UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Raising a child with Attention Deficit / Hyperactivity Disorder: exploring the experience of black parents

by

CYNTHIA LINDIWE TOM

Submitted in partial fulfillment of the requirements for the degree of

MA (CLINICAL PSYCHOLOGY)

in the Faculty of Arts
at the
University of Pretoria

PROMOTER: HANNES VENTER

FEBRUARY 2010

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DECLARATION

I declare that this mini dissertation is my own unaided work. It is submitted for the degree of Master of Arts (Clinical Psychology) in the Faculty of Humanities at the University of Pretoria. It has not been submitted previously for any degree or examination at any other university.

……..
Cynthia Lindiwe Tom

……. day of February 2010

ACKNOWLEDGEMENTS

I would like to extend my utmost gratitude to the following people:

Ntando, for inspiring this work

My promoter, Hannes Venter, for his words of encouragement, his guidance and constructive criticism during this process

My five participants, for their willingness to tell their story, without which this would not have been possible

ADHASA, for giving me access to their database

My husband, Madoda for his unwavering love, patience and support during this challenging time

My three wonderful kids: Sibulele, Sisanda and Avela, for being behind me 100%. You guys are the best

Nonhlanhla Mhlongo, Joelene, MaMthembu, MaDlamini for encouraging me when I needed it the most

My heavenly Father, in whom I trust.

ABSTRACT

Improvements in diagnostic measures over the years have resulted in more accurate diagnosis of ADHD. Whilst many studies have focused on ADHD as a disorder, few studies have looked at the experience of raising a child with ADHD. The aim of this study was to explore the experience of Black parents raising children with ADHD. The sample consisted of five Black parents who live the experience of raising children, between the ages of six and twelve years, with ADHD. An interview schedule with semi-structured open-ended questions was used. The study followed a qualitative research design with descriptive phenomenology as the worldview.

The themes that emerged from the data were around the experience of their child, the experience of ADHD and the experience of self. Black parents experienced their children's behaviour as hyperactive and uncontrollable. They also believed their children were socially withdrawn and isolated. Problems with inattention, not listening and being unable to concentrate were highlighted as experienced at school and at home. Black parents also stated that their children were clever and popular at school and at home, but had problems with speech. However, most were hopeful for their children's future.

Black parents raising children with ADHD had a reasonable understanding of ADHD as a disorder, even though the results of the study suggest that ADHD is still misunderstood in the Black population. Black parents experienced others as insensitive and blaming. The support from professionals was experienced as not satisfactory and there were concerns about the medication. Black parents experienced their style of parenting as harsh but accommodating. They experienced guilt and shame, blaming themselves for their children's condition. They also felt trapped, frustrated, alone, lonely, helpless, in despair and even depressed at times. However they viewed themselves as generally coping well. Core values such as respect for others, discipline and boundaries have remained in how they parent.

Key words: ADHD, parents' experience, black parents, descriptive phenomenology

TABLE OF CONTENTS

Appendices:

CHAPTER 1: INTRODUCTION:

1.1 Research question

What are the experiences of Black parents raising children with Attention Deficit / Hyperactivity Disorder?

1.2 Research problem

Extensive literature exists about Attention Deficit / Hyperactivity Disorder (ADHD) being the most commonly diagnosed childhood disorder (Firmin & Phillips, 2009). However, great inconsistencies and gaps exist in the knowledge of families of these children with ADHD (Johnston & Mash, 2001). Attention to the study of families with children with ADHD has waned prematurely since many of the questions regarding families of children with ADHD remain unanswered (Johnston & Mash, 2001). Significant research has focused attention on the child with ADHD and little attention has been given in literature to the experience of parents in raising a child with ADHD (Cosser, 2005). With only one study having been found by the researcher in South Africa that deals with the experience of parents raising a child with ADHD, further research is warranted and particularly in terms of how this phenomenon manifests in different cultural groups.

According to Neophytou and Webber (2005), ADHD needs to be understood in the context of cultural expectations. The effects of culture on ADHD remain unclear (Firmin & Phillips, 2009). Hook and Cockcroft (2002) state that the dominant culture in which a child grows up plays a role in how the child is perceived by people in that culture. Culture in this study refers to the "behaviour patterns, beliefs and all other products of a particular group of people that are passed on from generation to generation" (Santrock; as cited in Hook & Cockcroft, 2002, p. 24). Culturally defined stereotypes set the rules for how children should behave (Diamantopoulou, Henricsson & Rydell, 2005) within that culture. This study has therefore focused on Black culture by using black parents in the study.

Within the South African Black communities, there are certain cultural expectations about discipline, respect and obedience concerning children and how Black parents should raise their children (Viljoen, 1994). These values have dominated the culture of Black South Africans for a long time. For the child with ADHD, such cultural expectations about how children should behave around adults may be impossible to meet since children with ADHD are described as resistant to discipline, amongst other things (Still; as cited in Barkley, 1998). When children do not comply with these cultural rules, their behaviour is perceived to be inappropriate and is not tolerated (Diamantopoulou et al. 2005). This makes it difficult for a child with ADHD to behave in a way acceptable within Black cultural norms. Therefore black parents raising a child with ADHD face even more challenges due to cultural expectations that are hard to meet.

There have been historical differences in the number of children diagnosed with ADHD in countries outside of the United States of America (USA); resulting in more children diagnosed with ADHD in the USA than anywhere else in the world (Barlow & Durand, 2005). Recent studies show that there have been improvements in the accurate diagnosis of ADHD worldwide with most countries reporting similar rates of ADHD as in the USA (Barlow & Durand, 2005). Applying the same methodological procedures and diagnostic criterion has been influential in achieving the same rates of diagnosis worldwide (Polanczyk, de Lima, Horta, Biederman & Rohde, 2007). With the increase of diagnosis of ADHD worldwide, ADHD has become a concern for South African Black parents as well; thus a focus on this population.

Critics argue that ADHD is over-diagnosed and children are receiving unnecessary and inappropriate treatment (McLeod, Fettes, Jensen, Pescosolido & Martin, 2007). Media publications about ADHD not being a real or valid disorder fuel confusion in parents in their decision on whether to put their children on medication or not (McLeod et al. 2007). According to Barkley (1998) many children on medication do not show significant improvements. Some children also show significant side effects resulting in parents taking them off the medication. Many parents actually prefer not to use medication on their children (Barkley, 1998). How Black parents handle issues surrounding medicating their children with ADHD is of interest to this study as well.

According to McLeod et al. (2007) the role of diet as a cause of ADHD has been identified as a gap in the proper understanding of ADHD and its etiology. Many people still attribute ADHD to excessive sugar in a child's diet (McLeod et al. 2007). All of this has fuelled further confusion about the understanding of ADHD and its proper treatment. With poor access to health care amongst South Africans in general, unaffordable costs and low availability of services (Goudge, Gilson, Russell, Gumede & Mills, 2009), it is easy to see how parents would rather believe that their children's behaviour is due to too much sugar and therefore need to eat less sugar, than deal with a disorder that would be costly to manage and where proper care would be inaccessible. ADHD therefore, has become a more visible problem in South Africa as well, thus requiring more studies coming out of this country.

While growing up in South Africa amongst the Black population, ADHD was unheard of. The researcher's recent encounters with an increasing number of friends raising children with ADHD has sparked the interest to look not only at ADHD as a phenomenon but at the experiences that parents go through in their lives as they raise their children with ADHD. Many of these parents have stated that they would rather stay at home with their children than attend social gatherings as they fear that their children would be destructive. Some of them have not responded to birthday party or sleep-over invitations due to fear of embarrassment. All the above has made this a phenomenon within the Black South African family that needs exploration; thus the focus of the study on the Black parents' experience.

1.3 Aims and objectives

The aim of this study is to describe the experience of Black parents raising children with ADHD. The objective is to highlight the experiences of Black parents in raising their children with ADHD. This study can help to address the challenges related to raising children with ADHD. The information obtained from this study can help to generate hypotheses about raising a child with ADHD or confirm some of the previous findings on this phenomenon. Clinicians may also benefit by starting to plan intervention strategies that will accommodate the cultural aspects involved in a Black family.

This study therefore would like to create a platform where professionals dealing with families can start a discussion process on how to bridge the gap between diagnosis and actually living with the disorder.

Not much research has been done on ADHD in the Black population. By looking at parenting styles and the Black family, this study aims to explore how these interact not in causing ADHD but in possibly exacerbating the symptoms of a child already vulnerable due to ADHD.

It is hoped by the researcher that this study will raise awareness amongst the Black population of an increasing number of children being diagnosed with ADHD and the experiences that Black parents go through in raising these children. A look at child development has been necessary in this study so as to gain an understanding of how normal and abnormal development may affect the experience of black parents raising children with ADHD.

Lastly, a look at Black parents has been made to expand knowledge from previous studies that were done on other racial groups and also to bring in a cultural view on the phenomenon under study.

CHAPTER 2: LITERATURE REVIEW

2.1 Attention Deficit / Hyperactivity Disorder (ADHD)

2.1.1 History

According to Eisenberg (2007), there was no ADHD in the 1940's; such a term was just not heard of. However, Green and Chee (1997) state that ADHD was described as early as 100 years ago. Silver (1993) on the other hand states that descriptions of overactive children date back to the Old Testament. In 1937, Bradley, a paediatrician, described children recovering from encephalitis as hyperactive and distractible (Silver, 1993).

Even though one of the first references to the disorder was in the poems of German physician Heinrich Hoffman in 1865, much credit is awarded to George Still and Alfred Tredgold as being the first to focus attention on what is today known as ADHD (Barkley, 1998). In 1902, George Still presented a series of lectures describing children from his clinical practice who showed symptoms as seen today in children with ADHD (Karande, 2005).

Minimal brain dysfunction is an early label that was used in the 50's and 60's to describe children now referred to as having ADHD; since their brain injury was somehow unidentified therefore it was assumed that the brain injury was subtle, hard to detect or minimal (Wodrich, 1994). The minimal brain dysfunction was believed to be the root of all inattention, impulsivity and hyperactivity problems. In the 1960's and 1970's, *hyperkinetic reaction of childhood* was used since hyperactivity was singled out as the predominant element (Wodrich, 1994). Children with ADHD were therefore referred to as 'hyperkinetic.'

With the DSM II, came the first official diagnosis of *hyperkinetic reaction of childhood (adolescence),* now referred to as ADHD (Silver, 1993). In the DSM III in 1980, the term was changed to *attention deficit disorder (ADD)* with two subtypes namely ADD with hyperactivity and ADD without hyperactivity. Many researchers felt that inattention was the central deficiency (Wodrich, 1994). The term attention deficit

hyperactivity disorder (ADHD) was introduced in the DSM III-R to reflect that even though inattention was a primary issue, hyperactivity was also a very important factor of the disorder (Silver, 1993).

2.1.2 Diagnostic Features

The DSM IV-TR lists inattention, hyperactivity and impulsivity as common features present in children diagnosed with ADHD (Sadock & Sadock, 2007). Some children may only present with the inattentive subtype whilst some present with the hyperactivity and impulsivity subtype. A few may present with the combined subtype where both features of inattention as well as hyperactivity and impulsivity are present. In addition, the symptoms must be present before the age of 7 years and must be observable in at least two different settings in order for ADHD to be diagnosed (Sadock & Sadock, 2007).

According to Barlow and Durand (2005, p.491), problems of *inattention* include “not listening to others; losing necessary school assignments, books or tools; not paying enough attention to detail and making careless mistakes.” The pervasiveness of these problems across situations and their chronicity is the key to deciding if a child is genuinely inattentive (Wodrich, 1994).

Hyperactivity, on the other hand includes fidgeting, having trouble sitting for any length of time and always being on the go (Barlow & Durand, 2005). Wodrich (1994) states that ADHD children with hyperactivity seem to have a more severe form as they are more likely that those with the inattentive subtype to have conduct problems, to be impulsive, distractible and rejected by peers. ADHD children with hyperactivity are also the ones that are more likely to be referred for treatment than children with the inattentive subtype (Sadock & Sadock, 2007) as well as requiring higher doses of stimulants (Wodrich, 1994).

Finally, *impulsivity* includes blurting out answers before questions have been completed and having trouble waiting turns (Barlow & Durand, 2005). This impulsivity is seen to exist on the same spectrum as hyperactivity (Sadock & Sadock, 2007) therefore suggesting that children with hyperactivity symptoms will

most likely present with impulsivity symptoms as well. Social difficulties expressed by children with ADHD often result from impulse control deficits (Wodrich, 1994).

2.1.3 Clinical features of the disorder

Still (as cited in Barkley, 1998, p. 3-4) described children with ADHD as "aggressive, defiant, resistant to discipline, excessively emotional, passionate, showing little inhibitory volition, manifesting lawlessness, spitefulness, cruelty and dishonesty." He described the most prominent quality of ADHD as the 'immediate gratification of the self.' Hinshaw (1994, p.1) also described children with ADHD as displaying "learning disabilities, antisocial behaviours and being uniformly rejected by peers" which are associated with a negative prognosis. Even though these features are not diagnostic criteria of ADHD, they tend to co-occur with ADHD and are therefore associated features of ADHD.

Of greatest concern to parents and teachers alike is the fact that children with ADHD seem indifferent to punishment as they continue to engage in the same activities they were punished for; almost within hours (Still; as cited in Barkley, 1998). Woods and Ploof (1997) state that the capacity for behavioural conditioning in anticipation of rewards or punishment is fundamental to every human being's nervous system and therefore present at birth. However, children with ADHD seem to condition with difficulty, with the anticipation of rewards or punishment playing little part in motivating their behaviour (Woods & Ploof, 1997). They seem unable to draw from meaningful past experience in order to determine present behaviour; thus repeating the same mistakes over and over (Woods & Ploof, 1997).

What is required, therefore, is far stricter discipline and supervision so that immediate reinforcement follows directly after behaviour and not later thus helping the child link the behaviour with the reward or punishment (Woods & Ploof, 1997). This has to be done constantly and repetitively to facilitate learning (Woods & Ploof, 1997). The parent-child relationship is usually strained as a result, and parental frustration and fatigue develops, self-blame and depression results in mothers of children with ADHD due to their inability control their children (Wodrich, 1994).

2.1.4 Incidence

Grizenko, Shayan, Polotskaia, Ter-Stepanian and Joober (2008) state that ADHD is the most commonly diagnosed disorder in school-aged children, with a prevalence rate of 8% – 12%; thus the focus of the study on this age group. Other studies report a prevalence rate ranging from 2.2% - 17.8% (Skounti, Philalithis & Galanakis, 2007). This highlights great variations in the prevalence rate of ADHD across studies. Some of the variables affecting variability in prevalence rates highlighted by Skounti et al. (2007) include age, gender, population and cultural factors. What is considered abnormal in one culture may be more acceptable in another (Skounti et al., 2007).

Polanczyk, de Lima, Horta, Biederman and Rohde (2007) attribute the variability in prevalence rates to the fact that the ICD-10 and DSM-IV each recommend different ways of establishing diagnosis even though the same list of symptoms is used; resulting in prevalence rates being higher when using the DSM-IV than when using the ICD-10. Nevertheless, most studies agree that the disorder is more prevalent in boys than girls with the ratio ranging from 2:1 to 9:1 (Sadock & Sadock, 2007). In one study done in Taiwan, the over-representation of boys in a sample of Taiwanese children with ADHD also showed, according to Gau (2007), that this concept of more boys than girls does not only apply to Western countries.

2.1.5 Comorbidity

More than half of children diagnosed with ADHD have at least one other disorder (Miranda, Soriano, Fernandez & Melia, 2008). Between 30% and 67% of children with a diagnosis of ADHD meet diagnostic criteria for oppositional defiant disorder (Miranda et al. 2008). Other disorders comorbid with ADHD include conduct disorder and affective disorders (depression and anxiety) (Cosser, 2005). Tic disorder and Tourette's syndrome also occur often in children with ADHD even though in a small minority (Wodrich, 1994).

There is a strong association between ADHD and school problems (Wodrich, 1994). In a study done by Miranda et al. (2008), it was postulated that up to 70% of children

with ADHD show learning disabilities resulting in the need for special education. Having a child with ADHD also increases the risk of having siblings with learning disorders (Sadock & Sadock, 2007). Wodrich (1994) states that disorders of memory, language and visual perception seen in children with ADHD are severe enough to cause failure in the school environment. These learning disorders are devastating for children with ADHD because the children struggle to learn and produce work in class (Wodrich, 1994). Such co-existing problems with behaviour control, problems with learning and social relations are even more disturbing (Wodrich, 1994). They may fail to complete assignments or lose their work resulting in failure since work is not done (Wodrich, 1994).

It seems as if deficits in ADHD such as poor impulse control and attention problems prime the child for behaviour problems which may include arguing, losing one's temper and even stealing (Wodrich, 1994). Children with ADHD often feel they can do little right resulting in anger accruing within them (Wodrich, 1994). Such anger may escalate into unacceptable conduct. A child with ADHD who has experienced little success in socially accepted behaviours such as school and family may turn to unacceptable antisocial activities for success (Wodrich, 1994). With repetition of these acts, conduct disorder may ensue (Wodrich, 1994).

With comorbid disorders, it is clear how such added problems can intensify the experience of parents raising children with ADHD.

2.1.6 Theories

2.1.6.1 Evolutionary: The Hunters and Farmers Theory

Munden and Arcelus (1999) believe that ADHD occurs far too frequently to place those who have it at a disadvantage. They believe therefore that there should be some evolutionary advantage for those who have this disorder. About 200 000 years ago, the symptoms of ADHD would have been an advantage to those who had them (Munden & Arcelus, 1999). A hunter would need to be able to drop whatever he was doing in order to chase after prey (Munden & Arcelus, 1999). For his family to eat he would have to disregard the risks of chasing the prey and his impulsiveness and aggression in so doing would be seen as an advantage (Munden & Arcelus,

1999).The 'response readiness' of people with ADHD would be also adaptive in brutal or harsh physical conditions (Munden & Arcelus, 1999). However, modern society has become industrialised, organised and safer with the 'response ready' traits of ADHD becoming a disadvantage rather than an advantage (Munden & Arcelus, 1999).

With the advent of the agricultural revolution, man has needed to plan more carefully as they prepare land to sow taking into account the seasons and the weather (Munden & Arcelus, 1999); thus rendering the 'response readiness' quality of ADHD obsolete.

2.1.6.2 Biological

Flick (1996) sees ADHD as a disorder with a physiological basis, thus affecting the living person's functioning. Abnormal electroencephalogram (EEG) patterns have been found in children with ADHD which have been used as evidence for increased arousal in these children when compared to normal controls (Sadock & Sadock, 2007). According to Flick (1996), under normal circumstances, the responses of a child are often automatic due to an innate design for adapting to differing situations. However, a child with ADHD must compensate for the deficiencies in the nervous system physiology which causes them to react in ways that get them into trouble (Flick, 1996). These children are therefore "slaves to their own nervous system" (Flick, 1996, p. xii).

Frontal lobe dysfunction has also been implicated in ADHD (Koziol & Stout, 1993). This is shown by impairment in sustained attention and verbal fluency when conducting neuropsychological tests with these children (Koziol & Stout, 1993). Positron Emission Tomography (PET) scan studies have shown under-activity in areas of the brain involved in motor planning and control and those areas that control arousal and attention (Wodrich, 1994). Some studies have found decreased blood flow and less electrical activity in brain centres related to planning and control. Neurotransmitters were also found to be deficient in portions of the brain related to rewards and punishment in children with ADHD (Wodrich, 1994).

