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Coping Strategies of Single Mothers of Children with
Attention-Deficit/Hyperactivity Disorder (ADHD)

by

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A Thesis
Submitted to the Faculty of Graduate Studies
through the School of Social Work
in Partial Fulfillment of the Requirements for
the Degree of Master of Social Work at the
University of Windsor

Windsor, Ontario, Canada
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ABSTRACT

Single mothers of children with ADHD can experience significant levels of stress in their parenting role, however, little is known about the specific coping strategies these mothers use. This study investigated the coping strategies used by single mothers of children with ADHD who were involved in treatment. This qualitative study involved conducting a semi-structured interview with ten single mothers of children with ADHD. Results of this study suggested that mothers of children with ADHD used a variety of coping strategies that included: Utilizing behaviour management techniques, engaging in activities which have the potential to prevent stressful situations, utilizing self-calming, engaging in self-nurturing activities, developing and maintaining social supports, utilizing inappropriate parenting strategies, and engaging in activities that result in immediate self-gratification for the mother. Included is a discussion about these coping strategies as well as recommendations made regarding implications for social work practice, policy, and future research with this population.
DEDICATION

I would like to dedicate this thesis to my mother Carol Slobodnick, who passed away on May 12, 2007, after a courageous battle with A.L.S. (Lou Gehrig’s disease). Although she was not able to read this final draft or be there for my graduation, I know that she would be proud. I love her and miss her dearly.

I would also like to dedicate this thesis to the mothers who participated in this study. I admire these women for their commitment to their children and their strength in raising a child with ADHD as a single parent. I am appreciative that these mothers took the time to meet with me so I could collect the data to conduct this study. I wish them all much courage and success in raising their children, and hope that they continue to seek support from others when needed.
ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the support and guidance of many individuals. I would like to thank my wonderful committee members who have assisted me so much throughout this challenging process. I would especially like to thank my advisor Dr. Rosemary Cassano who has been more understanding and supportive than I ever thought possible. I have never met anyone more dedicated to the social work profession than her. She has been such a great mentor throughout this entire process and I will never be able to thank her enough for assisting me through this. In addition, I would like to thank my other committee members, Dr. Brent Angell, and Dr. Kim Babb who both have been very supportive and have been an integral part of this process.

I am grateful to Glengarda Child and Family Services for supporting me in returning to school to complete my M.S.W., and also for allowing me to interview clients from their facility. In addition, I offer much thanks to my colleagues who have been very encouraging, and to the mothers who volunteered to participate in this study.

I am thankful to my friends and family members for supporting me throughout the completion of this program, and for understanding when I was not able to spend time with them or attend certain functions due to the need to work on this research study. Specifically, I would like to thank my husband Andrew who has supported me in many ways throughout the entire process of completing the M.S.W. program. Our entire marriage was shared with school work, research and meetings, and now I am looking forward to having more time to focus on building our life and future together.
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CHAPTER I

INTRODUCTION

The purpose of this study was to gain knowledge and understanding of the coping strategies that are used by single mothers who have children with Attention-Deficit/Hyperactivity Disorder (ADHD). ADHD is a disorder characterized by developmentally inappropriate levels of inattention, overactivity, restlessness, impulsivity, and noncompliance (Fischer, 1990; Nixon, 2001; Pelham & Gnagy, 1999; Segal, 2001; Smith & Barrett, 2002). Pelham and Gnagy (1999) reported that the symptoms of ADHD result in grave impairment in many domains of functioning for affected children including school, family, and peer domains. Children with ADHD experience thoughts in their mind that shift so quickly they forget what they are supposed to be doing. They try to pay attention when someone is talking, but they often are preoccupied by other things such as a bird outside the window or an ant crawling across the floor. These children struggle with keeping still or controlling impulses, and are often reprimanded or embarrassed for not being able to manage their behaviour.

Childhood ADHD is a problem that not only affects the child but impacts parents as well. Parents of children with ADHD must learn to cope with their child’s difficult behaviour day after day, often without any respite.

Two things a mother of an ADHD child must learn is to be absolutely consistent and to be very, very nurturing. The child pulls everything out of you . . . constantly demanding all this attention, all this love, all this reassurance. And you just have to keep giving. (Anonymous Subject as cited in Segal, 2001, p. 263)

Fischer (1990) also agrees that the symptoms of ADHD strain the parent-child relationship severely. Clinicians have observed the stress created by being a parent of a
hyperactive child, but relatively few studies have attempted to assess this stress directly and identify its causes and effects (Fischer, 1990). Little research has been done regarding the parents, and in particular, single mothers of children with ADHD. Studies that have looked at the experiences of single mothers suggest that they experience more stress than women living with partners (Morgan, Robinson & Aldridge, 2002). Finding out how these single mothers cope with the stress of parenting a child with ADHD will be helpful in determining appropriate ways to provide service to these families.

**Purpose and Rationale for the Study**

The current study seeks to understand the coping strategies used by single mothers who have children with ADHD. There is a paucity of literature that focuses on parental coping and ADHD (Bailey, Barton & Vignola, 1999) and minimal research was found specifically on single mothers of children with ADHD. Expanding this knowledge base will assist professionals in planning appropriate interventions when working with clients who could benefit from information in this area. Knowledge acquisition about effective coping strategies could also assist in alleviating single mothers' stress in dealing with their children's difficult behaviour. Understanding how having a child with ADHD impacts on parental coping and management style can give clinicians some constructive guidance when counselling these parents (Bailey et al., 1999). More effective coping strategies can lead to healthier family functioning, thus fostering more positive outcomes for children with ADHD.

Children's Mental Health facilities across Canada deal with many children who are suffering from ADHD. Single parent families were the largest family type served at Glengarda Child and Family Services during the 2004/2005 fiscal year, with 67% of the
children attending the centre being diagnosed with ADHD (Glengarda Annual Report, 2005). Therefore, due to the large number of single parents raising children with ADHD, it is important that service providers are aware of the coping strategies and unique needs of this vulnerable population.

Although there have been some studies that have focused on coping strategies of parents who have children with ADHD, these participants differed from the participants in the present study. In one study, the participants selected were primarily middle to upper-middle class with most parents being college graduates in their early 30’s to 50’s (Segal, 2001). Another study used participants of married couples (Hammerman, 2000), and yet another researched mothers between the ages of 31 – 52 years old with a 68% employment rate (Bailey et al., 1999). In addition, the participants in the previous studies differ from the participants for the present study because the participants for the present study all have children enrolled in a day treatment program. These participants are single mothers, primarily poor or working poor with some post-secondary education who are involved in treatment at a children’s mental health centre.

**Summary**

The purpose of this study was to gain understanding of the coping strategies used by single mothers who have children with ADHD. As little research has been conducted in this area, this study will contribute to knowledge of working effectively with single mothers who have children with ADHD. Such knowledge can impact service design and delivery. It can also provide a foundation for future research pertaining to the coping strategies of single mothers who have children with ADHD.
CHAPTER II
LITERATURE REVIEW

The conceptual framework developed for this study on the coping strategies used by single mothers of children with ADHD comes from a variety of sources. First, the literature pertaining to ADHD in children is reviewed. Next, parenting a child with ADHD is examined, with a particular emphasis on parenting stress. Subsequently, coping with a child with ADHD is presented including parent characteristics, social supports and parenting skills. A brief review of the literature on single parenting follows. Lastly, the key conceptual definitions pertaining to this study are reviewed.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common childhood psychiatric condition, affecting between 3% and 5% (Cantwell, 1996; Children’s Mental Health Ontario, 2002; Jensen, 2004; Segal, 2001), or 3% - 7% of all school-age children (American Psychiatric Association, *DSM-IV-TR*, 2000). ADHD has gone through many names since it was first documented in 1845, including minimal brain dysfunction, restlessness syndrome and hyper kinetic reaction disorder (Glass, 2001). However, in those earlier years, children who displayed the behaviours that are now identified as ADHD were often viewed as troublemakers, lazy or disobedient children. In the 1970’s, researchers began to study these behaviours more closely. As the research progressed during the following years, ADHD came to be viewed as a medical disorder (Glass, 2001).

*Proposed Causes of ADHD*

Although the exact cause of ADHD is not well understood, research has identified
several factors that may contribute to the disorder. Research suggests that biological or genetic factors, environmental factors and experiential factors all may play an important role in making individuals more predisposed to inattentive behaviours (Cantwell, 1996; Tannock, 1998; Salend & Rohena, 2003). These factors may include neurological development, allergies, infection and disease, birth trauma, type of prenatal care, the child’s family life or the family’s socio-economic background (Salend & Rohena, 2003).

**Diagnosing ADHD**

There is no single test for ADHD, which makes the disorder difficult to diagnose. Assessing a child for ADHD generally involves a complete medical examination, in addition to gathering background information about the child’s school and family history. A variety of tests or checklists completed by the family and the child’s teacher can assist doctors, psychologists or psychiatrists in formulating a diagnosis of ADHD (Barkley, 1998). It is important to note that most children will have varying degrees of inattention, overactivity and impulsivity in various situations. Ultimately, the diagnosis of ADHD depends on the clinical judgment of the psychiatrist, psychologist, or doctor, taking into consideration data from several different sources, including behaviour-rating scales that are completed by teachers and family members (Root & Resnick, 2003).

According to the *DSM-IV TR* (2000), for diagnosing ADHD, the child must have six or more of the listed symptoms of inattention that have persisted for at least six months to a degree that is maladaptive and inconsistent with the child’s developmental level, or the child must have six or more of the listed symptoms of hyperactivity-impulsivity that have persisted for at least six months to a degree that is maladaptive and inconsistent with the child’s developmental level. In addition, the child must have had
some hyperactive-impulsive or inattentive symptoms that caused impairment prior to age seven years; some impairment from the symptoms must be present in two or more settings (i.e. at school, work, or home); there must be clear evidence of clinically significant impairment in social, academic or occupational functioning; and lastly, the symptoms must 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.

_Co-morbid Conditions and ADHD_

Co-morbid conditions also need to be taken into consideration when diagnosing a child with ADHD. Co-morbid conditions occur when the symptoms of ADHD overlap with other disorders making it difficult to diagnose one disorder or the other. Children with ADHD are more likely to have other co-morbid conditions such as Oppositional Defiant Disorder, Conduct Disorder, anxiety disorders, mood disorders, and learning disabilities (Abikoff & Klein, 1992; Cantwell, 1996; Harvey et al., 2003; Jensen, 2004; Pelham & Fabiano 2001; Root & Resnick, 2003; Segal, 2001). As many as two-thirds of elementary school children with ADHD who are referred for clinical evaluation, have at least one other diagnosable psychiatric disorder (Cantwell, 1996).

_Social Deficits and ADHD_

Children with ADHD display socially different behaviours such as interrupting conversations, blurtin out comments or answers to questions, failing to recognize important social cues, and handling frustration in an impulsive or unacceptable manner i.e., hitting others (Cantwell, 1996; Frankel & Feinberg, 2002; Salend & Rohena, 2003). Taking into consideration these behavioural difficulties, children with ADHD are
noticeably different from most of their classmates. Consistent with the current trend toward inclusion, most students with ADHD, whether they receive special education services or not, spend the majority of their school time in mainstream classrooms (Miranda, Presentacion & Soriano, 2002). Children with ADHD often struggle academically, and with maintaining their behaviour in the classroom. Offord (2001) states that 80% of children with ADHD have a specific learning disability and almost all children who are diagnosed with ADHD are identified in the school system as having a behavioural exceptionality. Due to the fact that these children are inattentive and many have co-existing learning difficulties, they are more at risk for academic failure and ridicule from others (Bloomquist & Braswell, 1991).

Given that children with ADHD have a tendency to be impulsive, they are more likely to intrude on others and speak out in the classroom (Salend & Rohena, 2003). Children with ADHD struggle with interacting appropriately with others. These children are more likely to be aggressive, withdrawn, and lacking in social skills, which results in poor peer relationships (Feinberg & Frankel, 2002).

**Treatment for ADHD**

Treatment for ADHD includes medication, individual counselling, marital/family counselling, group counselling, parent support groups, behaviour management training or other psycho-educational groups (Heriot, Evans, & Foster, 2001; Jensen, 2004; Yeschin, 2000). Stimulant medications such as Methylphenidate or Dexedrine are often used to reduce the symptoms of ADHD in children. Barkley (1998) reports that research consistently demonstrates the efficacy of stimulant medication in improving behavioural, academic, and social functioning in approximately 50% to 95% of children treated.
Pharmacological treatments for ADHD are more widely used, are less expensive, and have much more short-term empirical support than do psychosocial treatments (Jones, 2002). Although many treatments have been used with children with ADHD, behaviour modification combined with stimulant medication have resulted in clinically significant improvements in behaviour for these children (Pelham & Fabiano, 2001). Root and Resnick (2003) stated that a behavioural-psychosocial or combined behavioural-psychosocial with medication approach is more effective for dealing with the various co-morbid problems that many children with ADHD exhibit. Yeschin (2000) also agrees that the types of interventions for families that have a child with ADHD are those that are behavioural and psychopharmacological, combined with a systems approach that involves the whole family such as behaviour management training and family counselling.

Historically, it was believed that ADHD was outgrown during mid to late adolescence. It is now evident that two-thirds of children with ADHD will continue to have difficulties attributable to the disorder after adolescence (Jones, 2002). Given that ADHD is a chronic disorder, those identified will most likely require some treatment throughout the course of their lives (Root & Resnick, 2003). Ralph, Oman, and Forney (2001) estimated that 80% of children with ADHD will still have significant symptoms into adolescence, and 50% of these children will have such symptoms into adulthood. Tannock (1998) agreed that ADHD encompasses the life span, affecting children from preschool to school age and continuing through adolescence into adulthood.

**Prognosis for Children with ADHD**

Pelham (2003) reports that the prognosis for children with ADHD is: One-third
will have a tolerable outcome, where the child will appear to have mild problems but must use strategies to adapt to their difficulties; one-third will have a moderately poor outcome, where the child will continue to have a variety of moderate to serious problems, including school difficulties; and one-third will have a poor outcome, where severe dysfunction will be present and may even follow the child into adulthood. Early intervention and appropriate treatment may contribute to a more positive prognosis for children with ADHD (Pelham, 2003).

Given the pervasive and chronic nature of ADHD, it is not surprising that many parents find the disorder, and its associated features, extremely difficult to manage and find themselves distressed (Harrison & Sofronoff, 2002). Research findings suggest that child-ADHD characteristics function as a major contributor to parental psychological distress (Fischer, 1990). Due to the crucial role of parenting and the possibility of a negative long-term outcome for children with ADHD, it is imperative that we attempt to understand the impact of this disorder on parents so that appropriate interventions can be applied (Harrison & Sofronoff, 2002).

Parenting Stress and ADHD

Although parenting can be stressful at times for most everyone, parents of children with ADHD experience greater stress because of the additional parenting challenges they face. Parents of children with ADHD can experience considerable stress in their parenting role due to the exasperating symptoms of ADHD such as overactivity, impulsivity, inability to complete tasks, and continual resistance to discipline (Bailey et al., 1999). These symptoms are variable from day to day and situation to situation, are related to the developmental level of the child, the environmental context and the specific
demands being placed on the child (Segal, 2001). Dealing with these difficult and frustrating behaviours is not easy for parents, and it is not surprising that parents who are raising a child with ADHD would have more difficulties parenting their children.

**Managing ADHD Behaviours**

In relation to managing difficult behaviour, mothers of children with ADHD have characteristics that differentiate them from parents of control children (Bailey et al., 1999). Parents of children with ADHD were found to be more directive, negative and less socially interactive when interacting with their children, and children with ADHD were found to be less compliant and more negative with their parents (Johnston & Mash, 2001). These difficulties were more apparent with younger children, and such conflicted interactions have been observed for both boys and girls with ADHD in interactions with both mothers and fathers (Johnston & Mash, 2001). Parents may also respond to their child’s hyperactivity and impulsivity with less directive and controlling interactions which could result in a reduction of parental control efforts and a disengagement from parent-child interactions (Johnston & Mash, 2001). Research findings indicate that mothers of children with ADHD are less responsive to child-initiated interactions and in general, children with ADHD produced a negative reciprocal response in parents (Bailey et al., 1999). Parents of children with ADHD reported lower levels of parenting self-esteem, and more self-blame and social isolation in comparison with parents of children who do not have ADHD (Bailey et al., 1999; Morgan et al., 2002). They also reported significantly lower levels of parenting efficacy, which means they felt less competent, less capable of problem-solving, and less familiar with parenting than parents of non-problem children (Bailey et al., 1999).
Parents of Children with ADHD

ADHD has been found to be more common in the first-degree biological relatives of children with ADHD than in the general population (DSM-IV TR, 2000). Considerable evidence indicates a strong influence of genetic factors on levels of hyperactivity, impulsivity, and inattention as measured dimensionally (DSM-IV TR, 2000). Biological parents of children with ADHD are more likely than those of non-clinical control children to have psychopathology or psychiatric disorders (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Fischer, 1990; Johnston & Mash, 2001; Nigg & Hinshaw, 1998). Research has shown that parents of children with ADHD are more likely to have a history of childhood ADHD themselves (Nigg & Hinshaw, 1998). Research findings are generally consistent with current models of ADHD that are rooted in biological paradigms and emphasize neurobiological and genetic mechanisms as contributing factors to the behavioural characteristics of ADHD (Tannock, 1998).

Over the past few decades, investigators have also reported higher incidences of psychopathology other than ADHD among biological relatives of children with ADHD when compared to families of children without ADHD or adoptive parents of children with ADHD (Edwards, Schulz & Long, 1995). Parents of children with ADHD have been reported to be more likely to have a history of problems such as antisocial behaviour, alcoholism, learning disabilities, and a higher prevalence of affective disorders such as depression, have also been reported for parents of children with ADHD (Edwards et al., 1995). Fischer (1990) reported that alcoholism is more prevalent in families with two cases of children with hyperactivity than with a single case. Murphy and Barkley (1996) found that parents of children with ADHD were likely to be younger,
less educated, of lower socioeconomic status, and to report more symptoms of psychological distress than the parents of the non-ADHD control children.

Although, parents of children with ADHD are often more hyperactive, antisocial, and depressed when compared to parents of children without ADHD, the mental health of family members improved with time, particularly when the ADHD youngster left the home (Hechtman, 1996). Research in the area of ADHD has typically focused on the behavioural characteristics of children and has tended to neglect psychosocial and family environment. However, in more recent research there has been an increasing recognition of the stress faced by parents of children with ADHD and how these stressors can affect parent-child relationships or the parents’ ability to manage their children’s behaviour effectively (Morgan et al., 2002).

Several studies have directly assessed stress and distress in parents of children with ADHD. Many investigators have found that parenting stress is higher among parents of children with ADHD than parents of children without ADHD symptoms (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Baker & McCal, 1995; Fischer, 1990; Harrison & Sofronoff, 2002). There is widespread agreement that child characteristics account for the greatest amount of variance in parenting stress in parents of children with ADHD (Baker & McCal, 1995). Studies of parenting stress in families of children with ADHD have generally relied on comparisons between children with ADHD and children free of ADHD symptoms.

Baker and McCal (1995) conducted a study with 16 mothers who had a school-age child that had been diagnosed with ADHD, 16 mothers of children with a diagnosed learning disability (LD), and 16 mothers of non-referred children who exhibited no
emotional, behavioural, or learning disabilities. The study compared reports of parenting stress and child behaviour problems among all the mothers. The mothers of children with ADHD rated their children as displaying significantly more internalizing and externalizing behaviour problems than mothers of the non-referred children. In addition, mothers of children in the ADHD group indicated that their children had significantly more externalizing behaviour problems than the LD group and the mothers in the LD group reported significantly more externalizing behaviour problems than the non-referred group. Reports of parenting stress showed that mothers of children with ADHD experience significantly higher parenting stress due to child characteristics than mothers in the other groups. They concluded that externalizing child problem behaviours, particularly those related to hyperactivity and aggression, are a major contributor to parenting stress. Therefore, it is not surprising that parenting stress would be higher with parents of children with ADHD because these behaviours are common to children with ADHD.

In contrast, Fischer (1990) suggested an opposite, unidirectional relationship between parenting stress, parental perceptions of child behaviour and parent behaviour. She proposed that child behavioural disturbance may be the effect, rather than the cause, of pre-existing parenting stress. Conversely, other researchers suggested that it is the child’s behaviour, and the increased care-taking demands that hyperactive children impose on their parents, that results in increased parent stress, and therefore dysfunctional parenting (Anastopoulos et al., 1993; Baldwin, Brown & Milan, 1995; Morgan et. al., 2002).
Severity of the child's ADHD

Children may be impacted by ADHD in a range from mild to severe, and they may experience varying levels of difficulty with inattention, impulsivity, and over activity (Segal, 2001). Severity of ADHD behaviour is distressing to parents in their parenting role (Podolski & Nigg, 2001). As the severity of the child's ADHD increases, the parent's stress levels increase and their experiences become more difficult (Podolski & Nigg, 2001; Segal, 2001). Furthermore, with the high incidence of co-morbid conditions in addition to an ADHD diagnosis, several children will experience greater symptom severity as a result (Abikoff & Klein, 1992). The difficulty of managing children with ADHD is exacerbated by the presence of co-morbid conditions, regardless of whether they are related to illness, disability or learning difficulties (Bailey et al., 1999). The existence of a co-morbid condition has an impact on the use of coping strategies in mothers of children with ADHD (Bailey et al., 1999).

