COPING PROCESSES OF FATHERS WITH AN ADHD DIAGNOSED SON:
A GROUNDED THEORY APPROACH

by

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ABSTRACT

Children diagnosed with ADHD (attention deficit hyperactivity disorder) symptoms have a condition that adversely affects their attention, impulse control, and activity. The behaviour of these children, such as difficulty in complying with parental instructions, behaving impulsively, frequently interrupting and not staying on task, as well as having conflicts with siblings may be frustrating and demanding for parents. Research on their parents has mainly focused on maternal stresses, examined from a stimulus-response perspective. Little, if any, consideration has been given to the ecological validity of the research and to father’s parenting experiences. The present study explored the coping processes of eight fathers who have a son diagnosed with ADHD behaviour. Each father was interviewed for one hour to one hour and a half in a semi-structured format. Multiple demands on these fathers and their coping strategies and outcomes were identified using the constant comparison method (drawn from grounded theory). A range of coping strategies including exercise and relaxation, taking time-outs, administering their son’s medication, seeking professional help, learning about ADHD, and thinking positively were identified. Five themes were developed, and were: (a) what it was like before diagnosis, (b) reactions to son’s diagnosis, (c) types of demands, (d) types of responses to demands, and (e) outcomes. Findings support the iterative view of stress and coping process.
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This study would not have been completed without the participation, guidance, help, and support of many people, some of whom will remain anonymous. I would like to thank the fathers who volunteered to participate in this study for their courage and trust in sharing their most personal issues with me through their stories.

Having a technical background and familiarity with quantitative methods, I wanted to have a challenge; therefore, I chose grounded theory methods for this study to learn more about the subtleties of the English language, to enhance my counselling skills by being observant and curious throughout the interviews and data analysis, and finally to write my thesis. On a few occasions I doubted my sanity for choosing such a challenge and wanted to give up. I thank you sincerely, Dr. Bonnie Long, for helping me to believe in my sanity and for making my challenge an enjoyable one through your empathy, support, and encouragement. I would like to thank you equally, Dr. Bonnie Long, for the exceptional quality of your supervision, for your time and effort in paying such meticulous attention to the minutest aspects of my work and for facilitating my learning and appreciation of quality. My collected data would not have come to life without your expertise in grounded theory, Dr. Ann Hilton. Thank you for inspiring me throughout my work by your dedication to teaching and guidance, and by being so understanding and supportive of my situation. Thank you, Dr. Richard Young, for your special way of asking succinct questions that invigorated my creativity and abstract thinking and facilitated my learning process long after the question had been asked and my answer had been given. Thank you, Dr. Wendy Hall, for your time and commitment to offer the directed studies course. Thank you very much, Amir, for scanning and printing.
Dedication

I lovingly dedicate this work to Amir and Sara who continue to give me joy, to support me in my career change to counselling, and to show interest in my work.

Also,

I humbly dedicate this work to Life who, by taking my Soul through many phases of delight and sorrow, helped me in 252 ways to discover my strengths and weaknesses and reach higher planes in my never-ending quest for growth.
Children

And a woman who held a babe against her bosom said, Speak to us of Children.
And he said:
Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.

* * *

You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.
You may strive to be like them, but seek not to make them like you.
For life goes not backward not tarries with yesterday.
You are the bows from which your children as living arrows are sent forth.
The Archer sees the mark upon the path of the infinite,
And He bends you with his might that His arrows may go swift and far.
Let your bending in the Archer's hand be for gladness;
For even as He loves the arrow that flies, so He loves also the bow that is stable.

KHALIL GIBRAN, THE PROPHET
CHAPTER I
INTRODUCTION

Attention deficit hyperactivity disorder (ADHD) is one of the most frequent childhood disorders (5% to 10% of the juvenile population; Freed & Parsons, 1997), which can pose a significant management problem for parents and teachers alike (D’Alonzo, 1996). ADHD is the term currently in vogue; however, some literature refers to ADD (attention deficit disorder), ADD/H (attention deficit disorder with hyperactivity), and hyperactivity. ADHD is considered to be a chronic condition with a set of behavioural symptoms that typically include impulsive behaviour, an inability to maintain sustained attention, and overactivity (Bender, 1997). Although research on ADHD mainly focuses on children with ADHD diagnosed behaviour, results of studies of family interaction patterns and parental stress indicate that parents of a child with ADHD have more parenting stress than parents of children considered to be normal (e.g., Baker & McCal, 1995; Barkley, Anastopoulos, Guevremont, & Fletcher, 1992; Johnston, 1996). Because most of the research has focused on mothers, and neglected fathers, the purpose of this study was to examine the coping processes (i.e., demands, responses, outcomes, and the relationship among them) of fathers with an ADHD diagnosed son.

Reports of parenting stress have shown that mothers of children with ADHD behaviour experience significantly higher parenting stress due to their children’s characteristics, such as inattention and hyperactivity, compared with mothers of normal children (Baker & McCal, 1995). Moreover, parents of children with ADHD have been found to have a greater degree of marital dissatisfaction and lower marital adjustment, compared with the parents of nonproblem children (Barkley et al., 1992; Johnston, 1996).
On the other hand, Costas (1994) studied perceptions of the family environment of 30 boys with ADHD and their mothers and concluded that mothers of children with ADHD do not experience significant levels of psychological distress or psychopathology.

In a study of 104 children and their mothers, Anastopoulos, Guevremont, Shelton, and DuPaul (1992) demonstrated that overall severity of the child's ADHD was a significant predictor of parental stress. Maternal health and psychopathology were also significant predictors of parental stress. However, Baker and McCal (1995) also found that parenting stress, attributable to parental characteristics and family context variables, were not significantly different among a group of mothers of children with ADHD, mothers of children with learning disabilities, and mothers of normal children in a comparison group. Contrary to the results of these studies, Baldwin, Brown, and Milan (1995) found that family income and other financial stressors accounted for the largest percentage of the variance in caregiver stress, followed by the children's symptomatic behaviour. In addition, Baker (1994), who studied 20 married couples, reported that socioeconomic status was a predictor variable that was significantly associated with parenting stress (each couple had a child diagnosed with ADHD). Results of the above studies, which are representative of the research in this area, are not conclusive. Moreover, they take a narrow or static view of stress (without any consideration for changes in time and ecological conditions), do not explore coping as a process that changes, and do not provide a clear definition of stress.

Although several studies were performed in laboratories where parent-child interactions were observed (Barkley, Karlson, Pollard, & Murphy, 1985; Barkley et al., 1992; Johnston, 1996); in other studies, parents, mainly mothers, were asked to complete
questionnaires and instruments such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and Parenting Stress Index (Abidin, 1986; Baker, 1994; Baker & McCal, 1995; Baldwin et al., 1995). In a third group of studies, the researchers explored the effects of parent training programs, attended mainly by mothers, on the families with ADHD children (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Estrada & Pinsof, 1995; Odom, 1996). These deductive studies attempted to support or refute specific hypothesis. The main shortcoming of these studies is that the stress of parenting was studied in a static manner, providing little insight into the process involved in parenting these children, and did not explore how parents appraise their situation and cope with the extra parenting demands. Moreover, mothers of ADHD children were the focus of most of the research on the stress of parenting.

The stresses and coping strategies of parenting a child with ADHD diagnosed behaviour change as the child develops and parents’ personal and family resources change over time. To my knowledge no study has been done focusing on how fathers cope with a son diagnosed with ADHD behaviour. Because most research on parents of children with ADHD symptoms has been focused on indicators of parents’ stress, without considering how they are coping, researchers have missed the ongoing experiences of parenting ADHD diagnosed children in the context of their families.

What is lacking in these studies is a full understanding of what the process of coping is like for fathers. Knowing about the ongoing coping processes of fathers with an ADHD diagnosed son has important clinical implications in finding ways to enrich the lives of family members. The results of such a study may provide clinicians with knowledge of the interactions between fathers and their son with ADHD diagnosed
behaviour, and the coping processes of these fathers. Thus, the purpose of the present study was to examine the coping processes of fathers who have a son with ADHD diagnosed behaviour.

Common themes were identified through a constant comparison method, drawn from grounded theory (Strauss & Corbin, 1998). Grounded theory is a qualitative research method that specifies a set of inductive strategies for collecting and analyzing data, starting with incidents and experiences, and progressively develops concepts and categories from the data (Charmaz, 1995). Because caregiving roles and experiences change as the family context changes and the child grows, this proposed method was consistent with the purpose of the study, which endeavored to discover the processes of coping strategies of the fathers of an ADHD diagnosed son.
CHAPTER II
LITERATURE REVIEW

The stresses and coping strategies of parenting a child with ADHD diagnosed behaviour is a process that has not been considered in previous research. Moreover, the researchers, who have mainly studied mothers, do not present a clear definition of stress and treat stress as a static concept. Because of the social, political, and economical factors that are related to ADHD, I first review the history and etiology of ADHD, which has constantly changed in the past few decades. This understanding provides a context in which to explore parental stress and coping. Next, I examine the literature specifically about parenting children diagnosed with ADHD behaviour. This latter group of studies on parents of children diagnosed with ADHD behaviour focuses mainly on parental stress. Finally, I point out the shortcomings of the existing studies and restate the goal of the present study.

ADHD

The syndrome of ADHD has been known since the beginning of the twentieth century, although it has been called by different names and its diagnosis has been dependent on various groups of symptoms. "The history of Attention Deficit/Hyperactivity Disorder (ADHD) is mysterious and circuitous. It is at once a phenomenon in search of an accurate and proper name, and a named diagnosis in search of a phenomenology" (Cherkes-Julkowski, Sharp, & Stolzenberg, 1997, p. 14). In the early 1940s, as a result of correlational studies of children suffering from brain injuries who often displayed attentional, behavioural, and cognitive impairments, ADHD symptoms in all children, regardless of whether the injury could be validated, were attributed to brain
injury, and the term Minimal Brain Damage Syndrome was used (Cherkes-Julkowski et al.). This term was changed to Minimal Brain Dysfunction (MBD) in the 1950s and later in the 1960s the MBD terminology was replaced by “terms such as dyslexia, dysgraphia, dyscalculia, language disorder, and learning disabilities” (Cherkes-Julkowski et al., p. 18) that reflected more specifically the observable cognitive and behavioural traits.

In the 1970s, researchers recognized that attention, more than activity, was the main symptom of the disorder and the term Attention Deficit Disorder (ADD) emerged (Cherkes-Julkowski et al., 1997). The American Psychiatric Association (APA, 1980) used the term ADD in its 1980 diagnostic manual – it was considered a mental disorder under Axis I with three subtypes. The term ADHD appeared in the DSM III-R (APA, 1987) and subsequently, with some changes in diagnostic criteria, in the DSM IV (APA, 1994).

Bender (1997) cites Bradley as being the first practitioner to use stimulant medication in the 1930s to treat children with behaviour problems. Currently use of stimulant medication for children with ADHD behaviour is the most common intervention, and Ritalin (methylphenidate) is used approximately 90% of the time (Bender). Children’s behaviour under stimulant medication becomes less distracting and hence teachers and some parents see the medication as their saviour. Ritalin has become a household name and a powerful force behind some support groups for the parents of ADHD children. Freed and Parsons (1997), commenting on the overprescription of this medicine, state that “in our short-attention-span, quick-fix, want-it-now society, it’s no wonder that Ritalin is so popular. Ritalin is overprescribed as a way to help students more passively tolerate dull and outdated teaching methods.” (p. 217).
Based on the conceptualization that ADHD is a neurological disorder, various theories of its etiology have been postulated; however, due to the correlative nature of most of the research on the etiology of ADHD, no definitive cause-effect relationship has been established (Riccio, Hynd, & Cohen, 1997). It has been further shown that a number of different etiologies including genetic factors, prenatal/perinatal factors, food additives/refined sugar, allergies, and thyroid disorder may lead to ADHD (Riccio et al.). Despite much research over the past 3 decades that explored possible etiologies for ADHD, there is no consensus on the etiology of ADHD. Cherkes-Julkowski et al. (1997) consider family functioning and conflict to be an etiological factor and maintain that a correlation between poor parenting and ADHD behaviour in children has been shown in several studies; however, they state that more rigorous studies of the parent-child interactions show a certain synergy. Mash and Johnston (1990) also mention the reciprocal nature of parent-child conflict, but acknowledge that this reciprocity is not of equal degree. On the other hand, some research indicates that there is no evidence that ADHD is the result of social or environmental factors, such as poor parenting, poverty, family problems, and diet (Barkley cited by Riccio et al.). Among different theories, genetic predisposition manifested within the central nervous system is one etiological theory that has strong support; however, even within this area there are different approaches to research related to the neurobiological basis of ADHD (Riccio et al.).

ADHD is a condition that adversely affects children’s attention, impulse control, and activity (APA, 1994). The APA diagnostic criteria for ADHD are given in Appendix A. Three subtypes of ADHD have been identified. These are: (a) Combined Type, (b) Predominantly Inattentive Type, and (c) Predominantly Hyperactive-Impulsive Type.
Problems related to hyperactivity and inattention are among the most common behaviour disorders of children and adolescents (Goodyear & Hynd, 1992). According to the American Psychiatric Association, ADHD is one of the most prevalent childhood disorders reported by schools and mental health clinics; it is estimated that this disorder may occur in as many as 3% of children. Barkley (1990) has estimated a prevalence at 3% to 5% of school-age children and has suggested that these problems comprise 30% to 40% of the total referrals to child guidance clinics. ADHD is more frequent in males than females with proportions that range between 3:1 (male:female) and 9:1 in the literature (APA, 1994; Barkley, 1990).

In addition to the literature on the etiology of ADHD, there is other literature that argues that ADHD does not exist, or that it is over diagnosed (Freed & Parsons, 1997; Smelter, Rasch, Fleming, Nazo, & Baranowski, 1996). Smelter et al. suggest that ADHD has become a desired diagnoses, and maintain that there is no definitive test and no agreed-upon etiology for ADHD. For example, when a child is diagnosed and put on medication, some parents and teachers feel more competent in their dealing with the less active child. “Many parents and teachers actually embrace the label of ADD with relief, as it offers a name – an explanation for the inexplicable” (Freed & Parsons, 1997, p. 24). All children have socially unacceptable behaviours at one time or another, as part of their maturation process, and even adults could be hyperactive or distractible during boring situations (Smelter et al.). During stressful events, such as divorce or problems with peers, many children exhibit symptoms of ADHD (Freed & Parsons).

ADHD is one of the most researched conditions in the United States both because of concern about the status of the disorder as distinct from others and because of its
impact on a child’s development and his or her family, classroom, and community (D’Alonzo, 1996). It is estimated that 5 million children, 11% of the population age 6 to 17 years, are prescribed Ritalin each year (Breggin, 1997). However, because the diagnosis of ADHD is based on a number of observable symptomatology and is highly subjective, dependent on who is observing the child (Widener, 1998), political, economical, contextual, and cultural factors have an effect on the outcome of diagnosis, treatment, and research on ADHD. “The diagnostic criteria for ADHD are so diverse and subjective that a child who is not diagnosed by one physician may very well be by the next doctor that the parents take their child to. Parents have been known to engage in ‘physician shopping’…until a diagnosis of ADHD is made” (D’Alonzo, 1996). In the United States, low income families generally qualify for increased Medical or Supplemental Social Security Income benefits when they have a diagnosed ADHD child (Smelter et al., 1996), and schools get a federal bonus ($420 in 1997) for each student diagnosed disabled (Freed & Parsons, 1997). Also, in the United States, where Ritalin is used five times more than it is used in the rest of the world (Widener), many psychologists and medical doctors specialize in diagnosing ADHD at a cost from $1,000 to $2,000 (Freed & Parsons).

In different contexts, children’s behaviours could be perceived differently, indicating that ADHD symptoms are contextual and cultural. Widener (1998) notes that more diagnoses are made in the winter when children are confined to indoors, than in the summer when children’s active behaviour is acceptable outdoors. Some pediatricians have noticed an increase in ADHD referrals following report card time and parent-teacher interviews (Freed & Parsons, 1997). A high percentage of ADHD members have been
observed among hunting tribes, indicating that ADHD could have been a useful adaptation for survival (Hartmann cited in Freed & Parsons), and valued by some cultures.

Cramond (1994) found an overlap between descriptors for creativity and those for ADHD. She also reported that children taking Ritalin have lowered self-esteem and suppressed creativity. Also, adults who take Ritalin have reported decreased creativity (Freed & Parsons, 1997). Freed and Parsons, who believe that too many children are labeled ADHD, describe a child with genuine ADHD as one who typically has short attention span, rarely finishes a task, jumps from one activity to another, is physically and socially clumsy, and whose visual mind flashes randomly from one thought to another. Rather than labeling such a child as ADHD, Freed and Parsons consider the term “hyperimpulsive random visual processor” to be more accurate; however, they state whatever term is used, parenting this kind of child is a tremendous challenge. As for treatment of genuine cases of ADHD, Freed and Parsons suggest that before seeking medication other bases for the child’s difficulties be looked at and other interventions be tried.