Deficits in executive functioning as seen in children with ADHD are viewed to be due to one core deficit i.e. poor inhibitory control (Durston, 2003). The behavioural inhibition system (BIS) is responsible for each person's ability to slow down when faced with impending punishment (Barlow & Durand, 2005). However, when this brain system is not functioning at its optimum level in an individual, fear and anxiety that is produced by the BIS is less prominent resulting in children such as those with ADHD acting impulsively (Barlow & Durand, 2005). The impulsivity seen in children with ADHD can therefore be seen to be due to the BIS that could be malfunctioning.

Barkley (2000) believes that impulsivity and hyperactivity are part of the same problem which is behavioural inhibition. This behavioural inhibition, according to Barkley (2000), is the hallmark symptom of ADHD. Most problems experienced by children with ADHD therefore stem from their inability to inhibit behaviour.

Dr Bronowski proposed more than thirty years ago that what makes humans different from animals is our ability to delay a response i.e. we have an ability to wait for a period of time before responding (Barkley, 2000). This allows for past experiences to inform current ones thus allowing us time to respond appropriately (Barkley, 2000). However, children with ADHD do not possess this ability as they do not seem to learn from past mistakes (Barkley, 2000). This ability to inhibit behaviour is controlled by the orbitofrontal cortex which has been found not to be as active in people with ADHD (Barkley, 2000).

A location of single genes has not been confirmed in the psychopathology of ADHD, but rather an interaction of multiple genes located in different chromosomes (Hinshaw, 1994). Grizenko et al. (2008) believe that between 75% and 80% of ADHD symptoms are due to genetic factors. Children with ADHD are far more likely than those without to have relatives especially fathers and uncles with ADHD (Wodrich, 1994). ADHD has also been found in siblings of children with ADHD (Wodrich, 1994). This implies a genetic factor as contributing to the emergence of ADHD. ADHD is also associated with family members who have histories of aggression, legal difficulties and mood problems (Wodrich, 1994). Studies of twins also suggest a genetic component since identical twins both had the disorder far more frequently than when fraternal twins were looked at (Wodrich, 1994).

However, studies involving actual brain damage such as head injury, stroke or brain infection have failed to account for cases of ADHD (Wodrich, 1994). Furthermore, studies looking at lack of oxygen at birth or prematurity have also shown a weak association with the development of ADHD (Wodrich, 1994). This suggests a lack of agreement amongst studies on the biological aspects of ADHD.

2.1.6.3 Psychological

Psychologists view behaviour as resulting from an interaction of genetic and environmental influences (Woods & Ploof, 1997). Therefore ADHD can be viewed to be a result of innate qualities as well as influences from parents, teachers and even the community in which a child is raised. This makes the detection and targeting of specific genes difficult (Hinshaw, 1994). Rather, biological or environmental predisposing factors as well as precipitating factors all together combine to promote such behaviour as seen in children with ADHD (Hinshaw, 1994). Other factors may maintain or escalate disordered behaviour. Therefore, even though the causes of ADHD may not be related to the environment specifically, the environment may maintain or exacerbate disordered behaviour as seen in children with ADHD (Hinshaw, 1994).

2.1.6.4 Social

Maternal exposure to severe stress during pregnancy has been shown to increase the chances of having a child with ADHD (Grizenko et al. 2008). Maternal smoking or uses of alcohol during pregnancy have shown no clear causative role with ADHD (Wodrich, 1994). Parents of children with ADHD in turn have an increased incidence of hyperkinesis, sociopathy and alcohol use disorders (Sadock & Sadock, 2007). Learned behaviour in addition to inherited characteristics may be what is seen in children with ADHD (Wodrich, 1994).

Certain food colourings and additives have been proposed as possible causes of ADHD (Wodrich, 1994). Other concerns relate to sugar as an energy source and how it causes stimulation in the brain which leads to hyperactivity (Wodrich, 1994). However, other studies have failed to replicate these findings (Wodrich, 1994). Environmental lead has also been proven as having a weak association to ADHD symptoms (Wodrich, 1994).

2.1.7 Treatment

According to Brinkman et al. (2009), parents raising children with ADHD are faced with an enormous task of making a decision on whether to medicate their children or not. This causes parents a wide variety of stressors as they decide how to handle their child with ADHD (Brinkman et al. 2009). The decision by parents to seek treatment is often based on parents experiencing doubt in their own ability to handle their children, struggles they face as parents on a daily basis at home and at school and parental conflict amongst themselves as parents (Brinkman et al. 2009).

For most children with ADHD, medication is an important part of treatment and Ritalin is the most frequently prescribed psycho-stimulant (Richard & Russell, 2001). For lasting effects, clinicians advise combining treatment with other forms of treatment such as behaviour therapy and emotional counselling (Richard & Russell, 2001). Medication seems to be critical between the years 6 and 12 so as to avoid scholastic and social problems with peers (Richard & Russell, 2001). Whilst there are side effects to medication such as losing weight, losing appetite and temporarily growing slowly, most doctors believe that the drugs can be adjusted to the benefits of each child and mostly the benefits outweigh the potential side effects (Richard & Russell, 2001). Some of the short term benefits of medication include “a decrease in impulsive behaviour, hyperactivity, aggressive behaviour and inappropriate social interaction; with an increase in concentration, academic productivity and effort directed towards a goal” (Richard & Russell, 2001, p.95).

Even though medication is the first line of treatment for children with ADHD, there is increasing interest in multimodal approaches to treatment of ADHD (Poncin, Sukhodolsky, McGuire & Scahill, 2007). Behavioural interventions are often used in combination with treatment or alone. However, current research has failed to show the benefits of behavioural interventions on ADHD symptoms, when added to medication or when used alone (Poncin et al. 2007).

According to Barkley (1998) many children on medication do not show significant improvements. Some children also show significant side effects resulting in parents taking them off the medication (Barkley, 1998). Many parents actually prefer not to

use medication on their children (Barkley, 1998). Such arguments leave parents bewildered about the right course of action in helping their children with ADHD.

2.2 The Black Family

Little is known about ADHD in the Black population (Meyer, Eilertsen, Sundet, Tshifularo & Sagvolden, 2004). Preliminary research indicates that ADHD is the most diagnosed child psychiatric disorder in South Africa (Meyer; as cited in Meyer et al. 2004). ADHD-like behaviour has been observed in South African cultures proving that ADHD is not just a specific product of US and European cultures (Meyer; as cited in Meyer et al. 2004).

Although families all over the world have similarities, Western textbooks on the family are often unsuitable for a full understanding of the dynamics of Black South African family life (Viljoen, 1994). Amongst Black South Africans, there are many different language groups and a wide range of cultural histories and traditions (Anderson, 2005). Although there is diversity within African cultures, "certain commonalities are found in terms of value systems, beliefs, practices and others" (Mnyaka & Motlhabi, 2005, p.215). Certain values and norms underlie the family life of Black South Africans (Viljoen, 1994). These commonalities constitute the African worldview (Mnyaka & Motlhabi, 2005).

The most abiding principle of this worldview is known as the notion of *Ubuntu* (Mnyaka & Motlhabi, 2005). Understanding *Ubuntu* is crucial in understanding Black South African culture (Hanks, 2008). According to Hanks (2008) *Ubuntu* is the glue that holds African communities together despite what the West would consider to be overwhelming struggles and difficulties.

The word *Ubuntu* is found in almost all South African languages: "*Ubuntu* (Nguni), *Botho* (Sesotho), *Vumunhi* (XiTsonga) and *Uhuthi* (TshiVenda)" (Mnyaka & Motlhabi, 2005, p.215). *Ubuntu* is often used by many South Africans in different contexts and its meaning is often misunderstood (Bonn, 2007). Sindane (as cited in Bonn, 2007) looks at various definitions of *Ubuntu* and the concepts of respect for others, universal brotherhood for Africans, sharing and treating others as human beings

come out strongly. Bonn (2007, p.864) adds by stating that *Ubuntu* encompasses: *"compassion, tolerance, care, charity, understanding, empathy, equality, hospitality, honesty, trust, conformity, solidarity, mutual responsibility, taking care of everyone in one's community, respect, dignity and a concern for other's welfare."*

Respect for a person has dominated Black families for a long time and is very high on the notion of *Ubuntu* (Mnyaka & Motlhabi, 2005). It is "the basic pillar upon which all value systems rest;" with authority coming close to that (Viljoen 1994, p.19). Respect and obedience are often 'taken for granted' as a reality in the socialisation process of Black children (Viljoen, 1994). Therefore, a decline in respect and obedience is seen in the Black family as a decline in the authority of parents (Viljoen, 1994). Such a decline in parental authority in turn is often accompanied by feelings of helplessness and confusion over loss of authority over one's own children or loss of basic pillars upon which the family is formed (Viljoen, 1994).

Discipline is seen as one of the primary responsibilities of parents in raising a Black child (Makweya, 1998). A Black child is expected to know the difference between right and wrong (Makweya, 1998). However, "parents are finding it increasingly difficult to discipline children that attack them" (Makweya, 1998, p. 66) as is often seen in children with ADHD, which is accompanied by comorbid aggression and violent behaviour which are identified as associated characteristics of ADHD (Still; as cited in Barkley, 1998).

Due to migration, where Black fathers had to go and search for labour elsewhere, spouses had to rely on extended family members for support in raising their children (Anderson, 2005); a term called kinship. Kinship is an important metaphor to use in understanding how Black families organise around each other in terms of their neighbourhood and friendship ties (Ross, 1995). Kinship is important to understand in this study because Black families rely on such extended family and social support in coping with the stress of raising their children. Such kinship is seen as strength in Black family life (Viljoen, 1994). These strong kinship networks are able to deal with and embrace developmental challenges (Katabarwa, Richards & Rakers, 2004). The dispersion of dependents, especially small children amongst one's kin is a popular practice in Black families (Ross, 1995). In the past this was done to alleviate the

burden of caring for them if the family was poor or to make the children available for domestic and agricultural tasks in their extended families (Ross, 1995).

These practices form part of indigenous knowledge systems, which are localised systems developed over a long period of time (Nkosi & Daniels, 2007). These knowledge systems are not scientific or written down but are accumulated understandings that apply to non-Western rural societies (Asibey; as cited in Nkosi & Daniels, 2007). Because these knowledge systems are localised, they are difficult to transmit to other societies (Nkosi & Daniels, 2007). They enable families to view life in a holistic manner with a deep connection amongst the people, ancestors and religious beliefs and these are highly respected (Nkosi & Daniels, 2007). Indigenous knowledge systems provide the inner strength in Black families to endure hardships and make something out of nothing (Nkosi & Daniels, 2007).

However, with growing urbanisation, modern Black families are characterised by individualisation and competition amongst each other (Makweya, 1998). Such alienation may in turn impact the transmission of indigenous knowledge systems within the black community. Interaction with Western values has resulted in the dilution of important values resulting in the Black family not being as traditional as it was (Bonn, 2007). By the traditional Black family, this study refers to the pre-colonial period where family members were enmeshed in a web of relationships (Viljoen, 1994). The neo-colonial period had a radical effect on traditional family structures and was experienced as the disintegration of basic family structures (Viljoen, 1994).

Such gradual decay, decline and disorganisation in the families of Black South Africans are of great concern (Viljoen, 1994). The transition of Black families from rural to urban environments is seen as having contributed to a decline of parental authority (Viljoen, 1994). South African society is in the midst of change and in times of change some traditions are forgotten and lost; including *Ubuntu* (Bonn, 2007). A breakdown in kinship networks and sharing of knowledge systems is also seen (Bonn, 2007).

“Migrant labour system, influx control, forced settlement and pass laws have been some of the contributors to this breakdown of African family laws that existed during

Apartheid" (Kadalie; as cited in Nkosi & Daniels, 2007, p.13). Further breakdown of the Black family amongst the middle class and the working class has been due to high divorce rates (Nkosi & Daniels, 2007). However, certain value systems still remain thus putting an even extra burden on the modern family and its multiple roles (Viljoen, 1994).

2.3 Parent's Experience

A description of the value systems and norms as seen in Black South African families has been useful in this study in order to get a better understanding of some of the challenges that Black parents go through in general. Such challenges seen in cultural expectations such as discipline and sense of authority become difficult to maintain not only due to Westernisation of the Black family but also due to problems encountered with children who have ADHD as it becomes difficult for parents to discipline them or even teach them these values. Parent's experience of their child will be grounded in the cultural milieu they exist in.

Children function within a family system and therefore their behaviour has an effect on how parents view themselves as parents, especially mothers who are often blamed for their child's inappropriate behaviour (Neophytou & Webber, 2005). Traditional principles or theories on parenting that emphasize parental authority and children's obedience perpetuate the blaming of the mother for the lack of authority for the behaviour of their children with ADHD (Gau, 2007).

Parenting manuals often state that a "good child goes to bed quietly when told, does not fight violently with siblings, follows instructions, is well mannered and does not whine or throw tantrums" (Neophytou & Webber, 2005, p.315). As a result, parents raising children with ADHD often ask themselves if they are good enough parents, thus questioning their parenting abilities (Neophytou & Webber, 2005). This results in parents feeling that their child's ADHD is somehow their fault and maybe if they could have been stricter it would have changed the situation (Smith, 2002).

Furthermore, grandparents tend to blame parents for not doing enough, not being disciplined enough, organised enough and not giving direct help to the child; whilst

neighbours can be intolerant of a child who is hyperactive and has low frustration tolerance or exploding at each hurdle (Smith, 2002). Socialising is also an extremely difficult time for parents since a family day out seems to cause children with ADHD excitement resulting in hyperactivity which is often embarrassing to parents and leaves them worn out physically (Dean, 2005). Again, this experience makes parents feel inadequate as they continue to be blamed by strangers for not being able to control their children (Dean, 2005).

Fathers too tend to blame the mothers for indulging the behaviour of a child with ADHD which is distressing to the mother and results in problems in the marriage (Singh, 2003). Gau (2007) states that most mothers of children with ADHD perceive themselves to be receiving less family support. These mothers report severe behavioural problems in their children with ADHD at home with frequent parent-child conflicts (Gau, 2007).

A mother's self esteem seems to contribute to her experiencing psychological distress and an elevated sensitivity to the criticism by others of her parenting techniques (Vitanza & Guarnaccia, 1999). The mother's experience in raising a child with ADHD is often influenced by her own temperament, coping style, attitudes of her husband and extended family and financial resources to cope with the need for professional services (Segal, 2001) thus indicating that some mothers cope better than others in raising a child with ADHD.

Parents raising children with ADHD, especially children with comorbid oppositional defiant and conduct disorders, report lower marital satisfaction, engage in more overt inter-parental conflict and use more negative talk in their child-rearing practices (Wymbs, Pelham, Molina & Gnagy, 2008). According to Elias (2008), parents of children with ADHD are almost twice more likely to divorce by the time their child is 8 years old than parents of children without the disorder. In their effort to meet the challenges of a child with ADHD, the couple can strengthen their bond though and give themselves a sense of accomplishment (Elias, 2008).

According to Flick (1996), parents of children with ADHD often try the usual commands and discipline without success, thus causing frustration, anger and more

strict demands and commands being placed on the child. Whatever resource parents use to help their children, they still worry that they are not doing a good enough job (Smith, 2002). Eventually parents may give in and just let the child have their way. This Flick (1996) calls a state of 'learned helplessness' where parents feel they have tried everything and nothing has worked. Such parents often feel a sense of poor self-concept (Flick, 1996). This can be compared to the *learned helplessness theory of depression* as conceptualised by Martin E.P. Seligman (Barlow & Durand, 2005).

According to the learned helplessness theory, people become depressed when they decide they have no control over the stress in their lives (Barlow & Durand, 2005). They give up trying and become helpless about their situation and do not foresee any change in the future; which can lead to depression (Barlow & Durand, 2005). Studies show that there is a link between maternal depression and ADHD in their children (Lange et al. 2005).

According to Burke, Pardini and Loeber (2008), child disruptive symptoms often influence parental behaviours rather than vice versa. Parents of hyperactive children tend to give in to their children's misbehaviour (Keown & Woodward, 2002). The parents' ability to effectively manage their children's behaviour is usually strained, with the mother often coping less effectively than the father (Keown & Woodward, 2002). Children with disruptive behaviours also affect their parent's mental health with most parents suffering from stress, depression and fatigue (Kashdan et al. 2004).

Because an African individual is a communal being, inseparable from others (Mnyaka & Motlhabi, 2005), when a family member is in distress, other family members are affected by it as well (Silver, 1993). Parents, brothers, sisters and grandparents are all affected. When it comes to their other children without ADHD, parents feel guilty for not spending enough time with them as most of the time is dedicated to the child with ADHD (Dean, 2005). Parents often have a lot to manage in their relationship as husband and wife without having to deal with additional family stress (Silver, 1993). Having a child with ADHD stirs certain emotions and feelings that most parents find difficult to handle (Silver, 1993). Feelings of anguish, fear, anger, guilt and shame are quite common (Silver, 1993). This may result in denial

and 'cover up' of the child's condition which in turn causes the child with ADHD to feel unaccepted by their parents (Silver, 1993).

According to Smith (2002), even after diagnosis, parents go through a lot of emotions before they can face the truth about their child's difficulties. Parents may go through emotions like Kubler Ross's stages of grief where they may initially deny that there is a problem and rationalise why it is not a problem (Smith, 2002). They may have to deal with the fear, the anger and the guilt of having a child with difficulties. Parents themselves may want to blame somebody and may for a while believe that changing neighbourhoods, schools or doctors might make the problem go away (Smith, 2002). They generally have to grieve for what might have been before a process of acceptance of their child's strengths and weaknesses begins (Smith, 2002).

Smith (2002) also states that at times parents feel confused because they feel that their children are 'smart' know a great deal and seem to reason well and yet they cannot read or write. Confusion also occurs because teachers, doctors, psychologists and social workers may disagree not only on the diagnosis but also on the best way to manage a child with ADHD (Smith, 2002). This is anxiety-provoking for parents and also increases their frustration as they need to decide what is best for their child (Smith, 2002).

Even with all the multimodal therapies promised for children with ADHD, parents report that their children with ADHD have never been offered any extra form of therapy except for the medications (Dean, 2005). This, Dean (2005) believes, makes parents feel that the majority of professionals just do not care as they have to go back to their 'normal' lives whilst it is parents with children who have ADHD that have to struggle on their own.

Interestingly, giving medication to boys with ADHD may contradict the father's understanding of how boys should behave often resulting in a lack of acceptance of the diagnosis and the medication by fathers who have to face their own understandings of themselves and how they were as young boys, according to Singh (2003). This is in contrast to the mothers who tend to believe the medical explanation

for their son's behaviours (Singh, 2003). Father's feelings of personal failure, weakness and suspicions from wives regarding their husband's potential pathology are likely to impact the father's self esteem, the marital relationship and the relationship between father and son (Singh, 2003). Fathers also reported not revealing their son's difficulties to anyone outside the home resulting in them carrying a heavy burden by themselves with no support (Singh, 2003).