Difficulties at Home with Children who have ADHD

There is great potential for children with ADHD to encounter difficulties at home. Due to their inattention difficulties, many children with ADHD are incapable of listening or understanding parental instructions. Therefore, they are unable to complete the tasks that parents ask of them (Barkley, 1998). Often, such children are not able to sustain focus or attention long enough to complete even the most routine of household chores. The tendency of children with ADHD to be hyperactive and impulsive, can add to parents' frustration levels. Some children may have difficulty sitting through dinner, and others may jump on the furniture, interrupt conversations, or blurt out inappropriate comments. Although most parents consider these behaviours unacceptable, few have the
specialized parenting knowledge and skills that are necessary for bringing their child's behaviour under better control (Barkley, 1998). As parents become increasingly more aware of their inability to resolve these child management problems, many parents begin to experience secondary personal difficulties, including depression, guilt, stress, and marital strains (Barkley, 1998).

Coping

Coping shapes our emotions, but its most important function is to manage those emotions once aroused, as well as the sometimes troubling situations that initiate them (Lazarus & Lazarus, 1994). Coping is what we think and do in an effort to manage stress and the emotions associated with it, whether or not these efforts are successful (Lazarus & Lazarus, 1994). It is important not to confuse coping functions with coping outcomes. A coping function refers to the purpose of a strategy, and a coping outcome refers to the effect a strategy has (Lazarus & Folkman, 1984). Functions are not defined in terms of outcomes, although we can expect that the certain functions will have certain outcomes (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) identify two different kinds of coping, emotion-focused coping and problem-focused coping. Although emotion-focused coping strategies can involve actions, emotion-focused coping strategies involve more thinking rather than actions that change the person-environment relationship; while problem-focused coping strategies are action-centered forms of coping that do change the actual relationship (Lazarus, 1991). Emotion-focused coping involves modifications made in one’s internal reactions to the stressful situation (Snyder, 2001). An example of an emotion-focused coping strategy is when a parent reframes a situation by looking at it
with a different perspective which is less threatening or less stressful. Emotion-focused forms of coping are more likely to occur when there has been an appraisal that nothing can be done to change harmful, threatening, or challenging environmental conditions (Lazarus, 1991). For example, if we successfully avoid thinking about a threat, the anxiety associated with it is postponed (Lazarus, 1991).

Problem-focused forms of coping, on the other hand, are more probable when such conditions are appraised as able to be changed (Lazarus & Folkman, 1984). Problem-focused coping involves activities focusing directly on changing elements of the stressful situation (Snyder, 2001). For example, if a parent was planning to bring their child out for dinner, the parent would show problem-focused coping by bringing items and activities to keep the child busy in an attempt to keep the child from misbehaving at the restaurant. Problem-solving strategies are a type of problem-focused coping. Problem-focused efforts are often directed at defining the problem, generating alternative solutions, evaluating the alternatives in terms of their costs and benefits, choosing them and then acting on them (Lazarus & Folkman, 1984). Problem-focused and emotion-focused coping strategies can be used alone, or they frequently occur concurrently. The best coping often calls for a mixture of problem-focused and emotion-focused coping (Lazarus & Lazarus, 1994).

The way in which a person copes is determined in part by his or her resources, which include health and energy; existential beliefs or general beliefs about control; commitments, which have a motivational property that can help sustain coping; problem-solving skills; social skills; social support; and material resources (Lazarus & Folkman, 1984). When coping is ineffective, the level of stress is high; however, when coping is
effective, the level of stress is more apt to be low (Lazarus, 1999).

*Coping with a child who has ADHD*

There is limited research available on the coping strategies of single mothers who have children with ADHD. Many studies focus on how children with ADHD impact their parents’ lives but there are few studies that mention coping strategies and what life is really like for single mothers who have children with ADHD. Coping processes used to manage long-term stressful situations will differ from those used in response to acute stresses (Bailey et al., 1999). An analysis of the coping strategy literature reveals that several types of coping strategies exist and that researchers use a variety of terms to describe them (Bailey & Smith, 2000). Despite variations in terms, coping strategies appear to fall into two major categories, problem-focused coping and emotion focused coping as described by Lazarus and Folkman (1984). Understanding how having a child with ADHD impacts on parental coping and management style can give clinicians some useful guidance for working with these parents (Bailey et al., 1999). Several personal and socio-ecological resources have been reported to influence coping processes.

**Parent characteristics**

There has been some research into the impact of personality traits on the coping processes of parents with a child with ADHD. It appears that personality variables are important coping resources in themselves, and they also affect the availability of other personal and socio-ecological coping resources (Beresford, 1994). Viewing oneself positively can be regarded as a very important psychological resource for coping (Lazarus & Folkman, 1984). Parents who had optimistic thinking or used social supports
were more likely to use problem-focused coping strategies than pessimistic thinkers, who in contrast, were more likely to use strategies such as denial (Beresford, 1994).

Social skills are an important coping resource. Social skills facilitate problem-solving in conjunction with other people, increase the likelihood of being able to secure their cooperation or support, and in general give the individual greater control over social interactions (Lazarus & Folkman, 1984). Humour is also often mentioned as a coping resource for parents because research has shown that a sense of humour protects individuals from the negative side effects of stress (Beresford, 1994). Locus of control seems to be a major factor affecting the coping strategies used by individuals (Bailey et al., 1999). Individuals who believe they affect the courses of their lives have internal locus of control beliefs and those that believe their lives are controlled by external forces, and they can do nothing to change the courses of their lives, have external locus of control beliefs (Beresford, 1994). Individuals with internal locus of control beliefs are less vulnerable to the effects of stress than those with external locus of control beliefs; overall, findings suggested that internal locus of control beliefs appear to be associated more with problem-focused coping efforts than external locus of control beliefs (Beresford, 1994).

Social supports

Support from friends and extended family along with other forms of social support, are coping resources that may mediate the stress of parents with difficult children (Beresford, 1994; Podolski & Nigg, 2001). Bailey et al. (1999) indicated that parents draw upon a range of internal and external resources to facilitate the coping process and that marital status and spouse support are important variables in the coping
process. Beresford (1994) also found that in studies of families with disabled children, spouse support was the most important form of support for these parents. Exhaustion from caring for a difficult child may prevent parents from maintaining friendships, or friends and relatives may contribute to their feelings of isolation because they are unsure how to offer help (Beresford, 1994).

Availability of professional help and access to community resources are other factors that may influence positive coping strategies of parents of children with ADHD (Podolski & Nigg, 2001). If the parent is not aware of valuable services in the community, they may not exercise professional help or seek counselling for their family (Segal, 2001). If the family were to seek assistance from professionals, the parents would have extra support in developing an appropriate treatment plan for their child and family. Bailey et al. (1999) found that mothers of children with ADHD sought significantly more social support and used more emotion-focused coping than mothers of average children. Given that coping with a child with ADHD is an exhausting process, using indirect sources, particularly support, to facilitate effective coping is a wise strategy (Bailey et al., 1999).

Two approaches to life have been shown to be important coping resources. These approaches include the parent's ability to focus on the positive aspects of their child, and the ability of the parent to be able to adopt a day-to-day approach to life, rather than a plan for the future (Beresford, 1994).

Spiritual support or religious beliefs have been acknowledged as a coping resource for parents of children with ADHD (Beresford, 1994; Podolski & Nigg, 2001). Religious beliefs may offer a way for parents to interpret or redefine their child’s
disability which may enable parents to generate their own explanations for the course of events (Beresford, 1994). Research has shown that religious or spiritual beliefs play an important role in the way families handle a wide variety of stress (Beresford, 1994). If religious faith is a positive coping mechanism, then parents who use faith and faith practices as a resource to cope with their children’s problems may require less intense level of support services than parents who do not have this type of conviction (Hughes, 1999). Lazarus and Folkman (1994) indicated that individuals exhibit more effective coping if they receive social support, or even if they believe that they will receive social support when it is needed.

**Parenting Skills**

Parenting skills encompass those competencies or behaviours which enable parents to manage or deal with their children (Beresford, 1994). These skills include discipline, supervision, communication and negotiation with the child. Reports from intervention programs strongly suggest that enhancing parents’ skills to deal with behavioural difficulties considerably benefit the parent and child (Anastopoulos et al., 1993; Beresford, 1994; Danforth, Ulaszek, & Friedman 2004; McKee et al., 2004; Harvey et al., 2003; Weinberg, 1999). Increased competency in dealing with behaviour problems not only has the effect of reducing behavioural difficulties, but it also enhances parents’ sense of competence (Beresford, 1994; Heriot et al., 2001). Parents reported mild stress reduction in managing their child’s ADHD as a result of participating in a parent training program (Weinberg, 1999). In addition, positive parenting increases a child’s willingness to try to behave well and positive interactions allow for implicit learning of basic skills such as listening, waiting, trying, and controlling impulses (Heriot
et al., 2001). For example, in Segal (2001), a mother of an ADHD child felt that she had to become a "professional parent."

I do think you have to become a professional parent to parent these kids. I have heard professionals say that most kids are pretty resilient. ADHD kids are not. You cannot afford to just bumble through or do [as] you have done with your other kids. [They] need polished, skilled parents. [You] can’t learn from the seat of your pants. (Segal, 2001, p. 268)

Acquiring problem-solving skills is an important resource for coping. Problem-solving skills include the ability to search for information, analyze situations for the purpose of identifying the problem in order to generate alternative courses of action, weigh alternative courses of action, weigh alternatives with respect to desired or anticipated outcomes, and select and implement an appropriate plan of action (Lazarus & Folkman, 1984). In terms of parenting children with ADHD, the most used coping strategies in Bailey et al. (1999) were: Revising the rules for acceptable behaviour with the child; reviewing the situation to determine how it could be dealt with more effectively; encouraging the child to engage in a more positive activity; threatening to withdraw privileges; and explaining to the child the expected behaviours. Podolski and Nigg (2001) found that positive reframing (thinking about problems as challenges that might be overcome) was a common coping strategy used by parents of children with ADHD.

The least used coping strategies in Bailey et al. (1999) were the following: Pretending that their child’s behaviour is someone else’s problem; blaming someone else for their child’s poor behaviour; parent taking medication to cope; warning the child that they will tell another person who has authority over child (i.e., other parent, principal or grandparent) and dreaming that they are not in that situation.
Single Parenting

In the late 1960’s, 85% of all children lived in a two-parent household, but starting in 1970, the two-parent family rapidly began to disappear (Lang & Zagorsky, 2001). By 1998, about 68% of all children lived with two parents – a drop of 17 percentage points in only three decades (Lang & Zagorsky, 2001). One explanation for the increase in single parent families is the high divorce rate in the nation today (Paulin & Lee, 2002). Between 1980 and 1999, the number of divorces doubled, from 9.9 million to 19.7 million (Paulin & Lee, 2002). Deleire and Kalil (2002) indicated that 50%-60% of children born during the 1990’s will spend some time living with a single parent, usually their mothers. The Canadian Institute of Child Health (2000) reports that one in five Canadian children lives is a single parent family. According to the Glengarda Child and Family Services Annual Report (2005), single parent families were the largest family type served at 42% during 2005.

Single-parent families were significantly higher in Ontario as compared to the other provinces. Of the single-parent families in Canada, 38% of them resided in Ontario (Statistics Canada, 2005). Given the prevalence of the single-parent family type, gaining an understanding of the needs and challenges of single parents and their children is essential. Some single parents are well off; others are poor. Some have financial support and involvement with the other parent; others do not. Some have always been single; others are widowed or divorced. Some have an extensive network of supportive family and friends; others are relatively isolated. Some work; some do not. Some live alone with their children; others live with parents; and still others have another adult living in the home (Anderson, 2003).
Single parenting has a number of ramifications. Single parents are more likely to have increased financial difficulties and housing problems, and they are more likely to lack social supports, thus causing increased levels of stress (Beresford, 1994; Lipman et al., 2002). Financial hardship is frequently noted to be the most significant challenge that single parents face (Anderson, 2003). In addition, the absence of either parent may result in the children receiving less parental attention, assistance or control (Cherian & Malehase, 2000). Children clearly need their parents to read to them, discuss problems, help with homework, and give discipline and supervision. In a single parent family, there is usually much less parenting to go around (McLanahan, 1999). Many single parents complain that they rarely have periods of respite, and feel that there is no time in the day that they are not performing responsibilities, or worrying about them (Anderson, 2003). Coping with the loss of a relationship, and enduring financial hardship are common tasks that leave single parents and their children more psychologically vulnerable (Anderson, 2003). Compared to their married counterparts, single parents work longer hours, face more stressful life changes, are more frequently depressed, have more financial problems, and less emotional support in performing their parental role (Anderson, 2003). Access to community resources and activities is significantly diminished for children in disrupted families. The loss of income that typically accompanies divorce and separation restricts the ability of many families to become involved in community activities (McLanahan, 1999).

In addition, children from single parent families have been shown to present with more problem behaviour than did their peers from two-parent families (Cherian & Malehase, 2000; Deleire & Kalil, 2002). Anderson (2003) also concluded that children
who grow up in a household with only one biological parent are “worse off”, on average, than children who grow up in a household with two parents, regardless of the parents’ race or educational background.

**Single Mothers**

Single mothers make up 83.1% of single parents and head almost one million Canadian families (Statistics Canada, 1996). In 2001, 85% of single parent families in Windsor, Ontario were mother-led (Statistics Canada, 2001). In 2005, mother-led single parent families were more than four times more prevalent than father-led single parent families in Canada (Statistics Canada, 2005). Paulin and Lee (2002) found that 91 percent of single parent households are headed by a woman. Ricciuti (2004) agreed that the majority of single parents are women, and in addition, they generally tend to be poorer, less educated, younger, and more likely to experience racial discrimination that women in two-parent families. Growing up with a single mother is associated with adverse developmental outcomes for children and teenagers (Deleire & Kalil, 2002). The separation can affect children’s relationship with their mothers. Forced to play two different roles, that of father and mother, single mothers experience stress and often depression, which can adversely affect their parenting (McLanahan, 1999). With their time, energy and spirits stretched, some single mothers become too lenient and others become too strict or rigid (McLanahan, 1999). Poor, single, and frequently depressed mothers often must deal with higher rates of child problems while coping with the impact of poverty itself, which is a known influence on psychological functioning, child functioning and family relationships (Anderson, 2003).

Mothers who require the most support (those with the least income and education,
and the most psychological difficulties) tend to have smaller support networks and receive less help from them (Anderson, 2003). Support networks are crucial for the maintenance of successful single-parent households. Supportive live-in relatives or partners are important, because single-parent mothers who live independently often suffer greater financial and child care strains, and sometimes greater social isolation (Anderson, 2003). In addition, psychoeducational and support groups help single mothers find emotional and social resources away from or in the absence of family networks.

**Single Parenting with Children with ADHD**

Child rearing is difficult even when two parents are present. Yet single mothers face the same tasks that married parents do (for example, making sure that the children are clean, clothed, and fed; helping with homework; preparing children for school; earning money to pay the bills; and disciplining the children), but with fewer resources (Paulin & Lee, 2002). Furthermore, adding a disability such as ADHD makes single parenting even more challenging (Boyce, Miller, White & Godfrey, 1995).

Parents of children with ADHD are more than three times as likely to separate or divorce then parents of children without ADHD (Jensen, 2004). Single parents of children with ADHD perceive themselves to be more socially isolated and lonely (Beresford, 1994). Some studies of single mothers of children with ADHD have shown that these parents, as compared to married mothers of children with ADHD, are more sensitive to child-related stress (Chronis et al., 2004). Children from single mother families, compared with children in two-parent families, are known to have increased rates of psychosocial problems (Lipman, Boyle, Dooley, & Offord, 2002). Single mothers of children with disabilities are often younger, have less education, and lower
incomes (Boyce et al., 1995).

Studies of the coping behaviours of single mothers are relatively rare. The concepts of stress and coping are frequently noted in the literature, but there has been little research on the patterns of coping or the sources of resilience among single mothers (Heath & Orthner, 1999).

**KEY CONCEPTUAL DEFINITIONS**

*Attention-Deficit/Hyperactivity Disorder* – The American Psychiatric Association (2000) has defined ADHD in the Diagnostic Statistical Manual of Mental Disorders (4th ed.) text revision, as a persistent behaviour pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than what is typically observed in individuals at a comparable level of development. These behavioural patterns address such issues as: being inattentive to work or play activities, not listening to others, not following directions, having problems with organization and/or losing items, being distracted, moving or talking excessively, impulsivity, interrupting, or not being able to take turns in play or conversation (DSM-IV-TR, 2000). According to the DSM-IV-TR (2000), these behaviours must: be evident prior to the age of 7; interfere with the individual’s social, educational, and occupational performance in two or more settings (i.e., home, work, school); and not be related to other medical or psychiatric conditions, such as schizophrenia, or anxiety and mood disorders (DSM-IV-TR, 2000). In the past, ADHD and ADD were categorized as separate disorders. Presently, the term “ADHD” encompasses both.

*Coping* – “Coping represents a description of what must be done to keep his or her life at a reasonable high level of satisfaction” (Snyder, 2001, p. 4.). The term coping
is defined as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus, & Folkman, 1984, p. 141.). Coping reflects a person’s way of dealing with stressful situations. People draw upon a range of internal and external resources to facilitate the coping process (Bailey et al., 1999).

**Coping strategies** – The terms coping skills, coping styles and coping strategies were all used interchangeably in the literature. For the purpose of this study, the term “coping strategies” will be used. Coping Strategies are defined as actions, behaviours and thoughts used to deal with a stressor (Lazarus, 1984). According to Lazarus (1984) coping strategies have two functions: Emotion-focused which serves to ease painful or distressing emotions resulting from the stressor such as smoking a cigarette or having a hot bath; and problem-focused, which is doing something to change the problem situation such as negotiating or using social supports. According to Margalit, Raviv, and Ankonina (1992), coping strategies are “cognitions and behaviors used by the individual in evaluating stressors and in initiating activities with the aim of decreasing their impact” (p. 202). Coping strategies are often examined in terms of their efficacy. Effective coping alleviates the symptom and reduces emotional distress. Ineffective coping has the opposite effect of exasperating or escalating the problem (Beresford, 1994).

**Stress** – Psychological stress is defined by Lazarus and Folkman (1984) as “a particular 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. 19). Stress is defined in Snyder (2001) as “physiological and psychological reactions to either internal or external events (stressors) or, more comprehensively, as complex
relations between stressors, responses, and additional mediating variables” (p. 240).

Children – Children are defined in the literature as “school-age” (Root & Resnick, 2003; Johnston, 1996; DSM-IV-TR, 2000; Cantwell, 1996). For the purposes of this study, children will be defined as males and females between the ages of 5-12 years.

Mother – For the purposes of this study, a mother is defined as a biological mother of a child with ADHD.

Single mother – For the purposes of this study, a single mother has been defined as a biological mother who has a child with ADHD who is not cohabitating with the other biological parent.

Summary of the literature review

Given that little research has focused on the coping strategies of single mothers who have children diagnosed with ADHD, this study will contribute to a greater understanding and knowledge of this population. In view of the challenges attached to single parenthood and to parenting a child with ADHD, further research would contribute to the development of knowledge to assist these mothers in coping with their child with ADHD. This study is unique because it seeks to expand understanding of the coping strategies used by single mothers of children with ADHD. Such knowledge will be useful to professionals in providing these parents with the strategies they need to cope effectively with their child’s ADHD related difficulties.

The next section will discuss the methods of the study. It will include the research question, setting, participants, data collection methods and data analysis methods.
CHAPTER III

DESIGN AND METHODOLOGY

*Research Question*

This research study examined the following question in order to gain a greater understanding of the coping strategies utilized by single mothers who have children with ADHD: What are the coping strategies used by single mothers of children with ADHD?

*Study Design*

This qualitative study’s design consists of a case study using the technique of in-depth semi-structured interviews. The case study approach to qualitative analysis is a specific way of collecting data, organizing data, and analyzing data (Patton, 2002). The purpose is to gather comprehensive, systematic, and in-depth information about each case of interest (Patton, 2002). Qualitative research can be defined as research that produces descriptive data based on the spoken or written words and observable behaviours (Sherman, & Reid, 1994). Qualitative data consist of detailed descriptions of situations, events, people, interactions, and observed behaviours; direct quotations from people about their experiences, attitudes, beliefs and thoughts; and excerpts or entire passages of information obtained from the participant (Patton, 2002). Qualitative methods were chosen for this study because qualitative methods describe the experiences of people in-depth (Patton, 2002) and the purpose of the study was to determine or discover the coping strategies used by single mothers who have children with ADHD.