Theories of Stress

A major theory of stress and coping considered in the present study is that of Lazarus and Folkman (1984). Rather than earlier stimulus/response definitions of stress, Lazarus and Folkman define psychological stress as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 21).
There are two main types of appraisals known as primary appraisal and secondary appraisal. Primary appraisal, which is concerned with the assessment of whether or not an event is potentially harmful to the individual, consists of three kinds: (a) irrelevant appraisals, (b) benign-positive appraisals, (c) stressful appraisals. Stressful appraisals are in turn subdivided into three categories of harm/loss, threat, and challenge. Harm/loss is when the individual recognizes that some damage has already occurred, as in loss of loved person, self- or social esteem, or a severe injury or illness. Threat involves anticipated harms or losses that have not yet occurred and it permits anticipatory coping so that the individual can plan ahead to work through some difficulties in advance. Challenge appraisals focus on the potential gain or growth that the encounter might have, and are accompanied by pleasurable emotions such as exhilaration, excitement, and eagerness (Lazarus & Folkman, 1984). Secondary appraisal deals with evaluation of coping resources and options, which includes, but is not limited to, resources such as physical, psychological, familial, social, and material. Interaction of primary and secondary appraisals determines the degree a person experiences stress and the strength and quality of that person’s emotional reaction.

Lazarus and Folkman (1984) define coping “as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). This definition is concerned with what the person thinks, feels or does in a specific situation rather than simply the characteristics of that person; it is process-oriented rather than trait-oriented. Coping as a process implies that coping thoughts and acts change according to the stressful event encountered by a person. Also, in this definition coping is seen as an effort, meaning it is
intentional and not an unconscious reaction. Coping is also distinguished from outcome, regardless of the success of the outcome.

According to Lazarus and Folkman (1984), coping strategies serve two major functions, problem-focused and emotion-focused. Problem-focused coping is the effort to manage the problem by changing the person-environment relationship, such as confronting an issue or making plans to solve a problem. Emotion-focused coping either changes the way the stressful issue is attended to, such as denial, avoidance, and seeking social support, or changes the relational meaning of the stressful event, such as having empathy and understanding (Lazarus, 1993). Coping strategies, whether emotion- or problem-focused, are determined by cognitive appraisals and are dependent on the resources that are available to an individual in the context of a specific event (Lazarus & Folkman, 1984).

The above model of stress and coping provides a general framework for examining research on parenting stress, particularly the stress of parenting children with ADHD diagnosed behaviour. This model also provides a perspective on parents’ appraisal of their children’s behaviour. Whether a father appraises his child’s behaviour to be a challenge with potential for growth or whether he appraises the behaviour as a loss, or threat to the realization of his expectations of the child, may determine whether the same behaviour is perceived as stressful or not. It was expected that the present study would provide a broader view of the appraisal and coping process described in Lazarus’s model.

**Parenting Stress**
In this section, I review literature about parenting stress followed by studies of parents of children with ADHD behaviour. Before focusing on the stresses of parenting a child with ADHD symptoms, it is important to understand that parenting in general has its stresses and challenges, even when children do not have any mental or physical disabilities. These stresses and challenges of parenting, of course, are not the same for every family and vary over time for different parents according to their personal and social resources. Miller and Myers-Walls (1983) consider parenthood to be a normative life experience because about 90% of the population of the United States and Canada, who can have children, chose to do so. Although parenthood is considered as a status or role, parenting is seen by Miller and Myers-Walls as long-term intensive task and activity having stressors in three major groups—physical, psychological, and financial. However, they emphasize that there are other problems and difficulties that do not come under these three groups, such as loss of personal freedom, disagreements between parents about how money should be spent or children raised. Usually there are certain sequences of events that are anticipated and accepted throughout the life cycle of families; however, these anticipated, as well as unanticipated events could occur at unexpected times making family transitions a major source of stress (McCubbin & Figley, 1983). Events such as death in the family, major accidents, teenage marriage, dropping out of school, a birth of a child (especially unplanned) may be quite stressful for families. In the above case and almost all the research on stress of parenting children with ADHD behaviour, stress is viewed as a stimulus rather than a process. Because of this perspective on stress, a fathers’ appraisal of a child with ADHD diagnosed symptoms and their coping strategies has not been explored.
Kidwell, Fischer, Dunham, and Baranowski (1983) take a systems perspective on family stress and consider stress, which is seen as external stimulus, as not only inevitable, but necessary for growth and change. In Kidwell et al.'s perspective, interrelationships within the family may be stressful due to the developmental changes of the family members or the structure of the family system. The authors consider this stress to be normative in nature, rather than pathological.

Mash and Johnston (1990) see stressful parent-child interactions as characterized by high levels of control-oriented and negative interchanges that “are often accompanied by a lack of positive and mutually responsive interactions” (p. 313). Mash and Johnston, who have conceptualized parenting stress as a complex construct of behavioural, cognitive, and affective components, propose a model of parent-child interactive stress (Figure 1) that includes these components (a) Child Characteristics, (b) Environment Characteristics, and (c) Maternal Characteristics. Child characteristics include temperament, cognitive or physical attributes, and the presence of behavioural problems. Environmental characteristics include variables such as major adverse life events, daily hassles, and the immediate interactional context. Maternal characteristics include cognitions, affective states, personality attributes, behavioural skills, and health status. However, Mash and Johnston acknowledge that this model is conceptual and hypotheses based on it need to be investigated. Moreover, although this model considers influences of Child Characteristics and Environmental Characteristics on Parent Characteristics, it does not consider the direct effects of Parent Characteristics on the other two constructs, such as the effect of parent’s problem solving ability and use of available resources on Environmental Characteristics, or the effect of parents’ genetics and personal traits on
Child Characteristics. Also, this model does not treat stress and coping as an ongoing process that changes over time.

Figure 1. A model of stress in parent-child interactions (Mash & Johnston, 1990)

Parents of ADHD Children

Parents of children diagnosed with ADHD attempt to adjust to the demands of raising a child with special needs. When these parents learn of the diagnoses, they often experience feelings of sadness, isolation, denial, and depression (Bender, 1997). It is not uncommon for parents to overlook their own well-being and become involved in a "codependent" relationship with their child (Gehret, 1993). According to Gehret, "codependent people let another's behaviour affect them so much that they become obsessed with that effort to control" (p. 2). When parents are obsessed, they cannot think about or enjoy anything except taking care of the special child. A "codependent" relationship, in which parents often meet the demands of the child at the expense of other members of the family, brings anxiety to the family, and gives the ADHD diagnosed child some control over the family (Gehret). Paying particular attention to one child in
turn could promote sibling rivalry toward that special child, more misbehaviour among siblings, and more stress for parents. Mash and Johnston (1990) suggest that in most families of hyperactive children, the main source of parent-child interactive stress appears to be due to the child characteristics. Parental and environmental characteristics are considered important but have a secondary role.

Behaviour of ADHD children, such as difficulty in complying with parental instructions, impulsive behaviour, frequently interrupting and not staying on task, as well as having conflicts with siblings be very frustrating and taxing for parents. Some studies have been done in the past two decades with regard to different aspects of stress in families of ADHD children. However, compared with the research on ADHD as a disorder, and on children diagnosed with ADHD, studies on parents of children with ADHD behaviour are few and have not yielded conclusive results.

Research using Standardized Measures

In this section, I review studies that have used standardized measures and questionnaires, completed by parents, to measure parents’ stress. The significance of child characteristics in parenting stress was demonstrated by Baker and McCal (1995) who compared reports of parenting stress and child behaviour problems among mothers (n=16) of children diagnosed with ADHD, mothers (n=16) of children with a diagnosed learning disability (LD), and mothers (n=16) of non-referred children who had no emotional, behavioural, or learning disabilities. Mothers of children with ADHD (13 boys and 3 girls) were selected from a list 26 referrals over a 9-month period of participants in a parent training program for parents of children with ADHD. Mothers of children with learning disabilities (12 boys and 4 girls) were also selected from a referral list over a 9-
month period from a clinic specializing in the assessment of learning disabilities. Mothers of children in the non-referred group were selected from an undergraduate research pool. Measures were completed prior to participation in the program. For dependent measures two instruments were used; Child Behavior Checklist (CBCL) (Achenbach, & Edelbrock, 1983) and Parenting Stress Index (PSI) (Abidin, 1986). CBCL is a parent-completed behaviour rating scale for parents of children 4 to 16 years of age. It has 113 items that provide standard scores on empirically derived scales based on the child’s age and gender. PSI is a 101-item parent-completed measure of parenting stress that measures parenting stress due to child characteristics (Child Domain) and parent characteristics (Parent Domain).

To compare group differences on the dependent measures, a series of one-way multivariate analysis of variance were performed followed by one-way analyses of variance for significant effects. The results of this study showed that the mothers of children with ADHD experience significantly higher parenting stress due to child characteristics than mothers of children with learning disabilities and mothers of non-referred children. Baker and McCal (1995) found that parenting stress associated with hyperactivity and distractibility (subscales of PSI) was highest among the mothers of children with ADHD. The results of this study suggest that parenting stress due to parent characteristics and family context were not significantly different among the groups.

Baker and McCal’s (1995) study supports the general theory that parents of ADHD children have more parenting stress, compared with the parents of children who do not have a disability. The strength of this study is that parenting stress among parents of children diagnosed with ADHD behaviour was compared not only with a comparison
group, but also with parents whose children had another disorder; learning disabilities. Some of the limitations of this study are: (a) Parenting stress is defined in terms of parent and child characteristics and parents' resources, environmental characteristics, and developmental life events were not considered. (b) Two structured instruments that take about 90 minutes to complete do not seem to explore the context and the depth of the parenting experience of the participants. (c) The two dependent measures of parenting stress (PSI) and child behaviour problems (CBCL) were both completed by parents, which reinforces parents' perspective of or bias toward stress. (d) All ADHD group mothers were those who had voluntarily enrolled in a special parent training course for parents of ADHD children. Although the questionnaires and measures were completed prior to the course, these parents could have had ineffective coping strategies and might have been particularly stressed because they were motivated to attend a special parenting course. Finally, the inclusion of fathers in the research design would have added important information on family functioning. It is important to examine coping processes of fathers of children with ADHD behaviour, who are not seeking parenting training, in order to determine what type of resources these parents have, their appraisal of their interactions with their sons, their coping strategies, and the outcome achieved through those strategies.

Given that parenting stress levels can be high among families of children with ADHD, Anastopoulos et al., (1992) investigated the degree to which such stress was related not only to the child's ADHD, but also to various other child, parent, and family-environment circumstances. A total of 104 children and their mothers, selected from 200 referrals to a university clinic, met the study's eligibility requirements and served as
research participants. All of the children, 87 boys and 17 girls, met DSM-III-R criteria for an ADHD diagnosis (APA, 1987). They were between 4 and 12 years of age and did not have any evidence of severe sensory loss or language delay, cerebral palsy, pervasive developmental disorder, or psychosis. Measures used in this study were parent interviews, PSI (Abidin, 1986), CBCL (Achenbach & Edelbrock, 1983) for children 6 years of age or older, and Conners Parent Rating Scales (Goyette, Conners, & Ulrich, 1978) for children under 6 years old, as well as predictor variables assessing child characteristics, parent characteristics, and family-environment. Anastopoulos et al. used multiple-regression analyses and found that child characteristics (43% variance) and parent characteristics (41% variance), far more than family-environment circumstances (4% variance) are associated with the higher levels of parenting stress. Maternal health and psychopathology were the only other significant predictors (13%) to emerge from the hierarchical regression analyses.

Although this study had a very large sample size compared to other studies in this area, it did not have a comparison group to determine whether the results are specific to parents of ADHD diagnosed children, or typical of parents in general. For example, maternal health and psychopathology, which were significant predictors of stress in this study, could be valid for any parent who has poor physical and emotional/mental health, irrespective of their child’s health. This study’s findings are consistent with that of the previous study suggesting that child and parent characteristics, more than family environment and context are associated with higher parental stress for parents of ADHD diagnosed children. However, both studies used the same measures; CBCL (Achenbach & Edelbrock, 1983) and PSI (Abidin, 1986). Although this study supports the
relationship between parental stress and children’s ADHD behaviour, due to the
correlational nature of this investigation it cannot be ascertained whether these child and
parent factors directly cause parenting stress. Finally, this study, similar to most studies in
this area, did not involve fathers. Inclusion of fathers of the children diagnosed with
ADHD behaviour could have provided a different perspective.

Because evaluations of parenting stress have relied almost exclusively on
maternal reports, Baker (1994) examined whether differences exist in reports of parenting
stress between mothers and fathers of children with ADHD. Participants were 20 married
couples who each had a child diagnosed with ADHD. Couples were selected from a list
of referrals to a university-based psychology clinic offering parent-training services for
ADHD. Families met the following criteria: (a) the parents currently were married, (b)
the family had a male child with a primary DSM-III-R diagnosis of ADHD, and (c) the
child was free from any profound developmental and/or psychiatric disabilities. The
decision to include only male children was based on the fact that the referral pool
contained only three female children.

Mothers and fathers were requested to complete the measures separately and not
to discuss their responses. Dependent Measures were CBCL and PSI. PSI measures stress
due to child characteristics (Child Domain) and stress from parent characteristics (Parent
Domain). CBCL scores of Internalizing, Externalizing, and Total Behaviour were used in
a multiple-regression analyses to determine the effects of child and family variables on
parenting stress. Scores of the PSI scales (Child and Parent Domains) were used in a
separate regression analysis. Mean scores on the Child Domain revealed a small but
significant difference between mothers and fathers, indicating that mothers of children
With ADHD perceived their children to be more stressful than did fathers. There were no significant differences between mothers and fathers on the Parent Domain scores. Mothers and fathers showed no significant differences on their ratings of their children’s behaviour for any of the three scales (Internalizing, Externalizing, Total Problem Behavior) of the CBCL. For the Parent Domain score, SES was the only predictor variable that was significantly associated with parenting stress (14% of variance). This study found that higher SES was associated with increased parenting stress. A finding not reported elsewhere in the literature on parenting stress and ADHD. In fact, in contrast to this finding, Mash and Johnston (1990) noted that lower SES (e.g., poverty) is a contributing factor to parent-child stress in all families.

The results would suggest that fathers of children with ADHD experienced levels of parenting stress similar to those experienced by mothers, although mothers may be somewhat more likely to perceive child characteristics as more stressful. Years married accounted for slightly more variance in parenting stress than did parent gender. Parenting stress decreased as number of years married increased. There are indications that PSI scores of fathers tend to be lower than those of mothers in nondisabled populations (Abidin, 1986), suggesting that there may be characteristics of parenting stress that are common to all parents, including those who have children with ADHD behaviour.

Baker (1994) acknowledges that several considerations in this study limit the generalizations that can be made. First, the sample of parents was predominantly white, married, and middle to upper class. In addition they were parents who sought out parent-training classes for ADHD. Second, the study did not have a comparison group of parents with ‘nondisabled’ children. Another limitation of this study is that, similar to the
preceding study, it used two standardized measures, both completed by parents, which do not explore the context and the process of coping and appraisal for parents.

Research using Laboratory Observations

In this section, I review studies where parent-child interactions have been observed for a short time in laboratory. In a study by Barkley et al., (1992), parent-child interactions of adolescents diagnosed with ADHD with and without Oppositional Defiant Disorder (ODD) (APA, 1994), were studied to evaluate which of these disorders most contributed to the observed parent-child interaction conflicts. Two groups of adolescents and their mothers were evaluated. The children were between 12 and 17 years of age, and had no evidence of serious sensory, motor, or emotional disorders. The first group consisted of 83 adolescents who were consecutive referrals to a clinic specializing in ADHD and who met the research criteria for ADHD. The adolescents had to have: (a) Parent and/or teacher complaints of inattention, poor impulse control, and overactivity as established through a parental interview; (b) at least 8 of the 14 symptoms of ADHD as set forth in the DSM-III-R for at least 12 months, with an age of onset before 7 years; (c) if currently receiving stimulant medication, have approval from their prescribing physicians to discontinue it 48 hours prior to being in this study. The resulting sample consisted of 27 ADHD without ODD (ADHD) and 56 ADHD with ODD (ADHD/ODD). The community comparison group consisted of 77 adolescents and their mothers who were recruited through newspaper advertisement.

The adolescents and their mothers completed interviews and rating scales of family conflicts. ADHD and ADHD/ODD adolescents were required not to take their stimulant medication 48 hours prior to being in the study. Mothers also completed self-
report measures of psychological adjustment. The mothers and their teenagers were then videotaped while they discussed a neutral topic for at least 10 minutes and then discussed a list of five current significant conflicts with each other, also for 10 minutes. All of the statements by the mothers and adolescents were then transcribed and were coded into six behaviour categories separately for each participant. These categories were: Put Downs/Commands, Defends/Complains, Problem Solves, Facilitates, Defines/Evaluates, and Talks.

Barkley et al. (1992) found that mothers of adolescents referred for ADHD described their relationships with their teenagers as having more negative communication patterns, more issues in conflict with each other, and greater intensity of anger during those interactions than did mothers of adolescents in the community comparison group. These family communication and interaction problems were likely to be reported by mothers regardless of whether the ADHD adolescent also manifested a co-morbid ODD. It is suggested that the presence of ADHD in an adolescent is associated with a more angry and conflicted pattern of family communications at this age than that encountered in normal families. Although causal statements cannot be supported by these correlational results, Barkley et al. speculated that it may be the inattentive, impulsive, and generally immature self-regulatory behaviour seen in ADHD that increases these disagreements between ADHD teens and their families.