Misconceptions about psychopharmacological treatment are common, resulting in parents raising children with ADHD being hesitant about giving their own children medication (Dosreis & Myers, 2008). Many parents actually believe that ADHD medication makes their children 'zombies' resulting in poor compliance to medication (Dosreis & Myers, 2008). Dosreis and Myers (2008) further state that this is due to the fact that many parents do not view ADHD as a medical disorder but rather as a behavioural problem.

Many parents experience mornings, afternoons and bedtime as the most difficult times when raising a child with ADHD (Firmin & Phillips, 2009). The morning routine seems to exert pressure for school-going children in terms of managing the time before leaving home and making it in time for school. Parents feel that no matter how early they wake up, they always end up running out the door (Firmin & Phillips, 2009). After school homework-time has also been listed as challenging to parents as the children are likely to be tired and more distracted, whilst bedtime was another difficult time where parents' fatigue contributed to less patience in dealing with a child with ADHD especially when trying to calm them down (Firmin & Phillips, 2009).

It does seem that school is always a constant struggle as parents do not always know what is right for their children (Dean, 2005). Keeping them in a mainstream school may prove a nightmare as children are sent home regularly for being unruly, resulting in them missing a lot of classes and ending up with a fragmented sense of what they have learned (Dean, 2005). Parents also have to deal with mainstream schools not making an effort to give their children with ADHD lunchtime medication as prescribed (Dean, 2005). This causes problems as children start to be restless and disruptive once the medication wears off (Dean, 2005).

Firmin and Phillips (2009) believe that some parents of children with ADHD do show a high degree of involvement in their children's lives. With involvement in support groups, as shown in parents used in this study, the parents are educated about the clinical aspects of the disorder (Firmin & Phillips, 2009). Most parents agree that routine and structure are the most helpful in dealing with their children with ADHD (Firmin & Phillips, 2009). These routines have to be reinforced over and over again as there is no such thing as habits when dealing with ADHD, but constant routines (Firmin & Phillips, 2009).

Therefore, the parents' choice to adjust their lifestyles contributes to success in dealing with a child with ADHD (Firmin & Phillips, 2009). With most studies reporting a state of helplessness experienced by parents raising children with ADHD, Firmin and Phillips (2009) have brought a fresh perspective to prove that parents who show high involvement in their children's lives can experience success in raising their children with ADHD.

Parenting approaches that include "clear, concise instructions, structure without rigidity, nurturing a child's gifts and interests and constant approval of positive behaviour helps the children feel safe" (Smith, 2002, p.254). Herself a mother of three boys with ADHD, Dean (2005) explains how home life has to be so organised as to resemble a military regime rather than a normal relaxed home.

2.4 Parenting Style

Parents vary in their approach to child-rearing (Smith, Cowie & Blades, 2003). According to Smith et al. (2003, p.119), "authoritarian parents have strict ideas about discipline and behaviour that are not open to discussion, resulting in socially rejected children." An authoritarian parenting style has been shown to occur mostly in families with a child with ADHD (Lange et al. 2005).

Families who show intolerance and are punitive to inattention, over-activity and impulsivity exacerbate symptoms of ADHD in vulnerable children (Lange et al. 2005). Parents of children with ADHD tend to use more aggressive discipline methods (Lange et al. 2005). Often this does not result in parenting satisfaction in these

families (Lange et al. 2005). Mothers of children with inattentive-impulsive behaviour seem to show lower self-esteem and power-assertive parenting or force when parenting (Gerdes & Hoza, 2006). This is due to mothers viewing their children's behaviour as uncontrollable which induces frustration in the mother (Gerdes & Hoza, 2006).

Mothers of children with ADHD who show depressive and anxiety symptoms were less affectionate and more controlling with an overprotective parenting style (Gau, 2007). Parents often resort to loud commands and threats of punishment in trying to discipline their children (Wodrich, 1994).

Fathers, on the other hand, are often absent in forums or discussions that relate to parents and their children with ADHD (Singh, 2003). It has been shown that boys, in particular, behave better with their fathers than with their mothers (Singh, 2003). An authoritarian fathering style has been shown to be related to more positive behavioural outcomes in children with ADHD resulting in less antisocial behaviour towards their peers (Singh, 2003). Less effective parenting practices in mothers has been shown to be related to the severity in the behavioural disturbance of a child with ADHD (McLaughlin & Harrison, 2006).

Expressed emotion is a measure of parental attitude and informs us about the home environment (Peris & Hinshaw, 2003). It looks at critical and over-involved parental attitudes towards children with ADHD. Results have shown that high expressed emotion is associated with ADHD and aggression, with criticism having the greatest influence on ADHD symptomatology (Peris & Hinshaw, 2003). Being surrounded by too much negativity results in poor self esteem (Wodrich, 1994). The children therefore suffer from depression-related problems such as discouragement and demoralisation (Wodrich, 1994).

Parenting style in the traditional Black family is that of 'unquestioning disobedience' which can be viewed as a more authoritarian style (Viljoen, 1994). This means that parents do not ask what happened and why but will punish and possibly ask later. Such typical authoritarian parenting style as seen in Black families has been associated with exacerbation of symptoms of ADHD (Lange et al. 2005) which is a

good motivation for investigating parenting style in Black families when looking at ADHD.

In an interview that Schipani (2008) did with Martin Kutscher, one of the ways he advises in handling a child with ADHD is that rather than useless shouting or punishments which do not work, parents should find something to praise. It is important for parents to stay calm as no one can think clearly when overwhelmed, according to Schipani (2008).

Looking at the parenting style has been useful for this study to see if any of the forms of discipline used by the parents in the study contributes to exacerbating the symptoms of ADHD or curbing them.

2.5 Child Development

A child's development can be looked at in terms of the physical i.e. shape and size, the cognitive domain i.e. mental abilities and activities, and the psychological development; which is in terms of its behaviour and emotional responding to social circumstances (Hook, 2002).

The developmental theory chosen for this study is the ecological systems theory by Urie Bronfenbrenner. By ecology the researcher here refers to the interaction of people, not only with each other, but also with their environment (Fourie, 1998). The approach is systemic in the sense that there are different levels of interaction that the individual encounters and these different levels of interaction are also called subsystems (Fourie, 1998). The family, school and peers all map what is termed 'circles of influence' in a child's life and the behaviour seen in children is a reflection of these immediate circles of influence (Brendtro, 2006). A developing child, in turn, has a reciprocal relationship with the environment in which he develops meaning that whilst the environment influences how a child develops; a child also can impact the environment in various ways (Bronfenbrenner; as cited in Hook, 2002).

In Bronfenbrenner's theory, a positive or healthy development requires trusting bonds with "caring parents, supportive teachers and positive peers" which he termed

a “healthy ecology” (Brendtro, 2006; p.163). According to Brendtro (2006, p. 164), a healthy ecology is where the child is: *“Bonded to caregivers who offer positive discipline, teachers are supportive resulting in academic success and peers are accepting resulting in pro-social values.”*

High risk ecology or abnormal development, on the other hand, is where the child experiences: *“insecure bonds, inconsistent discipline, conflict with teachers, academic failure, peer conflict resulting in antisocial values”* (Brendtro, 2006; p.164).

Before Bronfenbrenner, “psychologists, sociologists, educators, anthropologists and other specialists all studied narrow aspects of a child’s world” (Brendtro, 2006, p.163). Bronfenbrenner’s theory has created a new field of study referred to as the ecology of human development (Brendtro, 2006). Bronfenbrenner’s theory of development offers equal importance to the environment of development i.e. ecology, as well as the developing child (Hook, 2002). Unlike other theories of development, in this theory, the child does not become the problem but their circle of influence i.e. the system within which they operate or are raised. (Brendtro, 2006). This is important in this study as the literature above stated that the environment interacts with biological aspects to produce the behaviour seen in children with ADHD.

Bronfenbrenner’s approach conceives of development as an ecological chain of associated influences (Hook, 2002). In other words, a child’s development is affected by the mother, the immediate family, the school environment and so on (Hook, 2002). A child’s healthy development is further entwined with the role it demands from parents, the stresses it place on the parents, the presence of family friends and neighbours. One therefore needs to look at ‘multiperson systems of interaction’ (Bronfenbrenner; as cited in Hook, 2002).

Bronfenbrenner’s ‘multiperson systems of interaction’ is divided into five layers: the microsystem, mesosytem, exosystem, macrosystem and the chronosystem (Feinstein, Driving–Hawk & Baartman, 2009). Bronfenbrenner uses the example of a collection of Russian dolls to describe how the layers are stacked inside each other, thus also indicating that each layer influences the other (Hook, 2002). Each layer, or

each subsystem, exerts some influence on a developing child and influences how children experience their environments (Hook, 2002). This in turn influences how the parent experiences their child. For the purposes of this study, the researcher will only focus on the exosystem and the macrosystem and how these may impact on the experience of a Black parent raising a child with ADHD. The impact of these two systems will now be looked at.

The exosystem refers to the social setting extending beyond the individual's immediate experience, which nevertheless affects them (Hook, 2002). The exosystem includes, amongst others, the interaction of parents with the extended family or next of kin (Hook, 2002) which are important for this study due to the focus on Black culture. Decisions and relationships of the parent with the exosystem exert an indirect influence on a child's life (Feinstein et al. 2009), which in turn has a direct impact on the parent's experience. Extended family plays an important role in Black families and their children since they offer guidance and support, especially during stressful times (Feinstein et al. 2009). Extended family members may reject children with ADHD due to them being perceived as unruly (Wodrich, 1994). This will have a negative impact on the parent raising a child with ADHD since Black parents rely on kinship networks in relieving the stress of raising children (Ross, 1995). Stress caused by the lack of extended family relations between the mother and members of her extended family affects the child's development and their relations with cousins and other family members (Swick & Williams, 2006).

The macrosystem refers to the "cultural values, customs and societal laws of the individual's community"; with the emphasis being on the community (Feinstein et al. 2009, p.13). Bronfenbrenner believed that it takes more than one person to raise a child (Brendtro, 2006). Therefore community support is of utmost importance when raising a child. This agrees with Black South African culture as stated by Mnyandu (as cited in Bonn, 2007), that it is the duty of the community to raise a child. Brendtro (2006) believed that this leads to normal development whereas 'solo parenting' is seen as disruptive to a child's development.

Bronfenbrenner's theory has been chosen for this study because of its phenomenological quality in the sense that subjects perceive their environment and

experience them themselves (Hook, 2002). How each person's environment is described then relies on how that particular person perceives it. In addition, Bronfenbrenner's theory is multicultural therefore allowing the environment to be experienced by the person based on their culture and the expectations of that culture (Hook, 2002). This has been an important factor in this study since the emphasis on culture has been embraced by the researcher.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The epistemological position taken by the researcher for this study is phenomenological because it is the belief of the researcher that the specific data regarding the experience of raising a child with ADHD are contained within the parents that raise children with ADHD. Such parents know best how to describe such an experience and so the participants of the study are the parents themselves. The researcher has therefore chosen phenomenology as a theoretical basis for this study.

3.2 Phenomenological Research

According to Patton (as cited in Cosser, 2005), with phenomenological research, the researcher also has a personal interest or is intimately involved with the phenomenon being studied. With the researcher's experience with close friends who have children with ADHD, the parents' experience has become a visible problem as its effects reverberate to the extra familial, of which the researcher is a part.

According to Reeder (1986, p. 1), phenomenology is a "self-critical methodology for reflexively examining and describing the lived evidence (phenomena) which provides a crucial link in our philosophical and scientific understanding of the world." Phenomenology attempts to ask how one knows a phenomenon exists and then it focuses on describing the lived evidence of the phenomenon (Reeder, 1986). The phenomenological method is also reflexive in that it allows the researcher to reflect back on their own experiences of the phenomenon under study (Reeder, 1986). Such human experience is important to science as it forms the basic evidence for our claims about the world (Reeder, 1986).

The phenomenological movement arose in Germany before the First World War and is regarded as both a research method, a philosophy and an approach (Dowling, 2004). Husserl is regarded as the founder of phenomenology (Reeder, 1986).

Husserl held the traditional empiricist view as he believed that all knowledge is based on experience (Reeder, 1986). Reeder (1986) continues by stating that Husserl's method is regarded as eidetic or descriptive and is sometimes referred to as objective hermeneutics. Husserl called his method *phenomenological reduction, bracketing* and *epoche* (Reeder, 1986).

The effort to maintain objectivity is central to Husserl's method and is called *bracketing*; meaning the suspension of all biases concerning the phenomenon being researched before collecting the data related to it (Dowling 2004). Such bracketing is what differentiates descriptive phenomenology from interpretive phenomenology (Dowling 2004). Heidegger, on the other hand, is regarded as the founder of hermeneutics or interpretive phenomenology (Dowling, 2004). His work differs from that of Husserl in the sense that Heidegger suggested that presuppositions may not be eliminated by the researcher when conducting research (Dowling, 2004). The interpretive enquiry stipulates that the researcher's biography be recognised as a vital part of what is being studied (Dowling, 2004). Therefore, interpretive phenomenology must be informed by existential thought (Darroch & Silvers, 1982). With interpretive phenomenology, researchers give their own insights into the phenomenon under study and the meanings associated with it (Kleiman, 2004).

Nevertheless, phenomenological approaches have in common the commitment to people's realities and their lived experiences (Darroch & Silvers, 1982). Husserl's descriptive phenomenology has been chosen for this study. Even though with this method, imposing steps may seem like doing great injustice to the phenomenon under study, some guidelines are necessary for researchers.

3.3 Research design

A qualitative research method was used as a research design. When one traces the history of qualitative methods in psychology, Ashworth (as cited in Devlin, 2006) reports that psychologists have always been interested in studying the experience of individuals without the knowledge of how to go about studying that experience. Qualitative approaches to research have therefore filled that gap for psychologists.

The work of Husserl, amongst others, helped pave the way for the emergence of interest in qualitative psychology as seen today (Ashworth; as cited in Devlin, 2006).

Unlike quantitative approaches, qualitative research methods aim at understanding a particular phenomenon of interest without testing hypothesis but rather generating hypotheses (Averbach & Silverstein; as cited in Devlin, 2006). Qualitative researchers are curious about daily social interactions and the meanings the participants themselves attribute to these interactions, thus grounding qualitative research in the lived experiences of people (Marshall & Rossman, 2006).

3.4 Participants

Phenomenology captures the phenomenon as it appears in daily life (Cosser, 2005). This was useful for this study since the aim was to look at the experiences of parents as they go through raising children with ADHD in their daily life. Participants must have lived the experience of interest. The parents that were used in the study are raising their children themselves and therefore live the experience of raising a child with ADHD.

Purposive sampling was therefore used in this study. Purposive sampling refers to precisely what the name suggests in that the sample is chosen with a purpose in mind (Ritchie, Lewis & Elam, 2003). The researcher chose participants because they have particular features that will enable understanding of the phenomenon under study (Ritchie et al. 2003).

In this study participants were accessed through the Attention Deficit Association of Southern Africa (ADHASA) which is an organisation offering support to families with children with ADHD. The advantage of using this organisation is that the children have already been diagnosed through educational or medical systems (Cosser, 2005). The researcher sent an email to ADHASA requesting permission to use their database specifically looking at Black parents with children who have ADHD and are within the ages of 6 and 12 years of age. Permission to use the database was granted by ADHASA. ADHASA then sent a bulk email on the researcher's behalf to all Black parents on their database who have children with ADHD and are within the

ages of 6 and 12 years. Looking at the impact of ADHD at this level of development was important because this stage involves schooling and peer relationships (Teeter, 1998) which are known as the greatest challenges in the development of children with ADHD.

Five participants in total were interviewed by the researcher. Out of the email sent by ADHASA only two Black parents that fit the profile the researcher was looking for responded. The other three participants were acquired through snowball sampling. Snowball sampling is a method used to increase the sample by asking participants to recommend others they know fit the profile and would be interested in the study (Devlin, 2006). Participants are added until the needed data requirements are met or data reaches saturation where no new information is brought by the addition of more participants (Kleiman, 2004). This according to Giorgi (as cited in Kleiman, 2004) usually ranges from one to a maximum of ten participants. Using this method allowed the researcher a maximum of five participants.

3.5 Data collection

This study relied on an in-depth interview strategy which captures a deeper meaning of experience as stated in the participant's own words (Marshall & Rossman, 2006). Phenomenological interviewing; a type of in-depth interviewing that is grounded in philosophical tradition was used (Marshall & Rossman, 2006). The purpose of this interviewing is to describe a phenomenon "shared amongst individuals" (Marshall & Rossman, 2006, p.105). Semi-structured interviews with open-ended questions were used to collect the data. True (1989) states that this type of interview leaves the interviewer with some discretion in the way questions are posed, as well as the wording of the questions. Interviews were guided by an interview schedule (See Appendix B). Most questions on the interview schedule came from the study done by Cosser (2005) on the parents' perspective in raising a child with ADHD. Other questions came from the literature review.

Since interviews are face to face, they, firstly, provide the interviewer with an opportunity to establish rapport with the participants which assists in the development of trust needed when probing sensitive areas (Rosnow & Rosenthal,

1996). Secondly, interviews allow the interviewer clarification and interpretation of questions for the participants. Lastly, interviews are flexible in that they allow the interviewer probing on the spot (Rosnow & Rosenthal, 1996). The interviewer tried to explain the questions in the person's mother tongue where problems were encountered with the understanding of the questions in English.

Husserl requires that *bracketing* or removal of oneself from presuppositions be maintained during interviewing so as to allow the essence to emerge (Groenewald, 2004). Essence in descriptive phenomenology means discovering the most essential meanings (Kleiman, 2004). In this study, the researcher made sure that she brackets her own preconceptions about the experience that parents have in raising children with ADHD. The semi structured interview is one way of achieving this because it provides guidelines even though it allows probing on the spot resulting in the duration of the interview and number of questions varying from one participant to another (Groenewald, 2004). This does not mean that the researcher forgets all their past knowledge, but rather holds such knowledge in abeyance and does not allow it to influence the present situation (Kleiman, 2004). In bracketing herself, the researcher did not ask leading questions to try and influence the process, but rather let the interviewees guide the phenomenon as it emerged. This was particularly important when dealing with questions on culture since the interviewer, an African herself, has some understanding of this culture.

Interviews were conducted at a time and place convenient for each participant. Four of the interviews were conducted at the participant's own homes whilst one participant preferred to be interviewed at the researcher's home. All interviews were conducted after working hours as it seemed convenient for all participants.

The informed consent form (See Appendix A) was handed to the participants at the beginning of each interview and it was also clarified; allowing any concerns to be addressed by the researcher. Parents, after the informed consent form was clarified, were then asked to sign the informed consent form agreeing to be interviewed as well as to be tape-recorded.

Each interview lasted approximately 45 minutes. The interviewer made sure that the interview setting was free from noise and interruptions as far as possible in order to allow clarity of taped material. To ensure the equipment functioned well, the interviewer used new tapes and new batteries for each interview. Each tape was then assigned a code e.g. Participant A, B, C, D and E (Groenewald, 2004). Transcripts were produced from the tape recordings and were transcribed verbatim by the researcher. With some interviews, the researcher had to translate the taped material from Zulu or Xhosa to English.