*Framework for Analysis of the Data*

The themes or findings of this exploratory research study were derived from the interview data by using an adaptation of the qualitative method of grounded theory.
Grounded theory is an approach and set of methods for discovering theories, concepts and hypothesis directly from the data rather than a priori assumptions, other research, or existing theoretical frameworks (Sherman & Reid, 1994). Grounded theory methods include constant comparison in which the researcher makes continual comparisons within and across cases or incidents and returns to those cases for analysis at a higher level of abstraction and understanding based on knowledge gained from the prior steps (Sherman & Reid, 1994). Constant comparison is a systematic method for gathering, recording, and analyzing qualitative data in which narrative data are analyzed and coded concurrently with the gathering of additional data (Sherman & Reid, 1994). Grounded theory methodology consists of well-articulated, systematic steps for data analysis, and stresses the importance of explaining and describing problems in detailed, comprehensive, contextualized ways (Rennie, 2000). While grounded theory emphasizes attending to the meanings respondents give to their own experience, it also permits the researcher to describe and explain problems at an abstract level and to potentially interpret participants’ experiences in ways that may not be congruent with their own understanding (Rennie, 2000). An adaptation of grounded theory was chosen as the tool to discover the emergence of hypotheses from the data.

**Setting**

Located in Windsor, Ontario, Glengarda Child and Family Services is a non-profit children’s mental health organization that treats children between the ages of 6-14 years old, and their families. Glengarda Child and Family Services offers a variety of programs including day treatment. Within the day treatment program, the services range from: assessment, including psychiatric, psychological, psychosocial, behavioural, and
educational; treatment including individual, marital, group and family counselling, social skills, anger and behaviour management, and parent training; and community support services are offered to assist the child and family to integrate successfully back into their community school. All children that are accepted for day treatment services at Glengarda Child and Family Services are not able to function appropriately in a community school setting and they also have difficulty maintaining their behaviour at home as well as in the community. Upon admission to Glengarda Child and Family Services, many children experience presenting problems such as aggression, hyperactivity, impulsivity, inattention, poor social skills, learning problems, defiance, and non-compliance.

Children admitted to day treatment report severe behavioural problems – 95% experience severe social skill deficits when engaging with another child or in a group situation, while 88% experience extreme impulsivity (Glengarda Annual Report, 2005).

Participants

The participants consisted of single mothers who had a child between the ages of 9-12 years old with ADHD in the day treatment program, and had been involved in treatment at Glengarda Child and Family Services for at least six months. Initially, this study was offered to all single parents including single fathers. However, only single mothers expressed interest in participating in this study. The focus of the study was then changed to represent only single mothers. Ten single mothers were interviewed to develop an understanding of what their experiences had been, from their own perspective, and to determine the coping strategies that they used. The interviews took place in the participant’s home with the exception of one interview which took place at Glengarda Child and Family Services because this participant did not feel comfortable interviewing
in her home. It was felt that interviews from ten mothers would be sufficient to gather enough data to generate common themes and develop hypotheses. The mothers were recruited by sending a letter to the potential candidates (see Appendix F). The mothers were asked to contact the researcher if they were interested in participating in this research study. The researcher then provided the interested mothers who met the criteria for the study, with a comprehensive information package and information letter (see Appendix A) explaining the study. If they were still interested in participating in the study, they were asked to sign a consent form to participate in this research (see Appendix B).

Data Collection Methods

The data were collected by in-depth semi-structured individual interviews that were conducted by the researcher and took place in the mother’s home with the exception of one interview that took place at Glengarda Child and Family Services. Open-ended questions were asked pertaining to the mothers’ experiences parenting a child with ADHD and how they coped with their child’s disorder (see Appendix C). Children were not present during these interviews. The interviews took approximately one hour to one and a half hours. Standardized prompts were used if the participant was struggling to provide a response to the questions. The researcher conducted a pre-test interview with the first mother to ensure that the questions in the interviewing schedule produced appropriate data for the study. After the completion of this initial interview, it was determined that the participant’s responses to the questions contained the coping strategies used with her child. The questions contained in the interview schedule were able to generate appropriate data for this study. All of the interviews were audiotaped,
transcribed and then the data analyzed for common themes in order to generate hypotheses. A consent form to audio-tape was signed by each participant prior to the interview (see Appendix E).

Due to the small sample size, the analysis was conducted manually by using constant comparison rather than using a data analysis computerized program. In addition, this allowed the researcher an opportunity to gain a greater familiarity with the data. The researcher reviewed the transcripts searching for the common themes in the responses of the participants. Each line of each transcript was read and then compared with all other lines and themes from each of the other transcripts. This process was repeated four times and each line on the transcript was numbered, and themes were highlighted, colour-coded and recorded. The themes were then collapsed into categories.

An incentive was offered to those who participated in the study including the mother who participated in the pre-test interview. Upon completion of the interview, each participant was given a gift certificate for ten dollars that they could use at the department store “Zellers”, which is located in several locations throughout the city of Windsor. The interviews were audio-taped and transcribed for analysis. Demographic information was also collected from each participant. This information was gathered from the child’s file at Glengarda Child and Family Services and from each participant directly (see Appendix D). Additionally, the researcher kept a journal of impressions and reactions to the interviews. These field notes were completed within a twenty-four hour period subsequent to the end of each interview.
CHAPTER IV

ANALYSIS OF RESULTS

The following information was derived from the analysis of the demographic information collected on each participant, the analysis of the field notes that were taken by the researcher after each interview, and by using discourse from the interviews that were conducted with each participant.

Demographic Information

The following information was obtained from each child’s file at Glengarda Child and Family Services upon consent of the mother (see Table 1 for a summary of these results by participant). In addition, demographic information was acquired directly from the mothers during the semi-structured interview, and when they were asked some additional questions prior to each interview (see Table 2 for a summary of these results by participant). All mothers were involved with initiating the referral for day treatment services at Glengarda Child and Family Services for their child. Seven children were referred by the community school in conjunction with the mother; two were referred by another community agency in conjunction with the mother; and one was referred by the mother alone.

Mother

The ages of the mothers ranged from 31 – 49 years old (mean age = 40 years). Five mothers did not indicate that they had a partner; four mothers indicated that they had a partner that lived outside of the home; and one of the mothers indicated that she lived with her partner. Five mothers indicated that their highest level of education they completed was secondary school; three stated that they had completed college; one
completed some university, and one mother had graduated from university with a Master’s degree.

With respect to their own medical and mental health conditions, seven mothers indicated that they did not have a medical or mental health condition. Of the three mothers who acknowledged a medical or mental health condition, asthma, diabetes, depression, high blood pressure, anemia, and arthritis were identified. During the pre-interview demographic questions, no mothers indicated that they had been diagnosed with ADHD. Interestingly enough, during the semi-structured interview, eight mothers reported that they had problems similar to their child’s difficulties. One of these mothers described what she was like as a child:

There was no such thing as ADHD, when I was a kid it was like, ah she’s just hyperactive, just let her go, she’ll wind down sooner or later. But it was hyperactivity, oh yeah I was very hyper. Oh, I was pretty much, kind of like (child), you got so much energy, and you’re doing something, and you’re doing three or four other things, and plus your mind’s got four or five other things on top of it, like go, go, go, go, I was like that too.

Another mother indicated that as a child she suffered from distractibility: “I always remember getting easily distracted in the classroom and stuff . . . and not being able to really sit still.”

An interesting finding was that five mothers identified themselves as being a “tomboy” when they were younger. One of these mothers responded when asked what she was like as a child:

Very busy. I was a tomboy. I was the one that was always getting hurt because I was always doing something I wasn’t supposed to be doing. I was difficult. I was a lot like (child). I was very set in my ways and I wanted things a certain way. I thankfully outgrew that.
Five mothers indicated that they were a “good child” and four of the mothers described themselves as a “shy” child in the school environment.

The mothers were asked about their annual family income as well. Three mothers indicated that their family income was between $10,000 - $15,000; two mothers stated their income was between $15,000 - $20,000; two mothers had a family income that was $10,000 or less; one had an income that was between $20,000 - $30,000; one had an income that was between $50,000 - $60,000; and one mother had a family income that was over $60,000. Therefore, seven or 70% of the participants had a family income that was $20,000 per year or less, which is below the LICOs (Low-Income Cut-Offs) or more popularly know as Canada’s poverty lines (Canadian Council on Social Development, 2006). Their source of income also varied. Five mothers indicated that they had steady employment. Of the five mothers without steady employment, four collected government assistance or pensions, and one worked temporary jobs in addition to receiving government assistance.

Child

The ages of the children with ADHD ranged from 9 – 12 years old (mean age = 10.5 years) and they were all males. Eight children had at least one biological sibling living in the home; one child had one step-sibling living in the home; and one child did not have any siblings. Five children still had contact with their biological father, while five children did not have this contact. Three of the five children with no father contact had a biological father who was deceased.

All of the identified children were diagnosed with ADHD. Nine children had been diagnosed by a child psychiatrist and the remaining child had been diagnosed by a
psychologist. Furthermore, reports completed by psychiatrists and psychologists in the child’s file indicated that all of these children had at least one co-morbid diagnosis. According to these reports, eight children were diagnosed with Oppositional Defiant Disorder (ODD), seven with a Learning Disability (LD), four with an anxiety disorder, two with Posttraumatic Stress Disorder (PTSD), two with possible Conduct Disorder (CD), and two with a mood disorder.

Mothers were asked if their child had another medical or mental health condition other than ADHD. Five mothers identified other medical problems that their children had including asthma, allergies, digestive problems, respiratory problems, lactose intolerance, and eczema. Although the case files indicated that all of these children with ADHD had at least one other mental health condition, not all of the mothers indicated this. Five mothers indicated a diagnosis of ODD; one mother indicated that her child had a LD; one indicated that her child had anxiety; one indicated that her child suffered from PTSD; one stated that her child had CD; and two mothers indicated that their child suffered from depression. Additionally, one mother indicated that her child had obsessive compulsive disorder, which was not indicated in the child’s file and one mother stated that her child had Tourette’s disorder, which also was not indicated in the child’s file.

All children were taking medication as part of their treatment regime. Eight children were taking a stimulant medication such as Methylphenidate or Dexedrine, and two were taking Straterra, a non-stimulant medication that is used to control hyperactivity and inattention. In addition, five of the children who were taking a stimulant medication were also taking Risperidone, an anti-psychotic medication that is generally prescribed to control aggressive behaviours.
During the interview, mothers were asked to talk about what it was like when their child with ADHD first began school. All mothers described behaviour difficulties that their children had at school such as impulsivity, hyperactivity, inattention, defiance, and aggression. Six mothers indicated that their child’s behaviour difficulties began while the child was in kindergarten. One participant shared the behaviour that her son was exhibiting while in school:

He was a discipline problem . . . he would in grade one hide under his desk and refuse to do work. He’d get up and he’d walk around, the teacher would call him back and he wouldn’t come back. He’d yell and get angry and say that he wasn’t going to do his work, and he’d throw stuff.

Mothers expressed extreme frustration in dealing with their child’s community school.

Five of the children had been suspended from school and three of the children were even expelled or removed from the school because of their behaviour difficulties. One mother shared what happened when her son first began school:

He got suspended from junior kindergarten . . . (he was) fighting with a kid, beating a kid up. Then he had a temper tantrum and the teacher tried to stop him. He called her everything but a white woman and threw a chair at her. After about a month, they asked me not to bring him back. They said that he wasn’t ready to come to school.

Another mother expressed frustration with her son’s community school:

The teachers were constantly calling me and telling me that my son was overactive and defiant. I was getting calls at least twice a week – can you come and get him, he needs to go home? It was hard. I didn’t even want to send him to school. I was like, what’s the point in sending him to school?

It is evident that dealing with a child with ADHD when they first begin school is very difficult and demanding and would no doubt raise the stress level for single parents.
Family

When the mothers were asked if there was anyone else in their immediate family with a medical or mental health condition, four mothers indicated that there were no immediate family members with a medical or mental health condition. Four indicated that someone in their immediate family had a medical condition including heart disease, cancer, diabetes, and acquired brain injury. Three mothers indicated that they had an immediate family member with a mental illness including depression, ADHD, anxiety, bipolar disorder and schizophrenia. Only one mother identified an immediate family member with ADHD.

Six mothers indicated that religion was not important to them. All four mothers who indicated that religion was important to them, attended church on a regular basis. One of these mothers indicated that religion “guides her interactions” and another stated that it contributes to her “ethics, values and morals”.

Finally, the mothers were asked if their child was involved in any community activities. Six mothers indicated that their child had some involvement in community activities. Of the six children who were involved in community activities, all but one had involvement in multiple community activities. These community activities included: church, cubs, swimming, soccer, lacrosse, basketball, youth group, hockey, and day camps. Four mothers stated that their child had no involvement with community activities.

Summary of Field Notes

After each interview, the researcher recorded any impressions and reactions to the interviews in a journal within a twenty-four hour period. These notes were later reviewed.
and compared for common themes. The following is a summary of what was found after
analysis of the researcher’s field notes was completed.

Eight mothers were interviewed while the child was not present. Two participants
were interviewed while the child was present in the home but in another room. Five
mothers cancelled their initial appointment and rescheduled the interview to a later date.
During three of the interviews, a friend or family member stopped by the mother’s home.
Although these visitors interrupted the interview momentarily, the interruptions did not
appear to be planned or intentional.

Five mothers lived in a type of geared to income housing; four mothers owned
their own house; and one rented a house with another person. Nine interviews took place
in the mother’s home. One mother did not feel comfortable with the researcher coming
to her home; therefore she was interviewed at Glengarda Child and Family Services. Of
those interviews conducted in the participant’s home, five took place in the kitchen; two
interviews were held outside in the backyard, and two were conducted in the living room.

All of the mothers were polite and made appropriate eye contact with the
researcher. In addition, all mothers welcomed the researcher with a smile and a positive
attitude and seemed to feel comfortable discussing the interview content. Two mothers
became tearful during the interview while they were discussing what it was like for them
to deal with their child’s behaviour difficulties. The researcher was empathetic with
these mothers and they were given an opportunity to further discuss their feelings with
the researcher. In addition, the researcher gave each participant a business card should
they want to contact the researcher at a later date to discuss their feelings or concerns.
One of the mothers called the researcher after the interview to state another strategy that
she used with her child because she had forgotten to mention it during the interview. Due to all of these mothers being clients from Glengarda Child & Family Services, they all had ongoing access to their assigned social worker for counselling and support.

**Interviews with Single Mothers**

With the exception of one, all of the interviews took place in the homes of the participants and all were conducted by the researcher utilizing the interview schedule as found in Appendix C. The researcher conducted a pre-test interview with the first mother to ensure that the questions in the interviewing schedule produced appropriate data for the study. After the completion of this initial interview, it was determined that the participant’s responses to the questions contained the coping strategies used with her child. The questions contained in the interview schedule were able to generate appropriate data for this study. All of the interviews were audiotaped, transcribed and then the data analyzed for common themes which were then collapsed into categories. This qualitative research study generated much data on the various coping strategies of single mothers who have children with ADHD. Following are the themes and categories that emerged from the interviews with the single mothers.

**Coping strategies used by single mothers of children with ADHD**

The ten single mother participants were asked to describe the coping strategies they utilized to deal with their children who have ADHD. The transcriptions were reviewed for common themes about coping strategies that the mothers have used while dealing with their children who have ADHD. Their responses fell into seven categories which now will be presented. (See Table 3 for these categories and related themes)
Utilizing behaviour management techniques with child with ADHD

All mothers mentioned that they were using some kind of behaviour management technique with their child. All mothers indicated that they take privileges away from their child as a form of discipline. They indicated that they remove privileges such as playing video games, watching television, or playing outside, to name a few. One mother spoke of a privilege that she removed: “I take away things. Right now he’s lost his privilege to watch Wrestlemania.” Two mothers indicated that although they take away privileges from their child, it is not always effective to change the child’s behaviour. As this one mother indicated: “Taking things away doesn’t work because they just find something else that they would prefer to play with and they’re still getting into just as much trouble . . . they don’t even remember losing what you took away.”

All mothers indicated that they have used a “time-out” as a form of disciplining their child. This usually consisted of the child going to his room to calm down as one mother explained:

I put him in his room. I usually go a minute per year. So now he’s ten, so he’ll stay for ten minutes. Sometimes if he’s settled and ready to talk, then maybe sometimes I may go in earlier, and sometimes maybe a little bit longer, he might need a little more time.

Two mothers stated that although they have tried using time-outs, this form of discipline has not been effective with the child. One of these mothers described her experience with discipline:

He doesn’t listen to time-outs. I give him time away from each other so he has time to settle and we can talk about it after. (Child) has put holes in walls. He would damage things if he is put on a time-out in his room. He put his foot through the wall.
Nine mothers indicated that they talk to their child about the problem or try to problem-solve with their child. Of these nine mothers, one mother described how she used problem-solving with her child:

I will sit down with (child) and explain to him why I was so upset and ask him . . . I’ll even ask him why do you think mommy was so upset? What did you do? . . . and he is able to tell me . . . it’s the typical on the ADHD, they know that they shouldn’t run across the street without looking, but it’s the impulsivity that they have.

Another mother described a similar situation:

If it’s something that went wrong, I try to mention it to him to try to find out why it was done, what was the cause of it to happen, what (he) was thinking at the time. Sometimes he’ll come out himself and know that it was him that was wrong, and it’s not so bad. But there’s other times where he did it his way and that’s all that’s to it because he can get bullheaded.

These two quotes give an idea of some of the symptoms children with ADHD exhibit and examples of how mothers deal with them by problem-solving with their child.

Five mothers reported that they use an incentive program to promote positive behaviour in their children. These incentive programs consisted of giving special privileges or rewards to their child in exchange for the child’s desirable behaviour. One of these mothers described an incentive program she uses with her child to encourage him to do his homework: “With the point system for his homework, come Friday, if he meets what needs to be done, we go for dinner.”

Five mothers identified that they use positive reinforcement by verbally praising their child to promote positive behaviour, as one mother stated: “I always praise him. I try to praise him as much as I can so hopefully he wants to concentrate more on that than anything else.” Five mothers reported that they use tangible rewards with their children.
One mother described her form of praising her child:

With (child’s) positive behaviours, I usually reward him with things... like verbal praise. Or I’ll tell him he’s doing really good. I’ll let him have extra time on the computer, or it’s not always a gift, it’s – you can sit in the front (of the car) or stuff like that.

Given that children with ADHD have difficulties with organization and focusing on tasks, it is likely that they would also need assistance with their routines in the home as this mother indicated: “Trying to keep (child’s) life on an even keel. Because when things are running smooth, he runs smoother... consistency and routine for (child).”

Three mothers felt that it was helpful to use sense of humour when dealing with their child with ADHD. One of these mothers stated “sometimes I can handle it with humour because he does have a really good sense of humour most of the time. He is as sarcastic as I am, so that works out really well.” Two mothers felt that “picking and choosing battles” with their child would result in fewer arguments. One of these mothers said:

You have to pick and choose your battles definitely. I’ve learned that (child) is very angry and very upset and very aggressive, so you need to back off and give him room or you may get a punch or kick or something.

By picking and choosing battles, mothers were able to let the smaller incidents go which resulted in less conflict between the mother and child.

The other responses were unique to each mother and each one was only mentioned one time. One mother indicated that it helps her by writing things down or making a list: “Other times I’ll sit, or even just make a list of what he’s done and what should have been done. What I should have said or what I should have done instead of what I said.” Another mother indicated that she tries to calm her child down or will
remove her child from the situation: “I try to calm him down, move him away from the situation. Try and get the other, the whatever caused it out of the way so he can settle down.” Lastly, one mother felt that reasoning with her child would assist in the problem-solving process.

*Engaging in activities which have the potential to prevent stressful situations with the child*

Seven mothers indicated that it is helpful to reduce their stress by spending positive time with their identified child. The rationale behind this preventative measure was that if the mother had more positive time with the child, the negative behaviour displayed by the child would decrease. One of these mothers indicated that “the more time you can spend with your child, the more they respond.” Nevertheless it is often difficult for single mothers to offer enough attention to their children, especially if there is more than one child in the home, or if the single mother is trying to maintain employment as well. Another mother illustrated how her child with ADHD responds to positive attention from her, and the frustration of not always being able to give him the attention that she feels he requires:

> If it’s only me and (child) in the house, and if I’m paying a lot of attention to him, playing a game with him, whether it be on the Gamecube or the PSP or whatever, even though that’s not what I like to do, if I do, everything’s fine. It’s going well. He likes that one on one attention, especially from myself, but I can’t always give it to him because I have two other children as well.

