted to show that executive functioning is impaired in persons with ADHD. While some results have been mixed there is sufficient evidence to conclude that behavioral inhibition is impaired in persons with ADHD. This reduced behavioral inhibition exhibits in four executive function areas: working memory, self-regulation of affect-motivation arousal, internalization of speech, and reconstitution (Wu, Anderson, Castiello, 2002).

EF has been researched heavily in the last decade. Geurts describes EF as mental control processes that enable self-control and problem solving for the attainment of a future goal (Geurts, H. Hilde, S. Verté, et al. 2004). EF involves meta-
cognitive domains such as response inhibition, working memory, cognitive flexibility (set shifting), planning and fluency (Ozonoff as cited in Geurts, H. Hilde, S. Verté, et al. 2004).

EF deficits are strongly linked to impaired functioning of the prefrontal cortex and its related networks. This link has been established through neural imaging studies that show involvement of prefrontal and connected structures in both ADHD and autism (Faraone & Biederman as cited in Geurts, H. Hilde, S. Verté, et al. 2004). There is a strong similarity in the prefrontal dysfunction of children with ADHD and autism. This prefrontal system includes the dorsolateral prefrontal cortex, lateral orbitofrontal cortex, anterior cingulated, supplementary motor area, and associated basal-ganglia structures. Guerts, et al found that children with autism have deficits in planning and flexibility, but children with ADHD do not. However, children with ADHD show an inhibition deficit not shown in the children with autism (Geurts, H. Hilde, S. Verté, et al. 2004).

All this suggests that the EF dysfunctions may be rooted in the same part of the brain, but have slightly different causality and therefore different symptomology. What we do know is that because of their ADHD, children have more difficulty engaging in the tasks of life in a goal-directed way. The inhibition deficit gets in the way of focusing on a goal and achieving it.
This results in frustration on the part of both the child with ADHD and the parents who have to raise them. Simple things like remembering to do chores, brush teeth, get ready for the day, follow instructions, etc., have an inherently higher set of obstacles for the child with ADHD. While it appears to be willful resistance, it is frequently a simple lack of ability to carry through on planned tasks because of the level of EF dysfunction associated with ADHD. The tension created in a family because of this lack of follow through can be a strong source of relational stress and also a significant source of low self esteem for the child who just can’t seem to finish what they start.

ADHD Prevalence in the General Population

Just over one hundred years ago George Still (as cited in Hallowell & Ratey 1995) described symptoms of children’s behavior that we today would identify as ADHD. In that short hundred years ADHD has moved from being little understood to being heavily researched with an abundance of hypotheses as to its origins and most effective modes of treatment. It has become one of the most commonly diagnosed disorders among school-aged children. ADHD has become part of the fabric of our culture relatively quickly, with people joking about being “ADD,” or “hyper” when they can’t sit still or have trouble concentrating. The word, “Ritalin,” has become a daily part of the lives of many children.
and families. The National Survey of Children’s Health 2003 reports that 6.9% of children between the ages of 4 and 17 have at some time been diagnosed by a health professional with ADHD. That translates to more than 4.4 million children. Of those children, 56% (over 2.4 million children) were reported to be taking some form of medication for their symptoms (National Survey of Children's Health, 2003). Other estimates of prevalence range from 8 to 12% of children. In addition, the prevalence of ADHD diagnosis reported among boys was 2.5 times higher than that of girls (National Survey of Children's Health, 2003). Other studies range from a boys to girls ratio of 10:1, down to 2:1 (Faraone, Sergeant, Gillberg, et al. 2003). Yet Gaub & Carlson, 1997 report ratios of 9:1 to 3:1, depending on whether the sample is clinically referred or community based. They attribute this discrepancy to the severity of the symptoms associated with persons who are referred to a clinical setting compared with those symptoms reported in community based settings.