Field notes were also taken during interviewing as well as immediately thereafter as these assist with what happened, what was involved, who was involved and why (Groenewald, 2004). Field notes also allow the researcher to reflect on what is happening over and above relying on tape-recorded material (Groenewald, 2004).

3.6 Data Analysis

A phenomenological method of analysing data was used. The most astute articulation of Husserl's descriptive method is found in writings by Giorgi (Kleiman, 2004) and was used in analysis of the data in this study. Phenomenological reduction is a device used in descriptive phenomenological analysis and requires bracketing as a first step (Kleiman, 2004). According to Giorgi, bracketing/epoche implies not taking a stand for or against but allowing the phenomenon to emerge (Groenewald, 2004). Phenomenological reduction also requires withholding any existential claims and presenting data as it presents itself rather than making ones own conclusions about what is presented (Kleiman, 2004).

Giorgi (1985) describes four essential steps in the phenomenological analysis of transcribed data. In the first step, the researcher needs to get the sense of the whole text (Giorgi, 1985). This was done through the researcher reading the transcribed text three times to allow the essence to emerge. Such reading by the researcher is not done in an interrogatory manner, but the reading serves rather as preparation for the next step (Giorgi, 1985).

The second step involves discriminating 'meaning units' by focussing on the phenomenon being researched as well as psychological criteria (Giorgi, 1985). In this step the researcher went back to the beginning and re-read each text, this time highlighting what she felt were natural meaning units which were chosen with psychological criteria in mind (Giorgi, 1985). What stands out therefore depends entirely on the researcher's perspective (Giorgi, 1985). In this study, the descriptions concerned with the parents' experience in raising a child with ADHD were highlighted, these being seen as what constituted meaning units. It was important at this step for the researcher to remain open-minded thus allowing genuine discoveries to be made rather than simply knowing what one is looking for and detecting it in the text as it is displayed (Giorgi, 1985). This was done by highlighting just about everything that constitutes an experience for parents in raising children with ADHD. This was important as part of the researcher bracketing herself out and allowing for genuine discoveries.

Once all the meaning units, usually expressed in everyday language, have been discriminated, the third step involved the researcher going through each one of them with the intention of transforming them into psychological language; keeping the emphasis on the phenomenon of the experience of parents in raising their child with ADHD in mind (Giorgi, 1985). The aim here is to express the psychological meaning behind what is said (Giorgi, 1985). Through the use of reflection and imaginative variation, the researcher tries to understand the central issue or the phenomenon of learning (Giorgi, 1985). The purpose of imaginative variation, also known as reduction, is to locate only those features of each participant's description that are essential to the lived experience (Martinez, 2000). In this step, the researcher transformed the meaning units into psychological language looking specifically at the meaning that is being communicated by the participants in describing their experiences of raising a child with ADHD. The researcher therefore looks at the meaning behind what is said.

The last step in the analysis of data involves the researcher's synthesis of all transformed meaning units or integration of insights from all participants in the study into a consistent statement regarding parents' experience in raising a child with ADHD (Giorgi, 1985). In this final step, the researcher first highlighted all the

transformed meaning units as themes that arose for each participant. Once this was done, the final themes that were chosen and presented as results were only those that were common to three or more participants of this study. This was a way of the researcher bracketing herself out and allowing only those transformed meaning units that came out of most participants' experiences to be focussed on rather than imposing themes based on own preconceived ideas. This meant that even though, for example, the researcher liked what Participant A said on a certain matter, if it only came from them and no other participant, it was not presented as a theme in the results section of this study. The full data on each participant including their meaning units as well as the transformed units is presented in Table 2 in the appendix section of this document.

3.7 Strategies for Ensuring Quality Research

Trustworthiness of the study focuses on methods to ensure that the researcher has performed the research process correctly (Sparkes, 1998). Such methods are parallel to the empiricist concept of internal and external validity, reliability and objectivity (Sparkes, 1998). Trustworthiness criteria include credibility, transferability, dependability and confirmability (Sparkes, 1998).

3.7.1 Credibility

Credibility refers to the trustworthiness of the data collection, analysis and conclusions (Eklund; as cited in Sparkes, 1998). One technique used to ensure credibility is through conducting checks with the participants where they are shown interview transcripts and are given an opportunity to agree or disagree with the way the researcher has represented them (Seale, 1999). However, according to Giorgi (as cited in Cosser, 2005) such a method is not really legitimate since only members of the same disciplinary community are in a position to critique or verify expressions. To ensure credibility, the researcher therefore relied on the supervisor as a critic and mentor for the material (Cosser, 2005). Furthermore, the participants were informed through the consent form that they may receive written feedback on the research report should they so wish.

3.7.2 Transferability

Transferability deals with the sharing and application of information beyond the study setting (Malterud, 2001). Transferability is ensured when a detailed description of the setting is given to allow readers to make their own judgement on the applicability of the findings to their own purpose or other settings they know (Seale, 1999). A thick description of the setting has been given in this study so as to allow the reader to make their own judgements about transferability to other settings. The researcher does not assume that the results of this study are generalisable to all settings.

3.7.3 Dependability

Having ensured credibility which is more concerned about the validity of the study, it is not necessary to demonstrate dependability separately (Babbie & Mouton, 2001). Where there is credibility, dependability is also ensured. Dependability deals with the reliability of the findings (Babbie & Mouton, 2001). For findings to be dependable, they must be predictable and stable (Lincoln & Guba, 1985).

3.7.4 Confirmability

Lincoln and Guba (1985) state that confirmability of the study deals with the study's objectivity. Objectivity exists when the inquiry is value-free (Lincoln & Guba, 1985). The researcher here allows for the data to speak for itself without being impacted upon by the researcher's own values or misconceptions (Lincoln & Guba, 1985). With the researcher bracketing herself out consciously in order to understand the phenomena as it emerges during interviewing and transcribing of data, the phenomenological research design contributes towards validity and truthfulness (Groenewald, 2004). Bracketing used in this study ensured that the researcher remains objective.

3.7.5 Reflexivity

Since the researcher enters the field of research with certain opinions about what the field is all about, reflexivity allows the researcher to identify preconceptions brought

by themselves into the study (Malterud, 2001). Such preconceptions may represent "previous personal and professional experiences, pre-study beliefs about how things are and what is to be investigated" (Malterud, 2001, p.484). The researcher in this study has endeavoured to reflect on her own experiences with friends who have children with ADHD. Even though the researcher has stated her own preconceptions, these have not influenced her in staying objective and bracketing herself out in entering the participants' unique world.

3.8 Ethical Considerations

The researcher followed the Code of Ethics for research involving human participants, as outlined by the University of Pretoria. There are two major ethical concerns involved in this study, namely, informed consent and confidentiality.

Each parent involved in the study was asked to sign a consent form to acknowledge that they have been informed about the study. The informed consent form was read and clarified to each participant and included the title of the study, purpose of the study, procedures to be followed by the researcher, risks and benefits for participating in the study, participant's rights and issues surrounding confidentiality. Participants' rights and confidentiality issues are highlighted as follows:

- Participation in the study is voluntary;
- They may refuse to answer any questions they would prefer not to;
- They may withdraw from the study at anytime;
- They have a right to written feedback on this research if they so wish;
- To ensure anonymity, no information that may identify them will be included in the research report and responses will remain confidential;
- Pseudonyms will be used from the onset in the transcripts as well as the report results;
- Direct quotes may be used in the report results but these will not reveal anyone's names;
- The research promoter will also not have access to their identity;
- All tapes and transcripts will be kept in a locked office at all times;

- Tapes and transcripts will be kept for a minimum of 15 years should the need arise for further research, and
- Should the need for the re-use of their data arise; permission will be sought from them through informed consent.

3.9 Dissemination of results

The results of this research will be disseminated in the form of a master's dissertation. The report will be available for participants, ADHASA and people interested in the research report academically. The report will be available in hard copy and electronic format at the University of Pretoria library. Participants will receive written feedback through the researcher if they so wish.

CHAPTER 4: RESULTS

4.1 Introduction

During the data analysis, meaning units (MU's) were discriminated from the transcripts focusing on the experience of parents raising children with ADHD. These MU's were then transformed into psychological language in order to express the psychological meaning behind what was said. In this step the researcher was focusing on the meaning being communicated by the participants. Table 2 in the appendices section of this paper gives such a profile for each participant.

Various transformed MU's were selected as themes for this research. Such themes were selected based upon commonality with themes from other participants. Only themes common to three or more participants were included in the final result of this study. This allowed the researcher to bracket herself out of the process and allow genuine discoveries to be made. Subthemes for each main theme were arrived at by looking at the connection of such subtheme with the main theme.

The main transformed MU's (themes) that came out of the data analysis were:

Experience of their child; with the following subthemes:

i. Experience of the child's behaviour
ii. Experience of their child at school and at home
iii. Thoughts on their child's future

Experience of ADHD; with the following subthemes:

iv. Parents' own experience of ADHD
v. Other's response to ADHD
vi. Experience with professionals on ADHD

vii. Experience with treatment for ADHD

Experience of self; with the following subthemes:

viii. Style of parenting

ix. Cultural values and norms

x. Parents' emotional experience of self

A discussion of the various themes now follows.

4.2 Experience of their child

Here the parents describe how they view their children when they watch them play and interact with others, the dreams and aspirations they have for their children, as well as coming to terms with some of the realities about their children with ADHD.

As indicated above, various subthemes emerged from this transformed MU regarding how the parents experience their child's behaviour at school and at home and what they thought about their child's future. As stated before, only themes that were common to three or more parents are presented by the researcher here.

4.2.1 Experience of the child's behaviour

- Most Black parents in this study experienced their children's behaviour as hyperactive and uncontrollable. The descriptions given by parents give one a sense of exasperation and being at one's wits end in trying to control their hyperactive and possibly impulsive children.

Participant D shows her exasperation:

"*He would jump around in the road and it's too dangerous, he would end up being hit by a car because he doesn't think. He talks a lot, he talks a lot and he doesn't think and last year nearly knocked by a car in front of me. He didn't even check left right whatever; he just walked into the road*"

Participant A tells of his inability to control his son:
"We are always alert, when he starts to run after a moving car and stuff like that. He is active, always running."

Participant B demonstrates the amount of activity involved when it comes to her daughter:
"She's hyperactive, she climbs a lot, she talks a lot, she's very bossy; always the teacher when they play, she always argues, does not listen. This person has a lot of energy"

Laments Participant E:
"It's not only that he's active, too active"

- The next descriptions suggest that parents also experience their children with ADHD as socially isolated and withdrawn and keeping to themselves, either intentionally or not.

Participant D's response indicates that her son's hyperactivity and impulsivity results in him being isolated and rejected by others; *"When he plays around his peers he causes too much trouble. Some kids will stay away from him"*

Participant A's response suggests that his son chooses to be alone:
"He prefers to play alone, play alone"

According to Participant C, her son may also be isolated due to his personality: *"He's a quiet child, he plays alone; he's an indoor child"*

4.2.2 Experience of their child at school and at home

- The general meaning that came out of this section was that the Black parents interviewed experienced their children as clever or smart as related by Participants B, C, D and E. This seemed quite important for most parents, almost to cling to as a sign of their children's 'normality' or being gifted in some way.

Participant B's experience indicates to her that her daughter is clever indeed: *"She's clever, she finishes before others, her school marks are always good."*

Participant C states that her child understands too quickly and ends up feeling like others are too slow and delaying him in class: "*The problem is that now he knows too much. He doesn't want to be told everything twice and other kids are making things slowly for him."*

Participant D states proudly, *"He understands very well and he's very bright"*

In Participant E's words, *"He's very smart. When there is a long route to do something he will find a short cut to it."*

- Additionally, Black parents experienced their children as inattentive, not listening or not able to concentrate at school or home as noted by the following Participants:

Participant C has concerns about her son's lack of concentration and forgetfulness. *"His problem is only one thing; concentration. He forgets, to me he worries me, he forgets."*

Participant E highlights the level of inattention: *"At school he couldn't concentrate for a long time. He would do one thing and then leave it, do the other thing, leave it do the other thing, leave it."*

Participant B indicates lack of concentration: *"At home she does not concentrate at all."*

Participant A complains: *"He does not listen!"*

- When speaking of how they experience their children with ADHD, the majority of Black parents in this study also related problems of speech which seem to continue even as the child grows.

Participant A relates: *"What is affected is speech. He has a problem with speech."*

Participant C adds, *"Especially when it comes to expressing themselves, that's the most difficult thing when it comes to Tshepo."*

Participant E's experience corresponds, *"I began taking him to speech therapy because he wanted to do everything haphazardly, you know, to speak properly. He still goes to OT to date."*

- When participants spoke about their children's relationship to others, parents in this study spoke fondly of their children with ADHD perceiving their children to be popular amongst the people they engage with.

Participant C states with pride, *"He's a very good boy, he's a loving child. Most of the people love him."*

To Participant D's amazement *"He's popular from there till the last street, they all know him."*

Participant E's son seems to be popular with girls as well: *"He is very sociable. He is a lover boy because of the personality. He's got a very good personality."*

4.2.3 Thoughts on their child's future

Even with ADHD and the challenges faced by parents, most parents were hopeful and saw a bright future for their children with ADHD. Black parents in this study reported putting in a lot of effort into making sure their children succeed and become something in life. The parents indicate as follows:

Participant A is hopeful as he states: *"When they grow and start looking after themselves, they outgrow it."*

Participant B feels her efforts have been worthwhile: *"I think she will be fine. I have seen some change ever since she started going to Bara."*

Participant C is more pro-active and uses positive talk in helping her son to become something in life: *"I try to help him understand himself, trying to let him know that this child has got this ADHD. I try to research about people who are ADHD like celebrities, the famous people. This person is like you at the end of the day you will be like this person. I try to put those pictures."*

Participant E is more structured: *"There is progress in what we are doing because I find that there is routine. You know I can see Tumi being a pilot, maybe engineering but not hard core things that require you to read, but things that are, he's visual. Things that include like graphics."*

4.3 Experience of ADHD

This theme tells us how the parents in the study experience ADHD itself as a disorder, how they have reacted to the diagnosis and how others close to them like family and friends have also reacted and how this has impacted the parents.

Various subthemes, in turn, emanated from this theme including their own personal experience of ADHD, experience of others with regard to their child with ADHD, experience of dealing with professionals and lastly the experiences with medication for ADHD.

4.3.1 Parent's own experience of ADHD

- In this subtheme, more parents than not showed a reasonable understanding of ADHD.

Participant C's understanding comes from her in-laws. *"They told me about concentration. They told me his father has ADHD. For me understanding ADHD comes from that family. Everybody in that house except the mother is like that."*

Participant D likes to inform herself: *"According to my understanding it has to do more with the behaviour. You know I am not an expert. I surf the internet, I check each and everything, whatever booklet or ADHD support group, I find it and I always try to inform myself about ADHD.*"

Participant E relates with conviction from her past experience working with children with ADHD herself: *"There's two elements. There's an attention seeking element because maybe of certain circumstances. There is an element of hyperactivity which is actually stimulated by the physiological; you know whatever you feed them. So it's a combination of factors. You know the one child I remember, he was actually 15, he actually literally used to induce epileptic fits, to get attention."*

4.3.2 Other's response to ADHD

- Participants in this study felt that whilst some people were understanding and supportive of them and their children with ADHD, others were not. The responses given suggest such lack of support to be due to others' lack of understanding of ADHD as a disorder.

Participant A gives a clear account: *"Others are supportive. Some don't actually understand what is it. They are just not informed about what's happening. When you go to the shops with him or the mall, people start looking otherwise you know."*

Participant B substantiates: *"My family responded well, positively. My sister helped me cope with it because she knows about it, she knows and understands it. The only problem was on the father's side, they didn't understand."*

Participant D gives some insight: *"You know it's not everybody who understands that Nathi is like this. It's very difficult to deal with a child because people think this child is naughty, not understanding shouting at the child. My mother is spiritual because everything she needs she prays. So she is very supportive. She knows how to speak with a child. All my friends are very supportive."*

Participant C is worn out by other's lack of understanding: *"They don't even understand it even now. They think Tshepo is mad whereas they don't understand; even my sisters they don't even understand this ADHD thing. His grandmother is starting to understand."*

- Most participants felt that others blamed them for their children's condition.

Participant B gives a good account: *"They still blame me for what has happened as they blame me even today; that this child wouldn't be like this."*

Participant C feels blamed for her son's 'madness' that others attribute to her: *"Most of them shout at me. They think I'm mad, they say I'm living in a mad world so I rather keep quiet."*

Participant D feels others compare her son's behaviour to hers: *"They say he is like you. He does things like you. So I tell them maybe. But it's only now that I'm an adult and I can control myself."*

- The participants in this study felt that others were insensitive in the way they spoke about their children with ADHD or how they spoke to them as parents.

Participant C shows this insensitivity: *"They would tell you he will end up being a gay or sissy. When Tshepo speaks they laugh."*

Participant B elaborates on the lack of sensitivity towards her from her in-laws: *"His sisters swore at me, phoning me and swearing at me cursing saying that I'm responsible for their mother's stroke."*

Participant D's experience: *"They used to phone me at my work and tell me that we cannot have this child here at school."*

4.3.3 Experience with professionals on ADHD

- Black parents raising children with ADHD agree that the experience with professionals has not been satisfactory. In their opinion, at times professionals have caused more confusion rather than actually clearing the confusion. The frustration is obvious in how the parents express their experiences.

Participant A relates the level of frustration which left them with even more confusion: *"We went to all sorts of doctors; several doctors, psychologists, someone dealing with bones. We started attending witchdoctors and all. The doctor said the boy is normal, healthy."*

Participant B relates her experience: *"I received a letter from the school, sent by the principal by the way, saying she mustn't come to the school until I go to the school."*

Participant D describes her pain caused by teachers: *"It's such a painfully long experience especially last year when they said he's expelled."*

Participant C shows her frustration and fears due to explanations given to her by professionals: *"It's frustrating because they told me if they didn't get help when they are young, when they are adults they become criminals. They can rob someone's car, my child can do theft. They are criminals, they are robbers, they hi-jack all those parts of dangerous criminals; that's how ADHD kids end up being."*

4.3.4 Experience with treatment for ADHD

- Even though most Black parents were using Ritalin to control their children's behaviour especially at school, parents had various complaints about the medication and its side effects. Parents feel they have no other option.

Participant A gives his experience with the treatment: *"Mine is on Ritalin three times. Chisandra is better than Ritalin. With Ritalin sometimes he gets fits."*

Participant C also had experience with side effects: *"He does this tic; they said I must be aware when he drinks medication there are other signs he's gonna do."*

Participant D shows her anger and frustration: *"I had to pay for medication. I'm on medical aid but it's so useless the whole thing. They are very expensive, I had to pay R420.00. I had to spend R400 on this Ritalin thing."*

4.4 Experience of self

Various other subthemes emerged from this theme such as parent's view of their style of parenting, cultural values they aspire to as well as what it is like for them to deal with their child's behaviour. A discussion of the subthemes follows.

4.4.1 Style of parenting

- Most parents experienced themselves as harsh, strict and shouting even though they believed they are also accommodating. This suggests some endeavour in creating balance in their parenting style.