Additional findings revealed that ADHD teens, whether ODD or not, had a greater number of issues over which there was dispute with their parents, as reflected in mothers' ratings on the Issues Checklist (Robin & Foster, 1989). They also demonstrated more anger intensity during these discussions relative to a comparison group of
teenagers. Furthermore, teenagers with both ADHD and ODD were more likely to engage in negative interactions with their mothers even during a discussion of seemingly neutral, nonproblematic issue—a pattern of interaction not seen in the normal teens. Similar to some other studies of ADHD children and children with behaviour disorder (e.g., Befera & Barkley, 1985; Webster-Stratton, 1988), this study of clinic-referred ADHD teenagers also found a greater degree of marital dissatisfaction in the mothers of ADHD teenagers having a co-morbid diagnosis of ODD than in those of the comparison group.

This study, similar to preceding ones, excluded fathers and studied mother-adolescent interactions in the laboratory. The laboratory observations and completion of structured measures is far from the real life situations of parenting children with ADHD behaviour. The process of coping and the context are not considered. Moreover, adolescents, who at home were under stimulant medication, by not taking their medication 48 hours prior to the laboratory observation most probably were not behaving the same as they would usually behave at home.

Parent-child interactions and parent characteristics in families of ADHD children have been studied by Johnston (1996) as well. In her study she compares families of nonproblem children with the families of ADHD children with lower (ADHD-LOD) and higher (ADHD-HOD) levels of oppositional-defiant behaviour. Johnston states that “it has generally been found that psychiatric disorders, substance abuse, family conflicts and separations, parenting stress, and criminal activities are more common in families of ADHD children who are comorbid for oppositional or conduct disorder than in families of ADHD children who do not have these accompanying diagnoses.” (p.86). In this study, a range of characteristics, including parenting self-esteem, social relationships, life
stress, and psychological disturbance were examined in both mothers and fathers of ADHD children. Forty-eight families referred to a parenting program for parents of 5- to 11-year-old children diagnosed with ADHD participated in the study. Children on stimulant medication were asked not to take it 24 hours prior to being observed in the laboratory. Using parent ratings on the IOWA Conners Aggression subscale, the 48 ADHD children were divided into groups with lower and higher levels of oppositional-defiant behaviour (ADHD-LOD and ADHD-HOD, respectively). Thirty-three families of nonproblem children were recruited through newspaper and community notices.

While each parent engaged in a 30-minute interaction with the child, parent-child interactions were videotaped from behind an observation mirror. The first 10 minutes of the parent-child interaction were devoted to free play. Then the parent was given a set of written instructions and materials for tasks the child was to complete. Tasks included activities such as sharpening a pencil, dusting a small table, sorting and folding socks, and sorting cards belonging to different decks. In the remaining 10 minutes, the child was to complete a set of age-appropriate academic tasks. Parent-Child Interactions and Parent Characteristics were measured as variables. For Parent-Child Interactions, reports of parent-child interactions were assessed using the Home Situations Questionnaire. This measure asks parents for the number and severity of the child’s problematic behaviour at home. For Parent Characteristics, the Symptom Checklist 90-Revised (SCL 90-R; Derogatis, 1983) was used to measure psychological distress. Maternal satisfaction was measured by the Dyadic Adjustment Scale (DAS; Spanier, 1976). Multivariate analysis of covariance was used for each group of parent-child variables and univariate analyses of covariance was used for DAS scores.
Results of this study suggest that, although certain difficulties in parent-child interactions are more common in families having ADHD children with higher levels of oppositional-defiant behaviour than in families having ‘nonproblem’ children, these difficulties also often appear in families of ADHD children with lower levels of oppositional-defiant behaviour. It was only on mothers’ reports of the severity of child problems, observed child oppositional behaviour, and parenting self-esteem that ADHD children with lower and higher levels of oppositional-defiant behaviour were distinguished. For both types of ADHD families, both mothers and fathers marital adjustment were lower than for nonproblem families.

A finding that is contrary to expectation, and may be due to differences in the measures, was that fathers of ADHD-LOD were more directive than the comparison group, whereas fathers of ADHD-HOD children did not differ from the comparison group. Johnston (1996) acknowledges other inconsistencies in this study. The measures of parental characteristics in this study revealed mixed results, as well as inconsistency in differences in life stress across the two measures used. This study lacks ecological validity, moreover, children were observed who had not taken their regular medication 24 hours prior to their interactions with their parents. Furthermore, all families of ADHD children were referred to a parenting training program, which could imply a bias in either children having a very high rate of oppositional-defiant behaviour, or parents lacked certain parenting/coping strategies, or both.

Another study that is based on observations of parent-child interactions (Befera & Barkley, 1985) examined potential sex differences in the parent-child interactions, parent and family histories, and parent ratings of child psychopathology in hyperactive boys and
girls. In this study, 30 ADHD diagnosed children, who ranged between 6 to 11 years in age and equally divided by sex, were selected from referrals to a child psychology clinic. A comparison group of 30 normal children of the same age range and equally divided by sex were recruited through friends of the families with hyperactive children. Mother-child interactions of free-play (for 10 minutes), in a playroom with furniture and toys were observed and recorded. After the free-play session, the mother was given a written set of instructions to have her child complete certain tasks. During this period that lasted 20 minutes, the mother, while supervising the child’s activities, completed the CBCL. Two observers (one for parent and the other for the child) recorded parent-child behaviours and responses for 5 seconds for each 10-second observation. A two-by-two analysis of variance was used with each measure, for free play and task sessions. Researchers found that there were no significant differences between hyperactive girls and boys in the nature of their personality and emotional disorder. Compared with the mothers of normal children, mothers of hyperactive children responded to the child’s compliance with more commands, directions, and negative remarks than did the mothers of normal children. It was also found that mothers of hyperactive children were more depressed and had more marital dissatisfaction and psychiatric disturbance than mothers of normal children.

The laboratory observation in this study is its main limitation. The dependent measures used in observations of parent-child behaviours and responses are very structured and are threats to the ecological validity of the study. In conclusion, Befera and Barkley (1985) expressed the need for replication of their study with a larger number of participants, and that their study is clearly exploratory in nature thus the results are only tentative.
A study using observation of parent-child interactions during free-play and task completion was conducted by Barkley et al., (1985) to examine the effects of ADHD children’s age on the mother-child interaction, as well as how different doses of Ritalin affects these interactions. Sixty ADHD diagnosed boys and their mothers were selected from referrals to child neurology and psychology clinics. For the comparison group 60 normal boys and their mothers were recruited from the names of the friends of the ADHD boys. Both groups of boys were subdivided equally into five age groups of 5, 6, 7, 8, and 9 years. All children were observed on four different occasions, about 10 days apart. During the first observation, serving as a baseline condition, children were off medication. The children then participated in a double-blind, drug-placebo cross-over design within age groups. Two different doses of Ritalin or identical placebos were employed twice a day. During the study, all mothers were observed with their children for a 20-minute free-play and a 20-minute task period when each mother had a list of 5 tasks to do with her child. Two observers recorded the parent-child interaction every 10 seconds for 5 seconds. Dependent measures were derived from a coding procedure for scoring parent-child interactions, as used in the preceding study (Befera & Barkley, 1985). After each drug condition, mothers completed a 16-item questionnaire about whether they experienced a behaviour problem with the child. A two-way analysis of variance (age level x drug condition) was used for parent-child interaction measures during free-play and task period.

Barkley et al. (1985) found that ADHD boys were less compliant, more negative, and less interactive than normal boys. It is also suggested that the mothers of ADHD children gave more commands, initiated fewer interactions toward their sons, and
responded less to their sons' interactions than mothers of normal boys. However, during the task period, significant effects for age were seen, indicating improved interactions in older as compared to younger children. Older boys were more compliant than younger boys, and their mothers gave fewer commands.

This study, similar to previous ones, relied on standardized measures, as well as observations in a laboratory. The coding system used in this study, as well as the previous study by Befera and Barkley (1985), is limited in measuring and interpreting parent-child interactions. Barkley et al. (1985) are aware of the limitation of the coding system and state that “future research should utilize coding systems that capture more qualitative aspects of social exchanges than did the present system” (p.713).

Summary and Critique

The studies reviewed are representative of research on parental stress of children with ADHD behaviour. All of these studies attempted to demonstrate the existence of a stressful relationship by observing parent-child interactions for a short period, or they relied solely on the completion of structured questionnaires and instruments by parents. Two instruments used in nearly all the studies are the PSI (Abidin, 1986) and the CBCL (Achenbach & Edelbrock, 1983), both completed by parents. One of these instruments measures parents' stress and the other the child's behaviour. When both instruments are completed by the same parent they may bias the results. Moreover, these and other questionnaires and instruments used in the studies are very structured and do not explore the unique context of each family's parenting process and their coping strategies. Getting married, giving birth to a child, promotion in a job, striving for success, and many other life stages and activities can be interpreted as stressful by some people and yet many
people enjoy them, because they appraise these events differently. All the researchers, who studied mostly mothers, concluded that parenting a child with ADHD behaviour is stressful, but they did not examine fathers' experiences. Moreover, almost all of the studies mentioned that their results were tentative and further research was required.

The present study addressed the main question: What are the coping processes of fathers who have a son diagnosed with ADHD behaviour. Sub-questions included: How do fathers feel about parenting their children? What are the demands on fathers? What are the dimensions of their coping strategies and in what context? What are the intervening conditions that supported or inhibited the efficacy of fathers' action/interaction strategies with their sons?

**Significance for the Present Study**

What is missing in research on parents of children diagnosed with ADHD behaviour is research that explores what fathers believe, feel, experience, and how they act while parenting a child with ADHD behaviour. A 30-minute observation of parent-child interaction in a laboratory, or completing standardized instruments by no means reflects these parents' challenging experiences of raising an ADHD diagnosed child. It is important to explore more thoroughly the personal experiences of the fathers of children with ADHD. Thus, the goal of this research was to explore the coping process of fathers with an ADHD diagnosed son. Grounded theory method (Strauss & Corbin, 1998) was used to explore the ongoing experiences of this population, and to construct general themes (i.e., categories) related to the coping process.

My research was sensitive toward and respected each father as an individual who had a particular experience according to his own contextual situation. Although the
outcome of the present study was not expected to be generalizable, the goal was to provide an in depth view of the experiences of some fathers with an ADHD diagnosed son and to identify their context and coping strategies.
CHAPTER III
METHODS

This chapter provides information regarding the methods used to gather and analyse data for the present study. The first section provides the rationale for using the grounded theory method and a brief introduction to grounded theory. The final section of the chapter provides a detailed discussion of the methods used in the present study.

Rationale for Grounded Theory

Grounded theory (Strauss & Corbin, 1998) can be used in areas where few research studies have been undertaken. Alternatively the method can provide a new perspective or transcend previous work in areas where considerable research has been undertaken. Although theories have been developed and considerable research has been conducted on the process of stress and coping, for the purposes of this study, the grounded theory method addresses the paucity of research on fathers who have a son diagnosed with ADHD behaviour and how they cope with the situation. Because grounded theory was developed to examine processes, it is particularly appropriate for the present study.

The goal of grounded theory is to systematically explore a phenomenon as a way of generating substantive theory (Heppner, Kivlighan, & Wampold, 1992). Substantive theory reflects one substantive area and is specific to a particular group (Strauss & Corbin, 1998). By theory, Strauss and Corbin mean “a set of well developed categories (e.g., themes, concepts) that are systematically inter-related through statements of relationship to form a theoretical framework” (p. 22) that explains some relevant phenomenon. The method of grounded theory, developed by Barney Glaser and Anselm
Strauss, "is based on the systematic generating of theory from data that itself is systematically obtained from social research" (Glaser, 1978, p. 2). Specific procedures and ways of examining the data are of utmost importance in grounded theory to achieve "generalizability, reproducibility, precision, rigour, and verification" (Strauss & Corbin, p.27).

Strauss and Corbin (1998) consider two different levels of analysis appropriate within a grounded theory framework. One level of analysis concludes with the construction of a core category and the development of a theory; the other level of analysis concludes with the development of categories. Conceptual ordering (i.e., development of categories) occurs when data are organized into discrete categories according to their properties and dimensions. Although development of categories is a requirement for constructing a core category for a fully developed grounded theory, it is sometimes "the desired research end point of some investigators" (p. 20). In the present study, the aim was to analyze data to the level of categories (i.e., themes) rather than to form a theoretical framework with a core category.

A fundamental premise of grounded theory is to let the key issues emerge rather than to force them into preconceived categories (Charmaz, 1995). Two primary characteristics of this method are (a) concurrent data collection and analysis, and (b) the constant comparison of data with emerging categories. In the constant comparison method, incidents are compared with other incidents for their similarities and differences in order to develop the properties and dimensions of the categories. This method calls on the researcher to constantly seek verification for any analytic structures that emerge throughout the study. According to Mertens (1998), the researcher needs to constantly
interact with the data by asking questions designed to generate codes, concepts, and categories. Codes are created when data are broken down into discrete components. From these codes, concepts are developed that lead to the development of categories (i.e., themes). The researcher begins by asking general questions of the data, such as, ‘What is going on here?’, ‘What accounts for what is going on?’, or ‘What problems are the participants trying to address?’ Researchers make comparisons, think about what they see, develop hypotheses, and test ideas.

Participants

In the present study, in line with its purpose and method, eight fathers of boys who have been diagnosed with ADHD behaviour were interviewed. Fathers were chosen for the study because a review of the literature in this area reveals that most studies focused on mothers, and only a few studies included both parents. Boys were chosen because the prevalence of boys with ADHD is higher than that of girls, because boys’ relationships with their fathers in this age group is considered to be different than that of girls, and, finally, it is beneficial to have participants somewhat homogeneous when such a small sample is used. Fathers were initially recruited who met the following criteria: (a) their sons were between the ages of 6 to 12 years old, (b) the boys had been diagnosed by a medical practitioner, a registered psychologist, or a psychiatrist, and (c) the parents had been informed that their son was diagnosed with ADHD behaviour. Whether the boys were diagnosed recently or for some time was not considered to be crucial to this study. The reason for the exclusion of the fathers of teenagers with ADHD behaviour was that the teenagers would likely be exhibiting behaviours related to the emotional and physical changes associated with puberty and such behaviours might confuse parents’ experiences
of their teens’ ADHD behaviour. Another reason for choosing the 6- to 12-year age range was that some research (i.e., Barkley et al., 1985; Mash & Johnston, 1990) has indicated that interactions with parents improve as children age, and that older boys (teenagers) are more compliant than younger boys (preteens) who have ADHD behaviour.

Demographics of Participants

A total of eight fathers who each had a son with ADHD behaviour and who met the criteria of the study were interviewed. These fathers were all Caucasian men and Canadian by several generations. They were diversified in their age, level of education, work status, and economic status. Some information about participants is given in Table 1. Participants were from the Greater Metropolitan Vancouver area and the Sunshine Coast.

Volunteer fathers were informed about the study and recruited through advertising flyers (Appendix B) that were posted on the UBC campus, Family Services of the North Shore, and North Shore Health (where ADHD assessment for North Shore residents usually takes place). Three inquiries were received in response to this method of advertisement, and only one father met the criteria for the selection of participants. Advertising flyers were also sent to CHADD (Children and Adults with Attention Deficit Disorder) support groups in the greater Vancouver area. Information about the study was given to other prospective participants by word-of-mouth, networking, and snowballing. Three fathers were recruited by word of mouth, one of them referred by his son’s therapist. The other 4 participants heard about the study through CHADD groups. In total 10 fathers responded, and of those, 8 met the screening criteria and were recruited for the
## Table 1

### Demographics of Participants

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Pseudonym</th>
<th>Age</th>
<th>Profession/Work Status</th>
<th>Marital Status</th>
<th>Number of Children</th>
<th>ADHD Son’s age/Birth order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>William</td>
<td>40</td>
<td>Emergency Response Worker</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; marriage</td>
<td>4</td>
<td>10 / 4 (from 2&lt;sup&gt;nd&lt;/sup&gt; marriage)</td>
</tr>
<tr>
<td>2</td>
<td>Steve</td>
<td>48</td>
<td>Seasonal worker, forestry</td>
<td>separated (was 2&lt;sup&gt;nd&lt;/sup&gt; marriage)</td>
<td>3</td>
<td>12 / 2 (from 2&lt;sup&gt;nd&lt;/sup&gt; marriage)</td>
</tr>
<tr>
<td>3</td>
<td>Mac</td>
<td>37</td>
<td>Senior Administrator</td>
<td>divorced</td>
<td>2</td>
<td>9 / 1</td>
</tr>
<tr>
<td>4</td>
<td>George</td>
<td>57</td>
<td>Not working, trained as teacher</td>
<td>married</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Cougar</td>
<td>34</td>
<td>Construction/oilfield worker</td>
<td>divorced</td>
<td>2</td>
<td>11 / 2</td>
</tr>
<tr>
<td>6</td>
<td>Mark</td>
<td>45</td>
<td>Manager</td>
<td>married</td>
<td>2</td>
<td>8 / 1</td>
</tr>
<tr>
<td>7</td>
<td>Tim</td>
<td>38</td>
<td>Realtor</td>
<td>married</td>
<td>2</td>
<td>7 / 2</td>
</tr>
<tr>
<td>8</td>
<td>Fred</td>
<td>50</td>
<td>IT Project Manager</td>
<td>married</td>
<td>3</td>
<td>8 / 1</td>
</tr>
</tbody>
</table>
study. The reason the other 2 fathers were not eligible was that one of them had a 14-year-old son and the other wanted therapy for his ADHD diagnosed child.