However, prevalence rates are subject to wide interpretation depending on several factors, including sample source, rater type and number, sample, age, interview and rating scale method, and diagnostic criteria. For example, prevalence rates diminish with age and increase when samples shift from school, to community, to clinic. Estimates of prevalence are also
greater when the diagnostic approach does not address impairment, as is the case with many rating scales (Faraone, Sergeant, Gillberg, et al. 2003).

The same National Institutes of Health survey noted that the incidence of ADHD diagnosis was significantly higher among insured children who were English-speaking and non-Hispanic (National Survey of Children's Health, 2003). In other words, when managed care money is available for the diagnosis and treatment of ADHD, the incidence of diagnosis increases. While this correlation does not prove causality it does raise the question of whether the lower diagnosis rates are caused by less access to medical care and the corollary – that if medical care was equally available to all populations, the diagnosis rates would be similar.

One significant difference between boys and girls has been supported by research. Girls with ADHD tend to have less externalizing behaviors than boys, including lower rates of conduct disorder than boys (Gaub & Carlson, 2003). Consequently, more research has been done on boys.

ADHD Etiology

ADHD has been described by various terms in the last hundred years – hyperactivity, hyperkinesis disorder of childhood, and minimal brain dysfunction (Seidman, Valera, & Bush, 2004).
The name changes over the years reflect a change in understanding of the causes of ADHD. George Still (as cited in Hallowell & Ratey 1995), in a series of lectures to the Royal Academy of Physicians in England, was the first person to attribute the symptoms of ADHD to genetic causes or to a brain injury at birth rather than the prevailing idea at the time that such behaviors were simply moral failure on the part of the child - an unwillingness to conform to socially acceptable patterns of behavior.

Today it is generally accepted that ADHD has a neurophysiological component. It is also generally accepted that there is a strong heritable component to ADHD. Numerous twins studies have born out the familial connection for ADHD (Faraone & Biederman, 1994).

In the late 1980s theorists had already been suggesting for over a decade that the problems of inattention and hyperactivity may arise from a deficit in the inhibitory mechanisms of the pre-frontal cortex (Gorenstein, Mammato, Sandy, 1989). Various neuropsychological tests were devised to assess the functional impairment of these persons. While it could be shown that persons who had experienced physical damage to the pre-frontal cortex exhibited many of the same symptoms of ADHD, the comparison of symptoms didn’t offer an answer, only a correlation (Mattes as cited in Gorenstein et al., 1989). Relatively recent advances
in imaging technology have enabled researchers to obtain much information about the actual physiological characteristics of the brain and compare the brain images of persons diagnosed with ADHD with the characteristics of the brains of those persons who do not display the ADHD symptoms. This research lends even more support to the conclusion that there are physical differences in the frontal lobes of ADHD-diagnosed persons compared with non-ADHD persons.

Identifying ADHD Remains An Inexact Task

ADHD has become well known, and has been reclassified and redefined in the DSM-IV-TR (APA, 2000). Also its etiology has been at least somewhat identified (Valera & Seidman, 2006). Yet it remains an enigma in many ways. Even Dr. Russell Barkley acknowledges that the changing names given to ADHD, along with changes in identified symptomology, indicates that a definitive understanding of ADHD and a robust etiology are still being sought (Barkley, 1998). There is no “smoking gun” that clearly names the definitive cause(s) of ADHD, without which many questions remain about its origins and treatments. Making a diagnosis of ADHD still involves judgment rather than hard science (Cushman, LeBlanc, & Porter, 2004).
**ADHD Effects on Family Members**

To “impact” means, “to fix firmly by,” or “to have a direct effect on,” or “to strike forcefully” (Merriam-Webster Online, 2005). Indeed, if drug sales of Ritalin and Adderall are any indication, ADHD is having an enormous impact on families today. In the following sections the impact of ADHD is broken down into several areas and examined in light of the studies reviewed.