Participant B responds: *"Sometimes you shout at her. I discipline and I shout and I explain to them why I shout at them. I can explain myself, my harshness."*

Participant D collaborates this by stating: *"I know I am a very shouting person, you see I like shouting; but don't do it with hatred even if he's totally wrong. I try not to shout."*

Participant E moves between two poles, at times negotiating and other times punishing: *"Me, I am a negotiation, you know, but the father is very strict. I punish him. I find that it is more painful to be punished. I take away your pocket money and that's bad."*

4.4.2 Cultural values and norms

- Whilst most parents believed that they have to accommodate their children with ADHD, they agreed that they come from a harsh culture and that Black culture is harsh and unaccommodating. They feel that although they cannot always stick to their cultural norms, however, certain values and norms such as respect for others, discipline and boundaries remain as indicated by the parents as follows:

Participant A illustrates this phenomenon clearly by stating: *"Normal culture; respect, discipline. When it comes to discipline he must give us time to speak. The way they raised me is different from the way I raise them. We were raised strict. As a kid there are boundaries. Boundaries are not there with him because you know he is sick."*

Participant B states, *"Xhosa culture says one should be harsh. I didn't grow up in a typical Xhosa set-up. I teach them respect."*

Participant C is more firm but the same themes of respect, discipline and boundaries are deduced from her response: *"I can say I am raising my child my own way which is learnt from home. My mother was a very very strict woman. I don't want kids who don't want to respect other people. I don't want kids who will stand up and what is this you know, asking touching. The child must know this is not my mother or father's house, he needs to behave himself"* (boundaries). *"If he needs something, he needs to ask. He follows my rules; what time to sleep, what time to watch, what channels to watch, he doesn't watch each and everything, he sleeps very early, after he eats he sleeps"* (discipline).

Participant E puts it like this: *"Here it is different from where I came from. We do a lot of things together. I acknowledge that culture evolves but there are certain norms for me and values that are not negotiable. She has to do her chores. There is a language that is acceptable to society. The mother next door is also a mother so you mustn't just listen to me you must listen to the mother next door. I teach them boundaries; there is a difference between how you talk to an adult."*

4.4.3 Parents' emotional experience of self

In this subtheme, parents described in detail their journey of pain and suffering due to raising a child with ADHD. Most parents seemed to have been affected emotionally by raising a child with ADHD.

- Parents described feelings of guilt, shame and self-blame in raising a child with ADHD.

Feelings of guilt and shame are deduced from Participant A as he states: *"It's the first time you know in my family; they are not used to it. It's not something they know. It's rare in our Black community you know. When I grew up it was not known by most people in the village you know."*

By Participant B chasing her, it suggests the inability to deal with the shame and guilt she feels towards her child: *"We chase her away here. If I am watching TV she comes and disturbs me, I chase her; we all chase her away."*

Participant C blames herself and also relates feelings of guilt: *"At first I thought my child was emotional because I shout. I thought maybe that's why my child is like this because I was shouting. I think I'm isolating myself from people because of the guilt of finding out that I've got a child who is like this."*

Participant E feels responsible: *"It was a challenge because you know as a parent you always think that I did something wrong."*

- Black parents interviewed reported feeling trapped, frustrated, being alone and lonely.

Participant B feels trapped, frustrated and alone. *"Right now I don't have friends here because I am new here. I can't go back at this age; I can't go back with what I've gone through. I am imprisoned here I don't have anywhere to go, no one to go to. There are days when I ask myself why me, why is this happening to me do you*

understand? Why do I have a child with ADHD? I don't need this. Why isn't my life cool, why don't I have a job? Her psychologist referred me to Liezel so that I can also get out my own frustrations because I do have my own you know."

Participant C echoes the same sentiments: *"He comes first in everything. I need to relax and go out, I can't, you can't. When he's not around during school holidays I don't go anywhere, I stay on my own thinking, sitting. I don't have an outside life, that's how I am. I am always alone."*

Participant D feels that being alone makes her inadequate: *"I don't have a husband I'm all alone. I don't have a man for support. But I keep getting worried that I will get to a point I can't describe so he must be well taken care of 24hrs."*

Participant E is trapped and frustrated: *"The reality is there's holidays, you're not always there and this is for me a progressive thing, you can't fix it in one day. For me as an individual it's very frustrating. It frustrates me a lot; it's very challenging."*

- When parents describe how they feel, descriptions of helplessness, state of despair and even depression at times came out strongly as indicated by parents as follows:

Participant A feels helpless when his younger children imitate his son with ADHD: *"My little daughter you know, he is running around with them because with the kids they think it's alright. They will run maybe break something because my brother is doing that. Of course it makes you sad. I'm sad. It's very sad you know."*

Participant B describes intense feelings of helplessness, despair and even depression: *"I'm tired, I'm tired, this daughter of mine has tired me. I wish I could cry. There are days when I feel that my heart is hard and sore. Sometimes I see the sun rising in my sleep."*

The fact that the father also has ADHD makes Participant C feel helpless as she watches the two together: *"I see similarities with his father. Everything, the body*

structure, the talking what they do. I hate his father's life and I even hate him so I do not want this child to be close to his father."

Participant D's pain is obvious: *"I couldn't get out of bed in the morning, I just couldn't stand up. I was so depressed. Very very very very long, a very painful hell of an experience for me."*

- Even with all the challenges faced by parents, some parents have praised themselves willingly or not for their efforts and believe they are coping well as indicated by these participants:

Participant E is modest: *"I think we are doing reasonably, you know reasonably well. There is progress in what we are doing because I find that there is routine."*

Participant D is not as modest: *"Wow me I afford, girl I do my best, I go all out when it comes to my kid. I want Nathi's behaviour to be channelled properly. I finally found ways of dealing with this and its working lovely and I feel much better now."*

Participant C reiterates: *"I don't know because sometimes you praise yourself that you are a good person. I'm fine."*

A discussion of the results now follows.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1 Introduction

The analysis of the results of the study ended with three main themes and ten sub themes. The first theme was the experience of their child with the subthemes of experience of the child's behaviour, experience of their child at school and at home and thoughts on their child's future. The second theme was the experience of ADHD. This resulted in subthemes of the parents' own experience of ADHD, other's response to ADHD, experience with professionals on ADHD and lastly the experience with treatment for ADHD. The last theme was the experience of self. This resulted in subthemes relating to the style of parenting, cultural values and norms and the parents' emotional experience of self.

A discussion of the findings above will follow and the findings will be integrated with theory. The aim here is to see if the results agree or disagree with the theory presented in this study. New findings that were significant for this study but not discussed in the literature review are also presented in this section.

5.2 Experience of their child

The results of this study show that the parents experienced their children as hyperactive and uncontrollable. The DSM IV-TR lists inattention, hyperactivity and impulsivity as common features present in children diagnosed with ADHD (Sadock & Sadock, 2007). Some children may only present with the inattentive subtype whilst some present with the hyperactivity and impulsivity subtype. Wodrich (1994) stated that ADHD children with hyperactivity seem to have a more severe form of ADHD as they are more likely than those with the inattentive subtype to have conduct problems, to be impulsive, distractible, rejected by peers and requiring higher doses of stimulants. The results suggest that children involved in this study are described by their parents as being severely affected by ADHD.

In addition, participants in the study described their children as not listening, inattentive and lacking in concentration. This suggests problems of inattention as described by Barlow and Durand (2005, p.491) as including “not listening to others, not paying enough attention to detail and making careless mistakes.” Sadock and Sadock (2007) state that some children present with the combined type of ADHD where both features of inattention as well as hyperactivity are present. Looking at the descriptions given by the participants in this study, there is an indication that most children in the study have the combined subtype of ADHD since most children have both inattention and hyperactivity symptoms; as presented above.

Black parents also described their children with ADHD as socially isolated and withdrawn. This finding is not supported by the literature in this study and may suggest a new finding. On the other hand, participants in this study described their children with ADHD as popular and well liked by others. This contradicts Hinshaw (1994, p.1)’s finding that children with ADHD are “uniformly rejected by peers.” Diamantopolou et al. (2005) also believed that children with ADHD are often rejected by peers.

Furthermore, Black parents described their children as clever and coping well at school. However, when looking at the results, four of the five children are at a special school indicating learning problems. This agrees with Miranda et al. (2008) who postulated that 70% of children with ADHD show learning disabilities resulting in a need for special education. This is further confirmed by the fact that four parents actually stated that their children have speech problems which is a disorder of language that often causes failure for children with ADHD in a school environment (Wodrich, 1994). Therefore, even though the children may have learning problems, parents raising children with ADHD believed their children were clever or smart. This agrees with the literature as Smith (2002) states that at times parents feel confused because they feel that their children are smart, know a great deal and seem to reason well and yet they cannot read or write.

Even though the literature was lacking in regard to thoughts that parents have for the future for their children with ADHD, this study suggests that with all the challenges they face, Black parents have hope and believe that their children will have a

successful future. Black parents in this study were proactive in making sure that the bright future they anticipate for their children with ADHD becomes a reality no matter the challenges they are faced with.

Though the study only published results that were common amongst most participants; the effect ADHD has on fathers is important in this study due to the differences in how the father in this study responded to the questions when compared to the mothers of children with ADHD.

As stated in the participant statistics, (Table 1: Appendices), only one father was interviewed in the study. Even though the questions posed to him by the researcher were open-ended, the responses he gave were limited and he did not respond freely to probing either. This agrees with the literature as stated by Singh (2003) that ADHD contradicts the father's understanding of how boys should behave often resulting in a lack of acceptance of the diagnosis. Fathers often have to face their own understandings of themselves and how they were as young boys which are likely to result in feelings of personal failure and weakness and suspicions from wives regarding their husband's potential pathology which are all likely to impact the fathers' self esteem (Singh, 2003). Fathers were also reported to be hesitant in revealing their son's difficulties to anyone outside the home resulting in them carrying a heavy burden by themselves with no support (Singh, 2003); which could have been the case with the Black father in this study.

5.3 Experience of ADHD

More participants than not seem to show a reasonable understanding of ADHD as a disorder. Meyer et al. (2004) postulated that little is known about ADHD in the Black population. The findings in this study suggest that this may be true for the Black population in general but not for Black parents that live the experience of raising children with ADHD. In this study, Black parents raising children with ADHD are doing more to gain a better understanding of ADHD in their children and are proactive in learning as much as possible about the disorder.

Black parents experienced some people as supportive towards them whilst others were not understanding of ADHD and were even critical and insensitive towards parents raising children with ADHD. This agrees with the literature as stated by Smith (2002) that neighbours can be intolerant of a child who is hyperactive and has low frustration tolerance or explodes at each hurdle.

Black children function within a Black culture and therefore their behaviour has an effect on how parents view themselves as parents, especially mothers who are often blamed for their child's inappropriate behaviour (Neophytou & Webber, 2005). Grandmothers tend to blame parents for not doing enough (Smith, 2002). In agreement with the literature, Black parents in this study felt blamed by others for their children's behaviour, including by family members. This often causes parents to feel that somehow their children's ADHD is their fault (Smith, 2002) as was seen in parents in this study. Parents also blame themselves and often ask themselves if they are good enough parents (Neophytou & Webber, 2005). This is perpetuated by neighbours, strangers and extended family that are intolerant of a child who is hyperactive (Smith, 2002). Participants felt that others were insensitive towards them and their children.

Further frustrations and confusion result from professionals not agreeing on the best way to manage a child with ADHD (Smith, 2002). This was affirmed in this study as parents raising children with ADHD experienced professionals as unsupportive, at times uncaring and being the source of confusion. Dean (2005) believes that most feel that the majority of professionals just do not care as they have to go back to their 'normal' lives whilst it is parents with children who have ADHD that have to struggle on their own.

Parents raising children with ADHD are faced with the enormous task of deciding whether to medicate their children or not often causing parents a wide variety of stressors (Brinkman et al. 2009). Ritalin is the most prescribed psycho-stimulant and is used mainly between 6 to 12 years so as to avoid scholastic problems (Richard & Russell, 2001). The majority of parents in this study admitted to their children being on Ritalin. This is in contrast to Dosreis and Myers (2008)'s view that parents would be hesitant in giving their children medication. Even though parents in this study are

not entirely happy with Ritalin, they gave their children Ritalin due to viewing their children as uncontrollable.

5.4 Experience of self

When it comes to parenting style, parents of children with ADHD tend to use more aggressive discipline methods (Lange et al. 2005). This agrees with the findings of this study where parents believed they were harsh to their children even though some gave indications to being accommodating in their parenting style. Such harsh parenting is due to parents viewing their children's behaviour as uncontrollable which induces frustration in the mother (Gerdes & Hoza, 2006). This was evident in parents in this study as they felt their children's behaviour was uncontrollable and many reported to being frustrated as a result.

Parents often resort to loud commands and threats of punishment in trying to discipline their children (Wodrich, 1994) as evidenced in our current study. This is an authoritarian style of 'unquestioning disobedience' as described by Viljoen (1994). Most Black parents think of the Black culture as harsh and strict with lots of shouting involved. On the other hand, parents believed that they were accommodating as well. This suggests a dilemma facing Black parents when it comes to disciplining their children with ADHD. Makweya (1998, p.66) agrees that "parents are finding it increasingly difficult to discipline children that attack them." Such 'attacks' are associated with conduct problems seen in hyperactive children.

Looking at culture, *Ubuntu* has been identified as the glue that holds African communities together (Hanks, 2008). This possibly suggests *Ubuntu* might be a protective factor in Black families. The results of this study disagreed with this where most Black parents interviewed felt alone and lonely, with others viewed as being insensitive and blaming. They felt unsupported by neighbours or strangers. This indicates the absence of the experience of *Ubuntu* amongst the Black parents interviewed. This supports Viljoen's (1994) statement that the gradual decay, decline and disorganisation in the families of Black South Africans is of great concern indeed.

South African society is in the midst of change and in times of change some traditions are forgotten and lost, including *Ubuntu* (Bonn, 2007). However, certain values and norms underlie the family life of Black South Africans such as respect and discipline (Viljoen, 1994). Even with the difficulties experienced by Black parents in raising their children with ADHD, values such as respect and discipline were a priority in all families and all agreed to trying as much as possible to enforce these in their children. Black parents interviewed also felt that in addition to respect for elders and discipline, setting boundaries was also important in raising their children with ADHD.

Black parents in this study often felt helpless in trying to control their child's behaviour which led to; helplessness, despair and depression at times. This is reiterated by Flick (1996) who believes that parents raising children with ADHD experience 'learned helplessness' where they feel they have tried everything and nothing has worked. They therefore feel depressed and fatigued as they feel they have no control over the situation (Kashdan et al. 2004).

Having a child with ADHD stirs certain emotions and feelings that most parents find difficult to handle (Silver, 1993). Feelings such as anguish, fear, anger, guilt and shame are quite common (Silver, 1993). This was supported by the findings in this study as most parents felt guilt and shame.

As indicated by Firmin and Phillips (2009), some parents have shown an active interest in their children's disorder through becoming involved in support groups and maintaining structure and routine as a way to deal with their children with ADHD. This has been shown to increase understanding of the disorder as seen with the parents in this study. Such knowledge also increased the parent's ability to cope better with their children.

5.5 Conclusion

In conclusion, a look at the limitations, strengths, implications of the results and directions for future research and recommendations follows.

5.5.1 Limitations and weaknesses of this research

Even though permission to do research was given by the ADHD support group of Southern Africa (ADHASA), only two parents that are members of this group responded to the email that was sent by ADHASA on behalf of the researcher. This means that the researcher cannot guarantee that the participants obtained through snowball sampling have children tested and diagnosed through the formal system for diagnosing ADHD.

None of the parents interviewed, especially those with partners, were interviewed with their partners present. This could have allowed richer descriptions to emerge and was therefore a limitation since it was not the intention of the researcher to interview mothers and fathers on their own.

The descriptive phenomenological method used in this study requires that the researcher bracket herself out and allow the essence to emerge. This seems a good idea since one should only present what was found. However, it is also limiting as some meaningful findings, if mentioned by only one participant, were left out of the data that was organised into themes, in order not to influence the process and make interpretations based on what the researcher had preconceived.

The sample consisted of only five participants. The results may therefore not be generalisable to all Black parents raising children with ADHD.

When doing the transcripts, the researcher had to translate some taped material from Zulu and Xhosa into English to allow a general understanding by all readers. This may be a limitation in this study as some meanings may be lost in translation.

Furthermore, Sotho speaking participants were interviewed in English which is not their first language. Again, their responses may have lacked depth as experience is culturally based and best explained using one's own language. This may have resulted in the weak responses received when it came to questions concerning cultural experiences. A look at the strengths of the research now follows.

5.5.2 Strengths of this research

The epistemological position taken by the researcher for this study is phenomenological and has been identified as a strength. Phenomenological methods give the 'lived experience' as related by participants in the study.

It is the belief of the researcher that the specific data regarding the experiences of raising a child with ADHD are contained within the parents that raise children with ADHD. Such parents live the experience so the participants of the study were parents themselves.

Secondly, this study has introduced the concept of culture and how this affects how Black parents feel about raising children with ADHD. This has been a strength as it offered a fresh perspective.

5.5.3 Implications of the results

The study has highlighted some of the experiences faced by Black parents raising children with ADHD. Most of the experiences are lack of support, lack of understanding and blame by others. This then has implications on how the public is educated about ADHD in general since without support from others, especially family, most parents felt alone.

Parents found their children to be uncontrollable. This highlights the need for the development of more support groups for parents. This would also help deal with parents blaming themselves for their child's disorder. Parents would also be able to learn discipline measures that work well with children who have ADHD and, lastly, such education measures would help deal with guilt, shame, helplessness,

frustration, despair and depression experienced by parents raising children with ADHD.

Even though parents used Ritalin to control their children's behaviour, most of them were not satisfied with it. This has implications for the future since a change of diet has been shown to work successfully in certain studies. More education is needed, especially in South Africa with most Black parents struggling financially.

5.5.4 Directions for future research

The combined type of ADHD came out as common in this study. It would be interesting to conduct future research to see if the findings are repeated.

This study was done among the modern Black families. A repetition in more rural settings would be recommended to see how rural Black parents have moved from the traditional Black family when compared to urban Black parents. It would be interesting also to find out how they have been affected by ADHD.

Future researchers could also include a larger sample.

Future studies could also look at diet as an alternative to medication since most parents, even though they had put their children on medication, seemed unhappy with it.

REFERENCES:

Anderson, K.G. (2005). Relatedness and investment in children in South Africa. *Human Nature, 16(1),* 1-31. Retrieved October 2, 2009, from SpringerLink database.

Babbie, E., & Mouton, J. (2001). *The practice of social research.* Cape Town: Oxford University Press.

Barkley, R.A. (1998). *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment (2nd Ed.).* New York: The Guilford Press.

Barkley, R.A. (2000). *Taking charge of ADHD: The complete authoritative guide for parents (Revised Edition)*. New York: The Guilford Press.

Barlow, D.H., & Durand, V.M. (2005). *Abnormal psychology: An integrative approach (4th Ed).* Belmont, CA: Thomson Wadsworth.

Bonn, M. (2007). Children's understanding of 'ubuntu.' *Early Child Development and Care, 177(8),* 863-873. Retrieved October 15, 2009, from Informaworld database.

Brendtro, L.K. (2006). The vision of Urie Bronfenbrenner: Adults who are crazy about kids. *Reclaiming Children and Youth, 15(3),* 162-166. Retrieved January 20, 2010, from EBSCOhost database.