**Procedures**

During the first telephone contact with respondents, a brief explanation was given and the caller’s questions were addressed. A copy of the Letter of Initial Contact (Appendix C) and the Informed Consent Form (Appendix D) were sent to five of the prospective participants. After receiving and studying the forms, participants called for an appointment. The other three respondents did not want any information mailed to them. During the initial telephone conversation, and after obtaining preliminary information, they arranged for an appointment. At the meeting, prior to the interview, the Informed Consent Form was read to the participant and his consent was obtained. Two copies of the form were signed, one of which was retained by the participant for his records.

Each father participated in an audio-taped interview (see Appendix E) through which he was asked to describe his relationship and his interactions with his son and his emotional, cognitive, and behavioural responses to his son. Each participant was also asked about the changes, if any, he had experienced due to his son’s diagnosis. Also explored were the ways each participant met the challenges of their son’s behaviour and how they took care of themselves. The interviews took a little over an hour and were held in a private counselling office in North Vancouver, except for one interview that was held at the participant’s office. Audio-taped interviews were transcribed by a professional transcriber and included a description of the sounds made by the participant or researcher such as laughter and sighs. A post-interview telephone conversation was held with one participant, in order to clarify some inaudible parts of the recorded interview. Guiding
questions were developed for the interview (see Appendix E). Examples of these questions are offered below:

1. Tell me about how and when you became aware of your son's problem.
2. What was distressing/anxiety provoking for you at that time?
3. What did that mean to you to have your son diagnosed? How did you make sense of that, and how did you deal with it?
4. Are there behaviours/attitudes/reactions of your son that you find difficult, challenging, or stressful?
5. What kinds of help do you have regarding your child?
6. What are your expectations of your son, for now and the future? Have your expectations changed after diagnosis? If so, how?

In practice, the questions were not asked verbatim in a rigid manner. Often the participants volunteered information that was germane to the trigger questions in the context of another answer to a question. To maintain the flow of the interview, participants were given the lead to comment on issues that were important to them. Near the end of the interview some areas of interest were probed if a participant had failed to talk about it spontaneously.

Analysis of Data

Thorough and insightful data collection and analysis are important parts of grounded theory. In grounded theory analyses, coding represents the systematic procedure by which the collected data are broken down, conceptualized, and regrouped together in a way to develop categories and their properties. To facilitate grouping of the data in this study, initially a lower level of coding, open coding, was used to generate an
emergent set of categories, and relevant questions were asked and memoed. In the second stage of the analysis, axial coding was used to conceptualize dimensions and properties of the categories and the relationship of the categories to each other.

Open coding, proposed by Strauss and Corbin (1998), is an “analytic process through which concepts are identified and their properties and dimensions are discovered in data” (p. 101). In this process, data are broken down into discrete events, incidents, ideas, and acts and are then given a name and identified as codes. These codes are closely examined for both similarities and differences in order to form concepts, and facilitate discrimination and differentiation among categories. This, leads to the development of the properties and dimensions of categories that explain “the when, where, why, how, and so on of a category that are likely to exist” (Strauss & Corbin, p. 114). Open coding can be done as line-by-line analysis, analysis of a whole sentence or paragraph, or the entire document. In all these cases questions are asked about the identified concepts to systematically specify what is discovered and to develop concepts into categories.

Axial coding is the analytic process in which the researcher puts the parts of the data identified and separated in open coding back together to develop properties and dimensions of categories and to make connections between categories. The process of asking questions of the data is continued; however, now the questions focus on the development of the categories and the relationships between the categories. In this phase, the researcher begins to formulate possible relationships and continues to search the data for verification or negation of the hypothesized relationships. Because the purpose of the present study was theme analysis or conceptual ordering (Strauss & Corbin, 1998), the analysis was complete at the end of this phase.
During the analysis of data, the processes of open coding and axial coding and the development of code into concepts, and into themes were not linear. As I continued open coding the first interview, I started asking questions and memoed certain concepts. With the progression of coding in the subsequent interviews, concepts were developed and similarities and contrasts between concepts were noted. By the time open coding for all the interviews was finished, most of the concepts had already developed into certain themes.

The goal of the present study was to identify categories (i.e., themes) that reflected the coping processes of fathers with an ADHD diagnosed son. Developing such constructs enables us to see how behaviours serve a purpose and relate to one another. Through open coding concepts were identified that led to the emergence of themes. In addition, circumstances and conditions relevant to concepts were identified and finally some properties and dimensions of themes were developed. An example of open coding is shown in Appendices F.

**Theoretical Sensitivity**

Theoretical sensitivity is an important characteristic of a grounded theory researcher. According to Strauss and Corbin (1990) the term "theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t" (p. 42). Theoretical sensitivity can be enhanced by studying literature, other research reports, and documents of different kinds (Stauss & Corbin). Moreover, professional experience, personal experience, and the ongoing analytic process of interacting with the collection and analyses of data can increase theoretical sensitivity. Although bracketing—being
aware of not allowing the researcher’s biases to affect the data outcome—is a requirement for some qualitative approaches such as phenomenological studies, grounded theorists attempt to use their background assumptions, knowledge, and interests to sensitize them to look for certain issues and processes in their data (Charmaz, 1995).

Personal experience is one of several conditions that have enhanced my theoretical sensitivity. My personal experience with this topic concerns a number of clients that I have worked with who were parents of sons diagnosed with ADHD behaviour. My education in the field of counselling psychology, and my awareness of the parenting strategies that I have used to enjoy my relationship with my two children are some of the factors that have also enhanced my theoretical sensitivity. At the same time I have not permitted my own personal views and experiences of parenting to dominate the way in which I structured the interviews or analyzed the data. My personal experience enhanced my theoretical sensitivity but did not overwhelm my analysis. With personal experience, having awareness and reflectivity as a source of sensitivity, say Strauss and Corbin (1998), “it is not the researcher’s perception or perspective that matters but rather how research participants see events or happenings” (p. 47). My experiences of having been born and raised in Iran, having been educated and worked in England, and having been in Canada for more than 11 years, combined with my professional experiences in engineering, and middle and top management positions, with frequent business trips to the Far East, Middle East, and Europe, give me a wide perspective and deep understanding of men’s challenges in different cultures and working situations. Finally, my change of career, my studies and training in counselling psychology, and my literature review of the present topic further enhanced my theoretical sensitivity. My
interest in the subject matter of the study arises from my theoretical sensitivity, from the
exposures I have had to ADHD diagnosed boys and to their parents, and from my career
interest as a counsellor to be able to understand the coping processes of the fathers of an
ADHD diagnosed son.

**Memoing**

Memoing, an important element of data analysis, is recommended to begin “at the
inception of a research project and continue until the final writing” (Strauss & Corbin,
1990, p. 198). Memos contain ideas that come to the researcher’s mind, such as the
researcher’s views, biases, insights, products of actual coding, and notes about sampling,
or questions to be asked. They enable the researcher to keep an ongoing record of the
analytic process. An example of a memo page is given in Appendix G. In the present
study, as well as writing field notes about my ideas and my observations of the
participants during the interview, I wrote memos after coding each interview, which in
turn gave direction to the coding of the subsequent interviews. In this way, my memos
helped me to compare and contrast individual interviews so that my coding became more
sophisticated with each subsequent interview.

**Ethics**

The University of British Columbia Behavioural Research Ethics Board approved
the Advertisement (Appendix B), and Letter of Initial Contact (Appendix C), Informed
Consent Form (Appendix D), and Interview Schedule (Appendix E). At the interview,
before starting the audio-tape recording and after addressing any questions that the
participant had, two copies of the Informed Consent Form were signed by the participant
and the researcher, one copy was kept by the participant.
Participants were informed that any information resulting from this research study would be kept strictly confidential. All documents including audiotapes, transcripts, and computer disks were identified only by code number, known only to the researcher, and kept in a locked filing cabinet. The researcher used pseudonyms, chosen by the participants, in writing and talking about the experiences, including the final report. Any information the participants indicated to the researcher to be “off the record” was not used. An exception to this confidentiality would occur if a participant told the researcher, or the researcher strongly suspected, that children were currently being abused or neglected. In this study, there were no reports or suspicions of current abuse. Upon final completion of this research project (a) all the audio-tapes of the interviews were erased, and (b) all paper-copy documents containing the raw data shredded. However, all the computer files containing the transcripts of each interview, identified only by the pseudonyms and accessible only by a password, are be kept for future validation, reference, and probable continuation of research.

**Rigour**

In qualitative studies there is no single “consensus on addressing traditional topics such as validity and reliability” (Creswell, 1994, p. 157). Guba and Lincoln (1989) talk about credibility, transferability, and dependability criteria for qualitative studies, rather than internal validity. For grounded theory, Strauss and Corbin (1990) consider a study to have rigour (a) when sufficient data have been collected to the level of saturation, (b) when theoretical sampling is used to collect relevant and appropriate data, (c) when the process and the conceptual development of the study are carefully documented to enable other researchers to reconstruct the same process, and (d) when conceptual density and
linkages are present. Sandelowski (1986) considers rigour in qualitative research to be met by achieving (a) creditability, (b) auditability, (c) fittingness, and (d) confirmability. This study has adhered to and achieved Sandelowski's four criteria for rigour.

Creditability and validation focus on the evidence that supports that a study presents a faithful description and interpretation so that people would recognize that experience after having read it in the study. The way creditability is reflected in this study include the choice of participants who provided the experiences of fathers who had a son diagnosed with ADHD behaviour. In addition, my own personal and professional experience supported the validation. Creditability was also supported by the way I sought validation from the participants. Upon completion of the analysis, the developed themes with their supporting quotations were sent to participants and any comments they might have had were examined. The participants found the material “insightful” and meaningful, thereby reflecting its creditability. The participants also commented on the usefulness and helpfulness of the findings, and one commented that it was “saddening.”

Auditability is when a reader can follow and understand the logic of the progression of the events in the study. Readers should be able to follow the decision trail, so that it is clear how the researcher made decisions and developed the themes, enabling other researchers to follow the procedures. In this study, auditability was supported by clearly describing how the interest in this subject area was generated, what methods I used, and how the methods clearly reflected the grounded theory methodology. The description of data analysis procedures illustrates how the themes were identified.

Fittingness refers to how well the findings fit the context outside the study situation. In this study, the selection of the participants, who were recruited through a
number of different ways and locations, enhanced diversity among them. The diversity among participants is strongly supported by: (a) Differences in marital status (single, separated, and married); (b) some had a single child who was diagnosed with ADHD behaviour, and some had from one to three other children; (c) ADHD diagnosed sons’ misbehaviour were noticed at different ages; (d) participants had diverse background, age, occupation, education, and income. Participants’ stories told were not the same and reflected some variation in their experiences, even though common themes could be identified. The purpose of this study was not to make any major generalizations, but to try to understand the process of coping with a son diagnosed with ADHD.

Confirmability or neutrality is obtained when the researcher remains impartial and the findings are not affected by the researcher’s biases. In the present study, even though the researcher had considerable personal experience with the subject, use of reflectivity helped support neutrality. Also, evidence that there was reasonable creditability for the fittingness and auditability supports confirmability.

Assumptions

Certain assumptions have been made in this study. These assumptions are that: (a) Fathers who were interviewed could articulate what was problematic for them in respect to their son with ADHD behaviour; (b) fathers understood my questions; (c) fathers were honest in the answers that they gave; and (d) I have understood and interpreted participants’ comments accurately, within the limitations of having English as second language.
CHAPTER IV

FINDINGS

The purpose of this study was to examine the coping processes of fathers with their son's diagnosis of ADHD behaviour. This chapter presents the major themes that emerged. These themes were subjected to constant comparative analysis within and among participants. Connections between the themes were explored and a tentative model developed (see Figure 2). In order to illustrate support for the emerging themes, extensive edited quotes are provided.

The themes that are described include (a) what it was like before diagnosis, (b) fathers' reactions to their son's diagnosis of ADHD, (c) demands on fathers, (d) responses by fathers to these demands, and (e) the outcomes from these responses. A schematic presentation of these themes representing the fathers' process of coping with an ADHD diagnosed son is shown in Figure 2. This schematic representation does not imply that the relationships are static, or boundaries between identified themes fixed. This process has a dynamic and recursive property, in that the outcomes may in turn influence future demands and responses. In addition, the process is temporal and types of demands and responses could change over time and are affected by influencing factors.

What it was Like Before Diagnosis

Fathers talked about what it was like before their sons were diagnosed with ADHD behaviour. They all commented that, as infants, their sons were difficult to deal with. They described how trying to comfort their infant son by picking him up and
Figure 2

The Coping Process of Fathers with an ADHD Son

Outcome influences reactions, demands, and responses

- What it was like before diagnosis
- Types of reactions to son’s diagnosis of ADHD
  - What types of reactions fathers had?
- Types of demands
  - What were the demands on fathers?
- Types of responses to demands
  - What did fathers do?
- Outcomes
  - What happened?

Influencing factors
walking him about and cuddling him might have worked for one son but not for another son. Although some sons liked to be cuddled, others rebelled when cuddled.

Many fathers recognized that their son’s behaviour or responses differed from other children at an early age, whereas others identified it more clearly when their son started to attend school:

... Right from the birth he was different than a lot of children and he presented problems that were not like most other people. He would get upset and cry and the only way you could calm him down was to pick him up and walk him around.

My wife recognized K. (son) was different right away as an infant, right when he was months old. K. didn’t like to cuddle, even as an infant he didn’t like to cuddle, he was always pushing away.

It was often the teacher(s) who were first to point out the son’s misbehaviour or lack of attention and the need for professional help. For many, this was when their son was first diagnosed. Fathers, in general, became concerned about their son’s misbehaviour and perceived it to be abnormal only after having been told that it was abnormal by school personnel or a third party. Generally 3 to 5 years had elapsed before fathers took any action regarding ADHD behaviours:

We (he and his wife) would get called into school and basically the school had told us that he’s just a very disruptive boy, having trouble functioning in the classroom etc., etc., so then we went to the Children’s Hospital.

He was attending school regularly and his teacher said that they had a visit from one of the support staff who had been watching him and were worried that he was hyperactive, he was certainly very active as a, like at the time 8 years old and so after discussions she recommended that we have him assessed by a doctor.

There was only one father who sought professional help for his son very early without being told by a third party:

We initially thought that he might have a hearing problem ... we had his hearing tested and it turned out that his hearing was exceptionally good. So, what we thought would be a good idea would be to go to a child psychiatrist.
A few fathers took action toward their son’s diagnosis within 2 years after they had noticed their son’s misbehaviour at school age.

Reactions to Son’s Diagnosis of ADHD

Fathers had different reactions and feelings when they first heard about their son’s diagnosis of ADHD. Types of reactions included (a) shock, (b) relief, (c) blaming, (d) denial, (e) guilt, and (f) worry. These reactions were not mutually exclusive. Some fathers had several types of reactions when they learned about the diagnosis. Some fathers were shocked when they learned about their son’s diagnosis. For other fathers it was a relief to have a label for their son’s misbehaviour and for still others it was a confirmation that something was wrong with their son and not with their own parenting skills. Some level of denial existed initially and this was manifested as resistance to diagnosis, or as behaviour counteractive to dealing with their son’s ADHD. Some fathers also mentioned feeling guilty. Different reasons for guilt were expressed by fathers; some felt guilty for having passed on the gene that predisposed their sons to ADHD; some felt guilty for the way they treated their sons prior to knowing about the ADHD diagnosis; another father felt guilty because he was not spending enough time with his other children; and yet another felt guilty for not knowing what to do to ease his son’s frustrations.

There’s a lot of emotions going on there accepting that ... So there was a lot of feelings, feeling sad for him, a lot of guilt when you lose your patience and you yell at him, then you feel guilty about it.

Shock

A number of fathers talked of their feeling of shock. A father, who felt the diagnosis was a shock, stated: “It put a lot of things in perspective, a lot of things that
we’ve been going through since he was born ...I found it was quite a shock!” Another
father talked about his reaction of shock, guilt, and concern for his son’s label: “For a
while I had a bit of a shock and I guess there was some guilt, and my concern was that he
was being labeled as a trouble maker.” The expressed reactions of shock had different
intensities. Some fathers felt “quite a shock,” whereas some others felt “a bit of shock.”

Relief

One father did not consider the diagnosis to be a shock. In fact he sounded
relieved to find that his “thinking was good” and to find out what was wrong:

Oh, it wasn’t a shock or anything. My thinking was good, we’re finally getting
down to the bottom. We knew that there was something wrong, a learning
disability or something like that.

Some fathers were also relieved to hear about the diagnosis mainly because it apparently
reaffirmed that the behaviour was not due to parenting deficiencies.

Oddly enough it was a relief to us because we thought we must just be the most
negligent parents in the world because we couldn’t deal with this kid ...We feel a
lot better about it ... or at least ... the frustrations are easier to cope with now
because we know the reason.

Through the assessment of his son’s diagnosis, in addition to feeling relieved to find an
explanation for his son’s behaviour, one father was relieved to find explanations for his
own behaviour.