Another mother also stressed the importance of spending positive time with her child:

> I think trying to find a lot of positive events that we can do together. Like say him and I could play a game or read a book together, or doing a computer game together, talking about it, talking about what to do, that kind of thing. Also, going to the park. One time I took him out to lunch just him
and I, we had a chance to talk. He really likes the one on one with me. And I think, it’s really funny, because the more that I try to make the effort to do that, to do the quality time with him because that’s what he’s so longing for, the less I find that he gives me a problem.

Five participants indicated that it was a support for them that their child was taking medication that assists in managing their child’s behaviour difficulties. One of these mothers spoke about her son before and after being placed on medication: “Since medication it’s not as bad, but before it was really bad . . . him being medicated was like the best thing on earth.” Another mother stated that: “Knowing that he is on his meds, he’s running smoother and he’s happier with himself. It relieves me of a lot of stress when he’s more comfortable with himself being on medication.”

An additional preventative measure indicated by two of the mothers was to get more sleep. One of these mothers expressed that it is more difficult to deal with her child if she has not had enough sleep. She expressed that she needs “to definitely get more sleep. I mean if you don’t have enough sleep at night, then it’s harder to deal with him.” One mother found it helpful to prevent behaviour problems if she only took one child out in the community at a time rather than dealing with two: “When we go shopping, I just take one, you can’t take them both because he has a real insecure jealousy of (his brother)”, and another mother found it helpful to bring someone else to help her with her child when she went out in the community.

Lastly, one mother found it less stressful to make spending time with her child a priority over doing some of the other household responsibilities. This mother stated: “I can let the house go, although that does bother me; I just don’t let people in the house.”
Utilizing self-calming

Eight mothers identified that they needed to have a separation away from their child when they are feeling frustrated by his difficult behaviour. Usually this was done by the mother taking some time alone in her room and the child taking some time alone in his room. One of these mothers stated “I put him in his room and usually I go to my room.” During this de-escalation stage, the mothers expressed some other things that they did to calm themselves or their child. At times some mothers indicated that they would have someone come over to watch the child so they could leave the house to have a break. A mother spoke of a time that someone came over to watch her child while she had some time to herself:

Actually one time all I did was pick up Timmy’s and come and sit outside, it was a nice day. Just came back here, sat outside and, it’s because then you don’t have to worry about dealing with it. You can think things through in your head, and then I feel better once I’ve worked it through in my head of what I’m going to do.

Relaxation techniques were identified as a coping strategy used by four of the mothers when they are frustrated with their child’s behaviour. One of these participants spoke of how it has been helpful to her to use relaxation techniques:

I learned coping strategies, to leave the area and give yourself space, don’t feed into arguments, I learned breathing and relaxation techniques. Before I didn’t think it was as important as it was, but I use them now and I know that it is working.

One mother stated that she copes by just “trying to let it go” while another mother found it helpful to put things into perspective and to remind herself that she is thankful for the things that she has. She indicated that it is helpful to:

Just take a moment and look around and see how beautiful it is, appreciate what you’ve got, and when you pray and thank God for your blessings, it’s a good way of taking stock.
of your situation. Realize that we’re falling in the ninety-nine point five category of being the best off in the world.

This participant also indicated that her mother had a good philosophy that she follows to help her get through each day, “you’re just thankful at the end of the day that everybody’s alive. You figure that would be a pretty good day, so you just continue on. It’s a good philosophy.”

**Engaging in self-nurturing activities**

All of the mothers indicated that doing something that they like to do was an effective coping strategy that they used to alleviate their stress of dealing with a child who has ADHD. The mothers revealed activities that they enjoyed doing or activities that made them feel better emotionally or physically. Some of the activities involved doing something physical like walking or cleaning. However, most of the activities listed were relaxing activities such as reading, taking a bath or watching television. It appears that the mothers benefited more from activities that were relaxing for them and assisted in calming their body. Five mothers indicated that watching television was a positive coping strategy that was used to assist them in dealing with the stresses of parenting a child with ADHD.

Five mothers reported that reading was a positive coping strategy for them to use. In addition, five participants indicated that it was helpful for them to take a bath or shower as a way to cope with the frustration of dealing with a child that has ADHD. One of these mothers stated: “Sometimes after the kids go to bed, I’ll have a nice hot bath, or I will read a book that I like.”

Three participants identified “listening to music” as helpful. Two mothers indicated that “going for a walk” assisted them in coping. Doing housework was
identified by two mothers as a way to reduce stress. One of these mothers spoke about how doing housework helped relieve her stress:

Clean the house. I do that all the time. Keep yourself busy doing something else. You still think about the stuff, but you’re keeping busy at the same time so you don’t get yourself so worked up. (It’s) kind of like wearing your stress off.

**Developing and maintaining supports**

Mothers of children with ADHD who have a larger support network will have more people available to them to rely on for support or assistance when they are struggling with dealing with their child’s challenging behaviours. All of the mothers identified the importance of having supports. The following are people that were identified in these mothers’ personal support network:

**Partner:** “I think the main person that I would have to say is my boyfriend”.

**Family member:** “If I can spend time with family, with relatives or whatever, that helps with my parenting because it gives me a break. It helps because they understand. They’re learning to understand because of me, because I explained it to them. So my family helps me with him when we’re all together and that gives me a sense of relief”.

**Friends:** “Well I have no family left, there’s just me. So really my friends are my family now, they support me one hundred percent”.

**Coworkers:** “People at work. I walk with a woman and we chat a lot”.

**Neighbours:** “It would probably be the friends and family. There’s one next door, one just down the street. I have good neighbours”.

Some mothers indicated multiple sources of support while others just indicated
one person they consider as a support to them. One mother indicated that family support
is so important to her that she does not think she could raise her children without the
support from her relatives:

My whole family is amazing. My grandmother takes him
almost one night a week guaranteed. My whole family, my
sister takes my children, my mom, everybody in my family.
My brother’s here almost every day. My whole family is a
huge support system. I wouldn’t be able to raise (my children)
without them. There’s no way I could do it.

In addition, formal supports such as community mental health agencies,
therapists, Children’s Aid workers, respite services, and staff members at their child’s
community school were seen as helpful by all of the participants in some capacity.
Specifically, all of the mothers indicated that their involvement with Glengarda Child and
Family Services has been a support for them: “Glengarda’s been helpful. You know I
give them credit for a lot of the stuff they’ve done with (child).”

When the participants were asked who or what their best support was, there was
an equal split in responses between a personal support such as a partner, family member
or friend, and a formal support such as a community mental health agency or therapist.
Four mothers indicated that their therapist was their best support; three mothers stated
that a friend was their best support; two indicated that their mom was their best support;
two indicated that Glengarda Child and Family Services was their best support; and only
one mother indicated that her partner was her best support. Two of the mothers gave
more than one response to indicate their best support.

Nine mothers indicated that it was helpful to have received some kind of
parenting workshop or behaviour management training for dealing with their child’s
behaviour. One of these mothers indicated that she found the parenting workshop at
Glengarda Child and Family Services helpful:

They (Glengarda) did have a parenting workshop, and that was good because it did give us (parents) some support. We could go in there and say our piece and what we needed to say and there was always somebody that had something that they could add or you know, try this, or try that.

Two participants indicated that they had attended college for education or training on dealing with children with behaviour difficulties. Two mothers commented that they had raised their children so this experience made them more knowledgeable about parenting a child with ADHD. One of these mothers indicated that she did not attend a parent workshop or receive any behaviour management training to assist with managing her child’s behaviour. When asked about any training she received on parenting, this participant’s response was: “None. I raised three kids on my own.”

Two of the mothers indicated that they found it supportive to be taking medication to help them cope with the stress and challenges of raising a child with ADHD: One participant stated: “Well going through all of this in the last couple of years, I’ve had to be put on medication myself, and I find that helps me to cope with things a little better.” These mothers felt that the medication helped them to relax and assisted them in managing their own emotions more effectively.

Even though prior to the interview, four mothers indicated that religion was important to them, during the interview, only two mothers indicated that they used religion as a coping strategy. These two mothers indicated that it was a support for them to have a faith and be involved with religion and prayer. One of these mothers indicated that: “Just me praying to God to make me able to stay calm and handle it so that I can help (child) keep it together.”
Utilizing inappropriate parenting strategies

During the interviews, some mothers indicated that they have used inappropriate parenting strategies in dealing with their child from time to time. These mothers demonstrated an awareness of their inappropriateness as they described these strategies. Three mothers indicated that they have used threats with their child. One of these mothers discussed a situation where she had used a threat with her child:

If I ask him please just do what I’ve asked, sometimes it works sometimes it doesn’t. It also works well too when I tell him fine, I’ll just talk to dad. I know it’s a threat I shouldn’t use but (it works).

One mother felt that her son did not respond to discipline and she indicated:

I don’t use a whole lot of discipline. It shows at times. I haven’t really needed a whole lot, just once things are calmed down, it seems to work. But maybe if more consequences were there . . . I don’t know if that would help or not.

Finally, one mother stated that she has been so frustrated with her child’s behaviour, she does not follow through. She stated: “sometimes it’s like I almost give him his way”. There are many ways to discipline a child with ADHD. What works with one child, may not work with another but it is likely that these three parenting strategies will not be effective with a child with ADHD or any child for that matter.

Engaging in activities that result in immediate self-gratification for mother

This category includes behaviours that the mother exhibited such as smoking, yelling, crying, and eating comfort foods. These behaviours seemed to soothe the mother for the short term but did not prove to be effective coping strategies. During the interviews with the mothers, nine mothers listed one or more of these four self-gratification responses. Five participants indicated that they were smokers and smoking
is one of their coping strategies. One of these mothers said: “I’m a smoker and I don’t foresee myself giving it up anytime soon.” Four mothers admitted that they yelled when they were frustrated. One of these mothers stated “to yell at him, that is my first response. I’m trying not to do that but definitely yelling is my first response. That’s a big thing around here, we’re constantly yelling at each other. It’s very loud.”

One mother thought that eating the foods she liked was helpful to relieve some of her stress. She stated: “Get some comfort food, although we are dieting now so I don’t get as much comfort food as I would like but it is amazing what you can get.” Lastly, one mother confessed that she gets so frustrated that she just “breaks down crying”.

**Summary**

A wide range of coping strategies were identified by these single mothers as a key component for dealing with a child with ADHD. The most common coping strategies, those used by five or more mothers, were the following: utilizing problem-solving or other behaviour management techniques with the child; spending more positive time with the child; the child taking medication; the mother taking some time away from the child; watching television; taking a bath or a shower; using formal or informal supports; mothers receiving training and education on ADHD; and the mother using smoking as a means of coping. Due to the degree of variation and frequency of the coping strategies used by the single mothers of children with ADHD, it is evident that these mothers use a combination of coping strategies at any given time.

The next section will focus on the obstacles that these single mothers faced while dealing with their child with ADHD.
Obstacles that interfered with parenting children with ADHD

Mothers were asked if there were any obstacles that they had to overcome with their children. These obstacles included many challenging events that occurred across many domains of the mothers’ lives. Six categories were generated from the data pertaining to this question. (See Table 4 for these categories and related themes)

Behaviour of their child with ADHD

All participants stated that dealing with their child’s challenging behaviour across multiple domains of life situations was an obstacle that they had to overcome. Each participant listed their own personal obstacles about dealing with their child’s specific behaviour characteristics. Two common themes, however, were identified among participants. The first common theme identified by three mothers, was dealing with their child’s behaviour while in public places. One of these mothers shared her experience with dealing with her child while out in public:

Being out, just dealing with a child that might take off at the least provocation. I remember going to stores he would love to play hide and seek, and he has no fear of being left, so he would just wander off when you looked in the other direction, I think that was the biggest (obstacle). We’d be looking all over for him and find out that he had just wandered off to look at T.V.s or something. (He’s) sitting in the chair watching T.V. and we were looking everywhere. That was probably the most stressful part... and never knowing when he might blow up.

Another mother described what it was like for her to bring her child to the grocery store:

“There’s times when I’ve had to leave my groceries in the store and go home because I just can’t deal with him anymore.”

The second common theme expressed by two mothers was dealing with their child’s temper. One mother stated: “Dealing with his temper, because you don’t know
how far it's gonna go. Some days it could be just stomping to the bedroom and other
days it could be tossing things all over the place.”

All other responses from mothers about the obstacles they have had to overcome
were specific to each individual mother and each of the following responses was
indicated by one participant. These responses included: Trying to understand child’s
difficult behaviour; living in an area with a lot of children who have behaviour problems;
dealing with child’s behaviour problems on the school bus; community day camp
denying their child permission to attend because of child’s difficult behaviour; dealing
with child’s lying, inattention, and impulsivity; driving in the car with the children when
the children are acting out; and dealing with the child running away from home.

*Issues around medication*

All children discussed in this study were taking medication to treat their ADHD
symptoms. Three participants struggled with making the decision to put their child on
medication to treat the child’s ADHD symptoms. One of these mothers explained that
she felt that she had no other options but to put her child on medication:

> At that time, ADHD, I didn’t know what they were talking
> about, I didn’t see anything in him, he’s just hyperactive, so
> he’s a little hyper. But see now-a-days with the schools,
> they don’t tolerate anything. It was getting to the point with
> me . . . I didn’t want him on meds but it’s the point of either
> he’s on meds or he can’t go to school.

Another participant shared her feelings about her son being on medication to treat ADHD
symptoms. She did not like the idea of him being on medication but she tolerated it
because when he is on medication, he is able to focus on his academic work and learn:

> The school has noticed a difference in (child’s) behaviour.
> That’s the reason he’s still on it. If they didn’t see anything,
> he would not be on that because I don’t like the medication
> but it’s either that or he just doesn’t learn.
Two participants struggled with the cost of the medication, as one mother indicated: “Well, his medication is very expensive. It’s probably close to two hundred, maybe even three hundred dollars a month.” Lastly, one of the mothers indicated that it was difficult dealing with side effects of her child’s medication:

Struggling with the medication is a part of it, with the medication it decreases (child)’s appetite, so I mean he is tiny for eleven years old. And also one of the side effects is insomnia, which he does have.

**Issues pertaining to the mother as a single parent**

Four mothers indicated that they had experienced difficulties dealing with their child’s father. Two of these mothers expressed differences in parenting styles and just having a poor relationship with the other biological parent. A mother shared her frustration with dealing with the child’s father:

The father and my divorce kind of interfered because we’re on different pages. If we could be on the same page I think it would be a lot easier maybe. Maybe not a lot easier but a little better to handle and to parent (child), because if (child) does something here and I would like (his father) to follow through, then that would show (child) that what he did was improper.

One mother illustrates in the following quote that she found it difficult to raise her child as a single mother:

Well it was a big adjustment to raise two children on my own, you know, as a single mom. It’s a very big job and a tough job. I’m trying to make it as successful as I can, and sometimes you get down on yourself because you feel you’re not being successful.

Surprisingly, throughout the interviewing process, only one mother mentioned experiencing financial difficulties. This mother felt that being a single parent on a low income, restricted what she was able to do with her children:
There's just not enough (money) these days, especially for kids, without having money. It's a big thing, money is a big thing, and any activities and stuff for them to do (costs money) and it's hard with my income and that.

Lastly, one of the participants struggled with maintaining employment. Due to her child's difficult behaviours, she was not able to keep a job because the school was constantly calling her to pick up her son. This mother indicated: "Trying to work. Because of the suspensions and the calls. You get calls at nine in the morning and you have to leave."

*Lack of constructive parenting skills*

Mothers felt that it was an obstacle trying to maintain certain parenting skills that are necessary in managing their children. Three mothers indicated that they struggle with maintaining consistent rules and routines with their child. One of these mothers stated that she would get so frustrated with her child's behaviour that she would feel like giving in to him just so his behaviour would settle:

Well like I said before too, it goes into the consistency, I think that is very hard to do because if you are having a difficult time with him, you just get frustrated, you just want a quick answer. With (child) there is no quick answer, I mean you have to work it out, and I think that for me just being consistent is a little difficult. Because there's times when you just want to give in sometimes just so he stops.

Another mother struggled with being consistent with her child because she was tired from working two jobs and time with her child was limited:

With having my two jobs, sometimes it was really, really hard to get consistent all the time because I'd be tired and I'd forget. He'd get a punishment. It's like you're grounded off your bike for two days, and the next day I would have already forgotten.

Some other obstacles that were mentioned under the parenting skill category were
specific to each individual mother and each one was only mentioned by one mother. These included: Trying to be more firm with child; remembering to give child positive reinforcement; the parent trying to manage their own emotions while interacting with her child; and lastly, one mother felt that she had to overcome the obstacle of being an advocate for her child as she stated:

I think that being an advocate for my child has been an obstacle that I've had to really . . . because I'm not a person who really puts them self out there and gets really firm about things. I've had to really learn to be more assertive for my child, because you almost have to really make people really understand that this is a serious problem and it needs to be addressed.

Multiple problems in the family

Some of the mothers were dealing with problems that had occurred within the family that were independent of their child’s ADHD related difficulties. Three mothers felt it was an obstacle to care for other family members who were ill or disabled in addition to dealing with their child who has ADHD. One of these mothers had to deal with the repercussions after an accident which left her other two children disabled. She stated that this was an obstacle for her to deal with because she had to spend so much time in hospitals with her other two children. As a result, time with her child with ADHD was limited. She indicated that the behaviour of her child with ADHD worsened after the accident as a result: “Well the accident. I’ve had to overcome his behavioural problems after the accident, he got really, really volatile, really volatile, really mouthy, and he went through a state of depression.”

One mother expressed frustration with trying to get the other children in the home to understand ADHD and the difficulties that children have dealing with it: “The biggest
adjustment is trying to get the other children to understand what’s going on with their brother.”

**Barriers with potential resources in the community**

The behaviours of children with ADHD do not go unnoticed; therefore, parents of children with ADHD will have to deal with several other individuals pertaining to their child’s difficulties. Seven mothers expressed problems with their child’s community school. One of these mothers expressed her feelings about her child’s community school:

> I found it a bit difficult (dealing with the school), especially when a principal and two teachers could not handle a five year old and I had to be called in all the time. I thought that that was their job and if they couldn’t handle a five-year-old then what were they doing there? That was my opinion at the time, not really understanding just how bad he was, because he didn’t really show that much opposition at home.

Five participants felt that their child was “labeled” by the community school and treated differently as a result. A mother shared her experience with her child’s community school: “I realize that he had a lot of different behaviors and everything else, but a lot of times he wasn’t the only kid involved in something, but he would be the one that got in trouble, because he’s already been labeled.”

Two mothers felt that it was an obstacle trying to “educate others” about their child’s disability. Other obstacles that were mentioned were specific to each individual mother and each one was only mentioned by one mother. These included: Being on the waiting list for social work services at child’s community school; applying for disability for their child; making the decision to enroll their child in day treatment services; dealing with problems that occur in the neighbourhood as a result of the child’s behaviour; and not being able to maintain a babysitter due to the child’s behaviour problems.
Summary

The majority of the obstacles that were mentioned during the interviews with mothers focused on dealing with one or more of the child’s ADHD related difficulties. The most commonly stated obstacles that these single mothers faced as stated by three or more mothers were the following: dealing the child’s challenging behaviour while out in public places; making the decision to place their child on medication; dealing with the child’s biological father; using consistent rules and routines with their children; dealing with another family member who is ill or disabled; dealing with incidents that occurred at the child’s community school; and mothers feeling that their child was labeled because of their ADHD related difficulties.

The next section will focus on advice that the participants feel would be helpful to give to other parents of children with ADHD.

Advice mothers would give to other parents of children with ADHD

This last section is comprised of the recommendations or advice that mothers felt would be helpful for other parents of children with ADHD. During the interview participants were asked to talk about any advice that they think would be beneficial to tell another parent who just found out that their child was diagnosed with ADHD. This question generated many different responses from these mothers. Their responses have been collapsed into the following five categories. (See Table 5 for these categories and related themes)

Developing parental qualities which would be helpful in parenting a child with ADHD

All participants indicated one or more characteristics that they felt are important for parents to have when raising a child with ADHD. Six mothers indicated that it is
important to have patience when raising a child with ADHD. One of these mothers gave
the following advice for a parent of a child with ADHD: “You’re going to have to have a
lot of patience. You have to be very consistent and you have to try to have as much
(patience) as you can because sometimes you just can’t, your life gets so busy.” Three of
the participants identified that it was important to have effective communication with the
child who has ADHD. A participant stated:

Give the child time, there is a lot of times that they want
to talk and if you push them away, then you might not
have that chance at it. They’re going to end up doing
worse and not being able to talk to you if you don’t
communicate. Use your communication. If it gets to
the point where there’s too much stress at that moment,
separate for a while, then go back to it.

Two mothers indicated that parents of children with ADHD should learn to accept
that their child has a disability. One of these mothers stated:

I think it’s important that parents know that you have
to be able to say to yourself ‘my kid has a disability’.
It took me nine years to accept it and until then, I was
just constantly wracking my brain as to what’s wrong
with my kid?