Brinkman, W.B., Sherman, S.N., Zmitrovich, A.R., Visscher, M.O., Crosby, L.E., Phelan, K.J., & Donovan, E.F. (2009). Parental angst making and revisiting decisions about treatment of attention-deficit/hyperactivity disorder. *Pediatrics, 124 (2),* 580-589. Retrieved September 01, 2009, from EBSCOhost database.

Burke, J.D., Pardini, D.A., & Loeber, R. (2008). Reciprocal relationships between parenting behaviour and disruptive psychopathology from childhood through

adolescence. *Journal of Abnormal Child Psychology, 36 (5),* 679-692. Retrieved October 2, 2009, from SpringerLink database.

Cosser, C.P. (2005). *Raising a child with attention deficit hyperactivity disorder: A parent's perspective.* Doctoral dissertation. Pretoria: University of South Africa.

Darroch, V., & Silvers, R.J. (1982). Biography and discourse. In V. Darroch & R.J. Silvers (Eds), *Interpretive human studies* (pp.3-21). Washington, D.C.: University Press of America, Inc.

Dean, D. (2005). ADHD and its impact on family life. *Mental Health Practice, 8(9),* 20-23. Retrieved October 5, 2009, from EBSCOhost database.

Devlin, A.S. (2006). *Research methods: Planning, conducting and presenting research.* California: Wadsworth.

Diamantopoulou, S., Henricsson, L., & Rydell, A-M. (2005). ADHD symptoms and peer relations of children in a community sample: Examining associated problems, self-perceptions and gender differences. *International Journal of Behavioural Development, 29(5),* 388-398. Retrieved October 10, 2009, from EBSCOhost database.

Dosreis S., & Myers, M.A. (2008). Parental attitudes and involvement in psychopharmacological treatment for ADHD: A conceptual model. *International Review of Psychiatry, 20(2),* 135-141. Retrieved September 8, 2009, from EBSCOhost database.

Dowling, M. (2004). Hermeneutics: An exploration. *Nurse Researcher, 11(4),* 30-39. Retrieved May 20, 2009, from EBSCOhost database.

Durston, S. (2003). A review of the biological basis of ADHD: What have we learned

from imaging studies? *Mental Retardation and Developmental Disabilities Research Reviews, 9,*184-195. Retrieved September 3, 2009, from EBSCOhost database.

Eisenberg, L. (2007). Commentary with a historical perspective by a child psychiatrist: When "ADHD" was the "brain-damaged child." *Journal of Child and Adolescent Psychopharmacology, 17(3),* 279-283. Retrieved September 05, 2009, from Google scholar database.

Elias, M. (2008). Children who have ADHD can strain marriages. *USA Today,* 1-2. Retrieved June 03, 2009 from EBSCOhost database.

Feinstein, S., Driving – Hawk, C., & Baartman, J. (2009). Resiliency and Native American teenagers. *Reclaiming Children and Youth, 18(2),* 12-17. Retrieved December 10, 2009, from EBSCOhost database.

Firmin, M.W., & Phillips, A. (2009). A qualitative study of families and children possessing diagnoses of ADHD. *Journal of Family Issues, 30(9),* 1155-1174. Retrieved July 31, 2009, from EBSCOhost database.

Flick, G.L. (1996). *Power parenting for children with ADD/ADHD: A practical guide for managing difficult behaviours.* New York: The Centre for Applied Research in Education.

Fourie, D. (1998). *Hypnosis in treatment: An ecosystemic Approach.* Pretoria: Unisa.

Gau, S.S. (2007). Parental and family factors for attention-deficit hyperactivity disorder in Taiwanese children. *Australian and New Zealand Journal of Psychiatry, 41 (8),* 688-696. Retrieved June 20, 2009, from EBSCOhost database.

Gerdes, A.C., & Hoza, B. (2006). Maternal attributions, affect and parenting in attention deficit hyperactivity disorder and comparison families. *Journal of*

Clinical Child and Adolescent Psychology, 35(3), 346-355. Retrieved June 20, 2009, from Informaworld database.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp.8-22). Pittsburgh, PA: Duquesne University Press.

Goudge, J., Gilson, L., Russell, S., Gumede, T., & Mills, A. (2009). Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC Health Services Research, 9(75),* 1-18. Retrieved September 10, 2009, from EBSCOhost database.

Green, C., & Chee, K. (1997). *Understanding ADHD: A parent's guide to attention deficit hyperactivity disorder in children.* London: Vermilion.

Grizenko, N., Shayan, Y.R., Polotskaia, A., Ter-Stepanian, M., & Joober, R. (2008). Relation of maternal stress during pregnancy to symptom severity and response to treatment in children with ADHD. *Journal of Psychiatry & Neuroscience, 33(1),* 10-16. Retrieved June 10, 2009, from EBSCOhost database.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3(1),* 1-26. Retrieved May 20, 2009, from EBSCOhost database.

Hanks, T.L. (2008). The ubuntu paradigm: psychology's next *force? Journal of Humanistic Psychology, 48(1),* 116-135. Retrieved July 10, 2009, from EBSCOhost database.

Hinshaw, S. P. (1994). *Attention deficits and hyperactivity in children.* Thousand Oaks: SAGE Publications.

Hook, D. (2002). Bronfenbrenner's ecological theory of development. In D. Hook, J. Watts & K. Cockcroft (Eds), *Developmental psychology.* (pp.312-324). Lansdowne: UCT Press.

Hook, D., & Cockcroft, K. (2002). Basic concepts and principles in developmental psychology. In D. Hook, J. Watts & K. Cockcroft (Eds), *Developmental psychology.* (pp. 14-28). Lansdowne: UCT Press.

Johnston, C., & Mash, E.J. (2001). Families of children with attention-deficit/hyperactivity disorder: Review and recommendations for future research. *Clinical Child and Family Psychology Review, 4(3),* 183-207. Retrieved May 10, 2009, from SpringerLink database.

Karande, S. (2005). Attention deficit hyperactivity disorder – a review for family physicians. *Indian Journal of Medical Sciences, 59(12),* 546-555. Retrieved May 18, 2009, from Google scholar database.

Kashdan, T.B., Jacob, R.G., Pelham, W.E., Lang, A.R., Hoza, B., Blumenthal, J.D., & Gnagy, E.M. (2004). Depression and anxiety in parents of children with ADHD and varying levels of oppositional defiant behaviours: Modelling relationships with family functioning. *Journal of Clinical Child and Adolescent Psychology, 33(1),* 169-181. Retrieved June 25, 2009, from Google scholar database.

Katabarwa, M.N., Richards Jr. F.O., & Rakers, L. (2004). Kinship structure and health care improvement in sub-Saharan Africa. *The Lancet, 363 (9427),* 2194. Retrieved July 10, 2009, from Science Direct database.

Keown, L.J., & Woodward, L.J. (2002). Early parent-child relations and family functioning of pre-school boys with pervasive hyperactivity. *Journal of Abnormal Child Psychology, 30(6),* 541-553. Retrieved June 21, 2009, from SpringerLink database.

Kleiman, S. (2004). Phenomenology: To wonder and search for meanings. *Nurse Researcher, 11(4),* 7-19. Retrieved May 05, 2009, from EBSCOhost database.

Koziol, L.F., & Stout, C.E. (1993). Conceptualizations of ADHD as an executive function disorder. In L.F. Koziol, C.E. Stout & D.H. Ruben (Eds), *Handbook of childhood impulse disorders and ADHD: Theory and practice* (pp. 48-59). Springfield, Illinois: Charles C. Thomas Publisher.

Lange, G., Sheerin, D., Carr, A., Dooley, B., Barton, V., Marshall, D., Mulligan, A.,Lawlor, M., Belton, M., & Doyle, M. (2005). Family factors associated with attention deficit hyperactivity disorder and emotional disorders in children. *Journal of Family Therapy, 27*, 76-96. Retrieved May 08, 2009, from Google scholar database.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park: SAGE Publications.

Makweya, S (1998). *A historical pedagogical perspective on discipline in the Black family.* MEd thesis. Pretoria: University of Pretoria.

Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *The Lancet, 358 (9280),* 483-488. Retrieved June 01, 2009, from Science Direct database.

Marshall C., & Rossman, G.B. (2006). *Designing qualitative research (4th Ed.).* Thousand Oaks: SAGE Publications.

Martinez, J.M. (2000). *Phenomenology of Chicana experience & identity: Communication and transformation in praxis.* Maryland, USA: Rowman & Littlefield Publishers, Inc.

McLaughlin, D.P., & Harrison, C.A. (2006). Parenting practices of mothers of children with ADHD: The role of maternal and child factors. *Child and*

Adolescent Mental Health, 11(2), 82-88. Retrieved June 25, 2009, from Wiley-Interscience database.

McLeod, J.D., Fettes, D.L., Jensen, P.S., Pescosolido, B.A., & Martin, J.K. (2007). Public knowledge, beliefs and treatment preferences concerning attention-deficit hyperactivity disorder. *Psychiatric Services, 58(5),* 626- 633. Retrieved May 18, 2009, from EBSCOhost database.

Meyer, A., Eilertsen, D.E., Sundet, J.M., Tshifularo, J., & Sagvolden, T. (2004). Cross-cultural similarities in ADHD-like behaviour amongst South African primary school children. *South African Journal of Psychology, 34 (1),* 122-138. Retrieved July 08, 2009, from EBSCOhost database.

Miranda, A., Soriano, M., Fernandez, I., & Melia, A. (2008). Emotional and behavioural problems in children with attention-deficit hyperactivity disorder: Impact of age and learning disabilities. *Learning Disability Quarterly, 31,* 171-185. Retrieved June 18, 2009, from EBSCOhost database.

Mnyaka, M., & Motlhabi, M. (2005). The African concept of ubuntu/botho and its socio-moral significance. *Black Theology: An International Journal, 3(2),* 215-237. Retrieved July 12, 2009, from EBSCOhost database.

Munden, A., & Arcelus, J. (1999). The *ADHD handbook: A guide for parents and professionals on attention deficit hyperactivity disorder*. London and Philadelphia: Jessica Kingsley Publishers.

Neophytou, K., & Webber, R. (2005). Attention deficit hyperactivity disorder: The family and social context. *Australian Social Work, 58(3),* 313-325. Retrieved July 28, 2009, from Wiley-Interscience database.

Nkosi, B., & Daniels, P. (2007). Family strengths: South Africa. *South African Marriage & Family Review*, *41(1/2),* 11-26. Retrieved July 12, 2009, from EBSCOhost database.

Peris, T.S., & Hinshaw, S.P. (2003). Family dynamics and pre-adolescent girls with ADHD: The relationship between expressed emotion, ADHD symptomatology and comorbid disruptive behaviour. *Journal of Child Psychology and Psychiatry, 44 (8),* 1177-1190. Retrieved May 14, 2009, from Wiley-Interscience database.

Polanczyk, G., de Lima, M.S., Horta, B.L., Biederman, J., & Rohde, L.A. (2007). The worldwide prevalence of ADHD: A systematic review and meta-regression analysis. *The American Journal of Psychiatry, 164 (6),* 942-951. Retrieved August 02, 2009, from Google scholar database.

Poncin, Y., Sukhodolsky, D.G., McGuire, J., & Scahill, L. (2007). Drug and non-drug treatment of children with ADHD and tic disorders. *European Child & Adolescent Psychiatry, 16 (1),* 78-88. Retrieved June 04, 2009, from SpringerLink database.

Reeder, H.P. (1986). *The theory and practice of Husserl's phenomenology.* Lanham, MD: University Press of America, Inc.

Richard, G.J., & Russell, J.L. (2001). *The source for ADD/ADHD: Attention deficit disorder and attention deficit/hyperactivity disorder.* Illinois: Lingui Systems.

Ritchie, J., Lewis, J., & Elam, G. (2003). Designing and selecting samples. In J. Ritchie & J. Lewis (Eds), *Qualitative research practice: A guide for social research students and researchers* (pp. 77-108). London: SAGE Publications.

Rosnow, R.L., & Rosenthal, R. (1996). *Beginning behavioural research: A conceptual primer (2nd Ed.)* New Jersey: Prentice Hall.

Ross, F.C. (1995). *Umntu ngumntu ngabanye abantu: The support networks of Black families in Southern Africa*. Pretoria: The HSRC Publishers.

Sadock, B.J., & Sadock, V.A. (2007). *Kaplan & Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry (10th Ed.).* Philadelphia, USA: Lippincott Williams & Wikins.

Schipani, D. (2008). Thriving with ADHD. *Scholastic Parent & Child, 15 (8),* 68. Retrieved August 05, 2009, from EBSCOhost database.

Seale, C. (1999). *The quality of qualitative research.* London: SAGE Publications.

Segal, E.S. (2001). Learned mothering: raising a child with ADHD. *Child and Adolescent Social Work Journal, 18(4),* 263-279. Retrieved August 03, 2009, from SpringerLink database.

Silver, L.B. (1993). *Dr Larry Silver's advice to parents on attention deficit hyperactivity disorder.* London, England: American Psychiatric Press, Inc.

Singh, I. (2003). Boys will be boys: Father's perceptions on ADHD symptoms, diagnosis and drug treatment. *Harvard Review of Psychiatry, 11(6),* 308-316. Retrieved August 04, 2009, from EBSCOhost database.

Skounti, M., Philalithis, A., & Galanakis, E. (2007). Variations in the prevalence of attention deficit hyperactivity disorder worldwide. *European Journal of Pediatrics, 166 (2),* 117-123. Retrieved August 01, 2009, from SpringerLink database.

Smith, P.K., Cowie, H., & Blades, M. (2003). *Understanding children's development (4th Ed).* Oxford, UK: Blackwell Publishing.

Smith, S.L. (2002). What do parents of children with learning disabilities, ADHD and related disorders deal with? *Pediatric Nursing, 22(3),* 254-257. Retrieved October 14, 2009, from EBSCOhost database.

Sparkes, A.C. (1998). Validity in qualitative inquiry and the problem of criteria: Implications for sport psychology. *The Sport Psychologist, 12 (4),* 363-386. Retrieved May 12, 2009, from EBSCOhost database.

Swick, K.J., & Williams, R.D. (2006). An analysis of Bronfenbrenner's bio- ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33(5),* 371-378. Retrieved January 20, 2010, from SpringerLink database.

Teeter, P.A. (1998). *Interventions for ADHD: Treatment in developmental context.* New York: The Guilford Press.

True, J.A (1989). *Finding out: Conducting and evaluating social research (2nd Ed).* Belmont, California: Wadsworth Publishing Company.

Viljoen, S. (1994). *Strengths and weaknesses in the family life of Black South Africans.* Pretoria: The HSRC Publishers.

Vitanza, S.A., & Guarnaccia, C.A. (1999). A model of psychological distress for mothers of children with attention deficit hyperactivity disorder. *Journal of Child and Family Studies*, *8(1),* 27-45. Retrieved June 10, 2009, from SpringerLink database.

Wodrich, D.L. (1994). *Attention deficit hyperactivity disorder: What every parent wants to know.* Baltimore: Paul H. Brookes Publishing Co.

Woods, S.K., & Ploof, W.H. (1997). *Understanding ADHD: Attention deficit hyperactivity disorder and the feeling brain.* Thousand Oaks: SAGE Publications.

Wymbs, B.T., Pelham Jr. W.E., Molina, B.S.G., & Gnagy, E.M. (2008). Mother and adolescent reports of inter-parental discord among parents of adolescents. *Journal of Emotional and Behavioural Disorders, 16(1),* 29-41. Retrieved July 09, 2009, from EBSCOhost database.

TABLE 1: PARTICIPANT STATISTICS:

Participant	Race	Age	Sex	Marital status	Culture	Child's sex	Child's age	Child's Medication
A	Black	42	M	Married	Sotho	Male	9	Ritalin & Schisandra
B	Black	39	F	Separated	Xhosa	Female	7	Ritalin
C	Black	34	F	Divorced	Sotho	Male	9	Ritalin
D	Black	38	F	Widowed	Tswana	Male	8	Ritalin
E	Black	41	F	Married	Sotho	Male	9	None

TABLE 2: PARTICIPANT PROFILES

PARTICIPANT A:

Meaning Units	Psychological Language
Behaviour 1. He prefers to be alone, play alone. 2. He's going to clap them. A child can come with other friends; he is going to clap them. 3. He prefers to play with them alone. My friend and no one else 4. He does not want others to touch his toys. If a third party can come, he does not want to share. He does not want to share his stuff with other kids. 5. Especially when we attend family gatherings, he starts saying I want this and jump around 6. He is active, always running, he does not listen, when you say stop and sit down, he will sit for a minute and three minutes.	- Parent experiences her child as ***withdrawn socially and isolated*** - The child seems to have no concept of how to relate to others and ***uses aggression*** when he does - Child also ***bullies others*** and is possessive in his relational style - Child seems overly protective of his belongings and ***does not trust*** others to share with them - Child ***embarrasses parents*** in social situations and is ***uncontrollable*** - He is ***hyperactive, cannot pay attention*** and is ***uncontrollable***
School 7. He's struggling at school. He	- Child has ***learning difficulties*** at

does not cope well actually, to write and read. 8. Crèche was so difficult for him because he went to crèche with other kids who are bright, so it was a problem. 9. What is affected is speech. He has a problem with speech. 10. If he needs attention, he needs maybe to hold you. Pointing, you know, he has to pull you by the hand and take you there.	school and ***not coping well.*** Parent experiences his child as ***stupid*** - Parent experiences his child's ***speech problems*** as another difficulty which he has to face as the child prefers not to talk as a result
<u>Understanding of ADHD</u> 11. I have not learnt that much. I can't really say you know what is the cause. Of course we don't know 12. Just some of the things that happen for a reason.	- Parent shows ***lack of understanding*** and a defensive attitude towards ADHD - "Things happen for a reason" used as coping strategy and looking at a holistic view
<u>Professionals</u> 13. We went to all sorts of doctors; several doctors, psychologists, someone dealing with bones. We started attending witchdoctors and all 14. The doctor said the boy is normal, healthy	- Parent ***shows concern*** about his son's condition - A sense of ***frustration with professionals*** who said there was nothing wrong - Parent relates his ***frustration*** when his son did not develop