We (husband and wife) were given a list of like 20 statements to read. And
(assessor) said, “How many of these apply to your son?” We both went through
them and ticked them off and he (son) had over 12, which indicated that he was a
strong candidate (for ADHD). I scored myself with 16 and my wife scored me at
18. So it was pretty obvious that I had attention deficit. It was positive in that
respect finding out about it. I certainly have attention deficit.

Blaming
Some fathers blamed their wife for their son’s misbehaviour. In addition to his ex-wife, a father also blamed other children for his son’s lack of concentration and he wanted his son isolated in the classroom. The teachers did not agree with him:

It’s my perception that they don’t misbehave, and they are good kids, its mum’s perception that they're misbehaving lots and they're not good kids, you’ve got to badger them all the time.

He (son) sleeps fine at my house, I don’t have to give him chlordane (medication). We’re (he and his ex-wife) on opposite ends of the spectrum when it comes to consistency and structure … she’s completely free flowing and has no rules, no structure, or anything.

When he’s trying to do activities that require focus and the other children are being distractive and that’s something that we need to work on, and we’ve used isolation techniques in the past where he’d have a desk away from the other children so when it came to focusing on those tasks, he’d have a better chance, but his teachers feel that he is capable of doing them in the time allotted even with his challenges, so they want to keep him integrated for now.

Denial

A few fathers seemed to have been in denial of accepting their son’s diagnosis of ADHD. Steve reported that he was in denial for a few years during which he resisted medication for his son. “I was in denial for quite a few years afterwards to the point where I tried everything but the prospect of going on Ritalin.”

Guilt

Some fathers mentioned that they felt guilty; however, reasons for the guilt were different. Some fathers felt guilty for having passed on the gene that has caused their son’s ADHD symptoms. A father said, “you do feel guilty, because they tell you that it’s from either the husband or the wife. It’s from the genes and so you know that for some reason it is your fault.” Another one felt guilty for the way he had been treating his son before he knew about his son’s diagnosis:
It doesn't take away the pain, an enormous sense of guilt about how I may have been treating my child, which I was treated, because of his qualities and his particular personality.

Different reasons for guilt were expressed by fathers: some fathers felt guilty for having passed on the gene that predisposed their son to ADHD symptoms; some fathers felt guilty for the way they treated their son prior to knowing about their son’s ADHD diagnosis; another father felt guilty because he was not spending enough time with his other children; and another father felt guilty for not knowing what to do to ease his son’s frustrations.

Worry

When some fathers learned about their son’s diagnosis of ADHD, in addition to other types of reactions, they became worried for their son’s future, anticipating failure and problems for their son:

I dreaded the idea that in a couple of years when he had gone from the primary grades at elementary school into the intermediate grades that it would have a bigger requirement on him and he would be having more problems.

Another father was also worried about his son’s future happiness and the label that he had:

I must confess that since the diagnosis we’ve been more aware of the challenges that he’s going to face. I worry about him being sort of dismissed by his teachers or branded as a trouble maker and not having friends …. I’m just very, very concerned that he’s just not going to be happy.

Within this theme, types of reactions fathers had to their son’s diagnosis of ADHD varied from total shock and disbelief to a sense of relief. Some fathers openly mentioned their denial of their son’s diagnosis, whereas other fathers minimized and reframed their son’s misbehaviour; blamed a third party for their son’s misbehaviour; or initially resisted the use of medication. Some fathers also felt guilty for different reasons
relating to their son. Fathers became concerned about their son’s behaviour mainly when a third party pointed it out or when they compared it to other children’s behaviour. Some fathers were relieved when they learned about other children who had worse behaviour than their son.

Demands on Fathers

Fathers experienced multiple demands from their son. Demands on fathers included (a) demands for attention, (b) demands on fathers’ physical energy, (c) demands on fathers’ emotional energy, (d) family demands, (e) work demands, (f) demands from their son’s school, and (g) demands on time.

Demands for Attention

Most fathers emphasized the attention demanded by their sons. Their son’s attention seeking behaviours ranged from wanting to show them something, to being annoying and causing upset, to behaving outrageously in order to obtain attention. A father talked about how his son demanded attention and related this to his son’s intelligence:

He wants attention a lot of times because he’s a really sharp little guy and he always has lots of ideas going on. I mean he’s always wanting to show us something and stuff like that, so in terms of demanding it’s more like, “come and look at what I’ve done here” or “come and let’s do this.”

Another father talked about his son’s demand for attention as a means of satisfying his need for stimulation, although at the expense of upsetting his younger brother:

J. (son), in his need to stimulate himself will interact with his younger brother and upset him. He’ll tease him. He’ll do something to get attention to get that stimulation that he needs.
William thought his son demanded attention because he could not deal with other aspects of his life. He said that his son’s need for attention was such that he would try to get it from whomever and by whatever means he could:

I think that it was too much for him to deal with certain aspects, so I think he’d demand attention from anyone who he could get it from, his sometimes outrageous patterns started. I think he realized that the more he did, the more attention he would get.

Irrespective of what fathers thought was the reason for their son’s attention-seeking behaviours; their son’s need for attention was demanding on fathers.

**Demands on Fathers’ Physical Energy**

Son’s hyperactivity behaviour was demanding on father’s physical energy. Some fathers who were younger, more fit, or liked physical activities met this demand with less difficulty. Father-son age differences ranged from 23 to 46 years. Keeping up with their son’s activity, for fathers who were older or were not physically fit, was a major demand.

One father, who was married to a busy professional woman, seemed to manage his time with his son to a certain extent, but was still challenged to find enough energy. Demands on his energy and time are apparent from his statement:

The challenge for us sometimes is finding the energy, and the time, and the more we have to be able to do that. I mean it’s definitely a challenge, the time and the energy are both of those commodities in short supply for each of us.

Demands on some fathers’ energy did not seem as severe as they were for others. A father comment, “I’m happy about my relationship with him (son), but I still need a little bit more energy for him and the other two siblings,” indicates a milder demand for energy. Another father was aware of his son’s high energy demands, being very active himself, he seemed able to meet his son’s energy demand:
A. (son) being very high energy and demanding, there's definitely a lot of energy around. I'm a very high energy individual as well so it wasn't a load really, I mean I didn't see it that way.

Fathers' perceived demand on their physical energy seemed to depend on their own level of physical activity and probably the severity of their son's behaviour.

Demands on Fathers' Emotional Energy

Some fathers felt emotionally more drained than others because of the demands from their son. One fathers' statement is an indication of how some fathers felt with their son's demand on their emotional energy:

I'm learning now there's certain things with K. (son) that are more down or more low energy for me than others and I'm aware of that now and that's not good ... It's very difficult because here's somebody you love tremendously and you want to help, but he'll suck, he'll suck all the energy out of you and spit it back at you.

A father, who was himself on antidepressants, talked about not being able to emotionally withstand his son's crying and sadness.

I'd come home. There's yelling and screaming. The boy's crying all the time. What's going on here and I'm trying to figure this out. I can't stand it. I feel emotionally drained.

Fathers described the demands on emotional energy differently. Some reported it several times and more directly while others did not mention it as frequently.

Family Demands

Because of their son's multiple demands on them, fathers were more involved with their son who had ADHD behaviour often at the expense of other members of their family. Several of the fathers who were interviewed were divorced from their son's mother and of those who were married, most talked about some degree of marital tension. Maintaining the marital relationship could be overshadowed by the son's demands.
I realize now, over the last 8 years, he’s taken up all my time when I am at home and I realize now it’s been, for my daughter, and not having equal time with her. My wife, it’s a big part of our problem and our separation now, not having the time as well. Very, very, very demanding, very demanding children, extremely demanding!

Some fathers talked about how their son’s behaviour had a ripple effect and created demands from their other children. One father noticed how his younger son had been affected, because of the special attention given to the older son:

J. (son) is the ferry, is the fast moving boat in the sea of our lives, creates a wake and it impacts everybody else. When something changes in the relationship here, it affects everybody else. When we realized things with J. had started changing our behaviour in the way we treated him, we noticed that there was subtle shifts in Jo (brother) … Jo has found that he can sprout out, that he’s demanding a little bit more attention and there’s all sort of little subtleties like that.

In another situation, reaction of older son was more overt, causing a lot of concern and stress:

Significant events took place one evening apparently and my oldest son … couldn’t take any more and he became very, very dysfunctional, very, very upset. He got very upset and physical with his younger brother where he was sitting on top of him and telling him he had to stop and threatening to choke him. I guess the situation had gotten about as bad as it could get.

It was important for another father to be able to balance his time between his two sons. Because of certain disabilities, his second son needed special care and attention too.

He’s (other son) got some challenges. He’s a language delay and he’s got some motor skill challenges as well … so I get him his big book of exercises for doing drawing and for doing his letters and things so he sits at another table and does that while A. (son) does his homework, then I just sort of interact with them both and he doesn’t feel like he’s being left out of the attention circle at all.

Demands for attention and time from other children manifested itself gradually for some and suddenly for others. In one case, the reaction of the older son who did not have ADHD was severe and sudden, whereas in another case the reaction of the younger son who did not have ADHD was a gradual and constant demand for attention.
Work Demands

The multiple demands on fathers because of their son’s ADHD behaviour greatly affected their work and increased the demands from work. Fathers who had flexible jobs considered themselves fortunate because they could manage their work demands more easily:

My job is very flexible, so I would be able to come in the middle of the day if I had to and discuss things with the school. It does take a lot of extra work and it is not something that you take lightly, so you need a job that is very flexible and so I was fortunate.

Another father also considered that his job flexibility was very important in dealing with his son. He was willing to change his company if need be to keep the job flexibility:

It has helped having that flexibility (in his job) and I’d like to keep it if I could because I’ve seen a benefit for myself and my family. That’s one of my goals to try and somehow continue that whether it’s with this company or another, having that flexibility I think is a positive thing.

Another father had a very busy schedule in a demanding industry; however, he could not meet his work demands because of the other demands from his son who had ADHD behaviour. He offered,

I’ve had to reduce my involvement at work significantly … I give my children half of my time so I’ve had to reduce my time here to deal with that plus I’ve almost eliminated travel from my job. It has made things more difficult. Our business is having a bit of a difficulty, right now we have to seek financing to keep operating. So that’s been another challenge.

Except for one father who was not working, others were affected by work demands to different degrees. At one end of the continuum, a father could not compromise his work demands because of financial pressures. At the other end some fathers could afford to maintain a flexible job.
Demands from Son’s School

Some fathers spent time with their son’s teachers and with school activities. Mainstream schools are set up to deal with children without problems. If a child has a problem, parents may have to work with the school to make sure the school does not label the child and/or give up on him. Some fathers considered themselves fortunate to have a flexible job. One father took on a proactive role with his son’s school to the extent that the school sent two teachers to take courses on understanding ADHD children better. After spending some time and effort, this father had established a good working relationship with the school personnel and was very happy with their support:

I sort of took the white knight approach. I started the fight with the school to keep M. (son) on track and not let him fall behind and when he was having difficulty at school, I think I spent every evening there talking to the teacher and talking to the principal and trying to get it where they were not harassing him, they were staying off of his back …

Although initially he was in conflict with the school, he eventually established a cooperative relationship and achieved his goal of not having his son “harassed.” His active role with his son’s school established expectations from the teachers that he would volunteer to accompany his son on school field trips and outdoor activities. He said, “Unfortunately when your child has been labeled with that, the school requires that you attend all outings with them.”

In comparison, another father did not have a cooperative relationship with the school. Although he had initially approached his son’s teachers about his concern regarding their teaching style, he did not have a cooperative response from them. In addition to different approaches that these two fathers had toward their sons’ schools, the differences between the two schools—first one was a small school in a rural area and the
second a large school in an urban area—seemed to be part of the intervening conditions that influenced the strategies chosen by parents. A father said that:

...You learn that some situations don’t fit and schools tend to teach to the average, the norm, the core, and the fringes get left out ...the system is very conservative. Teachers as a profession are the most resistant to change.

This father had initially talked with school personnel about his son’s ADHD behaviour. Although he said the principal was receptive, he was angry about the way his son’s teacher was expecting assignments to be done. He was angry about the methods the teacher used with his son, but he did not take any action to talk with the teacher:

There were differences in the way teachers responded to students, particularly those with ADHD behaviour. A father’s involvement with his son’s previous and present schools was the same; however, the outcome was different:

I think that things go easy for him in the classroom with the teachers and he seems to enjoy that, responding to that, he claims, and this may be a communicating factor that in his previous school ... he was being picked on.

In addition to the school demands on fathers, most fathers believed they were also expected to work with their son on schoolwork at home.

Demands on Time

The demand on time was mentioned many times both directly and indirectly by fathers and caused considerable stress:

It’s like holding two full time jobs and because you are not only dealing with your son or daughter with ADHD, you have a wife, you have other siblings that still require your attention....Having a child that’s ADHD is like having twins, quadruplets sometimes, because they are going in so many different directions.

Fathers felt they needed to be with their son to supervise his behaviour.

From a time point of view, he’s extremely demanding. Quite frankly if I would allow it, K. (son) would take up 24 hours a day, 7 days a week, 356 days a year. He’s extremely demanding.
Another father sounded guilty and regretful for having spent too much time with his son and not enough time with his daughter and wife:

I'm starting to realize now that there is a very big disproportionate time spent with K. (son) versus myself or any other members of the family. So, how did I deal with it? I'm, as I say it's something I know I'm struggling with right now,

Although this father realized that he had spent a disproportionate amount of time with his son, he seemed to be in a dilemma as to how to better balance his time. Difficulty balancing time between family members, work, personal needs, and their son was a concern for many fathers.

Another father was aware of his son's demands on his time, but somehow sounded tolerant about it:

G. (son) is still a source of stress in our lives, not necessarily negative stress, but just the stuff you have to deal with and in life everything that's on your plate just adds to the busyness. And he definitely puts a lot of stuff on our plate.

There were many demands on fathers and although some of the demands were not directly from their son, these demands were nevertheless accentuated because of their son's demands. Balancing time and resources between demands posed a challenge for fathers. Some fathers who looked at their priorities and chose to compromise some demands at the expense of others created new challenges for themselves.

Responses to Demands

The hyperactivity and inattention of ADHD sons and the multiple demands the sons put on fathers were stressful for fathers. Fathers responded to the demands in different ways and in different intensity. These responses can be broadly categorized into fathers' direct responses to their son, and fathers' responses for themselves. Fathers talked about what they did to respond to the demands. Interestingly, some of them...
focused on their own individual response and said, “I went with naturopath for him.”
Others referred to “we” as the responder, even in situations where the response was
singular, that is, “We went on medication.” Or “We’re taking a natural product called
Manetec and he has improved his mood.” The “we” reference likely reflects how the
problem is a family problem and reflected their intense personal involvement with it.

Fathers’ Direct Responses to Their Son

Fathers’ direct responses to their son were those responses that fathers had as a
reaction to their son’s misbehaviour, lack of attention, and poor school performance.
These responses included (a) getting angry, (b) spending more time with son, (c) doing
too much for their son, (d) using medication or alternatives to medication for son, and (e)
using different parenting skills and behavioural modification techniques with the son in
order to influence the son’s behaviour, (f) not knowing what to do.

Getting angry. Anger, with different degrees of intensity, was the first automatic
reaction that fathers had towards the sons. Some fathers just raised their voice to their
son, while other fathers used putdowns and swear words. A few fathers who in the past
used physical punishment expressed intense anger. One father relied on nagging and
expressions of anger to modify his son’s behaviour. In addition to expressions of anger,
nagging, and swearing, he had used unsuccessful physical punishment in the past, to
make changes in his son’s behaviour. Because his son was taking martial arts training and
was becoming stronger, he was cautious not to use physical punishment anymore and
instead found other strategies to deal with his son:

You’ve got to really watch because you always want to punch him. He’s getting
to the stage like he’s got a green belt and he’s down at C. (a martial arts club) …
You can’t bully him much longer. He’s got more marshal skills than I have … as
M. (wife) says, “Are you going to do this when he’s 16 and he’s got a black belt.
He’ll kill you?” (laughing). You can’t go to him and threaten him, because he will. He’s a big guy and he will, so from that aspect I have to look for other strategies.

Then nothing gets done … and everybody is peed off and then you say things that you don’t need to, you shouldn’t say that but I’ve told him … and it feels terrible …. You hold it in. You learn and it will come out, lashing out or something, insulting him or something like that. I’m trying to learn to control that.

Another father said that he had used physical punishment (“smacking”) in the past to change his son’s behaviour, a response that he related to his own upbringing. However, he felt ashamed and guilty for the way he treated his son.

I hate to say it, but I was a very angry parent with him and, I guess because of my background with my parents I used discipline as a way to try and get him to correct and it was the wrong avenue. I think we resorted to punishment and in all honesty I think there was some physical punishment involved.

Spending more time with son. Because of the demands of their ADHD son, fathers tended to spend more time with their son to do activities together or to supervise him. Some fathers spent more time, not out of choice, but to meet the demands made on them. In such cases fathers sounded overwhelmed and even resentful for spending time to meet the demands of their son at the expense of their other responsibilities. A father said that he was “struggling” with the “big disproportionate time” he was spending with his son.

Some fathers made conscious choices to spend more time with their son. They made changes to their life style or work schedule so they would have the extra time to spend with their son. One of the fathers had a very busy schedule in a demanding industry; however, he was one of the fathers who had consciously appraised his priorities and had chosen to make time for his children despite some business losses. He offered,

Another thing that I notice is priorities, very difficult to manage priorities, work related ones. I see activities and opportunities here being lost at work because of
these other demands and I’ve got to really consciously say that’s okay, they’ll be other opportunities, they’ll be other things and really in the greater aspect of the whole thing, where are my priorities. They’ve got to be with my children.