The understanding of the ways a person with ADHD affects his or her family has changed as the understanding of ADHD’s etiology and symptomology has changed. Generally, these studies point to a correlation between the severity of symptoms of ADHD and negative impact on the family system, on the mothers, and to a lesser extent on the fathers in the family system. Additionally, the marital relationship of a husband and wife can suffer negatively as a result of having one or more ADHD children in the family. Parents report lower levels of parenting satisfaction (Edwards, Barkley, Laneri, Fletcher, & Metevia, 2001), lower self-esteem (Mash & Johnston, 1983; Vitanza & Guarnaccia, 1999) and higher levels of negative parenting behavior (Edwards et al., 2001).

While much research has been done on ADHD in children and adolescents, and on its impact on families, less research has been done on the impact of an adult spouse with ADHD. As might
be expected, having a spouse with ADHD has significant negative impact on the marital relationship. It also negatively impacts the child-rearing efforts of the parents, and by inference, impacts the children (Eakin, Minde, Hechtman, Ochs, Krane, Bouffard, Greenfield & Looper, 2004).
Impact on the Person with ADHD

Generally lower quality of life. According to results of a study on Health Related Quality of Life in Children with ADHD, (Klassen, Miller, & Fine, 2004), these children have more parent-reported problems in terms of emotional-behavioral role function, behavior, mental health, and self-esteem. Their study goes beyond measuring the reduction of ADHD symptomology or behaviors in a person by trying to quantify what brings about well-being in that person’s life.

Whalen et al., (2006) also attempts to point out that quality of life is lower in children who exhibit more ADHD related behaviors. The study analyzes Palm Pilot entries by both child and parents throughout the day in an attempt to discover just what is going on inside the child, and the parent, during a typical day. Whalen concludes that even though all the subjects in their study are taking timed-release medications, and teachers are reporting significant improvements in attention along with lowered restlessness, there are still impacts felt by the child and the mother on a daily basis. These include restlessness, impatience, excessive talk and loudness, and difficulty concentrating.
Whalen concludes that the quality of life is still negatively impacted in spite of a reduction in reported symptoms. A potential flaw in this study may be that in order to participate, the subjects had to be able to master the technology required to keep the diaries.

Stress as a Measure of Effect on a Family

Stress is often a factor used to measure the effect of ADHD on families. Many of these studies use one or more instruments to measure stress in the parent or in the child (Balkwell & Halvorson, 1980; Breen & Barkley, 1988). A definition used in stress-related literature is that stress involves a mismatch between perceived resources, such as skill and self-efficacy beliefs, and the actual demands of the parenting role (Featherstone, Morgan, Robinson, & Aldridge, 2002). Parenting stress has also been described as, “the difficulty that arises from the demands of being a parent” (Anthony, Anthony, Glanville, Naiman, Waanders & Shaffer, 2005). For the studies that identify stress as a way of measuring the effect of ADHD on a family all studies generally agree that different forms of stress are correlated to ADHD in children and even in parents. The stressors that induce the stress come in various ways and the stress is manifested by one or more parents in various ways.
One study of 103 school age boys and their mothers (girls were not included so as to remove that variable from the equation) sought to correlate various factors, such as the level of dysfunctional interaction between mother and child, maternal self-esteem, daily hassles in the home, the mother’s sense of competence and the amount of social support available to the mother (Vitanza & Guarnaccia, 1999). Starting from the challenging behaviors of an ADHD child, the authors found that parenting stress and the psychological stress on the mothers increased as the behaviors increased. The psychological stress was identified as feelings by the mother of not being competent as a parent and also increased depressive symptoms.