15. He didn't have what you call normal development, where you see one when a child grows; when it will crawl all those things. He did not crawl for a year 16. Of course it makes you sad. I'm sad. It's very sad you know. 17. You feel uncomfortable with that 18. At Johannesburg Hospital they mentioned like something was wrong with the brain, damaged or something like that. 19. They suspect when the mother was delivering, they did something wrong. 20. It's the first time you know in my family, they are not used to it; it's not something they know. 21. It's rare in our Black community you know. When I grew up, it was not known by most people in the village you know. 22. I accept it because there is a lot of children you know. When you go there is lots of parents	according to what was expected of his age - Parent relates feelings of ***sadness*** and probably depression and being ***uncomfortable*** with the situation they are experiencing - Feelings of ***guilt*** and ***blame*** - Feelings of ***shame*** since they are the only one in the family - This has become an ***imposition*** that has come into their lives without being invited - ***Feels trapped*** - Parent ***does not feel alone*** which is ***comforting*** to him

and you talk. They don't call you alone. There is lots of other parents	
Medication 23. Mine is on Ritalin three times. Chisandra is better than Ritalin. With Ritalin sometimes he feels he's got fits.	- Child experiences side effects with medication which has concerned him and has thus caused him to seek alternatives - ***Disappointed*** with the medication
Parenting Style 24. We are not really harsh on him. But you have to be hard on him. 25. We are always alert, when he starts to run after a moving car and stuff like that. 26. We are just like normal parents. I just try my best. I try my best you know.	- Parent feels ***guilt about punishing*** his son - Feelings of ***imminent danger*** causes parent to be on the lookout at all times - Parent feels unsure of how he is doing as a parent and even though he says he tries his best, there is an underlying ***sense of despair and helplessness***
Response of others 27. Others are supportive. Some don't actually understand what is it. They are just not informed about what's happening 28. When you go to the shops with him or the mall people start	- Parent has ***mixed feelings*** about support from others who do not always understand - Parent is aware of stares from others which are

looking otherwise you know	***uncomfortable***
<u>Culture</u> 29. Normal culture; respect, discipline. When it comes to discipline, he must give us time to speak 30. The way they raised me is different from the way I raise them. We were raised strict. As a kid there are boundaries. 31. Boundaries are not there with him because you know he is sick.	- Father trying to instil values he grew up with of ***respect and discipline*** in his child but feels that he cannot because his child is sick. - Sensing some conflict causing the father feelings of ***helplessness***
<u>Other kids</u> 32. They are different hey, the other kids that are right you know but you have to treat all kids the same. 33. Because as they stay in one house somewhere along the line it's gonna affect them. My little daughter you know, he is running around with them because with the kids they think it's alright. They will run maybe break something because my brother is doing that	- Feels ***pressured*** to treat children equally - Other children in the house are affected by the behaviour of the child with ADHD which can create feelings of ***helplessness***
<u>Future thoughts</u> 34. They say it differs, some will	- Parent does not seem to have

come right you know. When they grow and start looking after themselves, they outgrow it	high hopes for his son and ***doubts*** if he will make it

PARTICIPANT B:

Meaning Units	Psychological Language
Behaviour 1. She's hyperactive, she climbs a lot, she talks a lot, she's very bossy; always the teacher when they play school, she always argues, does not listen 2. If you tell her to study she watches TV 3. This person has a lot of energy	- Parent experiences her child as ***hyperactive***, ***inattentive*** and ***uncontrollable*** - She also ***bullies others***
School 4. She's clever, she finishes before others & disturbs others, her school marks are always good 5. She argues with the teacher in front of others and is disrespectful	- Parent seems to show some ***pride*** in how ***clever*** her child is - She has ***mixed feelings*** because this causes her to disturb others and become disrespectful towards a teacher which concerns her as she ***values respect*** for elders
Home 6. At home she does not concentrate at all. She will give answers to anything that comes to mind 7. She will ask for you to listen for her and she writes it down 8. When it comes to school work she just doesn't care	- There is evidence of ***inattention*** especially at home - Child does not show concern for her work when at home even though she seems to ***cope well at school*** - Mum finds it ***difficult to***

9. Her school marks are always good, it's just here at home 10. The mind stays focused on the TV you are trying to take her away from	***control*** her at home
<u>Understanding of ADHD</u> 11. To be honest I don't know what is ADHD 12. I thought she may have emotional problems, moving maybe, change 13. We just thought it was part of growing up 14. I was not confused because she was growing up 15. I didn't see a problem. You know Black people will always think it's hereditary; she's either taken after someone in the family 16. Before I didn't know about it, I didn't care, I treated her the way I wanted because I didn't know she had ADHD 17. Now I've got an understanding it doesn't mean I don't discipline her 18. Knowing has helped a lot, a lot	- Parent is open about her ***lack of understanding of ADHD*** - Parent attributes her child's behaviour to change of environment - She also thinks her behaviour could be part of growing up. She is ***ignorant*** about ADHD and seemed unconcerned at the time - ***Black culture*** helps one live with the behaviour and understand the behaviour
<u>Professionals</u> 19. The teacher couldn't cope and other teachers couldn't cope. They	- Teachers not supportive

even threatened that they wouldn't go on a trip to the zoo if she came along. 20. I received a letter from the school, sent by the principal by the way, saying she mustn't come to the school until I go to the school.	
Parenting Style 21. Sometimes you shout at her 22. I discipline and I shout and I explain why I shout at them. I can explain myself, my harshness 23. The understanding I got from my mum is assisting me to cope. The love she gave me is making me able to give the same to my child; to make it fit for Sihle so that she can grow up a happy child	- Parent realises that she is ***harsh*** and shouts at her child a lot but is ***accommodating*** in her style as she explains to her why she shouts - The values learnt with her parents are what she tries to pass on to her child so that she can grow up with balance in her life
Others' response 24. My family responded well, positively 25. My sister helped me cope with it because she knows about it, she knows and understands it 26. Right now I don't have friends here because I am new here. The only friend I have is my sister and my sister's friends 27. The only problem was on the	- Parent has ***mixed feelings*** about how others view her. - ***Feels supported*** by her family - Her sister has been a pillar of strength for her since she has a better understanding - ***Feels alone*** as well with no friends - ***Feels blamed*** by in laws

father's side, they didn't understand. They still blame me for what has happened, as they blame me even today; that this child wouldn't be like this 28. His sisters swore at me; phoning me and swearing at me cursing; saying that I'm responsible for their mother's stroke	- In-laws are seen as ***insensitive*** and ***self-absorbed***
<u>Culture</u> 29. Xhosa culture says one should be harsh 30. I didn't grow up in a typical Xhosa set-up 31. I teach them respect; respect for themselves and to love themselves and to respect themselves	- Comes from a ***harsh culture*** which was not imposed on her as she was allowed to be herself - Parent has adopted and an ***individualistic*** way of raising children. ***Focus is on the self*** and less on others.
<u>Emotional experience</u> 32. We chase her away here 33. If I am watching TV she comes and disturbs me, I chase her; we all chase her away 34. It's difficult dealing with her behaviour, sometimes you feel like screaming and I feel like my head is going to explode because I need to shout, scream at her but I love her	- Parent finds it ***difficult to deal with*** her child and responds by chasing her away which is ***avoidant*** - Parent ***feels torn*** between her love for her child and wanting to shout at her at the same time with the shouting interpreted by her as lack of love for her - Has a lot of ***anger*** and ***feels***

35. I sometimes feel like screaming and shouting; I wake up, stand on my feet and wonder	***helpless*** and not knowing what to do***.*** Also ***feels anxious*** about the future
36. I'm not sure I'm even coping. I'm really not coping. Some people will even ask me how I'm coping	- She has ***lost all confidence in her abilities*** as a parent as she ***sees herself as a failure***
37. Her psychologist referred me to Liezel so that I can also get out my own frustrations because I do have my own you know	- She has a lot of ***frustrations*** that she needs to deal with herself and seems insensitive to her child's needs or in a ***state of despair***
38. Sometimes I see the sun rising in my sleep	- ***Not coping*** and finding everything too much to deal with. ***Feels helpless and hopeless***
39. I drink tablets like nobody's business; especially Disprin is my tea because I get headaches. I've had them for some time now but it's worse now because of this child	- Experiencing ***too much stress*** and ***headaches*** and relying on headache medication to cope. ***Sees child as responsible for her pain***
40. It's a bad day for me today. My marriage ended under mysterious circumstances. I'm still trying to cope with it. This situation with the kid who has ADHD, I don't work, don't have a house to celebrate my thirteenth anniversary	- She seems ***on the constant verge of breakdown***
	- A child with ***ADHD has complicated her life*** even more than the breakup of her marriage which she is trying to cope with on top of everything else
41. What he did was to buy a single trip not a return. He told me I might as well keep them. That is how my marriage ended	- ***Feels rejected*** by her husband
	- ***Unable to cope***
42. It's so funny I don't get fat when I	- ***Confused about her own needs*** which are in conflict with her

get stressed. It's the feet that get swollen. I don't know why my feet get swollen. My husband is so brilliant he has a Bcom and HDE.	child's needs
43. I'm tired, I'm tired, this daughter of mine has tired me	- ***Feels not good enough*** and idealises her husband who did bad things to her - ***Feelings of exhaustion***
44. I wish I could cry. I ask myself why, why should I cry. Not anything is going to change. Do I need a solution?	- ***Depressed*** and ***confused***
45. I can't go back at this age; I can't go back with what I've gone through. I am imprisoned here I don't have anywhere to go, no one to go to	- ***Feels like a failure. Feels trapped*** in a life she did not choose for herself - ***Lack of freedom*** to do what she really wants. ***Others are controlling her***
46. Sometimes I'm happy that I'm under her roof, sometimes I feel damn, if I were not under her roof, maybe I would have handled things better you see? I would hit this child but now I can't in front of her because she will tell me that a child is not supposed to be hit	- ***Feels empty, depressed*** and ***confused.*** She is also ***angry*** and finds it hard to accept her situation and constantly comparing herself to others. She is ***bitter*** about how her life has turned out
47. There are days when I feel that my heart is hard and sore, and ask myself why me, why is this thing happening to me do you understand? Why do I have a child with ADHD? I don't need this. Why isn't my life cool, why	- Has ***low self worth*** and therefore feels others see her the same way - ***Feels misunderstood*** by others and wishes they would let her be

don't I get a job? 48. Sometimes I feel my sister understands me, where I come from. Sometimes I feel she doesn't understand where I come from you know. She most probably thinks I'm mad also 49. Sometimes she thinks I'm too soft or whether she sees me as being too harsh? I even doubt my own sister 50. Some people understand me, some they don't	
<u>View of self as parent</u> 51. I don't even want to see myself. 52. I wish there was a video with a hidden camera that would film me when I go mad or whatever or even when I shout and stuff like that so that I would be able to rewind the scenes and see wrongs 53. I see myself as somebody who can't cope. Other people say I'm coping it's quite hard and confusing. I don't know where I stand 54. Somebody said why don't I get her into karate classes. Now where do	- Finds it difficult to look at herself as she will not like what she will see - Feels like she ***may be going mad*** and believes she is ***making mistakes*** - Finds it hard to accept positive feedback and ***believes the worst of herself***. It is all ***confusing to her*** - Feels ***others are insensitive*** to her plight - ***Feels helpless and hopeless***

I get that money? 55. I would need to hire a car to take her there and back 56. They say that energy can be directed towards some karate or dance lessons 57. Sometimes I feel a child with ADHD doesn't understand me as well as one without ADHD	- ***Everything seems insurmountable*** - Not in touch with what her own child is going through. Feels she ***needs to be understood by her child*** as well
<u>Future</u> 58. What I want is the way forward for my kid's sake and mine 59. I wish I would wake up and see that everything has changed 60. I think she will be fine. I have also seen some change ever since she started going to Bara. Even now she's currently been made a group leader it's quite amazing 61. If parents can be able to pick it up it would help a great deal 62. If like all teachers would understand	- ***Crying out for help*** - ***Feels like a victim*** - She is ***hoping for a miracle***. - ***Feels encouraged*** by the improvement in her child - A lot of 'if' which shows ***despair***

PARTICIPANT C:

Meaning Units	Psychological Language
Behaviour 1. He's a quiet child. He plays alone; he's an indoor child. He doesn't talk much, he's not hyperactive, he doesn't have signs of ADHD 2. He's ignorant. He asks strange questions from me, stupid questions 3. He's very emotional; he's not aggressive 4. His problem is only one thing; concentration. 5. He is taking Ritalin to help him concentrate. 6. He forgets, to me he worries me, he forgets. He wants to be reminded each and everything 7. He refuses, when he says he won't do a thing he will never do it	- The hyperactive symptoms of ADHD are not evident, creating ***doubt in the mother*** about her son's ADHD diagnosis - Seems ***socially withdrawn*** and ***isolated*** - Parent seems confused by her son and ***doubts his intelligence*** - Parent experiences her child as ***emotional*** - Child seems to have ***inattention*** problems which affect his ***memory*** - Mum seems ***anxious*** about her son's ***poor memory*** - Child showing ***oppositional traits***
School 8. Most of the people love him 9. He helps other kids most of the time. When he helps other kids with ADHD they do understand him but with normal kids others don't understand him	- Child is ***popular*** amongst other children with ADHD but not necessarily amongst those without ADHD

10. He loves his school very much; he enjoys everything that they do there 11. The problem is that now he knows too much. He doesn't want to be told everything twice and other kids are making things slowly for him. That's why they want him out of the school. They want to see if he is in a mainstream can he fit there?	- Child is ***coping well*** at school
<u>Home</u> 12. He's a very good boy, he's a loving child 13. He loves his younger sister, he loves me and he hates his father. He was close to his father until one day he found out that his father is not a right person, so he hates his father 14. He's comfortable, you can stay with him; you can leave him anywhere. 15. He's not … you know ADHD kids are active as such. No he only needs a remote	- Mum experiences her child as ***loving and easy to deal with*** - Mum makes a clear distinction between ***the love her son has for her*** and his younger sister in contrast to ***the hatred he has for his father*** - Mum describes her son as easy to manage and take care of. She is ***not struggling*** with handling him and feels that he is ***disciplined***
<u>Understanding of ADHD</u> 16. He hated school, hates writing because he doesn't know how to	- School was not easy for this boy initially as he struggled to

grab a pen. ADHD kids grab it the other way so he hates it because other kids used to laugh at him, hates schoolwork 17. He loves cellphones, likes everything that's technology 18. They told me I must change his diet. I made him a special diet. I didn't put too much sugar 19. They told me about concentration 20. They told me his father has ADHD 21. It's frustrating because they told me if they didn't get help when they're young, when they are adults they become criminals. His father is a criminal. He dropped out of school; he knows too much, he wants to win, wherever he is everybody listens to him 22. His father doesn't sit down because he doesn't know how to sit down. He will sit down for two minutes, he will stand up. 23. I thought my child he was this clever child, he was not hyper, he wasn't talking too much 24. When they are clever they are too clever but when they are stupid, they become more stupid	hold a pen - Mum has experienced the ***changing of his diet*** as an important step in managing her son successfully - Learning that her ***ex-husband had ADHD*** was a revelation for her which helped her uncover issues about ADHD and it's manifestations - Through watching her ex-husband's behaviour and that of his family, she was ***able to understand*** what was happening to her own son and why - Seems ***informed*** about ADHD

25. There was nothing wrong, I couldn't see anything 26. He's always in his father's family. For me understanding ADHD comes from that family. Everybody in that house except the mother is like that. His aunt is like that but she knows how to control herself. 27. That this is in the father's house. They don't understand each other, they are fighting, nobody wants to seek help 28. His grandmother is starting to understand. She thinks his child is a criminal. She is waiting for the police to knock and tell her there's your child there he's dead and then she will bury him 29. I said there's help but it's too late, nobody wants to face him in that family, they're afraid of him	
<u>Professionals</u> 30. They told me if he didn't get help, at the age of fifteen, they start doing all this you know, most of them go to jail 31. Most of those kids there, they are ADHD 32. They can rob someone's car, my	- Most of what this mum has learnt about ADHD has been fuelled by the ***husband's behaviour*** - She is therefore looking at and understanding ADHD with fear for her child turning out to be a

child can do theft. They are criminals, they are either robbers, they hi-jack all those parts of dangerous criminals; that's how ADHD kids end up being	criminal like his father ***(overprotective)***
<u>Style of Parenting</u> 33. I'm a very strict person, I don't want silly kids. I don't want kids who don't understand 34. Most of my sisters' kids are afraid of me. Others hate me. 35. My voice is high when I speak to kids. I raise my voice and every child listens and do whatever I want him to	- Again in the way she parents she is ***ruled by fear*** of what would happen if she is not ***harsh or strict*** - ***Authoritarian style of parenting*** seen in most traditional Black families which can make symptoms of ADHD worse at times
<u>Others' response</u> 36. They don't even understand it even now. 37. They would tell you he will end up being a gay or sissy 38. When Tshepo speaks they laugh at him. They think Tshepo is mad whereas they don't understand; even my sisters they don't even understand this ADHD thing 39. Most of them shout at me. They are telling me how I'm treating myself, how I ended up 40. They hate my husband, they think	- ***Others lack understanding*** of ADHD - She ***feels unsupported*** by her family members who ***laugh at her son*** and call him mad - Constant ***insensitive remarks*** that show lack of concern or care - She realises that ***others are critical*** of the way she conducts her life - Others are ***blaming her husband***

my husband is the one who made me to be like this 41. They think I'm mad, they say I'm living in a mad world so I rather keep quiet	for her life - She also ***feels misunderstood*** by others and ***marginalised***
<u>Culture</u> 42. I don't know about the Sotho culture. I can say I'm raising my child my own way which is learnt from home 43. My mother was a very very strict woman. She taught us how to be responsible for ourselves 44. He needs to be responsible of taking care of himself; to wash his underwear, socks and now he is starting to wash dishes 45. I don't want kids who don't want to respect other people 46. I don't want kids who will stand up and what is this you know, asking touching 47. The child must know that this is not my mother or father's house, he needs to behave himself 48. If he needs something, he needs to ask 49. He follows my rules, what time to sleep, what time to watch, what	- Feels ***confident*** in her ways of raising her son that she learnt from her mother - ***Being strict*** is taught early in life and therefore she believes that it should be the only way. Very ***authoritarian style*** - Teaching him ***responsibility*** is very important for her and creates independence - Respect is a value she enforces in her son in order for him to have ***respect for others*** and to have ***boundaries***

channels to watch, he doesn't watch each and everything, he sleeps early, after he eats he sleeps	
Emotional experience 50. At first I thought my child was emotional because I shout. I thought maybe that's why my child is like this because I was shouting 51. When I'm at home I would sit down and look at both people and my child. I see similarities with his father. Everything then, this thing frustrates me. 52. Everything, the body structure, the talking, what they do, they stutter. They become very angry if you don't understand them, that's how they are. You need to finish the sentence, you need to know what they want to say; so eish I'm frustrated 53. I don't have a life, wherever I go, where I am Tshepo is always with me. If you don't accept my child there's no way I'm going, that's how life is 54. I don't get time for myself. I think I'm isolating myself from people because of the guilt of finding out	- Parent ***blames herself*** for her child's feelings - At times she ***blames the father*** when she sees similarities between him and her son and it ***frustrates her*** - ***Blames her child*** as well for the ***loss of her freedom***, her life - Seems ***helpless*** and making a lot of sacrifices for her son. She has made ***her son her priority*** and let life pass her by in the process - Mum has made some lifestyle changes to accommodate her son and ***making him a priority*** - ***Feels guilty*** about her son's condition which results in blaming herself. She is ***socially withdrawn and isolated*** as a result of the guilt - She lives in constant ***fear and anxiety*** about her child and ***does not trust others*** to take good care of him

that I've got a child who is like this 55. I'm selfish now I'm with Tshepo all the time 56. I'm overprotective you know even when schools are closed I would rather take my child to work with me 57. He comes first in everything. I need to relax and go out, I can't, you can't 58. When he's not around during school holidays I don't go anywhere, I stay on my own thinking, sitting 59. I don't have an outside life, that's how I am 60. When he's not there I don't know what to do with myself; I'm always alone 61. It's forgetting that's worrying me; it's reminding him, these days I have to remind him	- Her over protectiveness could be masking her own fears about ***guilt and low self-worth*** - She has created her life around her son and when he is not around she ***feels lonely,*** with no one to turn to, which has contributed to the ***loss of her freedom*** - Again her son's ***poor memory*** is a great concern for her
<u>View of herself as parent</u> 62. I don't know because sometimes you praise yourself that you are a good person 63. I'm fine; it's just that even when I'm with my friends I do a lot of corrections. Somewhere somehow	- Believes she is a good parent but thinks others would disagree resulting in her ***doubting her own capabilities***