Whether fathers planned to spend more time with their son, or they felt compelled to do so, they had difficulty balancing their time and managing their priorities.

Fathers spent time with their sons doing activities together or supervising their sons. One father wanted to interact with his son as well as give structure to his son’s daily life. They both liked swimming:

I found that what helped me the most was more interaction with the children in activities that they were capable of handling. A. (son) really likes to swim so there is some structure in that you got to know how to swim or you’re gonna drown. But there’s a lot of freedom as well plus it’s a high energy activity and, A. doesn’t get a lot of high energy activities and I find that they’re so beneficial to him when we do things that really wear him physically, he’s much more manageable like he sleeps better.

Another father who spent more time with his son chose an activity that provided a personal outlet for him and allowed him to get away, and also met his son’s needs for contact and activity:

M.’s (son’s) mother and I were mostly exhausted all the time after being with M. … I sort of buried myself in scouting, and so kept M. very close to me but also gave me the opportunity to have outlets.

A few fathers did not spend much time with their son in doing activities. Because of financial constraints one father could not do outdoor activities with his son; however, he spent time with his son at home playing computer games and watching television:

They are playing games on the net and games on the CD’s and watching TV so they try and get as much time as they can. I can’t afford to take them skiing again this winter. I didn’t take them out last year, but if I had disposable cash, I’d be taking them skiing lots and on camping trips. I’d like to be taking them camping.
Compared to those fathers who spent a fair amount of time directly with their son doing activities, one father found being with his son was stressful and, as a consequence, he did not spend much time with his son doing such activities.

**Doing too much for their son.** Some fathers seemed to do too much for their son and they were aware of this. The oldest of the fathers (57 years old) who had the largest age difference with his son (46 years), did not do any physical activities with his son. He spent a lot of time helping him with his homework and assignments, more time than other fathers. Talking about his involvement, he said, “I tend to take over and almost do this. No, I don’t almost do the assignment, but put this here, write this there, this is how you spell this word…”

One father expected to change his son’s behaviour by being very kind and affectionate. He questioned his own motives for buying too many toys for his children. He justified his action as a means to get over his guilt:

> We probably buy them too many toys and sort of gizmo’s and gadgets and stuff like that and I worry sometimes that it’s maybe a little bit of a cop out and it helps us to get over our guilt [laughter]. It’s all about guilt I think, [laughter] the giving, the receiving [laughter].

Another father also tried to motivate his son by paying him money. Fathers who seemed to do too much for their sons implied that they were aware of what they were doing, but also that they doubted the effectiveness of their actions.

**Using medication or alternatives to medication.** The hyperactivity and inattention of ADHD sons were major stressors. Fathers felt they could decrease their stress if only they could modify their son’s hyperactivity and inattention. Parents used different interventions to modify their son’s behaviour and inattention. Fathers were often resistant in one way or another to the use of medication for their son. This resistance was either
due to their knowledge of the side effects (i.e., loss of appetite, loss of sleep, agitation, drug reaction) or to their denial of the diagnosis. One father was aware of his denial and openly talked about it. In addition to trying to modify his son’s behaviour by spending considerable time with him, he also tried to use alternative approaches to medication:

I was in denial for quite a few years afterwards to the point where I tried everything but the prospect of going to Ritalin. I went with diet. I went with allergies. I went with a naturopath. We, M.’s (son’s) mum and myself, tried very hard to find out whether there was another route to go.

This father attempted to manage his son’s behaviour through alternative approaches to medication and diet for 3 years before using medication. Adhering to diet had implications for the whole family. The strict diet deprived other members of the family from necessary nutrients. It was also time consuming. Diet was not generally found to be as effective as medication:

Before we went on medication, we went on a diet and if he drank milk it was like watching Dr. Jeckle and Mr. Hyde all in one. He would become very aggressive. He would be very violent towards his brother ....Dairy products was the worst, ice cream, milkshake, anything like that ... so for 3 years there we watched diet very closely. We actually all went off beef, pork, and we stayed very close to M.’s diet and everything that was allergic to we stopped eating as a family.

When this father eventually decided (after 3 years) to use medication for his son, he found that the medication was quite effective. However, despite his comment on the effectiveness of medication, he limited the recommended dose and did not give it on non-school days:

He was very short fused at that time and he’s still that way, but he is getting better with it. You can see quite a difference. If he takes his medication he’s a totally different child ....They said he could have three pills a day. We never went to that. We stayed with the two and we also would let him, if he didn’t want to take on a weekend we didn’t force it. We let him have his weekends and it sort of gave him some control.
Another father also seemed to be resistant to medication for his son. In contrast, he felt his wife preferred the idea of their son being on medication. He first tried alternative methods that demanded more time and attention, as well as consistency:

We went through a lot of different home management approaches, some homeopathic approaches, diet, but my wife just wasn’t capable of doing the home management, and that became evident right through the history that that wasn’t there and him being diagnosed as ADHD didn’t change her behaviour or personality as far as the home management, so it ended up being, medication was going to be the most effective way to help him deal with it as well as her .... [laughter] It ended up being the best thing for my son, because of the load that it imposed on the parents to use the other techniques. I think if there were different personalities involved, some of the other techniques would have been sufficient, so, the medication has been the most effective all around.

Although this father had accepted the use of medication for his son, he still maintained some control in administering the medication. Similar to the other father, he did not adhere to the recommended dose or frequency. In fact, he left it to his 9-year-old son to decide when to take the medication:

One of my goals is to start experimenting with his medication ... A. (son) chose not to take his dextrin and I said, “Fine, you’ve got my full support, you want to take it, you take it. If you don’t, don’t.” I didn’t see any noticeable difference in his behaviour ... I think over the long term he’ll be self managed. If he needs medication then he’ll take it but I think he’s noticing in himself when he needs it and he doesn’t.

Another father was also resistant to giving medication to his son; however, after the teachers were unhappy about his son’s behaviour and performance, he reluctantly accepted medication for his son. Although he did not want his son to take Ritalin, he said his son’s mother (his ex-wife) wanted their son to be on Ritalin in order to stay out of trouble:

I tried to intervene. I had a meeting with the school principal. I tried to discuss it with his mother and regrettably her choice was to take him to the family doctor and he recommended Ritalin and I was against him being on it ... I resisted him going on that for a number of weeks but in that time he was getting sent to the
office almost on a daily basis and when I found out how often he was, it was after he had been going through this for awhile, I became very concerned and I guess in my weakness or my fear I agreed that something needed to be done and that I would be willing to allow him to try Ritalin to see if it could help him to stay out of trouble at school.

Children taking Ritalin usually take one tablet (which is effective for 3 hours) in the morning and then during lunchtime. They are called to the office at school to take a second dose because the medication is left with the school nurse. It is a common practice to have the nurse administer the medication to prevent the second dose being missed or the medication misused by children. Some parents and children are embarrassed by this procedure. They find that being required to take a medication for a nonphysical problem leaves a stigma. This may be another reason for some fathers’ resistance to medication in this study. The father mentioned above, who resisted the use of medication for his son, later learned about the medication’s side effects (such as loss of sleep and appetite) and stopped his son’s medication, despite its positive effect on his son’s behaviour and performance:

I started to get the encouragement of some people to look into that drug and I did some research and decided that I’d made a mistake, although the evidence dictated otherwise because he did settle down and he was in less trouble.

The more I found out about dangers of Ritalin, the more I wanted it to be short term and, in fact, to be discontinued. So I went to work trying to convince his mother because she was, I think, just happy to have him not in trouble and she wasn’t receiving the phone calls from school.

Although, according to this father, his son’s mother wanted to use medication not to receive “phone calls from school”, he stopped the use of medication for his son and he only relied on behavioural modification techniques. He tried to change his son’s behaviour by changing his own responses towards him.
Another father who was also resistant to the use of medication said his son took the medication to help him focus. He minimized the use of medication, and, like some fathers, he exercised control by not regularly administering medication to his son. Although he said that he did not like the idea of using drugs, he believed in the use of some substances to change his son's behaviour and he used an alternative product to medication:

I didn't like the idea of Ritalin, giving medication, any drugs. Yes, he's on Ritalin but it's occasional because it upsets his stomach. We're taking a natural product called Manetec and he has improved his mood, it doesn't necessarily improve his performance I think. Just for him to focus he'll take Ritalin, one tablet, ten milligrams ....Definitely put them on Ritalin because for yourself like you think you want a good weekend or you want a good time with your kid this weekend, then do it especially for hyperactive and stuff ...

He considered medication as an effective way to control his son and facilitate them both having a "good time."

Most fathers used alternative approaches to medication for their sons. Fathers who used alternative approaches seemed to be satisfied with those approaches to some extent, but they considered medication to be more effective and less time consuming. Adherence to a strict regimen of diet and alternative approaches constrains the family's time and financial resources.

In summary, fathers were reluctant to use medication as their first choice to influence their son's behaviour constructively, but medication did seem to help sons to focus better and improve their behaviour. These positive outcomes tended to override the fathers' misgivings about medication. Only one father preferred not to use medication because of its side effects (i.e., decreased appetite, upset stomach). On the other hand, another father could not imagine how his son would function without medication. The
son’s reaction to medication or general state of health could be a condition influencing use of medication. Some fathers blamed their wives for wanting to give medication to their son to “manage” him better. A few fathers also mentioned the use of medication to manage their son so that they could have some calm and a “good weekend.” It seemed medication was used in some cases not so much for the son’s sake, but for the father, for the family’s well being, for peace of mind at home, and for a lack of complaints from school.

Using different parenting and behavioural modification skills. Parenting skills are those ways that parents communicate with and respond to their child in order to raise an emotionally healthy child. There are many books and programs to teach parents these skills. They teach responses such as, giving the child choices, using positive statements and not putdowns and blaming, being specific in praising and acknowledge the child’s achievements. Behavioural modification techniques and behavioural strategies involve certain behaviours and responses towards child’s misbehaviour in order to modify such misbehaviour. These are part of the broad spectrum of parenting skills and include things such as, using positive and negative reinforcements, letting the child learn from consequences of his/her behaviour, and breaking down tasks into smaller steps.

Fathers also used direct behavioural strategies with their son. One father and his wife learned to break down their son’s tasks into smaller segments, although this put more demands on them. He also expected to change his son’s behaviour by being very kind and affectionate to him:

What we have to do and what we have found has been successful is ... for example, when he’s got to sort of get up and get fed, get dressed, get teeth brushed and get out the door to school. What we do is we have a fairly fixed schedule ... by having lots of little milestones along the way then that seems to be
easier for him to deal with ... and just break it up in little segments ... It’s been more demanding on us in terms of having to keep that in mind.

This father has been able to eliminate “screaming fights” with his son by breaking down the tasks into smaller, more manageable parts. Although this strategy required patience and was more demanding of this father’s time, the outcome was more agreeable and perceived to be worth the effort.

Another father used different behavioural intervention strategies. He did not have a positive experience using time-outs and consequences with his son. The strategy he used was to be calm and patient with his son, to show affection for him, and to talk with him about an issue that was going on. Although he found this strategy to be emotionally draining, he felt good about the outcome and tried to be consistent in their use:

So how we’re now dealing with K. (son) is more working on attachment skills versus time-outs or consequences and they didn’t work (time-outs and consequences). They didn’t work at all. They don’t work. I mean it just doesn’t work, so now how we work with K. is to sit and talk to him when there is something happening or an issue or he’s doing something that is just not right, particularly with his little sister ... With working this, it is much more emotional draining. It’s difficult but you feel good at the end. You feel good.

In contrast, another father found that the use of consequences and positive or negative reinforcement helped dealing with his son. Both fathers spent time with their son and talked patiently when there was an issue. In summary, several fathers used the technique of breaking down their son’s tasks into smaller segments. Some fathers found giving structure to their son’s activities and using behavioural modification techniques to be demanding, but they adhered to such interventions because of their perceived positive outcome. Deferent behavioural interventions worked for some fathers and did not work for others.
Not knowing what to do. Fathers also said they did not know what to do. They were generally the fathers who did not have family and social support, and did not seek professional help. One father thought that by changing his son’s attitude that his son’s misbehaviour would change; however, he did not know how to help his son or how to change his son’s attitude except by reminding him all the time to change his attitude:

W. (son) worries and I don’t know how to help him that way. Part of it’s attitude, part of it is just that he can’t think and do things like normal kids can ... I try to get their attitude changed. I tell them you’ve got to get “can’t” out of your vocabulary. You can do it. I don’t know how ... I try to drill the ideas into him once in awhile and then I let it go for fear of boring him or sounding too repetitive but I can’t ... I keep trying to put these ideas in his head. This is your problem, this is what we need to do like I keep it day after day ...

Although this father knew that what he was doing was not working, he admitted to not knowing exactly what else to do.

What Fathers did for Themselves

Fathers did a number of things for themselves, as a reaction to the frustrations from the demands on them, or as an action toward developing knowledge and skills to lessen their frustrations. They (a) took time-outs, (b) did exercise and relaxation, (c) used prayer and reflection, (d) compared their son with other boys, (e) did positive thinking, (f) sought support from family and friends, (g) sought professional help, (h) learned about ADHD, (i) consumed alcohol and smoked cigarettes, (j) made choices, (k) got involved with work, and (l) were patient and tried to accept the situation. These responses were not mutually exclusive. For example, when a father was involved in a team sport, he was, at the same time, socializing and seeking support from friends.

Taking time-outs and avoidance. Fathers took time-out so they could have more control of their frustrations and emotions. They used time-outs to calm down and be able
to deal with problems in a better way. They also took time-outs to prevent themselves from acting in anger. A few fathers just wanted to avoid the problem. Fathers did not necessarily use the expression *time-out*, but they distanced themselves from frustrating events with their son, often to be able to get control of their emotions so they could then go back and attend to the issue:

I would quite often just go to another room, just try do some breathing to just catch my composure again, and just let the intensity of the moment subside a little bit. I would never walk away and not go back and leave it unattended ... Whatever reason, it doesn’t matter. Sometimes I don’t want to be with him right now. I don’t want him in my face right now, so I’ll either get a babysitter or if C. (wife) is up for it or if C., my wife, wants to take him fine I’ll just lie and listen to some music on my own, and sometimes I just like the silence. I find solitude in the silence.

Another father gave himself time-out so that he would not get out of control and smack his son. He wanted to get control of his anger and frustration and taking time-out allowed him to do that:

If it got down to my being completely frustrated I would just have to withdraw. I would have to get out ... or I’d smack him. If I completely lost control I’d spank him and that wasn’t very good ... I tend to withdraw. That’s how I have to sort of resolve the anger, is go be by myself and unwind. Sometimes it takes longer but usually like half an hour, 40 minutes, just let myself kind of take a deep breath. Now I can sort of come back and cope again.

Another father too was aware that he could lose his temper easily and become very angry. He was teaching himself to back off and take time-out. He said that one of his reactions was to

Walk away, just don’t pound the table and just don’t attempt to throttle him. I just go walk the dog or something, just get out, and just to remove myself from the scene.
Most of the responses that another father talked about were based on avoiding the frustrating issues: “If you can’t fix the problem, avoid it, walk away and get away from it.” Fathers who took time-outs talked about periods from 5 to 40 minutes.

**Doing exercise and relaxation.** Most fathers talked about participating in physical exercise and relaxation as a response to the demands. Exercises included activities such as, walking, hiking, swimming, playing team sports, and scouting. Some fathers did a type of formal relaxation, such as, deep breathing and loosening their muscles that they had learned from an instructor. Others played or listened to music, or used leisure time as a way to relax. Most fathers used a combination of these responses. For example one father exercised, played his guitar, and walked:

> I did work out at that time a lot so I was definitely relieving stress by exercising, which helped me to keep myself in like a sense of worth, value at a good level. Personally I’m a musician. I play guitar so I think I get a lot of relaxation out of that so playing my guitar. I love to walk. Sometimes I’d go for walks. Those are the things I do.

Another father was active in scouting, hiking, and team sports:

> Weekends, where I was away with other parents and working in the scouting movement, I did a lot of sports. I started playing baseball after not playing for years … just to get out and really think about something else.

This father went for walks and went on scouting expeditions not only for his son’s sake but to release his own tensions. These outdoor activities contributed to his health and gave him a sense of control and mastery as he became more experienced in a particular activity.

One father enjoyed doing activities that both he and his son liked. He did other things that, in addition to being a tension reliever, served other useful purposes. For example, he took the dog for a walk, attended to the laundry, or cleaned the house as a
means to release his tension. In fact, he simultaneously accomplished certain tasks that would have been an additional demand for his time later on:

So I would use exercise sometimes. We have a dog so I would take the dog out for a bit, try and get some free time but I found much more relief of the stress by doing the things that needed to get done, so I’d come home and I’d clean the house, I would do laundry and just do those day to day activities that weren’t being done in my absence and that helped me relieve the stress because now those incompletes were being done …. I’m using all sorts of techniques … breathing, timing, counting … it plays right into the stress management relaxation techniques. I want to get into more physical activities. I find that works well for me but with my schedule it’s been very difficult.

Although most fathers did some sort of exercise or relaxation, there were a few fathers who did not mention using any of these strategies or approaches.