An interesting finding was that mothers were more likely to experience greater psychological distress if they did not value being a parent or were not comfortable fulfilling that role. Vitanza also found a correlation between mother’s self-esteem and maternal depression. This caused the mothers to be more sensitive to criticism by others. In order to reduce stress levels in these families it may be necessary to bolster the self-esteem of the mothers, help them to value the role of mother and equip them with parenting skills to increase their feelings of competence.
In my internship I saw this maternal “taking on” of the child’s deficits particularly strongly in one couple. The son’s inattentiveness and distractibility made his academic work a point of frustration, but more so for the mother than for the son or the father. The son was diagnosed with ADHD. He presented with a number of traits that indicated a diagnosis of Oppositional Defiant Disorder (ODD), although he had not received that as an official diagnosis when I began to see the family. The boy had an Individualized Education Plan (IEP) set up, but was having difficulty following it. Rather than being able to release the child and accept his inability to perform in the same ways as his peers, the mother took on his deficit and displayed a great deal of anxiety around her son’s struggles. There was also a tug of war between the husband and wife because the husband was more willing to let things go and the mother wanted to ensure that the son performed according to his plan. One of the couple’s main points of contention in their troubled marriage was their disagreement over child-rearing practices. Their son’s ADHD exacerbated their frustration.

Another study related to parental competence found that there was correlation between mother’s negative parenting behavior and the behaviors of their sons (Edwards, Barkley, Laneri, Fletcher, & Metevia, 2001). One distinction about this study was
the presence of comorbid behavior, in this case, ODD. Eighty-seven male teens with a dual diagnosis of ADHD and ODD and their parents were studied along with a control group of 32 male teens and their parents (who were diagnosed only with ADHD) as a control group. Both the teens with the dual diagnosis and their parents rated themselves as having significantly more parent-teen conflicts.

Again, this tendency was played out in my work with this family. The son would react negatively to his mother’s negative parenting behavior, but he did not have the emotional intelligence or experience to know how to deal with his reactions. Often his response was socially unacceptable acting out in school and in relationship with his younger brother.

Parents used negative parenting behaviors in these conflicts - more with their ADHD/ODD children than the control group. Like the previous study, challenging behavior on the part of the teens was met with a stress reaction (negative parenting behavior) on the part of the parents. This time the child’s negative behavior was ratcheted up significantly by the presence of the comorbid ODD behaviors. What was interesting about this study was the differential impact that fathers had on the children and the difference in impact on the mothers versus the fathers in the conflict situations.
Teens were significantly more hostile toward their mothers than their fathers. Mothers reported that they were more angry than the fathers were in the conflict situations. Yet when the mothers, fathers and teens were together in conflict situations, there was more negative behavior than when just the mothers and teens were together in conflict situations. Mothers also reported more hostility and depression than the fathers. In other words, the stress appeared to settle more in the mothers than in the fathers. There is good reason to explore the reasons why this might be so and should indicate a direction for future research.

Sharing the Stress – ADHD Impacts the Parents

According to (Klassen, Miller, & Fine, 2004), parenting stress was increased when child behaviors, such as those associated with ADHD, increased in frequency and severity. The problems of children with ADHD have a significant impact on the parents' emotional health and parents' time to meet their own needs, and they interfered with family activities and family cohesion. Clearly the behaviors of the child or children with ADHD are creating their own stress. Relational struggles between children with ADHD and their parents are also a significant source of stress. However, another study claimed that as much as 42% of the stress was related to financial stress in the family.
and only 18% of the stress could be attributed to the frequency of a child’s ADHD behavior (Baldwin, Brown, & Milan, 1995).

These two studies are not necessarily contradictory, but they point out an interesting relationship. On the one hand there appears to be a directional relationship between child ADHD behavior and parenting stress, yet another study concludes that financial circumstances are responsible for much more of parental stress than the child’s behavior. How does one weigh all the factors that add to parental stress? In studies where the psychosocial impact of a family member with ADHD symptoms on a family was measured, the question of directionality was frequently mentioned. That is, does the stressful behavior of the ADHD symptom carrier produce the psychopathological reaction in the parents, siblings or spouse, or is there a two-way causality in which the psychopathology of the other family member exacerbates the symptoms of the ADHD symptom carrier (Klassen et al., 2004)?

Quality of Life as a Measure of Effect on a Family

In addition to stress as a measure of impact, several studies used the term, “quality of life,” as a way to identify the impact on the family, mother, father or child. Four different studies used various measures of quality of life to measure the
effect of ADHD on families (Klassen et al., 2004; Crowley & Kazdin 1998; Lange et al., 2005; Whalen et al., 2006).