Two mothers felt that it was important to manage their own emotions when
dealing with a child with ADHD. They indicated that it is important to “learn to hold
your temper in” and remember to “try not to raise your voice with your child”. The
remaining advice from mothers regarding how to parent an ADHD child was specific to
each mother and each was only mentioned once. This advice was: Realize that you are
doing the best you can in raising your child; try to maintain a positive attitude; do not
allow others to stereotype your child; and advocate for your child.
Acquiring appropriate behaviour management strategies

Most mothers had some behaviour management advice for dealing with a child with ADHD. Seven mothers stated that being consistent with your child is the most important thing to remember when it comes to dealing with children with ADHD. One mother describes why it is so important to be consistent with children with ADHD:

No matter what, be consistent on something, when you are saying that you want something done just keep on it, because the minute you break is where they got you. Probably about the biggest one that I have a problem with, is after so long you know, you just want to block it out, or you say all right, do it, but that’s why it will never change, because you just let go of it, if you’d be more persistent, eventually it will work, it just takes time.

Four mothers suggested trying different behaviour management strategies with the child until one is found that works. One of these mothers stated the following in regard to parenting strategies. She stated that her advice would be to “try lots of different things until you actually find one that works”.

Two mothers recommended that a parent who has a child with ADHD should seek behaviour management advice to assist them in parenting their child.

Finally, each of the following responses regarding acquiring appropriate behaviour management strategies was mentioned one time by only one mother for each. This advice consisted of: “ADHD children can only handle one task at a time. If you give them more than one thing, they can’t handle it. It’s too much stuff on their plate”; “separate yourself from your child”; “keep your child busy”; “don’t give your child more than one task at a time”; and “limit your child’s diet of preservatives”.

Accessing appropriate medical resources

Seven mothers suggested that it would be helpful for the child to see a psychiatrist
or physician to confirm a diagnosis of ADHD and determine if their child would benefit from a trial of medication. One of these mothers advised a parent who has a child with ADHD:

I feel that they should for sure have him medically tested . . . and scales, like you know how they do those scales? Keep an eye on him and I’m not a big fan of medicating a child, but you know when you have a child with ADHD, you have no choice but to say yes.

Two mothers felt that if a child is diagnosed with ADHD, the parent should try medication to see if it works to assist in alleviating the child’s ADHD symptoms. One participant felt that parents should get more information on the medication for ADHD before placing their child on it: “Get your doctor on your side, talk to the doctor. Let them know what’s happening at home, maybe they can you know, do some testing to find out if your child needs medicine.”

**Seeking external resources for education and support**

Nine mothers recommended that they feel it would be helpful to seek mental health services for a child that has ADHD. One of these mothers described how the services she had received at Glengarda Child and Family Services have been helpful for her family:

Glengarda. They have done a lot, I mean since (child) has been there I give them a lot of credit for the stuff they’ve done there, you know? Big time, if I didn’t have them, I’d have (child) home schooling him and what good would that do?

Six mothers suggested that it would be beneficial for parents of children with ADHD to do reading and research on ADHD to learn more about the disorder. One of these mothers indicated what she would tell another parent who has a child that has been
diagnosed with ADHD: "I would tell them to read up, and to learn, or to take a course or a class or whatever is out there, do some research and study on ADHD."

Six mothers stated that parents of children with ADHD should attend parenting groups or workshops to increase their knowledge about different positive behaviour management strategies they can use with their child. As one mother stated, "any classes that they could take ... parenting classes in general, and maybe family counselling or something. We had family counselling and it was good."

Five mothers indicated that it would be helpful to have support from friends or family members to assist them in dealing with their child who has ADHD as one participant indicated: "Get as much help as you can. Use all of your resources, your family resources and get as much education on the disability as you can."

Two mothers stated that it would be helpful for parents of children with ADHD to work in collaboration with the child's community school and one mother said that everybody involved with the child "needs to be on the same page" when working with the child.

**Involving the child in community activities**

Being involved in community activities is important to keep children active especially for children with ADHD who have more energy than most children. Getting involved in the community also enhances children's social skills and peer interactions. Two mothers suggested that parents of children with ADHD should involve their child in a physical community activity "so he can run off some of the energy."

One mother indicated that a parent who has a child with ADHD should become involved in religion. Her advice to a parent of a child with ADHD was:
Get a religion if you can, if you have it in you. It helps to know that somebody’s looking out for you above. Sometimes you feel alone in the world, get the network or help that either can physically help you, mentally help you or spiritually, because it’s hard to go it alone. You have to have somebody to back you up.

Summary

All mothers had several words of advice that they would suggest to other mothers who have a child with ADHD. The advice that was most commonly stated by five or more mothers was the following: have patience when dealing with a child who has ADHD; it is important that mothers use consistent parenting strategies with their child; it is beneficial for the child to see a psychiatrist or physician who can confirm a diagnosis of ADHD; it is important for their child and family to receive mental health services; do reading and research to learn more about ADHD; it is valuable to attend parent support groups and parenting workshops; and it is necessary to have support from friends and family when you have a child who is diagnosed with ADHD.

All mothers indicated that it was frustrating to raise a child with ADHD. Some of the other words that were used to describe what it is like to raise a child with ADHD consisted of: Difficult; stressful; hard; draining; challenging; and emotionally tiring.

One can conclude that it is extremely exhausting for these single mothers to deal with their child’s demanding behaviours on a daily basis.
CHAPTER V

DISCUSSION

This study focused on the discovery of the coping strategies of single mothers who have children with ADHD. This section compares and contrasts the major findings of this study with the relevant literature. A discussion of the demographic information; the coping strategies of single mothers who have children with ADHD; the obstacles that interfered with parenting children with ADHD; and the advice which mothers would give to other parents of children with ADHD will be presented in this section.

Demographic information

Mother

All mothers were involved with initiating the referral to Glengarda Child and Family Services. This is not surprising given that Glengarda Child and Family Services offers a voluntary service where parental involvement is mandatory. Seven children were referred in conjunction with the community school. It is the experience of the researcher that community schools quickly become involved with treatment recommendations for children who are experiencing social, emotional and behavioural problems in the school setting. This occurs because many community schools do not have the resources to deal with the severity of the child’s behaviour, therefore, they are in search of an alternative placement where the child can receive treatment.

Five mothers cancelled their initial appointment and rescheduled the interview to a later date. These cancellations most likely occurred due to the busy schedules of the single mothers rather than avoidance. When the participants were interviewed, they were all pleasant and accommodating to the researcher. Furthermore, when one of the sessions
ended, the participant hugged and kissed the researcher. Another participant contacted the researcher subsequent to the interview to inform her of another strategy that she forgot to mention during the interview. Judging by their responses, it appeared that this research provided a benefit to the participants by allowing them an opportunity to discuss their feelings and experiences with the researcher.

The ages of the mothers ranged from 31 – 49 years old (mean age = 40 years). The mean age of the mothers in this study was slightly younger than the mean age of the mothers of children with ADHD in other studies (Bailey et. al., 1999; Segal, 2001). Additionally, all of the mothers in this study were single mothers, which is consistent with the literature suggesting that single parents are more likely to have children who exhibit problem-behaviour. The risks that accrue to children in single-parent families are well documented in the literature (Martin, Emery & Peris, 2004). Much of the research on single-parent households has focused on the link between single-parent families and poor outcomes for children, indicating that children in these households may experience an array of problematic behaviours including an increased risk for externalizing behaviour (Martin, Emery & Peris, 2004). This is also consistent with the families that are involved in treatment at Glengarda Child and Family Services where single-parent families were the largest family type served in 2005 (Glengarda Child and Family Services Annual Report, 2005).

Research suggests that single mothers of children with disabilities often have less education, and lower incomes than single mothers of children who do not have disabilities (Boyce et al., 1995). Surprisingly, all of the mothers in this study had completed secondary school and five of the mothers had received post-secondary
education. However, consistent with the literature, seven of the participants had a family income that was $20,000 per year or less, which is below the LICOs (Low-Income Cut-Offs) or more popularly know as Canada’s poverty lines (Canadian Council on Social Development, 2006). Five mothers in the present study lived in a type of geared to income housing. Fischer (1990) reported that families with hyperactive children live in undesirable areas. Additionally, children who are raised in homes where the family income is less than $20,000, are 1.3 times more likely to be growing up in substandard housing as are children from middle-income families, and 2.4 times as likely as are children from high-income families (Ross, Scott & Smith, 2000).

Research has shown that parents of children with ADHD are more likely to have a history of childhood ADHD themselves (Nigg & Hinshaw, 1998). This implies that ADHD may have a genetic predisposition. It has been suggested that 25-30% of parents who have children with ADHD have significant ADHD symptomatology themselves (Harvey et al., 2003). This suggests that inattention and impulsivity are likely to be common characteristics among parents of children with ADHD (Harvey et al., 2003). It was surprising in the present study that none of the mothers indicated that they had suffered from ADHD themselves. However, when the mothers were asked to describe what they were like as children, eight participants indicated they had experienced some ADHD related behaviour difficulties as children. Another interesting finding was that five mothers referred to themselves as a “tomboy” when they were younger. Mothers said that as children, they were busy, active, into sports and one said that she was so active, she injured herself frequently. All of these behaviours are stated in the literature as being indicators or symptoms of ADHD (DSM-IV-TR, 2000).
When mothers were asked if religion was important to them, six indicated that religion was not important to them. Spiritual support or religious beliefs have been acknowledged as a coping resource for parents of children with ADHD (Beresford, 1994; Podolski & Nigg, 2001). Research has shown that religious or spiritual beliefs play an important role in the way families handle a wide variety of stress. Religious beliefs may offer a way for parents to interpret or redefine their child's disability (Beresford, 1994). Contrary to the literature, religion was not found to be an effective support for the majority of mothers in this study. Only four mothers indicated that religion was important to them and attended church on a regular basis. In addition, only two mothers indicated during the semi-structured interviews that religion was used as a coping strategy.

Child

All of the children identified in this study were males. This was consistent with the literature indicating the prevalence rate for ADHD is higher for males (DSM-IV-TR, 2000). In addition, 82% of the children admitted for day treatment at Glengarda Child and Family Services in 2005 were males (Glengarda Child and Family Services Annual Report, 2005).

A surprising finding was that three of the children involved in this study had a biological father who was deceased. There were no correlations found in the literature about children with ADHD having a father who is deceased. This appeared to be a relatively high percentage and it would have been interesting to ascertain the cause of death for these three fathers to determine if there was a commonality among the three.

Children with ADHD are more likely to have other co-morbid conditions such as
oppositional defiant disorder (ODD), conduct disorder (CD), anxiety disorders, mood disorders and learning disabilities (Abikoff & Klein, 1992; Cantwell, 1996; Harvey et al., 2003; Jensen, 2004; Pelham & Fabiano 2001; Root & Resnick, 2003; Segal, 2001), which may cause greater impairment in functioning. Consistent with the literature, all of the children in this study had co-morbid conditions. Although the case files indicated that all of these children with ADHD had at least one other mental health condition, not all of the mothers indicated this. Five mothers indicated a diagnosis of ODD when eight were actually diagnosed with ODD. Only one mother indicated that her child had a LD when seven were actually diagnosed with a LD. Only one mother stated that her child had anxiety when there were four children diagnosed with an anxiety disorder. One mother indicated that her child suffered from PTSD while there were two reported in the case files as being diagnosed with PTSD. One mother stated that her child had CD when there were two diagnosed with having CD. Two mothers indicated that their child suffered from depression which was accurate because the case files indicated that there were two children diagnosed with having a mood disorder. Additionally, one mother indicated that her child had obsessive compulsive disorder, which was not indicated in the child's file and one mother stated that her child had Tourette's disorder, which also was not indicated in the child's file.

Perhaps these findings reflect that these participants were not clear on what constitutes a mental health condition. Alternately, they may not have understood their child's diagnosis and therefore responded incorrectly. Although these co-morbid conditions were identified in all of the children discussed in this study, no effort was made to establish the severity of the co-morbid conditions. However, the presence of
several co-morbid conditions could contribute to greater child ADHD symptom severity (Podolski & Nigg, 2001). Bailey et al. (1999) indicated that the difficulty in managing children with ADHD is exacerbated by the presence of co-morbid conditions, regardless of whether they are related to illness, disability or learning difficulties. Furthermore, these mothers may have exhibited a coping strategy by underreporting their child’s co-morbid conditions in the form of denial.

All children in this study were taking medication as part of their treatment regime. Medication is frowned upon in some of the literature as an appropriate treatment for all children with ADHD (Hartmann, 1997). Regardless, stimulant medications such as Methylphenidate or Dexedrine are often used to reduce the symptoms of ADHD in children (Jensen, 2004). In this study, eight children were taking a stimulant medication such as Methylphenidate or Dexedrine and two were taking a non-stimulant equivalent. Barkley (1998) reported that research consistently demonstrates the efficacy of stimulant medication in improving behavioural, academic, and social functioning in approximately 50% to 95% of children treated. Pharmacological treatments for ADHD are more widely used, are less expensive, and have much more short-term empirical support than do psychosocial treatments (Jones, 2002).

It is this researcher’s experience that most children who are diagnosed with ADHD seem to benefit from stimulant medication, showing improvements in their behaviour as well as their ability to focus and concentrate on tasks. However, medication alone does not give children the skills that they will need to be successful academically, socially and behaviourally. Medication assists in controlling ADHD symptoms such as inattention, impulsivity and distractibility which then allows children to be able to focus.
After being able to focus, children will be able to learn the skills and coping strategies needed to be successful. Pelham and Gnagy (1999) agreed that empirically validated treatments for ADHD include psychostimulant medication, behavioural treatment, and their combination.

Five children who were taking a stimulant medication were also taking Risperidone, an anti-psychotic medication that is generally prescribed to control aggressive behaviours. It is likely that these children were prescribed this medication to treat a co-morbid condition as all five of them had more than one diagnosis. It is not uncommon for a child with a dual diagnosis to be taking more than one type of medication.

**Family**

ADHD has been found to be more common in the first-degree biological relatives of children with ADHD than in the general population (DSM-IV-TR, 2000). When mothers were asked if there was anyone else in their immediate family with a mental health condition, three mothers indicated that they had an immediate family member with a mental illness including depression, ADHD, anxiety, bipolar disorder and schizophrenia. Inconsistent with the literature, only one mother identified an immediate family member with ADHD. A possibility for this could be that until recently, ADHD was often left undiagnosed. Prior to the 1970’s when researchers began to study ADHD behaviour more closely, ADHD was not viewed as a medical disorder (Glass, 2001). Perhaps there were other family members suffering from ADHD but it had not been formally diagnosed.
Coping strategies of single mothers who have children with ADHD

The coping strategies used by mothers in this study were primarily problem-focused coping strategies in that attempts were made to make changes in the source of stress. According to Lazarus and Lazarus (1994), the best coping calls for a mixture of both problem-focused and emotion-focused coping. The mothers in this study used a mixture of both types of coping; however, problem-focused coping was used more frequently than emotion-focused coping. It appears that the problem-focused strategies used by these mothers made them feel good about themselves as parents. This is consistent with the self-esteem and self-efficacy literature that suggests internal locus of control can provide feelings of self-efficacy and improved self-esteem (Lazarus, 1991). The more these mothers can see changes that they facilitate, the more self-esteem and self-efficacy they develop.

The following coping strategies were used by the single mothers of children with ADHD in this study.

Utilizing behaviour management techniques with children with ADHD

Congruent with standard practices in child management, all mothers mentioned that they were using some kind of behaviour management technique with their children. All mothers indicated that they take away privileges from their children as a form of discipline. Additionally, all mothers stated that they have used a “time-out” as a form of disciplining their child. In support of these techniques, Gurian (1997) whose work focused on boys, suggested that they should receive a time-out when necessary. He recommended that time-outs be combined with the loss of toys and privileges. In
addition, when the parent needs a time-out, they are encouraged to take one as well.

Nine mothers in this study stated that they have used some type of problem-solving with their child. Acquiring problem-solving skills is an important resource for coping. Problem-focused efforts are often directed at defining the problem, generating alternative solutions, evaluating the alternatives in terms of their costs and benefits, choosing them and then acting on them (Lazarus & Folkman, 1984). In the study completed by Bailey et al. (1999), all mothers reported that the most common way of dealing with a difficult child was to use coping strategies that tended to be problem-focused. Consistent with the literature supporting healthy coping, the mothers in this study displayed a wide range of these problem-focused efforts reflecting the attempts of these mothers to problem-solve with their children.

Discipline is not only provided for inappropriate behaviour. Part of disciplining and behaviour management is also using preventative strategies such as incentive programs and positive praise. Gurian (1997) defines discipline as “a systematic approach to teaching a child appropriate behavior by building character, testing self-esteem, and teaching social skills,” (p.161). Consistent with the literature and with Glengarda Child and Family Services’ philosophy on using incentives, all mothers used some kind of incentive with their child such as verbal praise, giving tangible rewards or using a structured incentive program at home.

Humour was also mentioned as a coping resource for parents because research has shown that a sense of humour protects individuals from the negative side effects of stress (Beresford, 1994). The use of a sense of humour was indicated by three of the mothers as an important coping strategy for dealing with their child’s difficult behaviour.
Only two mothers indicated that “picking and choosing their battles” was an effective behaviour management technique used with their children. It is the opinion of the researcher that this strategy should be used by more mothers to prevent them from getting into power struggles with their children. This strategy is often used with children at Glengarda Child and Family Services and is called “planned ignoring”. The principle behind this strategy is that parents need to ignore their child’s negative attention-seeking behaviour unless it becomes unsafe for the child or others. If at any point, the child’s behaviour becomes unsafe, then the parent needs to intervene immediately. If used properly, this strategy has the potential to decrease undesirable behaviour and increase appropriate behaviour in children with ADHD.

*Engaging in activities which have the potential to prevent stressful situations with the child*

The parent’s ability to focus on the positive aspects of their child was determined to be important when it comes to coping. Seven mothers indicated that spending positive time with their identified child was helpful in reducing their stress. These parents indicated that when they spend more positive time with their child, the child’s behaviour difficulties decrease. Although this strategy appeared to be effective for mothers in this study, it was not found in the literature as a coping strategy for dealing with children with ADHD. However, literature on parenting in general suggests that when parents spend positive time with their children, it encourages desirable behaviour in the child (Sanders, Markie-Dadds, & Turner, 2002).

The use of medication as treatment for ADHD symptoms in children has been reported to be a prosperous form of treatment that achieves positive levels of success for young children with ADHD (Heriot, Evans & Foster, 2001). All of the children in the
present study were taking medication to treat their ADHD symptoms. Five of the participants indicated that it was a support for them that their child was taking medication that assists in managing the child’s behaviour difficulties.

**Utilizing self-calming**

Eight mothers identified the need to have a separation away from their child when they are feeling frustrated by their child’s difficult behaviour. Usually this was done by the mother taking some time alone in her room and the child taking some time alone in his room. In support of this technique, Gurian (1997) suggests that parents should take their own time-out when necessary. When parents are frustrated with their child’s behaviour, it is helpful that they remove themselves from the situation. This allows the parent some time to calm down and think about how they are going to handle the situation with their child. Utilizing self-calming can be a form of emotion-focused coping if the emotional reaction to the stressor is changed by implementing the self-calming strategy.

Relaxation techniques were identified as a coping strategy used by four mothers when they are feeling frustrated with their child’s behaviour. Relaxation techniques are beneficial to assist in calming and lowering blood pressure when stress levels are high. If used properly, these techniques are also helpful in preventing a more severe conflict situation from occurring. Relaxation techniques have been extensively researched and have become widely known for being used as an active coping skill (Singer & Powers, 1993; Flick, 1998).

Podolski and Nigg (2001) found that positive reframing, such as finding a positive outlook from a negative or stressful situation, was a common coping strategy used by
parents of children with ADHD. Lower maternal distress was associated with greater use of positive reframing (Podolski & Nigg, 2001). Segal (2001) found that mothers were sustained by adopting positive reframing that enabled them to continue to cope with their children with ADHD. Only one mother in this study found it helpful to use positive reframing. She indicated that it was helpful for her to put things into perspective and to remind herself that she is thankful for the things that she has. Perhaps the low frequency for positive reframing reflects the lack of emphasis on this particular strategy in the parenting programs to which these mothers were exposed.