Praying and reflecting. There were a few fathers who used prayer. A father who attended church regularly prayed daily and read scriptures when he felt tense. Another father prayed occasionally, and yet another father thought it would be good if he prayed sometimes. One father’s main responses to his daily demands were to reflect and re-examine the issue and read scriptures on regular basis. A few fathers talked about choosing a quite place and doing some thinking and reflecting:

If I’m feeling particularly challenged in one aspect or something isn’t going the way I’d like it, I can re-examine it from a spiritual point of view and go, okay, so why am I doing this? Is it strictly for my own selfish desires? Is it being selfless? Is it for someone else? What’s the greater purpose of what’s going on? … I’ll get back into scripture on a regular basis to help me with any particular issues. Even in the day-to-day management part.

Another father considered himself a faithful man and occasionally used prayer. Another father also did not pray often, but said that it helped when he went to church.

Comparing. Fathers often compared their son with other boys, either directly by observing others or by comparing them with what they read or heard. By doing this they
were able to get a sense how their son was doing. Comments such as the following were heard:

I worked with kids who were no problem at all and so in some ways it was a help and in some ways it was a hindrance, because I would look at these children and have no difficulty with them and then look at my son and get very frustrated again, but I learned to deal with that, knowing that not every child is the same you cannot, never catalogue them into same group.

They (people at support group) talk about holes in the wall being a regular occurrence with their children ....having trouble with the law, extreme problems at school, barely able to cope, and I go, you're not describing my son (laughter) ... That's not the ADHD I know, so if he (son) does have ADHD truly then it must be very mild.

Seeing children who were behaving worse than their son made fathers feel better about what he was doing:

Children have come to scouting that have been on Ritalin for certain reasons and I would look at them and their behaviour level was worse than my child, which made me feel good because maybe I was doing something right or maybe my son was doing something right. So, in some ways being exposed to more kids with all different behaviour problems made it easier on me to deal with my son.

Thinking positively. Looking at their son’s characteristics positively and appraising certain events and demands in a positive manner was a strategy that some fathers used to become more tolerant and accepting of their son’s condition and of demands on themselves. Many fathers held the belief that “whatever had happened had happened” and “there must be a reason for it.” Optimism and belief that things would improve in future was common among fathers:

I think the most encouraging thing was when a teacher told me that children with ADHD are usually executives or in some form of multi task business when they get older ... that disease or whatever it is, is going to actually help them when they get older .... That cliché that says there’s always a light at the end of the tunnel ... There is always a light at the end of the tunnel.
A few fathers used this expression of, "there's always a light at the end of the tunnel." Some fathers seemed to have the ability to look at a problem from different perspectives and reframe it in a positive way. They were generally hopeful for the future of their son and did not have long-term concerns.

Seeking support from family and friends. As a response to the overwhelming demands on them, some fathers sought help from family and friends. Some fathers who could seek support from their spouses, family, or others to spend time with their son seemed to be able to find time for other purposes than their son's demands. One father had a good relationship with his wife and obtained physical and emotional support from her. He also found his mother and sister very supportive:

My wife I guess who's probably my biggest support. We're still huge emotional supports for each other. I would talk to C. (wife). We've helped each other that way .... My wife is continuing to support and help me emotionally .... Actually my sister as well ... My sister has worked with autistic children for years, voluntary, all voluntary, and she's just that type of person and she's worked with autistic kids and probably ADHD kids for years now and I'm starting to find her a good source and support.

Although he had good family support, he did not have a network of close friends. He sounded regretful about not having close friends, whom he considered very important when he was dealing with an ADHD son at home:

I don't have a big support network as far as friends go, which is very interesting. I think being a closed person up to now is part of it ... but I was just so involved in work and then the family that all of a sudden I woke up, six months to a year ago and don't really have a lot of friends to give a call to .... I think it is very important for someone like myself who's in an environment that I'm in with an ADHD child to have a local support network as well with friends, close friends, where you can get away and be with somebody.
In contrast, one father did not have an understanding relationship with his wife and did not have family support; yet he had a large circle of friends who were not only emotionally support for him but also partners in activities that they all enjoyed.

There are two other fellows that I practice (hockey) with, I get along with extremely well and one in particular we socialize with a lot. I play hockey, ice hockey and floor hockey with groups, different groups of guys and so I do have a lot of ... support in the sense that I’ve got a really strong sort of group of friends that I spend a lot of time with and, uh, and that’s very helpful ...

Another father received emotional support from his own family, but primarily through telephone conversations he had with them.

I’ve got a sister in M. (a city) who gives me a lot of support and then I’ve got a brother in V. (another city) and my mum is over in C. (another city) so telephone. What’s it twenty bucks a month long distance plan (laughing).

By being active in both a church group that met weekly and a local support group for parents of children with ADHD that met monthly, he had a good network of social support. Some of these support groups provided not only emotional support and understanding for each other, but they also provided information and strategies about dealing with ADHD children through the use of guest speakers, videos, and printed materials. He commented on his support group:

They’re (support groups) excellent and we get a lot of really good guest speakers as well and a lot of management techniques. Like last week we had the people from (a) School Board in to speak with us about what ADD means to the school board, how to get help, what does that help mean, what you can expect, how you should approach different things and it was just a really, really excellent meeting.

Family and social supports that fathers sought were emotional and physical. When emotionally supported, fathers felt understood and validated. Physical support helped to relieved some of the time demands. They could spend some time with other family members, on their work, or on themselves. Some fathers had emotional and/or physical
support, at different degrees, from spouse, family members, and/or friends, whereas other fathers said they had no one from whom they could seek support.

Seeking professional help. Although fathers sought professional help for the diagnosis of their son, some fathers also sought professional help for themselves in order to be able to deal more effectively with the demands from their son. Lack of financial resources, or lack of knowledge of, and belief in the usefulness of therapy and counselling seemed to be reasons some fathers did not seek professional help. One father did not think a professional could be of any help; however, later he implied that his financial constraints were a reason for not seeking good professional help for himself:

Definitely, I don’t think talking to doctors (psychologists) is of any benefit. I think that’s a waste of time because doctors: Some of them know nothing about it. Some of them know a little bit about it, and none of them know enough about it so I think it’s a waste of time talking to doctors ....Their bills are hardly in the budget ... You’ve got to rationalize it, make a decision. Do you pay the money out so there’s good help or do you try and do it yourself?

In contrast, another father learned from a professional how to best respond to his son at the time of his son’s diagnosis. Although he found that the method suggested was not effective, he was not discouraged and he did not give up on consulting specialists. Thus, he went on seeing a therapist for himself, and another professional (with his wife) to learn how to deal with misbehaving children:

We were led to believe this boy needs discipline. He needs structure, consequences, time-outs, sitting in the corner, etc., etc., and that’s when things became really tough for us because we tried to enforce that and quite frankly, at least with our child, that doesn’t work .... I’m in counselling myself and this was for myself, just my personal life and marriage and family and everything else, and I’ve been for about a year now and so I work with my therapist ... just sitting and talking to him about how to deal with the situation ... C. (wife) and I are going together to see another fellow. He is a psychiatrist that specializes in wilful children.
This father also spent the time and money to attend a residential week of training to help him in self-realization and reflection:

I went to H. (a residential program) for a week and I spent a week over there with counselling and what have you which was tremendous for me. It was actually a tremendous thing I did. It was a huge personal awareness of me and a lot of that. It’s called Responsive Individualism, and a lot of that is to do with breathing and how to breathe.

Another father went to counselling for himself to deal with his feeling of guilt. He also took courses on how to deal with misbehaving children:

It is a guilty feeling ... and going to counselling did help me get through that. Yes, it wasn’t my fault ... I didn’t mean to give it (gene) to him. I didn’t even know I was carrying it, so the counselling helped me in that respect.

This father did not have financial constraints and seemed willing to get as much professional help as he could, but according to him, the children’s hospital in his city was not of much help and no parent support groups existed:

There was a time that I went and talked to a counsellor for myself, not M. (son). I never went to a parent support group because there was none locally and I hate to say it, but I didn’t get much support from the Children’s Hospital at the time when M. was diagnosed.

In addition to seeing a psychiatrist for his son, another father also went to counselling to cope better with his temper:

I’m not always good at coping with him. I do sometimes lose my temper and that’s not effective ... at all. It’s not effective for me. So dealing with it, that patience, the expectation, and management training, that’s something I’m working on now. I’m taking my own counselling as well and we’re looking at trigger points.

Fathers also sought professional help for other reasons, such as; to learn more about ADHD symptoms and interventions, to learn more effective parenting skills, and to learn how to deal with their own emotions. Lack of knowledge, financial constraints, and availability of services seemed to be factors that affected their seeking professional help.
Learning about ADHD. Within different degrees, fathers wanted to know about ADHD, the symptoms, and the interventions. Some fathers seemed more concerned about gaining such knowledge and used professional services to assist them in this. Other fathers learned about ADHD through support groups, books, and the media:

A lot of the stuff that I had was information that I found in library books and the doctor gave me a pamphlet and then article that I would find in the paper. There’s been some excellent programs on the TV where they talk about children with ADHD ... I made sure I watched them.

A few fathers relied on their wives to search and obtain relevant information. There were a few fathers that, although they acknowledged the importance of having information about ADHD, they did not seek information or a greater understanding of ADHD symptoms. Because he had no access to institutional or professional help or to support groups, one father tried to get help through books, television programs, and newspaper articles about ADHD and said, “The more I read about it, the more I could understand what M. (son) was feeling and how to talk to him.”

Consuming alcohol and smoking. A few fathers consumed more alcohol and smoked more in response to the demands on them—some to a serious extent:

The only option I had (when trying to avoid getting angry) was to run out in the garage and get away from the noise. Usually you can’t hear the kids from the garage crying. Less frequently, you can’t hear mum screaming at them, so I go out in the garage, have another beer, have another cigarette .... A steady supply of beer, coffee and cigarettes, sedation, sedation and stimulation.

Similarly, another father used alcohol to relax and get rid of his tension:

I think the reason that I drink is because there’s a stimulus there. I like the feeling. It’s like smoking pot. I enjoyed smoking pot because I got stoned. It gave me a different perspective on things. It was a stimulus. It’s the same thing about doing the drugs. I did all sorts of drugs when I was younger ... I know I drink. I love to get drunk and I’ve always done that. I used to binge drink and everything else. I don’t deny it. I know I like it and I like the feeling of being drunk.
One of the fathers made a point about not using alcohol to cope, “I don’t turn to alcohol or any thing like that, it’s just I don’t go pour myself a drink.”

**Making choices.** Some fathers responded to the demands on them by making choices and looking at their priorities. One father planed his priorities and made choices:

I’ve just started to make choices for myself and not necessarily for everybody else. I mean, this might be what K. (son) wants to do right now, but it’s not what I want to do right now or L. (daughter) or even C. (wife). Getting to know your needs and wants, sort of thing. There’s certain things you need in life and there’s certain things you want in life and making those choices and I just found being that way is helpful for me. It’s helped me to function in the environment and live in the environment that you have to live in, with an ADHD child like K. It’s looking after myself is what it’s doing.

He also talked about having made a choice between meeting his work demands and meeting his children’s demands:

Another thing that I notice is priorities. (It’s) very difficult to manage priorities, work-related ones. I see activities and opportunities here being lost at work because of these other demands and I’ve got to really consciously say that’s okay, there will be other opportunities. There will be other things and really in the greater aspect of the whole thing, where are my priorities? They’ve got to be with my children. Now that doesn’t mean that doesn’t cause stress when you have to make those choices and say I think this is really important, but my children at this point must come first.

Making choices to give priority to certain demands at the expense of other demands was not easy. Such decisions produced new challenges.

**Getting more involved with work.** Some fathers involved themselves in their work as a strategy against other demands. This strategy benefited one father by bringing much needed financial gains and in taking his mind away from his problems:

Work 15 hour, work 20, work 8 in a week, work 35, so I come out of the oil field, you work 80 hours a week, and I come down here and work 15 or 20 and that should be a stress causer, but it’s just the way things are down here. I don’t know as long as I can get enough work I’m not under too much stress whatever else is going on. Just peace of mind of being able to pay my bills and keep up with the usual.
Another father's way of coping with the tension at home was to get away and spend more time doing business travel. The financial gains of being more involved with work were not as important for this father as they were for the other one:

I think I probably traveled a lot more than maybe I had to and I think a lot of it was getting out of the environment. It's hard to say, but I look now I'm a little more objective and maybe a little more insight and I think there was probably more traveling going on there. It was probably one way that I dealt with it back there maybe without really even being aware of it was to get out of the environment of the household.

Work gave another father a sense of being in control, something he did not always experience when dealing with his son:

I probably tend to retreat to my work more. I will go into office. I really do have work to do, but that's one of all the things on my plate that's easiest for me to deal with because I can just go and do it (laughing). All the other sources of stress are going to be there anyway but this thing I can go and do and actually get something accomplished, so I do find going into the office ... actually strangely therapeutic because it's at least taking control of something that I can control.

Fathers who involved themselves with work as a response to their son's overwhelming demands, usually had some secondary benefits such as financial gains and a sense of being in control of one area in their life.

**Being patient and accepting the situation.** Most fathers talked about being patient and accepting their situation. One father talked about the importance of being patient with his son, "The first thing is it requires patience, so obviously I wouldn't say it, but it definitely will require patience." He also used patience as one way to avoid getting frustrated.

Well more like with homework it was more patience. I would let him get up and vent his frustration and then have him come back and sit down at the table and join me instead of trying to get on one and one with him in a yelling match ...I
knew that I had to be more patient so that was to be the thing, that patience was going to work the best with me and losing my patience was not going to help.

This father used self-talk to maintain his patience when something bothered him. Being an entrepreneur, another father was not patient by nature, although he was aware of the importance of patience and felt he had to work on being patient. He consciously tried different techniques to become more patient:

Yes, patience is something I work on quite a bit. Definitely patience! I’m impatient by nature and that’s definitely an attribute of the high energy part as well. I am a goal oriented, very driven, and patience isn’t something that came with my package .... I consciously try to be more patient.

In summary, fathers responded in varying ways to the demands on them. Some fathers, mainly those who had sought professional help and learned about ADHD, had a wider repertoire of responses that they could choose depending on the circumstances. Fathers made some responses directly to their son as a reaction to change their son’s demands or misbehaviour. Other times responses were made for their own sake to become more understanding, more accepting, and more relaxed with their son’s demands and misbehaviour.

**Outcomes**

Outcomes are the result of responses, or lack of it, to an issue or a problem. Although fathers responded differently toward their demands, their goal for the outcome was more consistent, that is, to eliminate some of their tension and frustration and to help their sons academically and socially to become more successful. Responses generally had multiple outcomes. Irrespective of their goals and intentions, fathers’ responses usually had a range of outcomes, some of which were intended and others not. Some of the outcomes of fathers’ responses in this study were gained knowledge of ADHD,
acceptance, self-growth and realization, compromise and ability to balance time, effect on physical health, and effect on emotional health.

After fathers learned about their son's diagnosis of ADHD, for the most part, their expectations of their son changed, and consequently they changed the way they responded to their son. As fathers accepted the diagnosis and learned more about ADHD symptoms as well as skills to help them deal with their son, their expectations and responses became more in accord with their son's situation and accordingly they tended to be less frustrated. Most fathers lowered their expectations for their son's routine tasks and short-term goals, but did not change their long-term expectations. They expected their son to excel and to succeed in the future. Optimism and positive attitude of fathers towards their son's situation helped them to look at their son's demands on them as transient and to be hopeful for "the light at the end of the tunnel" and the future of their son. Acceptance of their plight helped fathers to compromise and reach a balance, that was more workable for them, among their demands. Fathers who had taken parenting training or had been to counselling became more understanding of their son's shortcomings and reported a repertoire of more facilitative responses than fathers who had not sought help to deal with their son.

Spending more time with their son gave some fathers the sense of being able to do as much as they could, "When you've done your job, at least you feel some self worth and a good self image as a parent that you've done all that you can." Quality of the time spent with their son differed and depended on the type of activity. By doing too much for their son, some fathers made their son more dependent; yet, there were advantages to this. The fathers felt in control and felt good whenever they were involved with their son,
especially when they had few skills for interacting with their son in a constructive manner. Those who viewed satisfactory school performance and lack of teacher complaints as a measure of their son’s well-being, believed that their son was doing well when in fact the son’s schoolwork was satisfactory due to the father’s efforts.

The physical activities and exercises that fathers engaged in, such as swimming, walking, hiking, workout, and team sports, all had the primary effect of helping to release tension. Other benefits included promoting physical health, allowing more time to be spent with their son when activity was done together, and increasing their connections with others through socializing when an activity was done with friends. Doing outdoor activities, in addition to contributing to the fathers’ health, also facilitated a sense of control and mastery as they became more experienced in a particular activity. The use of relaxation, whether deep breathing, muscle relaxation, resting, or listening to or playing music generally helped fathers to be calmer, to feel more in control of their emotions, and to interact more in a positive and constructive manner.