The main point that these studies sought to make is that it is inadequate to measure the symptoms of the ADHD child or the symptoms of stress, or the psychological distress of the family members. Rather it is more valuable to find a measure of the quality of life that will guide intervention and identify when a meaningful therapeutic change has occurred. Indeed, in the one study where Palm Pilots were employed to record daily diaries, one of the findings was that although the symptoms of their ADHD were controlled by time-release medications, every ADHD child recorded significant psychopathological symptoms consistent with their diagnosis (Whalen et al., 2006). This may indicate that a different measure other than symptom reduction would be valuable in marking progress of clients on the road to well being.

**Negative Parenting Behavior**

Negative parenting behavior was the subject of more content than any other item in the articles reviewed. Two of the studies reported that parents of hyperactive children tend to be more authoritarian in their parenting style. (Woodward, Taylor, & Dowdney, 1998; Lange et al., 2005). Children who display hyperactivity are more frequently the objects of parenting behaviors that are aggressive and less proactive. Parents in this study
were more negative, more commanding, and less responsive to their child’s good behavior than control groups. Parents were also more prone to provide greater structure and control than for children who do not exhibit hyperactive behavior. The parents also demonstrated a negative affect with their children more frequently.

In the second study, (Lange et al., 2005), children with ADHD were compared to children with mood or anxiety disorders and against a control group. Parents more often displayed an authoritarian parenting style with the ADHD children, even more so than with the children who had mood or anxiety disorders. Again in the Woodward study it was found that mothers more frequently reprimand and punish their sons compared to mothers of control boys (Woodward, Taylor, & Dowdney, 1998). These parenting choices, and the responses of children to them, may have an escalating effect so that stress is increased over time.

Edwards et al., (2001) measured the communications and conflict management behaviors of parents and children where the children had comorbid disorders of ADHD and ODD. Their communication skills and conflict management behaviors were tracked and analyzed. It was found that the children with comorbid ADHD/ODD exhibited more issues of conflict, more aggressive conflict tactics and more anger intensity during those conflicts. It was
also found that the ODD characteristics accounted for most of the negative parenting responses and not ADHD. This is significant because of the high degree of comorbidity associated with children who have ADHD. By one assessment about half of children diagnosed with ADHD qualify for a comorbid diagnosis of either ODD or Conduct Disorder (Lange et al., 2005).

One could argue that treating the child’s ADHD symptoms may not lower the stress levels in the family nearly as much as treating the symptoms of the comorbid disorder. More research needs to be done on various combinations of comorbid disorders with ADHD in order to identify more precisely what stresses can be attributed to which disorder and, therefore, what interventions should be recommended.

**Depression and Low Self-Esteem in Parents**

Mash & Johnston (1983) found that depression and low self-esteem in a parent were related to children having ADHD. Mash found that when one ADHD sibling interacts with another non-ADHD sibling, whether or not the mother is present during the interactions, there is a correlation with lower self-esteem in the mother.

Nineteen years later, building on the model that Mash developed, Vitanza & Guarnaccia (1999) concluded that there is a significant correlation between a mother’s low self-esteem and
maternal depression in the context of parenting children with ADHD. Breen & Barkley (1988) found that the actual severity of the behaviors in the child is not as important as the mother’s perception that the child is behaving in ways that are stressful to the mother. This suggests that the cognitive beliefs of the mother are more significant than the actual behaviors of the child.

Breen & Barkley were studying whether boys and girls with similar levels of ADHD symptoms were perceived as being equal in the eyes of the mother as evidenced by the mothers’ levels of depression, marital distress and health problems. They compared groups of boys and girls with ADHD against another group of girls referred for various clinical conditions (none being ADHD), with a control group of girls having no diagnosed disorders. Symptoms of maternal depression were the same relative to the ADHD boys and girls, but symptoms of maternal depression were actually higher in the non-ADHD girls with other disorders.