**Engaging in self-nurturing activities**

These self-nurturing activities consisted of coping strategies which reflected emotion-focused coping. Emotion-focused forms of coping are more likely to occur when there has been an appraisal that nothing can be done to change harmful, threatening, or challenging environmental conditions. Emotion-focused coping strategies are used to maintain hope and optimism, to deny both fact and implication, to refuse to acknowledge the worst, to act as if what happened did not matter, and so on (Lazarus & Folkman, 1984). The function of these strategies is to reduce the unpleasant physical and emotional sensations of being stressed. Emotional-focused coping at the emotional level aims to change the emotional state. Watching a comedy show on the television, reading an amusing book, having a hot bath, and going out for a run are examples of emotion-focused coping strategies directed at the somatic level of emotional distress (Beresford, 1994). Consistent with the literature, five mothers identified that watching television or a movie was helpful to them. Five mothers indicated that taking a bath or shower assisted them to relax. Five mothers felt that reading was useful for relaxation when under stress.
It was interesting that so many mothers indicated that they used reading as a coping strategy given that reading involves a level of concentration. Being under a consistent high level of stress, it would seem likely that these mothers would have difficulty concentrating. Four out of the five mothers who identified reading as a coping strategy had completed post-secondary education. Perhaps these mothers’ higher levels of education oriented them to reading as a pastime or an escape.

All of the self-nurturing activities listed by the mothers were those which could be done without having to spend money. This finding could possibly reflect the strengths of these single mothers in their being able to carry out self-nurturing activities despite their low income.

**Developing and maintaining supports**

All single mothers in this study indicated that social supports are important when it comes to coping with their child’s behaviour difficulties. Only two mothers indicated that they had few social supports. The remainder of mothers had several supports and indicated that they relied a great deal on their social supports to assist with coping.

Bailey et al. (1999) indicated that parents draw upon a range of internal and external resources to facilitate the coping process and that marital status and spouse support are important variables in the coping process. Five participants indicted that they had a partner and of those mothers, only one mother indicated that her partner was a support for her. Research has indicated that spouse support was related to positive outcomes in mothers. Findings suggest that spouse support is the most important form of support to parents of children with a disability (Beresford, 1994). Given that only one mother indicated that she had a significant other with whom she was residing, the
majority of the mothers that participated in this study were lacking this important spousal support.

Parents of disabled children perceive themselves to be lonely and socially isolated, especially single parents. The lack of informal social support can be one of the most stressful factors associated with caring for a disabled child (Beresford, 1994). Support from the extended family and friends, together with other forms of social support, are coping resources that may mediate the stress of parents with difficult children (Beresford, 1994). All mothers in the present study indicated that they had one or more informal social supports that included friends and extended family members. Segal (2001) found that many mothers of children with ADHD described their extended family members as being a source of support for them. Beresford (1994) stated that parents experience social support in a number of ways. A partner or friend to confide with, a neighbour who offers practical help, a respite care worker, a support group or a helpful doctor are some of the many sources of social support for parents of disabled children. Practical support such as childcare provided by the extended family was also indicated in the literature as an important source of support for parents of children with disabilities (Beresford, 1994).

Availability of professional help and access to community resources are other factors that may influence positive coping strategies of parents of children with ADHD (Podolski & Nigg, 2001). All of the mothers involved in the study had received professional help with coping or managing their child’s behaviour because they were involved in treatment at Glengarda Child and Family Services, which was a formal support for these mothers. Formal supports such as community mental health agencies,
therapists, Children's Aid workers, respite services, and staff members at their child's community school were also seen as helpful by all participants. All mothers indicated that their involvement with Glengarda Child and Family Services had been a support for them.

Parent training and using parenting strategies was mentioned quite frequently during the interviews with these single mothers. The mothers tended to use their parent training and parenting strategies to assist in coping with their child's challenging behaviours. Research supports that behavioural parent training programs that teach parents how to manage their children's inappropriate behaviour and encourage prosocial behaviour are well-established treatments for children with ADHD (McKee et al., 2004). In addition, parents reported mild stress reduction in managing their child's ADHD symptoms as a result of participating in a parent training program (Weinberg, 1999). The mothers in this study had been involved in treatment at Glengarda Child and Family Services for six months or longer. Therefore, they had ample opportunity to participate in the various parenting workshops and parent-training. Nine mothers had received parent training or education about ADHD and dealing with the child's behaviour difficulties.

**Utilizing inappropriate parenting strategies**

A minority of mothers indicated that they have used inappropriate forms of parenting strategies with their child. Three mothers indicated that they had used threats with their child such as threatening to tell another person of authority such as a spouse or partner because the child was not listening. Using threats was also recognized in Bailey et al. (1999) as a coping strategy used by mothers of children with ADHD. However, it
was one of the strategies used the least by the mothers in their study. Although threats may work for the short term, the child will likely not learn to listen to and respect the rules and limits set out and enforced by the mother. By threatening to always have a partner do the disciplining, whenever the partner is not there, the mother loses respect and authority, and will likely continue to struggle with managing the child’s behaviour (Gurian, 1997). Research in Beresford (1994) also concurs that ineffective coping exasperates or escalates the problem.

*Engaging in activities that result in immediate self-gratification for the mother*

Five participants indicated that they were smokers and identified that smoking was one of their coping strategies. These mothers indicated that smoking assisted them to relax when they were feeling stressed. It is likely that smoking relaxed them for the short term but it did not help any of the problems with their children or make the stressful situations go away. Beresford (1994) indicated that smoking cigarettes is considered an emotion-focused form of coping because it serves to ease painful or distressing emotions resulting from the stressor or in this case, from the child’s frustrating behaviour. Smoking has been thought of as a way of self-medicating for ADHD. Untreated individuals with ADHD have twice the risk for cigarette smoking (Biederman, Spencer, Wilens, Prince, & Faraone, 2006). Of the eight mothers who identified they had some difficulties similar to their child’s, three were smokers. If these mothers did in fact have ADHD, smoking may have been a form of self-medication for them.

Smoking was not well documented in the literature as a coping strategy for dealing with children with ADHD. However, Singer and Powers (1993) indicated that when overwhelmed by disability-related grief and practical demands, it is common for
parents to neglect taking care of themselves. For many parents, regular meals become suspended, sleep is disrupted, and smoking and drinking gradually increase (Singer & Powers, 1993). Singer and Powers (1993) recommend that these parents receive support for both monitoring their self-care and identifying strategies to promote their self-care. Gordon (2007) agreed that mothers of children with special needs tend to neglect taking care of themselves. Single mothers of children with ADHD would benefit from a greater focus on self-care. The physical and mental well being of mothers appears to be critical in order for them to deal with the challenges of raising a child with ADHD.

Four mothers admitted they yelled and or cried when they were frustrated with their child’s behaviour. Yelling and crying were not found in the literature as effective coping strategies for dealing with children with ADHD. Sears and Sears (1995) indicated that yelling at a child is an indicator that the parent does not have control over his/her own emotions. Additionally, parenting literature highlights the importance of parents being a positive role model for their children thereby modeling appropriate behaviour, which would not include yelling (Sears & Sears, 1995; Flick, 1998).

Obstacles that interfered with parenting children with ADHD

When mothers were asked if there were any obstacles that they had to overcome with their children, many different obstacles were revealed which included many challenging events that occurred across many domains of the mothers’ lives. There were some common themes that emerged but there was a relatively low frequency for each category.

Behaviour of their child with ADHD

All participants stated that dealing with their child’s challenging behaviour across
multiple domains of life situations was an obstacle that they had to overcome. It is important to state that all of these children had a co-morbid condition, which likely contributed to some of the child’s behaviour problems. The responses of the participants illustrated the wide range of behaviour which challenges these mothers. Each participant listed their own personal obstacles about dealing with their child’s specific behaviour characteristics. Two common themes, however, were identified among participants. The first common theme identified by three mothers, was dealing with their child’s behaviour while out in public places. Phelan (2003) emphasizes that parents often have to deal with their child’s behaviour difficulties in public places, which involves a threat of public embarrassment. Fear of embarrassment and public disapproval has at times made even the most competent parents forget what they are supposed to do, change their tactics and crumble (Phelan, 2003). Given that these mothers had children with behaviour problems, it is likely that they felt distress when bringing their child to public places; or they tried to avoid bringing their child to public places to prevent potentially embarrassing situations.

The second common theme expressed by two mothers was dealing with their child’s temper. Aggression is not listed in the DSM-IV-TR as a symptom of ADHD. However, aggressive behaviour is listed in the DSM-IV-TR as a symptom for other disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD). Of the two mothers who indicated they had struggled with dealing with their child’s temper, one had a child who was diagnosed with ODD, and the other had a child who was diagnosed with ODD and possible CD. Therefore, their temper problem or aggression may have been related to a co-morbid condition rather than ADHD.
**Issues around medication**

All children discussed in this study were taking medication to treat their ADHD symptoms. Three participants struggled with making the decision to put their child on medication as a form of treatment. Thoughts and feelings about placing children on medication is a contentious issue and there is much research that discusses both the pros and cons of using medication for children diagnosed with ADHD (Hartmann, 1997; Jensen, 2004; Pelham & Gnagy, 1999). It is the experience of the researcher that this is a decision with which many parents experience difficulty. Parents worry that if children begin taking medication for ADHD, their child will experience negative side effects, their child’s health will be placed at risk, or they worry that their child may become a substance abuser in the future. Generally, having a child take medication is used as a “last resort” when other modalities of treatment have not been effective.

**Issues pertaining to the mother as a single parent**

Several mothers identified items unique to single parenting which interfered with parenting their child with ADHD. Being a single parent alone has many implications but raising a child who has ADHD adds to the difficulties of being a single parent. Four mothers indicated that they had experienced difficulties dealing with their child’s father. This is consistent with the literature that there is often conflict between parents after a divorce or separation (McLanahan, 1999). Spouse support is the most important form of support to parents of children with a disability (Beresford, 1994). These mothers were not only lacking a spouse, but they were also experiencing difficulties with their relationship with their child’s father, therefore creating additional stress.

Surprisingly, throughout the interviewing process, only one mother mentioned
experiencing financial difficulties in spite of seven mothers having an income of $20,000 per year or less. Perhaps the additional supports that Glengarda Child and Family Services provided compensated for some of their financial limitations. Glengarda Child and Family Services offers the following services free of cost for families involved: sponsorships at Christmas time; luncheons throughout the year; four weeks of summer program for their children; counselling; parenting workshops; and travel expenses for families in need (see Appendix G for a list of supports and services that Glengarda Child and Family Services offers to clients). Additionally, 50% of the participants lived in geared to income housing.

Payne (2001) indicated that people living in poverty value people as their prized possessions rather than materialistic items. In poverty, the clear understanding is that one will never get ahead, so when extra money is available, it is either shared or immediately spent (Payne, 2001). Payne (2001) also indicated that individuals in poverty usually have a strong belief in fate and destiny, therefore believing that they do not possess the power to make certain changes in their lives.

**Lack of constructive parenting skills**

Three mothers indicated that they struggled with maintaining consistent rules and routines with their children. Children with ADHD have difficulty organizing tasks and activities; often do not follow through with instructions; and are often forgetful in daily activities (*DSM-IV-TR*, 2000). Due to these deficits, children with ADHD require a great deal of structure, consistency and routine, and without it, they will likely not be able to function effectively on a daily basis. Gurian (1997) concurs that a healthy disciplinarian is consistent in reinforcing and punishing a child's behaviour. It is important that parents...
work out a way to be systematic rather than random so their children will become aware of the expectations. Consistent with the literature, in Segal (2001), mothers of children with ADHD reported the need to assist their children with many tasks and provide structure for their daily routines. This structuring and consistency also occurred in many other areas like assisting the child in organizing homework, preparing to study, or in planning time with peers (Segal, 2001). This was likely difficult for the mothers in this study due to their time constraints and because they were single parents who the majority did not have a spouse for support.

One mother indicated that she struggled to be an advocate for her child. Although this was only indicated by one mother, being an advocate was found in the literature to be an important quality for parents who have children with ADHD. In Segal (2001), mothers of children with ADHD found that they had to overcome their fears and learn to advocate for their children. The mothers in Segal (2001) learned to find the necessary resources to assist them and their children.

*Multiple problems in the family*

Some mothers were dealing with problems that had occurred within their family that were independent of their child’s ADHD related difficulties. Three mothers felt it was an obstacle to care for other family members who were ill or disabled in addition to dealing with their child who has ADHD. Parents of disabled children face a great deal of stress (Beresford, 1994). For the mothers in this study, their situation was exasperated by being a single parent. Three mothers in this study had to deal with another member in their family who became ill or disabled in addition to their child with ADHD, which increased the parents’ stress levels and limited their time with their identified child with
Barriers with potential resources in the community

Seven mothers expressed extreme frustration in dealing with their child's community school. Five children had been suspended from school and three children were even expelled or removed from their community school because of their behaviour difficulties. It is not surprising that these mothers became frustrated with dealing with their child's community school. It is the experience of the researcher that community schools when dealing with disruptive behaviours or aggressive children, follow strict policies and procedures which often results in meetings with the child's parents, alternate planning or programming for the child, or suspending the child from school.

All mothers described behaviour difficulties that their child had at school such as; impulsivity, hyperactivity, inattention, defiance, and aggression. Six mothers indicated that their child's behaviour difficulties began while the child was in kindergarten. The behaviour that these children exhibited while at school is consistent with the literature and the onset of ADHD. In order to confirm a diagnosis of ADHD, some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before the age of seven years and some impairment for the symptoms must be present at home and at school (DSM-IV-TR, 2000). Children are generally not diagnosed with ADHD until they are school-age. Research suggests that behaviour problems of children with ADHD become more evident when the child first begins school. It is difficult to establish a diagnosis of ADHD in children younger than age four or five years, because their characteristic behaviour is much more variable than that of older children and may include features that are similar to symptoms of ADHD (DSM-IV-TR, 2000). As these
children enter elementary school and their academic and behavioural demands increase, their high level of inattentiveness and its negative impact on their school performance may start to cause frustration, social rejection, low self-esteem, and a dislike of school (Salend & Rohena, 2003).

Five participants felt that their child was “labeled” by the community school and treated differently as a result. The literature supported that ADHD is often a judgment that characterizes a child as a problem student, incapable of carrying out normal activities. McCluskey and McCluskey (2001) indicated that it does not take long for children with ADHD to develop a negative reputation at school or in the community, thus causing them to be labeled. While in the community, other people may frown upon parents who have hyperactive children, not fully understanding the child’s special needs. McCluskey and McCluskey (2001) also indicated that adults get frustrated with ADHD children and naturally blame the parents for not providing enough structure and discipline at home.

It is upsetting for parents to feel that their child has been labeled because children who are labeled with ADHD are often provided with fewer expectations for success, and are given the least amount of teacher attention (Levine, 1997). Levine (1997) also suggested that children with the ADHD label tend to be blamed, detested, and ultimately separated from the mainstream of typical childhood experiences. Even though labels are helpful for establishing classification, diagnostic, and treatment sequences, as well as providing a foundation for research and prevention, most literature has focused on the negative consequences that result (Gentschel & McLaughlin, 2000).
Advice mothers would give to other parents of children with ADHD

*Developing parental qualities which would be helpful in parenting a child with ADHD*

Six mothers indicated that it is important to have patience when raising a child with ADHD. This is not surprising given that children with ADHD have many frustrating behaviour difficulties relating to their impulsivity, inattention, and hyperactivity. Children with ADHD often: have difficulty playing quietly; are in constant motion; fidget with their hands or feet; make inappropriate noises; talk excessively; interrupt or intrude on others; and get easily frustrated to name a few. Given that these types of behaviours can be very frustrating, they require much patience that will assist the parent to remain calm. Flick (1998) indicated that remaining calm creates an environment most conducive to maintaining close relationships and keeping children under control.

Three participants identified that it was important to have effective communication with their child who has ADHD. Using effective communication is important when dealing with children with ADHD. Getting the correct information to the child may be the most critical part of the entire behavioural sequence. As many children with ADHD are distractible and hear only parts of communications, it is important to check out whether the child has received the entire message (Flick, 1998). Once one becomes more effective in communicating, some problem behaviours may literally “disappear” (Flick, 1998). This is viewed as a strength for these three mothers who have understood the importance of having effective communication with their children who have ADHD.
Acquiring appropriate behaviour management strategies

Seven mothers indicated that being consistent with their child is the most important thing to remember when it comes to dealing with children with ADHD. The majority of participants stated that consistency and routine is very important to have in their home when dealing with a child who has ADHD. Maintaining structure and routine is critical so the child knows exactly what to expect. The key is to have an established routine in which the components change to heighten and maintain the child’s interest (Flick, 1998). Rief (1998) also indicated the importance of providing as much structure and predictability in the home as possible. Establishing some rules, routines and schedules in the home will help life run smoother (Rief, 1998). Structure creates a positive environment for the child which sets the conditions that encourage desirable behaviour to happen (Sears & Sears, 1995).

Four mothers suggested that mothers with children with ADHD should try different behaviour management strategies with the child until one is found that works. Each child with ADHD is a unique individual and may not respond to the same behaviour management strategy as another child. It is the experience of the researcher that at Glengarda Child and Family Services, the behaviour management strategies used with the children are generally tailored to meet each child’s individual needs.

Accessing appropriate medical resources

Seven mothers suggested that it would be helpful for the child to see a psychiatrist or physician to confirm a diagnosis of ADHD and determine if their child would benefit from a trial of medication. Despite literature which expresses reluctance to use medication (Hartmann, 1997), the use of stimulant medication to reduce ADHD
Coping with Children with ADHD

symptoms in children is well documented in the literature (Jensen, 2004; Root & Resnick, 2003; Abikoff & Klein, 1992). Barkley (1998) reports that research consistently demonstrates the efficacy of stimulant medication in improving behavioural, academic, and social functioning in approximately 50% to 95% of children treated.

Pharmacological treatments for ADHD are more widely used, are less expensive, and have much more short-term empirical support than do psychosocial treatments (Jones, 2002). Some have raised concerns about possible over-prescribing of medication. Possible over-prescribing such as prescribing stimulants for children who do not meet the diagnostic criteria for ADHD, is an area that is important and not well researched (Jensen, 2004). It is likely that this is not the case for children at Glengarda Child and Family Services given that all children who take medication are closely monitored by a child psychiatrist or another health care professional.

Seeking external resources for education and support

Nine mothers recommended that they feel it would be helpful to seek mental health services for a child that has ADHD. When a child is diagnosed with ADHD, the literature supports these families receiving treatment. Multimodal treatment methods are recommended including: Individual therapy; marital/family therapy; support groups; psychoeducation; outreach and multidisciplinary collaboration; social skills and extracurricular activities; special education; psychopharmacology as needed; and behaviour modification techniques (Yescin, 2000). All of the above mentioned treatment methods are offered to children and families at Glengarda Child and Family Services.

Six mothers suggested that it would be beneficial to parents of children with
ADHD to do reading and research on ADHD to learn more about the disorder. The literature concurs that the information a mother acquires regarding ADHD, as well as regarding what is known to date about the interventions, will assist in her child’s development of compensatory behaviours (Segal, 2001). The mother then must assimilate that information and utilize it for the benefit of herself and her child, discern what areas of cognition or perception are affected, and then attempt to understand how her child’s behaviours can be framed in the light of that understanding (Segal, 2001).

Six mothers stated that parents of children with ADHD should attend parenting groups or workshops to increase their knowledge about different positive behaviour management strategies they can use with their child. Research suggests that increased competency in dealing with behaviour problems not only has the effect of reducing behavioural difficulties in the child, but it also enhances the parent’s sense of competence (Beresford, 1994). Additionally, behavioural parent training programs that teach parents how to manage their children’s inappropriate behaviour and encourage prosocial behaviour are well established treatments for children with ADHD (McKee et al., 2004). Data suggests that mothers used more effective parenting strategies after parent training than they did before (McKee et al., 2004).

Five mothers indicated that it would be helpful to have support from friends or family members to assist them in dealing with a child who has ADHD. Research recognized the importance of social supports when dealing with a child with ADHD. Social support and the availability of social resources have been extensively explored in families coping with a disabled child. Beresford (1994) indicated that parents of disabled children perceive themselves to be lonely and socially isolated, especially single parents.
Social isolation or lack of informal social support can be one of the most stressful factors associated with caring for a disabled child (Beresford, 1994). Social support has a number of functions including emotional support, information, practical help or encouraging feelings of normality (Beresford, 1994). Even though all single mothers in this study indicated that social supports are an important factor when it comes to coping with their child's behaviour difficulties, only five mothers would advise that social supports are helpful to another mother who has a child with ADHD.

**Involving the child in community activities**

Access to community resources and activities is significantly diminished for children in disrupted families. The loss of income that typically accompanies divorce and separation restricts the ability of many families to become involved in community activities (McLanahan, 1999). In this study, four mothers stated that their child was not involved in any activities in the community. Six of the mothers indicated that their child had some involvement in community activities. Of the six that were involved in community activities, all but one child had involvement in multiple community activities. Some mothers wanted their child to be involved in community activities but due to the disruptive behaviour of their child, they were not able to enroll their child. Even though six mothers had children involved in community activities, only two mothers indicated they would advise other parents to have their child involved in community activities.