Personal growth and changes in perspective and attitude toward their son occurred for some fathers after they were challenged in dealing with their demands, after they gained knowledge about the behaviour of other people’s children, and after they learned more about ADHD symptoms. Through reading about ADHD and also working with other children, a father became more knowledgeable and subsequently changed his attitude toward his son. This, in turn, resulted in him being more understanding and less frustrated. Most fathers viewed the challenges that they had with their son as positive and attributed certain changes in themselves to those challenges. One father credited his involvement in scouting, that he enjoyed very much, to his son:
I guess I never could picture myself being a person that could work with multiple kids at any given time and I have been able to have the pleasure of being in groups of hundreds of kids and doing activities and I don’t get frustrated (*laughing*). Because when you have a child that can be very frustrating, other children don’t seem to be, don’t seem to bother you .... I have to thank my son for it because if he hadn’t have been the way he was, I would have never got involved and so I enjoy that, I really do enjoy scouting and it’s my son that got me into it.

All the outcomes mentioned above led to a better emotional and physical health for fathers and a better relationship with their son. Not all responses necessarily had a positive and constructive outcome. Certain responses such as not knowing what to do and consequently not taking any constructive actions, or using putdowns and anger with their son, or consuming more alcohol and smoking more seemed to have the outcome of increasing tension, and affecting emotional and physical health in a negative way perpetuating more frustration and worsen relationship with the son.
CHAPTER V
DISCUSSION

The purpose of this study was to examine the coping processes of fathers who have a son diagnosed with ADHD behaviour. In this chapter, I indicate to what extent the findings are reflected in the literature, and also identify the main contributions of this study. Then, any relation between the findings and theories of adaptation to demanding situations is explored. Finally, clinical implications, and limitations of the study are presented and suggestions for future research are given. The terms responses, coping responses, and coping strategies are used interchangeably.

Reflections of the Findings in the Literature

Although there is a paucity of studies directly related to the coping process of fathers who have a son diagnosed with ADHD behaviour, the results of several studies relate to the findings of the present study. Bender (1997) reported that when “parents” learned about their child’s diagnosis of ADHD, they often experienced feelings of sadness, isolation, denial, and depression. Fathers in this study also mentioned feelings of sadness, denial, and use of antidepressants when they talked about their responses to their son’s diagnosis. In the present study, half of the fathers were either separated or divorced from the mother of their son with ADHD behaviour. The other half of the fathers who were married talked about strains on their marital relationship as well as inconsistencies and contrasts between their parenting styles and those of their wives. They mentioned how dissimilarities in their parenting style hindered use of certain strategies such as home management and providing their son with structure. Previous studies have also found a greater degree of marital dissatisfaction and lower marital adjustment among parents of
children with ADHD behaviour, compared with the parents of nonproblem children (Barkley et al., 1992; Johnston, 1996). In a study on parenting similarities and children with ADHD behaviour, Harvey (2000) suggests that parenting dissimilarity between parents of children with ADHD behaviour may contribute to the disruptive behaviour problem of these children and to marital dissatisfaction between parents. Some of the previous studies reported that socioeconomic status was associated with parenting stress (Baker, 1994; Mash & Johnston, 1990), and financial stressors accounted for the largest percentage of variance in caregiver stress (Baldwin et al., 1995). In the present study, lack of financial resources seemed to inhibit fathers from seeking professional help, and also made it more difficult for fathers to compromise work demands for their son’s demands.

In the present study, there were fathers who talked about alcohol consumption as a response to the demands on them. Pelham and Lang (1999) have indicated that externalizing behaviour disorders of children are associated with an increased risk of familial alcohol problems. Pelham and Lang also consider that parental alcohol problems may contribute to a child’s misbehaviour, which in turn, may intensify parental drinking. This suggests a recursive relationship between parental response and a child’s behaviour, which is consistent with the present study’s findings.

A few fathers mentioned that they had ADHD symptoms and one father found out about it during his son’s assessment. A recent study (Weiss, Hechtman, & Weiss, 2000) considers it not uncommon for a parent, when completing an ADHD assessment for a child, to discover that he or she has the same symptoms. Weiss et al. also state that some parents with ADHD symptoms may be very tolerant of their child’s ADHD behaviour. In
the present study, some fathers who mentioned their own ADHD symptoms seemed to enjoy actively engaging with their son in physical activities.

Findings of the present study are to some extent reflected in Mash and Johnston’s (1990) conceptualization of parenting stress as a complex construct that includes behavioural, cognitive, and affective components (see Figure 1). Mash and Johnston’s model does not include direct effects of parent characteristics on child characteristics and on environmental characteristics, whereas they consider that child characteristics have a direct effect on parent characteristics. Findings of the present study suggest that fathers’ characteristics, such as their cognitive and physical attributes (i.e., thinking positively and level of physical activity), drinking and avoidance patterns, or their own upbringing may influence their son’s characteristics (i.e., behaviour). Fathers’ characteristics also influenced the environment because they perceived life events and demands differently (e.g., some fathers were optimistic, they considered their son’s demands to be transient, and they were hopeful for their son’s future). Inclusion of these relationships and a process view of stress would enhance Mash and Johnston’s model.

**Contributions of the Present Study**

Most of the research on parents of children diagnosed with ADHD revealed that these parents have higher stress than parents of nonproblem children (e.g., Anastopoulos et al., 1992; Baker & McCal, 1995; Barkley, 1990; Barkley et al., 1992; Mash & Johnston, 1990). The studies considered stress as static and negative, and did not explore what parents did (i.e., how they coped) with such stress. The present study examined some of the coping strategies that fathers, who have a son diagnosed with ADHD behaviour, use when under multiple demands or stressors. As outlined in Chapter IV,
fathers used different responses for similar demands at different times. Findings presented in the model (see Figure 2) indicate that demands and responses were affected by influencing factors (conditions) and that a recursive process (compared to stimulus-response stance of previous studies) is involved in fathers' coping strategies. Also, demonstrated in the present study is the temporal nature of the demands, how they changed as certain influencing factors changed. Finally, it is evident from the findings that not all fathers considered their son's demands on them as being negative. Some fathers used the words 'challenge' and 'challenging' and attributed some personal growth and positive changes to having those challenges. This is consistent with challenge appraisals (Lazarus & Folkman, 1984), in which a person focuses on the potential gain or growth that a demanding encounter might bring.

Fathers tended to use similar types of strategies for similar events. For example, when some fathers were becoming frustrated and became angry, they gave themselves time-outs. However, fathers had different intentions for similar responses to similar events. One father gave himself time-out to get his "composure" back to go and deal with the issue. Another father took time-out to prevent himself from "smacking" his son, and yet another father took time-out to relax and take care of himself. Thus, understanding a father's intention in using a particular coping strategy is important.

The findings of this study are consistent with the adaptational stress and coping model (Lazarus & Folkman, 1984) discussed in Chapter III, in contrast with the stimulus-response view of stress used in previous research that compared parents of children with ADHD behaviour with parents of nonproblem children. One difference between Lazarus and Folkman's relational stress and coping model and my tentative proposal is that I have
considered fathers' feelings and thinking (positively) as responses, whereas, the adaptational stress and coping model identifies them separately as appraisals. However, in a recent study Folkman and Moskowitz (2000) consider positive reappraisal to be cognitive strategies for reframing a situation in a positive way and they indicate that this type of coping is important for caregivers to sustain their efforts over long periods of time. There are iterative relationships amongst all the components of the model including between appraisals and coping strategies, and moreover, outcomes also influence the responses (i.e., coping strategies). The actions fathers took regarding their son’s medication has been considered as a response; however, it also can be considered an outcome of fathers’ increased knowledge of ADHD and the medication. This indicates that coping and outcomes are not as distinguishable as theory might suggest, and demonstrates the difficulty in operationalizing Lazarus and Folkman’s theory by trying to clearly and definitively identify what are the coping strategies and what are the outcomes. Operationalization of the theory is further complicated by the fact that fathers’ intention for their responses also has to be considered; although fathers used similar responses, their intentions for outcome were different.

Tentatively, it seemed that fathers’ responses were influenced by several factors. For example, one father who did not seek professional help commented that the fees for professional help were not in his budget. Another father attributed his harsh responses towards his son to his own background and upbringing, although he changed his responses to his son when he learned more about ADHD symptoms. Generally, fathers’ responses may be influenced by factors such as their financial resources, their understanding of ADHD symptoms, their own upbringing and background, their own
physical and emotional health, the severity of their son's ADHD symptoms, their relationship with their spouse, the availability and acceptability of social and professional support, their work flexibility, their values and beliefs, and the nature of their interaction with their son's teachers. Because these influencing factors may change over time, fathers' responses to the same demand may change too. Lazarus (1993) states the limitations of coping process approach to be the inadequacy of the coping measures to relate to the whole person who has specific priorities, intentions, belief system, and social connections. The present study has indicated how these factors influence the coping strategies.

The main coping responses explored in this study were (a) getting angry, (b) using medication or alternatives to medication for son, (c) using parenting and behavioural modification skills, (d) spending more time with son, (e) doing exercise and relaxation, (f) seeking social support, (g) seeking professional help, (h) learning about ADHD and medication, (i) making choices, (j) thinking positively, and (k) getting more involved with work. These coping strategies could be grouped in different ways. By some of their responses, such as use of medication for their son, fathers tried to solve the problem. Fathers' other responses were directed at dealing with their emotions, such as thinking positively and becoming more understanding of their son. With the provision mentioned before that the relationship and overlap between coping and outcome is too complex to use these coping strategies to develop an instrument, the main coping strategies that were identified in the present study confirm most of the eight coping types used in the Ways of Coping Questionnaire (Folkman & Lazarus, 1988). Fathers' responses of anger and trying to change their son's attitude were 'Confrontive coping'. Fathers who used self-
talk, and tried to get their composure back before reacting were using 'Self-controlling' type of coping. 'Seeking social support' was a type of coping that most fathers used. Breaking their son's tasks into smaller step and using specific behavioural interventions were 'Planful problem solving'. Some fathers who avoided the stressful events were using 'Escape-avoidance' type of coping. Fathers who took time-outs and used relaxation were using 'Distancing' type of coping.

**Clinical Implications**

Implications of the findings of this study for clinicians are important because the findings provide a detailed understanding of the demands on fathers who have an ADHD diagnosed son, as well as the coping strategies they use. Findings of this study suggest that demands (i.e., stressors) on fathers, who have a son with ADHD diagnosed behaviour, should not be viewed in an isolated way. Awareness that most demands are affected by influencing factors and their nature or intensity change over time helps clinicians to choose a more effective approach when counselling this population. The knowledge that although fathers noticed their son’s misbehaviour from an early age, they did not seek professional help until several years later when their son’s disruptive behaviour was brought up to their attention by their son’s teachers has implications for earlier interventions. Awareness programs and literature can be developed for parents to inform them of certain behaviours that children may have that need closer examination and consultation with professionals. The view that some fathers had about their son’s teachers and the way these fathers dealt with the school personnel indicate the need for certain programs to enhance better rapport and communication early between school
personnel and parents. Also, need for some educational programs in classroom management and dealing with misbehaving children for teachers is indicated.

An implication in using a qualitative research method is that such an approach may be therapeutic in itself, because it allows time for participants to talk about their own situation in an accepting environment. In the present study, all fathers felt good after having had a chance to talk about themselves, about their family, and in particular about their son and their relationship with him. Representative of fathers' reflections and feelings on the process of the interview are comments such as, "I'm reflecting as I'm talking and it's definitely encouraging for me," and "It's always interesting to put a lot of these things into words. It's always an educational process, so I find it a helpful process, but I just don't want to talk to my wife about it."

**Limitations**

Demographically, the participants were Caucasian, and hence the results may not apply to a different cultural and ethnic groups. Despite diversities among the fathers, all of them were volunteers. The fact that they were the only volunteers out of many fathers who had heard about this study indicates certain differences between this group of fathers and the other fathers who have an ADHD diagnosed son and were informed about the study but did not volunteer. The fathers who volunteered may have exhibited more help seeking behaviours. The results of the present study do not link coping strategies with specific demands. Also, the identified coping strategies may differ from general parenting coping strategies by their intensity. As a researcher, English being my second language, I may have missed certain connotations and innuendoes from fathers' statements. On the other hand, because of my particular attention to certain words and their different
meanings in another language, I may have examined some statements from a different perspective that enhanced abstraction and conceptualization of the themes that emerged. Finally, a limitation of grounded theory approach is that the findings are not universally applicable, and therefore the results cannot be generalized for other groups and different ecologies.

Suggestions for Future Research

The data obtained from the interviews were very rich in the sense that fathers talked about and revealed different aspects of their lives. Although examining all those aspects was not within the scope of the present study, exploration of such aspects is important in enhancing further understanding of these fathers. Control was an issue to which a few references were made indirectly such as getting involved with work to feel more in control. Findings of a study on the father-son relationship between fathers who have a high need for control and those who have a low need for control may indicate some differences in the quality of such relationships. Another area that needs more investigation is the high incidence of marital discord among parents of children with ADHD behaviour. Although some studies suggest that a child's ADHD behaviour is the cause of such discord, taking an attachment theory perspective (Erdman, 1998), children with parents who have relationship problems may demonstrate ADHD symptom-like behaviours that can easily be mistaken for ADHD symptoms, causing over diagnosis of ADHD.

Conclusion

In conclusion, this study contributes to a better understanding of coping processes of fathers who have a son with ADHD behaviour. Multiple demands on these fathers and their coping strategies and outcomes were identified. A range of coping strategies
including doing exercise and relaxation, taking time-out, administering their son’s medication, seeking professional help, learning about ADHD, and thinking positively were identified. Five themes were developed. These were (a) what it was like before diagnosis, (b) reactions to son’s diagnosis, (c) types of demands, (d) types of responses to demands, and (e) outcomes. Findings support the complex and overlapping relationship of coping strategies and outcomes and the iterative view of stress and coping process.
REFERENCES


APPENDIX A

DSM IV ADHD Diagnostic Criteria

Diagnostic and Statistical Manual of Mental Disorder (APA, 1994)

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of *inattention* have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

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

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

*Hyperactivity*
(a) often fidgets with hands or feet or squirms in seat  
(b) often leaves seat in classroom or in other situations in which remaining seated is expected  
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)  
(d) often has difficulty playing or engaging in leisure activities quietly  
(e) is often “on the go” or often acts as if “driven by a motor”  
(f) often talks excessively

(continued)
DSM IV ADHD Diagnostic Criteria (continued)

Impulsivity
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).
APPENDIX E

Interview Schedule

A – Demographic Questions

Some of the following questions would have been answered prior to the interview meeting. Answers to other questions would be obtained indirectly during interview by using general background questions at the beginning and more specific questions towards the end of the interview, if the required information had not been obtained.

1. Name, Address and telephone number, Age.

2. Married or single parent.

3. Occupation. Are both parents working? Fulltime or part-time?

4. Age and sex of other children.

5. Age and school grade of the son diagnosed with ADHD symptoms.

6. Was the son on medication now? If not, has he been on medication? For how long?

   What medication?

B – Semi-structured Interview Questions

The following are a sample of trigger questions that were used, but not necessarily in this order or verbatim.

1. Tell me about how and when you became aware of your son's problem.

2. What was distressing/anxiety provoking for you at that time?

3. What did that mean to you to have your son diagnosed? How did you make sense of that and how did you deal with it?

4. How did you interact with your son before his diagnosis?

5. How was parenting after diagnosis? What did you do differently?
6. How are things going on with your son now? What do you do differently?

7. Are there behaviours/attitudes/reactions of your son that you find difficult, challenging, or stressful?

8. What do you think and what do you do in such a situation? How does it work for you?

9. What kinds of help do you have regarding yourself and your son?

10. What makes it harder/difficult? What is at stake? How do you manage?

11. How has your son’s behaviour affected your relationship with other members of your family?

12. What are your expectations of your son, for now and the future? Have your expectations changed after diagnosis?

13. Do you have any worries for your son, for now and future?

14. Is there anything that I have missed? Is there anything that you want to say/add about yourself or your son?

15. How did you feel being interviewed?
APPENDIX F
Example of open coding

Participant #3

111. R: And how did you deal with it?
112. P: Yes, and, um, we went through quite a period um, discussion on whether we should medicate or not.
113. As well we went through a lot of different home management approaches, some homeopathic approaches, diet, um, but my wife just wasn't capable of doing the home management, right, and that became evident right even though the history that that wasn't there and him being diagnosed as ADHD didn't change her behaviour or personality as far as the home management.
114. So, it ended up being, medication was going to be the most effective way to help him deal with it as well as her.
115. R: Effective for who? For your son or time management?
116. P: (laughing) That's a double edged question, um, it ended up being the best thing for my son, um, because...
117. of the load that it imposes on parents to use the other techniques, um, I think if there were different personalities involved, some of the other techniques would have been sufficient so, yeah, the medication has been the most effective all around and he’s on a very small dosage of one of them, I understand to be the milder.

Demands | Outcome
--- | ---
Responses/Reactions | Conditions/Context
APPENDIX G

Example of a Memo Page

3

Knew on being wife!
Medication was not the first choice. Tried
a list of different approaches.

What makes a father choose
Medication or alternatives?

#1 & #2 didn't use medication as first
choice either!

Is there a stigma attached to medication use?
What about the fact that the medication
seems to be effective and allows children
to focus? Does the positive outcome
needed by family overcome the misgivings
about medication?

How do fathers struggle to get information on alternative
approaches? What makes them prefer one over
the other?

Considered wife
not capable to use
Medication.

#1 blamed wife
too for issues

But: Stigma?

See page 23/2

Alternative
approaches

Needs calming

time evening?

Partner's support

Side effects?