Following this thread of depression as an impact on mothers of ADHD children leads to the issue of directionality. The question of directionality appears in most of the articles reviewed for this paper. Maternal reports of greater depressive symptoms correlated with greater evidence of psychopathology in the children. However, Breen & Barkley (1988) state that it is not known
whether the depressive symptoms of the mothers were caused by the psychopathology in the children or whether the psychopa-thology in the children was a reaction to the depression in the mothers.

Baldwin (1995) tried to establish directionality in his study of levels of parental stress in families with ADHD children. The frequency (not the same as severity, but a component of it) of ADHD behavior in children was compared with other stressors and parents were asked to identify which stressors were most related to their increased level of stress. A potential problem with this approach was that all the subjects were from a poor socioeconomic background. There was no way to compare the differences between the level of stress associated with the ADHD children and various socioeconomic conditions. The questioning was a setup to produce the desired result. There was correlation, but was there causality, or directionality? It could not be determined from the study as it was set up. With many of the correlative studies the same conclusion was drawn, as was true in the Baldwin study. Baldwin suggested that there could be no directionality established and that a future re-search should attempt to establish some causality between fac-tors such as maternal depression and ADHD behaviors.
Marital Satisfaction

Eakin et al., (2004) concluded that marital satisfaction was lower for wives whose husbands were diagnosed with ADHD. Ninety-six percent of the wives of the ADHD spouses reported that their husband’s condition interfered with their functioning in one or more ways: general household organization/time management, child rearing practices, communication and general marital relationship. Implied in this finding is the additional stress to the wife of the ADHD husband. At the same time the husbands did not report any significant impairment in the marital relationship. It may also be significant that all the spouses with ADHD were male. One way that this research could be expanded would be to study the opposite situation – wives with ADHD and their impact on the husbands.

Faraone (2003) examined the impact of parental ADHD on their assessment of their children. The study found that there is no evidence of discrepancy between reports for the ADHD spouse and the non-ADHD spouse. Since the sample was over 300, some validity and generalization can be made for this conclusion. In other words, just because the parent has or does not have ADHD, their assessment of their child is not biased.
Does the Gender of the Child Change the Impact of ADHD on the Family?

So far only boys have been represented in the studies reviewed. What about girls and the impacts of their ADHD behavior? Are there differences in either the behaviors presented by the girls or the impacts of their behavior on the family? If the behaviors are similar, do they produce the same stress reactions in the parents, or does gender make a difference?

In terms of parental stress, Breen and Barkley (1988) found that there was no difference whether the children were boys or girls. In a study about child psychopathology and parenting stress, 52 children between ages 6 and 11 participated in four groups: boys with ADHD – hyperactive subtype, girls with the same diagnosis, girls with different, non-ADHD clinic-referred girls without ADHD, but with some other form of psychopathology, and lastly a control group of girls with no known psychopathology. Generally the more depressed experienced greater stress in their role as parents and greater stress in their health. Depressed mothers also were less accepting of their children’s behavior and tended to perceive the children as more demanding of their time. The more severe are the child symptoms, the greater is the stress on the parents, or in this case, the mothers. This is consistent with the general findings of this review. With
such a small sample, however, it may be difficult to generalize this result without further larger scale studies. Within the limited scope of this literature review’s articles one can say that there is no significant difference in impact on the family whether the child is male or female.