**Summary**

This chapter compared and contrasted the major findings of this study with the relevant literature. The coping strategies of single mothers of children with ADHD and the obstacles to parenting children with ADHD were discussed. In addition, the advice
that these mothers would offer to parents of children with ADHD was examined. The
next chapter will focus on the conclusions, recommendations and limitations of this
study.
CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to answer the following research question: What are the coping strategies used by single mothers who have children with ADHD? The focus of the study was an in-depth exploration and understanding of the coping strategies of these single mothers. The literature was reviewed and no previous studies were found that investigated the coping strategies of single mothers who have children with ADHD.

The participants in this study consisted of single mothers who had a child between the ages of 9-12 years old with ADHD in the day treatment program at Glengarda Child and Family Services, and had been involved in treatment there for at least six months. The ages of the mothers ranged from 31 – 49 years old (mean age = 40 years). Ten single mothers participated in this study and were interviewed to develop an understanding of what their experiences had been, from their own perspective, and to determine the coping strategies that they used.

The data were collected by in-depth semi-structured individual interviews that were conducted by the researcher. These interviews took place in the mother’s home with the exception of one interview which took place at Glengarda Child and Family Services because this participant did not feel comfortable interviewing in her home. Open-ended questions were asked pertaining to the mothers’ experiences parenting their child with ADHD and how they coped with their child’s disorder. The interviews took approximately one hour to one-and-a-half hours. Standardized prompts were used if the participant was struggling to provide a response to the questions. The interviews were audio-taped and transcribed for analysis. After the data were transcribed, the
transcriptions were reviewed for common themes, which were then collapsed into categories. An adaptation of grounded theory was used as the analytic method for deriving these themes from the interview data. This study provided rich data about the coping strategies of single mothers who have children with ADHD.

**Coping strategies used by single mothers of children with ADHD**

The following categories of coping strategies were derived from the in-depth semi-structured interviews with the mothers of children with ADHD who participated in this study:

1. Utilizing behaviour management techniques with the child.
2. Engaging in activities which have the potential to prevent stressful situations with the child.
4. Engaging in self-nurturing activities.
5. Developing and maintaining supports.
6. Utilizing inappropriate parenting strategies.
7. Engaging in activities that result in immediate self-gratification for the mother.

The mothers in this study tended to use more problem-focused coping strategies (using time outs, problem solving, incentive programs, and verbal praise) with their child rather than emotion-focused coping (using relaxation techniques, watching television or a movie, reading, taking a bath or shower, and listening to music). This is surprising given that at times, the mothers seemed to feel they had little or no control over their child’s ADHD symptoms. When there is little or no control over a situation, the literature suggests that emotion-focused coping is more likely to be used. Problem-focused coping
strategies may have prevailed over emotion-focused coping strategies with this population because all of the mothers in this study had been involved with Glengarda Child and Family Services for at least six months, with most being longer than six months. Problem-focused coping strategies are the strategies that Glengarda Child and Family Services tends to promote for dealing with children with behaviour difficulties. The coping strategies utilized by these single mothers appeared similar to the coping strategies of two-parent families documented in the literature (Beresford, 1994; Bailey et al., 1999; Segal, 2001). The wide range of supports and services that these mothers were able to access as a result of being involved with Glengarda Child and Family Services may account for this finding (see Appendix G for a list of services that Glengarda Child and Family Services offers to clients).

**Obstacles that interfered with parenting these children**

The major obstacles which these mothers identified as interfering with parenting their child with ADHD were the following:

1. Behaviour of their child with ADHD.
2. Issues around medication.
3. Issues pertaining to the mother as a single parent.
4. Lack of constructive parenting skills.
5. Multiple problems within the family.
6. Barriers with potential resources in the community.

The specific examples contained in the themes in each of these categories varied. Most of the mothers, however, found it frustrating dealing with incidents that occurred at the child’s community school and half of the mothers felt that their child had been
labeled as a result of their ADHD difficulties. Some mothers found it difficult dealing with their child’s challenging behaviour while in public places, some struggled with dealing with their child’s biological father, and other mothers had to deal with other members in their family who were ill or disabled.

**Advice these mothers would give to other parents with a child with ADHD**

The major advice that mothers in this study thought would be important to give to other mothers of children with ADHD consisted of the following:

1. Developing parental qualities which would be helpful in parenting a child with ADHD.
2. Acquiring appropriate behaviour management strategies.
3. Accessing appropriate medical resources.
4. Seeking external resources for education and support.
5. Involving the child in community activities.

There were some differences between what the mothers in this study identified as a coping strategy for themselves and what they would recommend to other parents who have a child with ADHD. For example, all mothers used self-nurturing activities as a way of coping but no mothers recommended this to other parents; the majority of mothers felt that it reduced stress to spend more positive time with their child but no mothers recommended this to other parents; and all mothers identified the importance of having support from friends and family members but only half of the mothers recommended this to other parents. These differences could have occurred because the mothers had discussed the coping strategies that they themselves used with their children earlier in the interview. They may have not felt the need to bring them up again for the last question of the interview which asked what advice they would give to other parents who have a child
diagnosed with ADHD. Perhaps if this question had been asked earlier, it would have generated responses with a wider range of coping strategies which would be recommended to other parents. In addition these differences could have occurred because of the socialization of women and mothers in our society. Women and mothers tend to take care of everyone else first and then put themselves last.

**Limitations of the study**

A limitation of this study is that there was a small sample size; therefore the results cannot be generalized to the larger population. In addition, all of the participants were chosen from a children’s mental health facility, which tends to accept the most severe behavior-problem children for services. The children who are accepted for treatment at Glengarda Child and Family Services have problems functioning appropriately in the school setting, the community and in the home environment. Therefore, this research is specific to single mothers of children with ADHD who are receiving treatment at a children’s mental health facility and cannot be generalized across the entire population of single mothers of children with ADHD.

A second limitation is that the data from the interviews with these single mothers was obtained from a researcher that was employed at Glengarda Child and Family Services. Due to this methodology being utilized, it allowed the researcher to use her own knowledge and experience with this population to formulate conclusions from the data. Perhaps another researcher would have derived different results or had a different perception of the interview content. Every researcher inevitably brings their own bias to their research. Standards for recognizing bias and for determining objective truth are difficult to define, especially since human observation and subjective experience are

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laden with perceptual, cultural, and contextual biases that must be taken into account (Sherman & Reid, 1994).

Another limitation is that this sample is comprised of older mothers with the mean age being 40-years-old. Perhaps younger mothers would have generated different data and different coping profiles.

**Implications for social work practice**

This section will present the implications and recommendations for the micro, mezzo and macro levels of social work practice.

**Micro level of practice**

The results of this study indicated that it would be beneficial for these mothers to have more emphasis placed on their own self-care. It is important for social work practitioners to educate these mothers about the importance of taking care of themselves. If these mothers experience inadequate self-care, it is likely that they will not be able to provide the most effective care to their children. Self-care is challenging for many women in our society due to their care-giving responsibilities. However, these women need to be assisted to make self-care a priority for themselves. The mothers in this study illustrated many strengths in terms of using self-nurturing activities. A wide range of self-nurturing coping strategies that involved spending little or no money such as, taking a bath, reading, listening to music, going for a walk, and using relaxation techniques were utilized. The experiences of these mothers demonstrate that despite their economic circumstances, they are still able to carry out self-care and self-nurturing.

Careful differential assessment regarding each child’s individual unique needs should be carried out. Medication for children with ADHD was viewed as helpful by
mothers in managing their child’s ADHD symptoms. Today medication seems to be a common form of treatment for children with ADHD, which has increased from previous years. Medication as a form of treatment for children with ADHD should be individualized. Medication may be viewed as a quick solution to treating ADHD in children, therefore, it is important to ensure that children who are using medication do require it and would benefit from it. Regular appointments with a child psychiatrist may be helpful in determining which children would benefit from medication.

ADHD has become a growing concern in North America. Mother’s of children with ADHD need to become aware of how this “labeling” can lead to stigmatization in our society, which then may become a barrier for the child to achieving their goals. For example, as adults, these children who were diagnosed with ADHD may not be able to enlist in the armed forces because ADHD is classified as a mental illness in the DSM IV TR 2000.

*Mezzo level of practice*

It is recommended that mothers participate in parent training or behaviour management training. Learning how to problem solve effectively seems to be important in developing healthy coping strategies for dealing with children with ADHD. An exclusive focus on behaviour management, however, does not seem to be sufficient. Parent education should focus also on the wide range of effective coping strategies documented in the recent literature. These strategies include: Promoting self-care, using relaxation techniques, positive reframing, using effective communication with their child, and becoming an advocate for their child. The Positive Parenting Program (Triple P) which involves discussion of a wide range of coping strategies is an example of a holistic...
program for parent education (Sanders, Markie-Dadds, & Turner, 2002). The Positive Parenting Program (Triple P) aims to make parenting easier and more enjoyable. It offers suggestions and ideas on positive parenting to assist parents to develop a positive relationship with their children and to help children develop appropriately. The positive parenting approach suggested in the material that is used has been developed through over 20 years of research at the University of Queensland in Australia. This program is based on contemporary knowledge, is internationally recognized, and has been found useful by many parents (Sanders, Markie-Dadds, & Turner, 2002).

Social workers should continue to be involved in research so they are aware of the needs of children with ADHD. Not all children with ADHD fit into one “type” and therefore treatment needs to be individualized. It may be important to look at adapting the child’s environment to meet the child’s needs rather than attempting to have the child adapt to the environment, which could be difficult for the child to do given their needs.

Involving children in community activities will assist them to develop appropriate social skills and foster positive peer relationships. This will also provide respite to the mother if the child is involved in activities outside of the home. As a social support network has been identified as an important resource for coping, it is recommended that mothers become involved in support groups especially if they lack a wide range of social supports. Research has indicated that it is also beneficial for mothers of children with ADHD to access services from mental health facilities. This allows the whole family to have access to valuable services such as assessment, counselling, and parent training. Social workers should ensure that parents are aware of how to access formal supports and develop informal supports. This may involve referrals, provision of information about
available resources in the community, as well as educating parents about strategies for
developing and maintaining informal supports.

This study found that when these mothers spent more positive time with their
children, it was helpful in reducing their child’s behaviour difficulties. This could be
difficult for a single mother especially if she has more than one child or is employed
outside of the home. Nevertheless, it is important to encourage mothers to spend positive
time with their children regularly. Some mothers may require assistance from social
workers in setting priorities regarding their many responsibilities. In addition, a parent
involvement and positive feedback program where mothers come into an agency and
learn to spend positive time with their child, may facilitate a transfer of this experience to
the home environment.

Macro level of practice

For children with ADHD, social workers must be aware of and form liaisons with
relevant systems in the community, especially with the child’s community school. Due
to the majority of mothers in this study having had difficulties dealing with their child’s
community school, there needs to be a focus on building a constructive working
relationship between the parent and the community school. Staff at the community
school may require education regarding the needs of the child with ADHD. Children
with ADHD are recognized as challenges for teachers as they are mainstreamed into
regular community school classrooms. Teachers need to have the resources available to
them so they can effectively teach these children. Teachers dealing with children with
ADHD need to be aware of teaching strategies, behaviour management techniques and
ways to modify the child’s environment in order for the child with ADHD to meet with
success in a community school placement. For those children requiring an educational placement in a children’s mental health facility, the community school should be informed of the progress the child is demonstrating while receiving this service. Such a service plan would assist with re-integration once the child is discharged into the community school.

Additionally, parenting programs need to be more widely available in the community, not just in children’s mental health facilities. Such services would facilitate early intervention, which may prevent negative outcomes as well as strengthen the existing resources available for mother-led families where there is a child with ADHD. These parenting programs should go beyond behaviour management training and involve other important subjects such as self-care, self-esteem and promoting positive interactions with children.

Children’s mental health facilities need to ensure that the needs of children with ADHD and their families are being met. Training and education of staff should be presented on a regular basis to ensure that the most appropriate interventions are offered as supported in the current literature and research. Program evaluation should occur to ensure that the needs of these clients are met and appropriate services are offered to them. In addition, it is important that staff members are able to be empathetic and appreciative of the challenges these single mothers have in raising a child with ADHD.

Implications for policy

Children with mental health concerns often have difficulty functioning in a community school setting. One of every five children is reported to struggle with their mental health (Children’s Mental Health Ontario, 2007). Due to the increasing number
Coping with Children with ADHD

of children with mental health difficulties, there should be more resources available for these children in community school settings. Specifically, children with ADHD are frequently suspended from their community school as a result of their ADHD-related behaviour difficulties such as inattention, hyperactivity, and impulsivity. By being diagnosed with ADHD, these children will likely continue to have these problems throughout the course of their education. If services and supports were attached to the community school system, more children would receive the help they need more rapidly. In addition, fewer children would need to be removed from their community school and placed in a children’s mental health facility for their education. Services should include parent training and parent support groups. If services in one’s own community became a reality, children would spend less time on waiting lists for admission to a children’s mental health facility. In addition, children and their families would have continued formal supports available upon discharge from children’s mental health centres.

Another option for follow-up service would be available if mental health facilities developed parent support groups for discharged clients. These support groups could be set up initially by a social worker and then gradually become a self-help group for parents. The social worker would then take on a consultant role. This follow-up service would allow an opportunity for these parents to continue to have ongoing support upon discharge. Self-help groups may then eventually develop as autonomous services for parents of children with ADHD.

The findings in this study reinforce the importance for a human service system in our society which ensures the basic needs for housing, food, clothing, and the health care of its citizens are met. Without these basic needs being met, single mothers of children
with ADHD would likely not manage as well in terms of coping with their child. This is of special import when the high incidence of poverty among mother-led families is considered. In this study 70% of the mothers had a family income of $20,000 per year or less, which is below the LICOs (Low-Income Cut-Offs) or more popularly know as Canada's poverty lines (Canadian Council on Social Development, 2006).

Implications for future research

As a result of the findings in this study, the following recommendations for future research were made:

1. Single mothers of children with ADHD who attend community schools and have had no intervention should be studied regarding the coping strategies used with their children. It is hypothesized that the coping strategies of single mothers of children with ADHD attending community schools with no intervention will differ from those coping strategies articulated by the participants in this study. The researcher would postulate that mothers of children with ADHD attending community schools may not use as many formal social supports or they may not use as many problem-focused coping strategies such as the ones that are taught at Glengarda Child and Family Services.

2. Parent training and education programs for single mothers of children with ADHD should be investigated utilizing a pre-test/post-test design. It is hypothesized that the coping strategies used by single mothers of children with ADHD will differ subsequent to a parent training and education program. At the post-test, it is hypothesized that mothers
will use a wider range of coping strategies than were used prior to the parent training and education program. Depending on the type of parenting program, the mothers may exhibit more self-care or self-nurturing activities. In addition, by attending a parenting group would expand the mother's social support network.

3. It would be interesting if these same mothers could be studied one year after discharge from Glengarda Child and Family Services. This would determine whether the coping strategies which these single mothers utilized had changed after the supports available from Glengarda Child and Family Services had been removed. The researcher predicts that some of these mothers would have fewer social supports after the services from Glengarda Child and Family Services has been removed for one year. In addition, with this formal support withdrawn, stress levels would increase and problem-focused strategies would likely be compromised and the self-nurturing activities would be sacrificed. Both of these conditions could lead to regression of the gains that were made in treatment.

4. Single mothers of children with ADHD with few social supports, both formal and informal, should be compared with those mothers with well developed social supports to see if there are differences in their coping. It is hypothesized that mothers with well developed social supports would use different coping strategies with their child with ADHD than those mothers with fewer social supports. The researcher postulates
that the mothers with well developed social supports would exhibit a
d wider range or coping strategies which would include more supports
involving self-care. The mothers with few social supports would likely
pay minimal attention to self-care because these mothers would not
have as many people to assist them with their child and therefore,
would likely have a greater amount of stress.

5. All of the children in this study had a dual diagnosis. It would be
interesting to determine if there are differences in the coping strategies
of single mothers of children with an ADHD diagnosis without co-
morbid conditions compared to the mothers in this study. It is
hypothesized that the coping strategies of single mothers of children
with an ADHD diagnosis without co-morbid conditions would differ
from the coping strategies of single mothers of children with an ADHD
diagnosis with co-morbid conditions. The researcher believes that the
mothers of children with ADHD without co-morbid conditions would
have a well developed social support network and an opportunity to
spend more positive time with their children. In addition, mothers of
children with ADHD with co-morbid conditions would likely use more
inappropriate forms of coping due to their high stress level and the
increased behaviour difficulties of their child as a result of the co-
morbid condition.
Table 1 - Summary of the participant's demographic information

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>42</td>
<td>Yes</td>
<td>11</td>
<td>Yes</td>
<td>Complete College</td>
<td>Greater than $60,000</td>
<td>Employment</td>
<td>ADHD, ODD, LD, Mood Instability</td>
<td>Psychiatrist</td>
<td>Concerta, Risperidone</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>Yes</td>
<td>10</td>
<td>Yes</td>
<td>Some University</td>
<td>$10,000 or less</td>
<td>Child Support &amp; Government Assistance</td>
<td>ADHD, ODD, LD, Anxiety Disorder</td>
<td>Psychiatrist</td>
<td>Methylphenidate</td>
<td>Parent &amp; Big Brothers of Windsor</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>Yes</td>
<td>11</td>
<td>Yes</td>
<td>Complete Secondary</td>
<td>Between $10,000 - $15,000</td>
<td>Pension</td>
<td>ADHD, ODD, LD</td>
<td>Psychiatrist</td>
<td>Methylphenidate &amp; Risperidone</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>4</td>
<td>33</td>
<td>Yes</td>
<td>12</td>
<td>Yes</td>
<td>Complete Secondary</td>
<td>Between $15,000 - $20,000</td>
<td>Government Assistance</td>
<td>ADHD, ODD, LD, Anxiety Disorder</td>
<td>Psychiatrist</td>
<td>Methylphenidate &amp; Concerta</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>5</td>
<td>34</td>
<td>None Noted</td>
<td>11</td>
<td>No</td>
<td>Complete College</td>
<td>$10,000 or less</td>
<td>Employment</td>
<td>ADHD, ODD, LD, Anxiety Disorder, Possible CD</td>
<td>Psychiatrist</td>
<td>Straterra</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>6</td>
<td>49</td>
<td>None Noted</td>
<td>10</td>
<td>Yes</td>
<td>University Degree</td>
<td>Between $50,000 - $60,000</td>
<td>Employment</td>
<td>ADHD, ODD, LD</td>
<td>Psychiatrist</td>
<td>Straterra</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>7</td>
<td>43</td>
<td>Yes</td>
<td>9</td>
<td>Yes</td>
<td>Complete College</td>
<td>Between $10,000 - $15,000</td>
<td>Employment &amp; Government Assistance</td>
<td>ADHD, ODD, Possible CD &amp; Mood Disorder</td>
<td>Psychiatrist</td>
<td>Methylphenidate &amp; Risperidone</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>8</td>
<td>31</td>
<td>None Noted</td>
<td>12</td>
<td>Yes</td>
<td>Complete Secondary</td>
<td>Between $10,000 - $15,000</td>
<td>Employment</td>
<td>ADHD, ODD</td>
<td>Psychologist</td>
<td>Dexedrine &amp; Risperidone</td>
<td>Parent &amp; School</td>
</tr>
<tr>
<td>9</td>
<td>45</td>
<td>None Noted</td>
<td>10</td>
<td>Yes</td>
<td>Complete Secondary</td>
<td>Between $20,000 - $30,000</td>
<td>Employment &amp; Child Support</td>
<td>ADHD, LD, PTSD, Anxiety Disorder, Depression</td>
<td>Psychiatrist</td>
<td>Concerta, Risperidone</td>
<td>Parent &amp; Mental Health Agency</td>
</tr>
<tr>
<td>10</td>
<td>39</td>
<td>None Noted</td>
<td>11</td>
<td>Yes</td>
<td>Complete Secondary</td>
<td>Between $15,000 - $20,000</td>
<td>Pension &amp; Child Support</td>
<td>ADHD, LD, PTSD</td>
<td>Psychiatrist</td>
<td>Dexedrine</td>
<td>Parent &amp; School</td>
</tr>
</tbody>
</table>
Table 2 - Summary of the demographic information from the interview questionnaire by participant