I'm very strict 64. Maybe I'm comparing him too much you know	
Medication 65. Yes short attention, you know cause they are ruled by the Ritalin 66. It works for 8 hours and when it's off his body he sleeps, he doesn't talk that child 67. He does this tic, they said I must be aware when he drinks medication there are other signs he's gonna do	- Ritalin is a necessary burden for her as she feels her son cannot cope without it making it ***a burden*** - The trouble seems to be the tics that are side effects of the medication
Other kids 68. There's a lot of difference. Those kids they do things for themselves, they know what to do. 69. For me those kids are responsible 70. Especially when it comes to expressing themselves; that's the most difficult thing when it comes to Tshepo	- Comparing her son to her sister's children makes her feel like her son does not measure up to expectations - ***Speech problems*** seem to be present
Future 71. I try to help him understand himself, trying to let him know that this child has got this ADHD 72. I try to research about people who are ADHD like celebrities, the famous people. This person is like	- Parent has been very active in channelling her son's life in a direction she believes would be beneficial for him which also ***gives her control*** - She's her son's number one

you at the end of the day you will be like this person. I try to put those pictures 73. You can proceed, you can go to mainstream. So I'm encouraging him 74. Now he doesn't stutter. He's changing everyday 75. I hate his father's life and I even hate him so I do not want this child to be close to his father	supporter and wants what's best for him which shows great ***concern*** for him - She is driven by the ***hatred*** and fear she has for her son's father and does not want her child to end up like him

PARTICIPANT D:

Meaning Units	Psychological Language
Behaviour 1. He grew up with a lot of energy. He was hyperactive around 11 months 2. If he doesn't get the bottle he'll jump out of the cot or take the bottle if it's too late and throw it all over the wall 3. Maybe we have visitors in the house, he will start taking drinks throwing or answering back 4. He would jump around in the road and it's too dangerous, he would end up being hit by a car because he doesn't think 5. He talks a lot, he talks a lot and he doesn't think and last year nearly knocked by a car in front of me. He didn't even like check left right whatever, he just walked into the road 6. Sometimes he bangs the door, he throws tantrums, he likes throwing tantrums 7. Sometimes he can be very nice, he can be good, he can listen the whole day and then tomorrow it's	- Her child started showing ***hyperactive symptoms*** and ***low frustration tolerance*** at an early age - He seemed ***uncontrollable*** and the mum had to be ***constantly alert*** - ***Impulsivity*** has come out strongly in her description of her son - At times he is good which makes him ***unpredictable***

another day. He's unpredictable 8. At one stage I don't know he took somebody else's chips and he had his own. I don't know they say he took a pear I don't know like hurt another child or whatever. There are lots of incidents that he has done 9. Say I would have a new radio or a new cellphone he will break it down	
<u>School</u> 10. He understands very well and he's very bright 11. Even if I can show you Nathi's report, it will show you it's got, it's a normal academic report and the second one report is the behaviour 12. He's got influence; he can just influence all those kids. All these children listened to him because everything he said was correct 13. When he plays around his peers he causes too much trouble. His friends are therefore younger. 14. Some say Nathi is very naughty and blah blah blah, some kids will fight back, some kids will stay away from him. There has been a	- Parent sees her son as doing well academically and being a ***clever child*** - She believes that her child is ***influential*** because she knows a lot - He is ***rejected by peers*** though because of his negative behaviour and may suffer low self-esteem - He ***prefers younger friends*** due to his rejection by his peers

whole lot of fights	
Home 15. He loves his brother so much but they fight every now and then. Sometimes they will kick each other in front of everyone but he loves his brother	- Child seems to have a ***good relationship with his brother*** but the parent downplays his aggressive behaviour
Understanding ADHD 16. According to my understanding it has to do more with the behaviour. You know I'm not an expert. 17. It can be controlled 18. I thought he would grow up. I thought it was an easy thing 19. I surf the internet, I check each and everything, whatever booklet or ADHD support group, I find it and I always read that I always try to inform myself bout ADHD 20. I can see changes, like he will say Mama I need to go to the bathroom or whatever 21. He's so good now I started learning from him that this is how I should treat them 22. I shouldn't scream because screaming at him you make him mad because he loves attention.	- Parent has ***some understanding about ADHD*** and is open about her lack of understanding initially - ADHD is ***controllable*** - Parent takes an active interest in her child ***(concerned)*** and wants to find out as much as possible in order to help him - Feels that even though this seems rare amongst the Black communities, White communities have known about it longer and so she tries to gain information from them so that she can increase her knowledge ***(others do not understand)*** - She has ***put in a lot of effort*** in trying to learn more about ADHD in order to help her understand her child better

23. He hates to be ignored 24. This thing is now coming out in Black communities. I also get advice from Whites at work. So I ask them for advice on ADHD because these things are common in White people	- Her ***efforts seem to be paying off*** as she can see changes in her child's behaviour
<u>Parenting style</u> 25. I know I am a very shouting person, you see I like shouting; but don't do it with hatred even if he's totally wrong. I try not to shout 26. At first I was very bitter. I wanted to hit him; I wanted to do that but now I have that understanding 27. But if you hit him, you don't understand this child they say he is an attention seeker you will never know, they love attention. If he's done something wrong and you scream and hit him it doesn't work but there's ways of dealing with it. I only learnt this year how to deal with it.	- This parent has educated herself about managing her son's behaviour and realised that even though the behaviour causes her to want to shout, it is not what is good for her son – ***emotional intelligence*** - She ***was bitter*** but feels more in control now - She believes that children with ADHD are ***attention seekers*** which is why they act out
<u>Others' response</u> 28. Around the neighbourhood they used to complain all the time 29. I get complaints from the transport	- ***Family and friends*** seem to have responded positively and ***are very supportive*** with the support from her mother who is

guy. He will tell me that he did this and that and now I was at work they just came in and brought him 30. But around here I have a problem to such an extent that this other neighbour told me that Nathi started swearing and he hit my child without my consent because he doesn't know that Nathi as a condition 31. It's just that his brother fortunately understands Nathi's condition. He knows about the Black kids living with ADHD in Motswako. He listens to it. He's interested to know more about Nathi's condition 32. You know it's not everybody who understands that Nathi is like this. 33. It's very difficult to deal with a child because people think this child is naughty, not understanding, shouting at the child 34. My mother is spiritual because everything she needs she prays. So she is very supportive. She knows how to speak with a child. She knows how to command 35. My mum's family find him very funny; everybody loves Nathi.	spiritual and able to handle him better that his mum can - ***Neighbours and strangers have not always responded positively*** with some bad experiences with a neighbour who hit her son - It is ***frustrating for her*** that others do not understand - She finds courage in the support she gets from her other son who is understanding and supportive of his brother - Things get ***hard and difficult*** for her at times especially when it comes to how others respond to her son - ***Popular child*** who is loved by others - Dealing with advice from others has been a constant source of ***frustration and disappointment*** - It is ***infuriating for her*** that people can be so insensitive and ignorant and yet tell her what to do

36. All my friends are very supportive 37. He's popular from there till the last street they all know him 38. People don't understand. People believe in traditional things that do not work. They say no you must take this child to so and so, he'll be healed. 39. They try to advise all of a sudden; wrong things; telling me the negatives without understanding that this child has behavioural problems 40. You know how Black people are. They can be so ignorant and naïve.	
<u>Culture</u> 41. I raise them to be well-mannered and to keep away from wrong 42. I teach my children to do the right things because they come from a family of love 43. I try to be spiritual at all times, you have to. I am someone who believes a lot. I pray a lot	- ***Good manners*** and ***doing the right thing*** are important for her - Seems to have ***learnt some values at home*** that she is passing on to her son - ***Spirituality*** is one thing firm in this home and is passed on from the grandmother - ***Spirituality is her only coping mechanism***

<u>Emotional experience</u> 44. I couldn't get out of bed in the morning, I just couldn't stand up. He will cry from waking up until his car comes to get him 45. I was so depressed, I told my colleagues because he is 9 years full and I used to get this everyday, I didn't know what to do 46. When my husband died he was like two and a half. I don't have a husband I'm all alone I don't have a man for support 47. Very very very very long, a very painful hell of an experience for me 48. It's such a painfully long experience especially last year when they said he's expelled, I felt like that woman has no child. They used to phone me at my work and tell me that we cannot have this child here at school 49. I keep asking myself that is there nobody that can help me figure this because this is a new thing 50. When you're in front of people that's where he will embarrass you. You dare shout in front of	- She has gone through periods of ***fatigue, exhaustion and even depression*** due her son's behaviour which she experienced as ***out of control*** - ***Mornings before school have been the hardest*** - There are feelings of ***helplessness*** as well - ***Feels alone*** without her husband and feels it would have been different had he been around - The ***suffering*** endured by this parent has been ***endless*** and she cannot find proper words to describe it - Her son having been expelled from school was the biggest hurdle she has had to face and the i***nsensitivity of others*** left her feeling ***helpless*** and ***without hope*** - She feels she still ***needs to learn more*** and does not feel she has achieved mastery of the situation. She is ***insecure*** - She has ***experienced embarrassment*** in front of

people; he will so embarrass you. I am telling you 51. Sometimes I get miserable that I feel like crying but all I can tell you is I'm trying other ways, other better ways. But I keep getting worried that sometimes I will get to a point I can't describe so he must be well taken care of 24hrs 52. But for me it as actually worked for me to take him to Rant en Dal school. It brought out the best in me of raising him as well 53. I finally found ways of dealing with this and it's working lovely and I feel much better now	others due to her son's behaviour - She gets ***miserable and depressed*** because she ***feels drained*** by the fact that she believes she has to watch over her son 24 hours - Finding a new school for him has been a an eye opener and she ***feels more secure*** now than before
<u>Future</u> 54. Wow me I afford, girl I do my best, I go all out when it comes to my kid 55. I want Nathi's behaviour to be channelled properly 56. They say he is like you. He does things like you. So I tell them maybe. But it's only now that I'm an adult and I can control myself	- She sees herself as ***coping*** - She has put measures in place to make sure her son turns out well ***(concerned)*** - She acknowledges ***she may have ADHD as well*** which is brave and courageous of her
<u>Medication</u> 57. In Krugersdorp, that's when they said you know he needs to be on	- The new school seems to have done a lot towards managing her son's behaviour ***(proactive***

medication 58. I don't want to lie, ever since he was on it there is a change and people can see it too 59. I had to pay for medication. I'm on medical aid but it's so useless the whole thing. They are very expensive, I had to pay R420.00. I had to spend R400 on this Ritalin thing	***parent)*** - Even though the medication is working, she is angry about what she has to spend each month and is looking for someone to sympathise with her

PARTICIPANT E:

Meaning Units	Psychological Language
Behaviour 1. He was very fussy as a child; not everybody could pick him up 2. When he was crawling, he used to do that backwards 3. One day he came crawling like a monkey from up till down 4. Whenever he takes sugar, if he was actually doing at 60km, he would do it two times 5. He plays too much to the extent that when he comes home he is finished, all he does is bath eat and sleep 6. He broke a lot of things as a child. He destroyed a couple of things at crèche playing 7. He was fearless. He was so rough, you know 8. You know, he's actually restless 9. It's not only that he's active, too active. The other thing is that he could not sit in one place and concentrate 10. He would throw himself on the	- Parent noticed that her child was ***different from an early age*** - She experiences her as ***hyperactive, restless and unable to concentrate*** - ***uncontrollable***

floor	
School 11. At school he couldn't concentrate for a long time. He would do one thing and then leave it, do the other thing, leave it, do the other thing, leave it 12. In terms of actual tasks, when you have to do the tasks, he does the task like fast. He does it so fast and there is no focus so the actual desired outcome is not what he wants	- At school he was unable to concentrate and presented with symptoms of ***inattention / lack of focus***
Home 13. He doesn't have problems with interacting with other kids. He is very sociable 14. He is a lover boy because of the personality. He's got a very nice personality 15. I can leave Tumi in people's homes and I don't have a problem	- At home she experiences her as ***having a good personality and well liked by others / popular***
Understanding ADHD 16. It has to do with attention seeking from the child 17. There's two elements. There is an attention seeking element because maybe of certain circumstances. When they feel that they are not getting attention,	- Her understanding of ADHD is that ***it has two elements*** - ***Attention seeking*** is one part which is due to ***unmet needs that trigger untoward behaviour*** - ***Hyperactivity*** is due to

they try to do things in order to draw your attention 18. There is an element hyperactivity which is actually stimulated by the physiological, you know, whatever you feed them. So it's a combination of factors 19. You know the one child I remember he was actually 15, he actually literally used to induce epileptic fits, to get attention 20. You need to identify what are the triggers that actually makes the child to seek attention 21. I attribute it to food, most of the time. Because I had an option of putting him on medication but I didn't, but it's the discipline, it goes with discipline 22. It actually creates imbalances in his brain	***physiological processes that are influenced by their diet*** - According to her experience ***food eaten can create imbalances in the brain leading to hyperactivity*** - misinformed
<u>Parenting style</u> 23. Me, I am a negotiation, you know but the father is very strict 24. I punish him. I tell him you know you're gonna be grounded, you won't go and visit anywhere; that works for me. I sometimes feel bad, but I do not reverse it	- Parent is using ***emotional punishment*** and believes it teaches her child a lesson he can remember rather than physical punishment as she believes he would forget why he was punished

25. I told the father that corporal punishment is not going to work with this kid. They are not from our world; they won't understand what it is. Because you beat the child up it's finished at that particular time, you know he may go back and repeat the same thing 26. I find that it is more painful to be punished. I take away your pocket money, and that's bad	
Others' response 27. I really find that there is a lot of awareness that needs to go on in our community 28. They give kids two cents to go and buy, you know Simba chips from the township with all the things 29. They don't understand the condition 30. At first they didn't grab the concept. I still think they still don't grab the concept 31. You are consciously aware that people are looking at you. 32. I just tippex them, I just behave like I don't see them 33. It becomes very difficult to deal with your situation and still be	- She feels that there is ***a lack of awareness and understanding in communities*** - Awareness of stares from others ***(insensitivity)*** but learning to ignore them and deal with the situation at hand - As a defence mechanism, she prefers not to concentrate on how others see her as a parent - ***In control***

worried about other people because they don't understand what you are going through	
<u>Culture</u> 34. Here it's very different from where I came from 35. We do a lot of things together 36. I acknowledge that culture evolves but there are certain norms for me and values that are not negotiable 37. She has to do her chores 38. There is a certain language that is acceptable to society 39. The mother next door is also a mother so you mustn't just listen to me you must listen to the mother next door 40. I teach them boundaries; there is a difference between how you talk to an adult 41. It's important for them to learn team work 42. I tell them about integrity because it's important; you can't lose your reputation. If you do something now, the world will remember; so it's important that they conduct themselves in a manner, I'm not saying that is acceptable to	- She believes that ***culture is evolving*** and therefore ***certain things are allowed now*** that would not be allowed in the past - However ***certain principles remain and are non-negotiable*** like ***doing of chores, using proper language when talking to adults, respect for elders, boundaries/knowing your space, integrity towards others and themselves builds character***

society but it's acceptable to them	
<u>Emotional experience</u> 43. Junk food is a problem, it aggravates them 44. When he eats sweets he becomes hyperactive 45. The problem is that I think the only reason why sometimes I am a bit cautious is because I fear that if he starts to eat something and then he starts acting strangely 46. I could see that this child is overdoing things 47. My most fear was that he didn't have boundaries. So I was actually scared that he's going to get injured one of these days 48. It was a challenge because you know as a parent you always think that I did something wrong 49. The reality is there's holidays, you're not always there and this is, for me this is a progressive thing, you can't fix it in one day 50. For me as an individual it's very frustrating 51. But it's very difficult for me because firstly I have to be aware of intraspace first, you know. So it	- She feels that ***diet is causing hyperactivity and strange behaviour*** - She has always feared something was wrong - At times ***she blamed herself*** that she could have done something wrong to cause her child to have ADHD - She ***realises it's a chronic condition*** - ***Feelings of frustration*** - She is ***aware of own emotions*** when dealing with him – ***emotional intelligence*** - It is ***frustrating for her*** how this whole thing is affecting her daughter

requires a lot of EQ from my side. The challenge is that I have to control my emotions in order to deal with him 52. It frustrates me a lot, it's very challenging. I think more importantly, it breaks my daughter, you know.	
<u>View of self as parents</u> 53. I think we are doing reasonably, you know reasonably well 54. There is progress in what we are doing because I find that there is routine. He knows that when he comes from school he comes home he gets changed, he goes to the gym, he does his homework, he baths, you know we sit and chat	- ***Succeeded*** in implementing ***structure or a set routine*** for their son which is working for them
<u>Treatment</u> 55. I began taking him to speech therapy because he wanted to do everything haphazardly, you know, to speak properly. He still goes to OT to date 56. The doctor suggested that we put him on Rivatrol and I said no 57. I saw a dietician, the dietician said no lets try a diet 58. So now I started cutting down on	- Speech therapy (***speech problems***) - Occupational therapy - She ***does not believe in using drugs*** - Chosen to look at his ***diet, encourage sporting activities and involving him in Kumon*** - Importance of ***keeping him***

sugar, I never buy sweets in my house, I never buy Simba chips 59. We eat lots of veggies, less starch, no junk 60. The other thing that helps, activities; that's now soccer, cricket so now he's got no spare time. He needs to do this, he needs to do this but to date he still goes to OT 61. I think Kumon also helped a lot because then there is a routine he gets into. The lessons are more structured	***occupied with a lot of structure and routine***
<u>Other kids</u> 62. It's a challenge because they are different 63. At any given time you want equity, you want to be able to say to them I've put you on an equal footing. 64. Fifi used to feel like he's getting away with murder; so I try by all means to make sure that what I do for Tumi I do for the other one 65. But more irritating it's the act. It really pieces Fifi off. It's frustrating for her. She felt that he was embarrassing her at school 66. We had lots of chats with Tumi	- She is trying to treat them the same but ***it is a challenge*** - Daughter often felt embarrassed by her brother - Family addresses challenges and concerns collectively - ***Feels supported*** by her family

and Fifi	
Future 67. He's very smart. When there is a long route to do something he will find a short cut to do it 68. He's very very innovative, you know creative in doing things 69. He's not a fan of comprehension. He doesn't like sitting and reading 70. He's left brain dominant 71. He's very very observant. 72. He analyses things you know, a lot 73. I don't see Tumi becoming a lawyer, a social worker or a psychologist, I don't. He will never manage because there you have to go through the theory. 74. You know I can see Tumi being a pilot, maybe engineering but not hard core things that require you to read, but things that are, he's visual. Things that include like graphics	- Inability to concentrate or his short attention span has allowed Tumi to find ***smarter*** ways of doing things rather than taking the long route. This has been ***a positive experience for the mother*** as she talks about his future proudly