**Impact of ADHD Compared To Other Disorders**

Lange et al., (2005) reached the conclusion that children with ADHD compared to children with a mood/anxiety disorder showed no significant differences when compared on the following characteristics: stress, support and quality of life, current family functioning, parenting style and satisfaction in the family of origin. Three groups of parents and children were compared: twenty-two mothers and thirteen fathers of twenty-two boys with ADHD, twenty mothers and fifteen fathers of twenty boys with a mood or anxiety disorder, and a control group of twenty-six mothers, sixteen fathers and twenty-seven boys. They were compared based on several factors: stress, support and quality of life, current family functioning, parenting style and satisfaction in the family of origin. Both clinical groups showed higher levels of stress in the families and lower levels of social support. Current family functioning was lower in the clinical groups compared to the controls.
Two things about this study extend the knowledge of this review. First the ADHD and mood/anxiety disorder groups showed no significant differences. If this kind of correlation can be extended to other disorders, then more can possibly be learned about the causes of family stress from studies of other disorders and their impact on family functioning. Second, the ADHD parents reported a higher level of authoritarian parenting than the mood/anxiety groups or control groups. This is consistent with the study that measured stress in families with children who have comorbid ADHD/ODD (Edwards et al., 2001). It would appear to extend the generalization that parents who experience the stress of challenging child behavior tend to react by adopting a more authoritarian parenting style. Another study in this review also found the same correlation (Woodward et al., 1998).

Additionally, there was less parenting satisfaction among the parents of children with ADHD than among the rest of the children with disorders. This finding may correlate the earlier study where one result of stress in the family was diminished feelings of competence as a parent (Edwards et al., 2001).
Conclusion

Future research in these areas can fall into several types.

The relationship between depression in the mother and the behavior of the ADHD child – how does one identify which came first and has a causal link to the other? In order to provide valid data this question would seem to require longitudinal data rather than relying on self-reporting by the parents of the onset and presence of depression or the presence of ADHD symptoms in the child.

Another dimension for possible research is ways in which fathers both contribute to and remediate the stress in a family that is present due to an ADHD child. From this limited sampling of research articles the impact of ADHD on fathers and mothers appears to be different. Most parenting behavior modifications rely on the mothers changing their parenting styles.

Still another possible avenue for research is the impact of an ADHD father or mother on his or her ADHD child. If the symptoms of ADHD in a child bring about stress in the parents, is there a similar impact in the other direction? Would a parent with a diagnosis of ADHD bring about such stress in the family or in the relationship with a child that symptoms of ADHD could be increasingly observed in the child? Conversely, if a parent
is treated for ADHD and experiences a significant reduction in symptoms, what impact would that have on a child with ADHD?

Another question raised by this literature review is this: why do fathers not seem to experience the same levels of depression so clearly associated with the mothers of ADHD children? How much of this difference in impact on the male versus female parent is due simply to the amount of time spent with the child? How much of this difference in depressive symptoms may have some correlation to gender differences?

One could also explore the question of the impact of multiple ADHD siblings on a family. Is the impact additive or multiplied by introducing more ADHD children?

Comorbidity of ADHD with other disorders is still another dimension for research. Which aspects of the stress in a family are caused by the ADHD behaviors and which aspects are caused by the other behaviors? Since so many ADHD children have comorbid disorders, what can we learn about the various combinations of comorbid disorders and how potent each one is in producing stress? And also, what is behind the fact that so many children diagnosed with ADHD also are diagnosed with another disorder? What kind of correlation exists between etiologies of different disorders?
Another aspect of ADHD in families that could be researched is the relationship between ADHD behavior, parental stress and negative parenting. Is it true that parents under stress actually communicate that stress to their children and induce negative behaviors without exhibiting negative parenting behaviors? Or, are the parents stressed as a result of having to deal with the children diagnosed with ADHD and their stress has little or no impact on the expression of symptoms by the child?

Another study concluded that it is not the reality of the child’s behavior that creates stress, but the parent’s perception of negativity in the child. What does that finding imply about cognitive therapy as a way to reduce the stress levels in families? What manner of cognitive therapy would be most effective?

Regarding the future of research on ADHD, the disorder remains an enigma in many ways, even though there has been much progress toward unraveling its causes. While there have been significant advances in etiological research, doctors, psychologists and psychiatrists still cannot definitively enumerate the causes of the disorder. It is still difficult to diagnose ADHD with certainty. There remains no definitive laboratory test to show that one person has ADHD and another does not. The complex
nature of the family system lends complexity to the task of unscrambling its impacts and its etiology. As outlined in the conclusions above there is ample room for future research.
References