<table>
<thead>
<tr>
<th>Participant</th>
<th>Participant's Medical or Mental Health Conditions</th>
<th>Child's Other Medical or Mental Health Conditions</th>
<th>Immediate family with Medical or Mental Health Conditions</th>
<th>Is Religion Important to Participant?</th>
<th>Is Child involved in Community Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High Blood Pressure, Anemia, Arthritis, Diabetes</td>
<td>Allergies, respiratory problems, lactose intolerant, ODD</td>
<td>Diabetes, Heart Disease, Cancer</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Diabetes, Depression</td>
<td>Digestive Problems, Depression</td>
<td>ADHD, Diabetes, Anxiety &amp; Depression</td>
<td>Yes</td>
<td>Yes - Church, Cubs, Swimming</td>
</tr>
<tr>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>None</td>
<td>None</td>
<td>Depression</td>
<td>No</td>
<td>Yes - Church, Basketball</td>
</tr>
<tr>
<td>5</td>
<td>None</td>
<td>Behaviour problem, ODD, OCD, Depression, Anxiety</td>
<td>None</td>
<td>No</td>
<td>Yes - Soccer</td>
</tr>
<tr>
<td>6</td>
<td>None</td>
<td>Eczema, ODD, LD</td>
<td>None</td>
<td>Yes</td>
<td>Yes - Church, Cubs, Youth Group</td>
</tr>
<tr>
<td>7</td>
<td>None</td>
<td>ODD, Conduct Disorder</td>
<td>Bipolar Disorder &amp; Schizophrenia</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>None</td>
<td>ODD, Tourettes</td>
<td>None</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Asthma</td>
<td>Asthma, PTSD</td>
<td>Heart Disease</td>
<td>Yes</td>
<td>Yes - Church, Soccer, Day Camps, Basketball</td>
</tr>
<tr>
<td>10</td>
<td>None</td>
<td>None</td>
<td>Acquired Brain Injury</td>
<td>Yes</td>
<td>Yes - Hockey, Lacrosse, Day Camps</td>
</tr>
</tbody>
</table>
Table 3 – Coping strategies of single mothers who have children with ADHD.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>THEMES</th>
<th>FREQUENCY (out of 10 mothers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilizing behaviour management techniques with child with ADHD</strong></td>
<td>a. Mothers felt that it was helpful to remove privileges as a consequence for their child’s inappropriate behaviour.</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>b. Many of the mothers used a time out as a way of disciplining their child.</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>c. Using problem solving with the child was found to be an effective behaviour management technique.</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>d. Mothers felt that using an incentive program promotes positive behaviour in their child.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>e. Mothers felt that giving their children verbal praise was effective in promoting positive behaviour in their child.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>f. Mothers felt that using tangible rewards with their children was helpful in promoting positive behaviour.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>g. Using a sense of humour with the child will help the mother remain calmer when dealing with behaviour difficulties.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>h. Picking and choosing battles with children will result in fewer arguments with child.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>i. Making a list or writing down what happened will help the mother to develop a plan of action to use with her child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>j. It is helpful to remove the child from the situation so the child can calm down.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>k. Reasoning with the child will assist in the problem solving process.</td>
<td>1</td>
</tr>
<tr>
<td><strong>Engaging in activities which have the potential to prevent stressful situations with child</strong></td>
<td>a. Spending more positive time with the child seems to increase positive behaviour in the child.</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>b. Some mothers felt that their child was more manageable when on medication.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>c. Mothers were more able to deal with their child’s difficult behaviour if they were well rested and had enough sleep.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d. It was helpful and proactive for one mother to take only one child out in the community at a time.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. One mother made spending time with her child a priority over household chores.</td>
<td>1</td>
</tr>
</tbody>
</table>
### Engaging in activities which have the potential to prevent stressful situations with child (con't)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>f.</td>
<td>One mother felt that it was helpful to bring someone else along with her when bringing her child in the community.</td>
<td>1</td>
</tr>
</tbody>
</table>

### Utilizing self-calming

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Separation from the child will assist to calm the mother.</td>
<td>8</td>
</tr>
<tr>
<td>b.</td>
<td>Using relaxation techniques will assist to calm the mother.</td>
<td>4</td>
</tr>
<tr>
<td>c.</td>
<td>It is helpful if the mother is able to “let certain issues go”.</td>
<td>1</td>
</tr>
<tr>
<td>d.</td>
<td>It is helpful to keep things in perspective such as thinking that “other people are worse off”.</td>
<td>1</td>
</tr>
</tbody>
</table>

### Engaging in self-nurturing activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Mothers identified that watching television or a movie was helpful to them.</td>
<td>5</td>
</tr>
<tr>
<td>b.</td>
<td>Mothers felt that reading was useful to relax them when under stress.</td>
<td>5</td>
</tr>
<tr>
<td>c.</td>
<td>Taking a bath or shower also assisted to relax the mothers.</td>
<td>5</td>
</tr>
<tr>
<td>d.</td>
<td>Mothers felt that listening to music helped them to alleviate some of their stress.</td>
<td>3</td>
</tr>
<tr>
<td>e.</td>
<td>Going for a walk was effective for reducing stress for some mothers.</td>
<td>2</td>
</tr>
<tr>
<td>f.</td>
<td>Some mothers found that doing housework helped them to cope with their child’s behaviours.</td>
<td>2</td>
</tr>
</tbody>
</table>

### Developing and maintaining supports

<table>
<thead>
<tr>
<th>Support</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>It was important for these mothers to have emotional support from friends or family.</td>
<td>10</td>
</tr>
<tr>
<td>b.</td>
<td>Mothers sought formal supports from community providers.</td>
<td>10</td>
</tr>
<tr>
<td>c.</td>
<td>Mothers received training/education about ADHD.</td>
<td>9</td>
</tr>
<tr>
<td>d.</td>
<td>Mothers felt that their parenting experience contributed to their knowledge about parenting a child with ADHD.</td>
<td>2</td>
</tr>
<tr>
<td>e.</td>
<td>Some of the mothers were taking medication to assist with coping.</td>
<td>2</td>
</tr>
<tr>
<td>f.</td>
<td>Religion was important to some of these mothers as a way of coping.</td>
<td>2</td>
</tr>
<tr>
<td>Utilizing inappropriate parenting strategies</td>
<td>Engaging in activities that result in immediate self-gratification for mother</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>a. Mothers found that the children listened when they threatened their child i.e. telling another adult with authority.</td>
<td>a. Smoking assisted to relieve some stress in parenting for some mothers.</td>
<td></td>
</tr>
<tr>
<td>b. One mother felt that her child did not respond to discipline so she did not use it.</td>
<td>b. Yelling and crying were reactions of some of these mothers in response to their child’s behaviour difficulties.</td>
<td></td>
</tr>
<tr>
<td>c. When frustrated with her child, one mother would give in and allow her child to get his own way.</td>
<td>c. Eating “comfort foods” assisted one mother to feel better when she was feeling stressed.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
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<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Table 4 – Obstacles that interfered with parenting children with ADHD.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>THEMES</th>
<th>FREQUENCY (out of 10 mothers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour of their child with ADHD</td>
<td>a. Dealing with the child’s challenging behaviour while in public places was difficult for mothers.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b. Mothers found that it was an obstacle trying to deal with their child’s temper.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c. One mother struggled with trying to understand her child’s difficult behaviour.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>d. One mother felt that it was an obstacle to live in an area where there are many children with behaviour problems.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. One mother was frustrated by her child’s behaviour while on the school bus.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>f. One mother felt it was an obstacle that her child was denied permission to attend a community day camp because of difficult behaviour.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>g. Dealing with her child's lying was difficult for one mother.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>h. Dealing with her child’s inattention was an obstacle for one mother.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>i. One mother struggled with dealing with her child’s impulsivity.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>j. One mother felt it was distracting driving in the car while her children were acting out.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>k. One mother struggled with her child running away from home.</td>
<td>1</td>
</tr>
<tr>
<td>Issues around medication</td>
<td>a. Making the decision to place child on medication to treat ADHD symptoms.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b. Being able to pay for their child’s medication was a struggle.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>c. Dealing with the side effects of their child’s medication.</td>
<td>1</td>
</tr>
<tr>
<td>Issues pertaining to the mother as a single parent</td>
<td>a. Some mothers found it difficult dealing with their child’s biological father.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>b. One mother felt that it was difficult raising a child as a single parent.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c. One mother struggled financially.</td>
<td>1</td>
</tr>
<tr>
<td>(Issues pertaining to the mother as a single parent)</td>
<td>d. One mother struggled with trying to maintain employment.</td>
<td>1</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Lack of constructive parenting skills</td>
<td>a. Mothers struggled with using consistent rules and routines with children.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b. One other struggled trying to be firm with her child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>c. One mother stated that she forgets to give her child positive reinforcement.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>d. It was important for one mother to find a way to manage her own emotions while interacting with her child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. One mother struggled with being an advocate for her child.</td>
<td>1</td>
</tr>
<tr>
<td>Multiple problems within the family</td>
<td>a. Some mothers had to deal with another member in the family who was ill or disabled in addition to dealing with their child with ADHD.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b. It is difficult to get other children in the home to understand the needs of the child who has ADHD.</td>
<td>1</td>
</tr>
<tr>
<td>Barriers with potential resources in the community</td>
<td>a. Dealing with incidents that occurred at the child’s community school was difficult for these mothers.</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>b. Mothers felt that their child had been labeled due to their ADHD difficulties.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>c. Mothers found that they had to educate others in the community about their child’s disability and unique needs.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d. One family had to wait on the waiting list before they were able to access services for the child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. Going through the process of applying for disability for her child was complicating.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>f. Making the decision to enroll child in a day treatment facility was difficult.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>g. It is frustrating dealing with problems that occur in the neighbourhood as a result of the child’s behaviour.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>h. One mother was not able to maintain a babysitter for her child due to her child’s behaviour problems.</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 5 – Advice mothers would give to other parents of children with ADHD.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>THEMES</th>
<th>FREQUENCY (out of 10 mothers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing parental qualities which would be</td>
<td>a. It is important to have patience when dealing with a child who has</td>
<td>6</td>
</tr>
<tr>
<td>helpful in parenting a child with ADHD</td>
<td>ADHD.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. It is necessary to have effective communication with your child.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>c. Mothers of children with ADHD must accept that their child has a disability.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d. Mothers feel that it is helpful to learn how to manage their own emotions such as controlling their own temper when interacting with their child.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>e. One mother felt that it is helpful to be an advocate for her child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>f. It is recommended that a mother come to a realization that she is doing the best she can in raising her child.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>g. Maintaining a positive attitude is helpful in coping with a child who has ADHD.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>h. One mother felt that it is important not to let others stereotype her child.</td>
<td>1</td>
</tr>
<tr>
<td>Acquiring appropriate behaviour management</td>
<td>a. It is important that mothers use consistent parenting strategies with their children.</td>
<td>7</td>
</tr>
<tr>
<td>strategies</td>
<td>b. It is recommended to try different strategies with the child until one is found that works.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>c. It is helpful to get behaviour management advice to assist in parenting children with ADHD.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>d. One mother felt that it was beneficial to separate from the child when frustrated and have some time away on their own.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>e. It is important not to give children who have ADHD more than one task at a time because it overwhelms them.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>f. It is important to keep children with ADHD busy so they do not get bored.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>g. One mother felt that limiting her child’s diet of preservatives was helpful in decreasing her child’s ADHD symptoms.</td>
<td>1</td>
</tr>
</tbody>
</table>
### Accessing appropriate medical resources

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>It is beneficial for the child to see a psychiatrist or physician who can confirm a diagnosis of ADHD.</td>
<td>7</td>
</tr>
<tr>
<td>b</td>
<td>When a child is diagnosed with ADHD, it was recommended that medication is tried to see if it is helpful for the child.</td>
<td>2</td>
</tr>
<tr>
<td>c</td>
<td>A mother should get information about the medication her child is taking.</td>
<td>1</td>
</tr>
</tbody>
</table>

### Seeking external resources for education and support

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Mothers felt that it was important for their child and family to receive mental health services.</td>
<td>9</td>
</tr>
<tr>
<td>b</td>
<td>Mothers felt it was helpful to do reading and research to learn more about ADHD.</td>
<td>6</td>
</tr>
<tr>
<td>c</td>
<td>Mothers found it valuable to attend parent support groups and parenting workshops.</td>
<td>6</td>
</tr>
<tr>
<td>d</td>
<td>It is necessary to have support from family and friends when you have a child diagnosed with ADHD.</td>
<td>5</td>
</tr>
<tr>
<td>e</td>
<td>It is helpful for mothers to work in collaboration with the child’s community school.</td>
<td>2</td>
</tr>
<tr>
<td>f</td>
<td>It is important that everybody involved in the child’s life is working together when it comes to dealing with the child.</td>
<td>1</td>
</tr>
</tbody>
</table>

### Involving the child in community activities

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>It is beneficial for the child to become involved in physical activities</td>
<td>2</td>
</tr>
<tr>
<td>b</td>
<td>It is supportive to have a faith and attend church on a regular basis.</td>
<td>1</td>
</tr>
</tbody>
</table>
LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Coping strategies of single parents who have children with Attention-Deficit/Hyperactivity Disorder (ADHD).

You are asked to participate in a research study conducted by Michelle Sullivan, B.S.W., R.S.W., from the School of Social Work at the University of Windsor. These results will contribute to thesis research supported by Glengarda Child and Family Services, in partial fulfilment of the requirements of the degree of Master of Social Work at the University of Windsor.

If you have any questions or concerns about this research, please feel to contact Dr. Rosemary Cassano from the School of Social Work, University of Windsor at 253-3000 ext. 3080.

PURPOSE OF THE STUDY

The purpose of this study is to gain knowledge and understanding of coping strategies that are used by single parents who have children with ADHD.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:
- sign a consent to have your interview audio-taped
- give permission for the data collected to be used for research
- give permission to use your background information in a private and general way
- participate in an interview 1 - 1.5 hours long

Ten parents will be interviewed for this study. The questions that will be asked during the interview will focus on what it is like parenting a child that has ADHD. These interviews will take place at Glengarda Child and Family Services or a place convenient for those involved.

POTENTIAL RISKS AND DISCOMFORTS

There are no major anticipated risks to you associated with participation in this study. Some degree of discomfort may occur while discussing some of the stressors and difficulties in your life. If discomfort does occur you may choose not to answer particular questions or terminate the interview at any given time without prejudice. You will have an opportunity to discuss your thoughts or feelings with the researcher after the interview. In addition, you will continue to have access to your social worker/case manager at Glengarda Child and Family Services.
POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

This study has the capacity to benefit single parents of children with ADHD. It may benefit these parents by giving them knowledge about effective coping strategies and assisting in alleviating parent’s stress. It will be helpful to professionals by enhancing their knowledge of coping strategies and planning appropriate strategies when working with clients who have children with ADHD. Finally, it will be beneficial to children because effective coping/parenting strategies can lead to healthy family functioning and positive outcomes for children.

PAYMENT FOR PARTICIPATION

If you agree to participate in this study, after your interview is completed, you will receive a $10.00 gift certificate from Zellers.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will be kept private and will not be disclosed to any other person without your permission. The only exception is in the case of reported child abuse. To ensure the privacy of data, your name will be replaced with a number and data will be stored in a locked filing cabinet. No identifying data will appear in the results. After the thesis is completed, the raw data will be shredded. Only the investigators will have access to the audio-taped interviews which will be erased upon completion of the thesis, which is anticipated to be December 2006.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. Your current or future service provisions will not be affected in any way if you choose not to participate in this study. You may also refuse to answer any questions you don't want to answer and still remain in the study. You have the option to withdraw your data from the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

Upon completion of this thesis, a summary of the research findings will be mailed to each participant. If you are interested in further reviewing the findings, you will be able to contact the researcher at Glengarda Child and Family Services at 257-5106 for more information.

SUBSEQUENT USE OF DATA

These data may be disseminated through publication in professional journals or presented at professional conferences.

Do you give consent for the subsequent use of the data from this study?

☐ Yes ☐ No
RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; telephone: 519-253-3000, ext. 3916; e-mail: lbunn@uwindsor.ca.

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

_________________________________________  __________________________
Signature of Investigator                        Date
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SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study "Coping strategies of single parents who have children with Attention-Deficit/Hyperactivity Disorder (ADHD)" as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

______________________________
Name of Participant

______________________________
Signature of Participant

__________
Date

SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

______________________________
Signature of Investigator

__________
Date
APPENDIX C

The Interviewing Schedule

1. Tell me what it is like for you to raise your child

Probes:
- What has been the biggest adjustment for you and your family?
- What is most difficult for you in terms of parenting your child with ADHD?
- What do you struggle with the most?

2. How do you cope with your child’s behaviour?

Probes:
- How do you respond to those behaviours that you see as positive?
- How do you respond to those behaviours that you see as negative?
- Is there anything you do that makes you feel better?
- What do you do to help you relax?

3. What do you think has helped you the most as you have parented your child?

Probes:
- Tell me about the things you tried with your child that worked?
- Tell me about strategies that helped just a little bit?
- What seems to relieve some of the stress in parenting your child?

4. When you were young, how did people describe you as a child?

Probes:
- What would your parents say about you?
- What would your teachers say about you?
- Did you have any difficulties similar to your child’s?

5. Describe your support network (extended family, friends, etc.).

Probes:
- Do you have family members or friends that are there to support you?
- Have you attended any support groups or other community events?
- What has been your best support for yourself?
- Does your child have contact with his/her father/mother?
6. Tell me about any training that you have received on parenting

Probes:
- Have you received behaviour management training? From who? Was it helpful?
- Have you attended parenting classes or a parent support group? Where? Was it helpful?
- What were the most helpful things that you have learned?

7. How do you discipline your child?

Probes:
- When your child misbehaves, what do you do?
- What seems to work the best with your child?
- What seems to work the least with your child?

8. What was it like when your child first started school?

Probes:
- How do you feel about the way the school handled your child?
- What was your child’s behaviour like at school?
- What was your experience with the school?

9. What are the obstacles you have had to overcome with your child?

Probes:
- Have you dealt with people/situations that interfered with parenting your child?
- What was it like for you?
- What was most helpful to you?
- What did you learn from the experience?

10. What advice would you give another parent who has just found out their child has been diagnosed with ADHD?

Probes:
- What do you think would be important to tell other parents that have children with ADHD?
- What strategies or tips would you tell other parents to assist them to parent their ADHD child?
- What kinds of supports would you recommend for this parent?
APPENDIX D

Demographic Information

I. File Schedule
(After signed consent was obtained, the following information was acquired from the participant’s file for research purposes and to be able to mail the results of the research findings to each participant upon completion)

1. Name of participant
2. Age of participant and child
3. Mailing address
4. Family constellation
5. Family income
6. Child’s diagnosis
7. Child’s medication
8. Referral source
9. Parent’s level of education
10. Parent’s employment

II. Interview Questionnaire
(The following questions were asked to each participant prior to the formal interview)

1. Does your child have other medical or mental health conditions other than ADHD?
2. Do you have any medical or mental health conditions?
3. Is there anyone else in your immediate family with a medical or mental health condition?
4. Is religion important in your life? If yes, in what way?
5. Is your child involved in any community activities?
CONSENT FOR AUDIO-TAPING

Title of Project: Coping strategies of single parents who have children with Attention-Deficit/Hyperactivity Disorder (ADHD).

Research Participant’s Name:

Birth Date of Participant:

I give my consent to the audio-taping of the interview that will be conducted for the research project: “Coping strategies of single parents who have children with Attention-Deficit Hyperactivity Disorder (ADHD)”. I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the taping be stopped. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. Tapes are filed by number only and stored in a locked cabinet.

I understand that confidentiality will be respected and the reviewing of materials will be for professional use only. All audiotapes will be destroyed upon completion of this thesis, which is anticipated by December 2006.

(Signature of Research Participant) (Date)

(Signature of Investigator) (Date)
Services that Glengarda Child and Family Services Offers to Clients (free of cost)

- Counselling and assessment services
- Parent training/education and behaviour management training
- Referral and access to other community resources
- Summer day camp for child and siblings for four weeks per year
- Staff support is offered during the summer for children that would not be able to attend community day camps without staff support due to their behaviour difficulties
- Assistance with transportation as needed (i.e. bus fare, staff offering rides)
- Daily breakfast program for children
- Occasional hot lunches for children and families
- Lunch is provided for children if they forget their lunch or do not have a lunch that day
- The agency has provided families with shoes/boots as needed when families would not otherwise be able to afford the cost
- There is a clothing closet where clients can come and take clothing or coats as needed
- There is a weekly swimming program, daily social skills recreation program, pet therapy program, “grandparent” matching program with Malden Park Continuing Care Centre, music therapy program, and other regular organized sports and activities for the children
- Families in need receive sponsorships at Christmas time which is provided by donations from individuals or companies in the community
- An annual Christmas luncheon is held for all family members to attend, which includes the child sitting on Santa’s lap and receiving a gift
- Parents are invited to attend field trips and family picnics
REFERENCES


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VITA AUCTORIS

Michelle Sullivan (née Slobodnick) was born in 1973 in Windsor, Ontario. She graduated from the University of Windsor with a Bachelor of Arts (Psychology) degree and Bachelor of Social Work degree in 1997. She worked at Maryvale Adolescent and Family Services in Windsor, Ontario for nearly two years prior to taking her current position at Glengarda Child and Family Services in Windsor, Ontario. She has worked as a social worker at Glengarda Child and Family Services since 1999. Michelle is currently a candidate for the Master’s degree in Social Work at the University of Windsor and hopes to graduate in June 2007.