How mothers of children with Attention Deficit Hyperactivity Disorder experience educational psychology support

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How mothers of children with Attention Deficit Hyperactivity Disorder experience educational psychology support

by

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(Educational Psychology)

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PRETORIA

DEDICATION

To Sam and Jess, with all my love.

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⌘ Professor Kesh Mohangi, thank you for your endless support, wisdom and encouragement. I could not have wished for a better supervisor.

⌘ The Research Musketeers. I could not have done this without you girls.

⌘ My parents, thank you for your unconditional love for me, your integrity and the opportunities you have afforded me in life. I am so blessed to be your daughter.

⌘ My sisters and my brothers-in-law. You are my best friends and I cannot thank you enough for what you mean to me.

⌘ My husband, Matthew, I love you. Thank you for your patience, support and ability to see the good in everything. You are my hero.

DECLARATION

I, Karen Archer (student number 112341567) hereby declare that all the resources consulted are in the reference list and that this study titled: *How mothers of children with Attention Deficit Hyperactivity Disorder experience educational psychology support* is my original work. This dissertation had not been previously submitted by me for any degree at another university.

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Karen Archer
April 2013

ABSTRACT

How mothers of children with Attention Deficit Hyperactivity Disorder experience educational psychology support

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The purpose of the study was to explore how mothers experience the support provided by the educational psychologist for their children with ADHD. The conceptual framework utilised for this study incorporated systems theory, collaborations and inclusive education in South Africa. In this study, I followed an interpretivist paradigm using a phenomenological approach. A qualitative case study design was selected, with five purposefully and conveniently selected mothers whose children had been previously diagnosed with ADHD by an educational psychologist. The participants took part in either a focus group or a one-on-one interview. Two main themes emerged following the thematic content analysis of the interviews, namely: *How mothers experience their children with ADHD* and *How mothers experience support of their children with ADHD.*

The findings of this study suggest that mothers of children with ADHD expect a deeper level of support from an educational psychologist. The findings also indicate that mothers experience parenting children with ADHD stressful and that they need reassurance and emotional support from the educational psychologist. The results show the need for a more inclusive school environment and it highlights the importance of the role of the educational psychologist sharing knowledge and working collaboratively with educators, the Institutional Level and District Based Support Teams and the various health care practitioners to provide support to the child and family.

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Keywords:

⌘ Inclusion
⌘ Inclusive education
⌘ Attention Deficit Hyperactivity Disorder
⌘ Educational psychologist

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CHAPTER 1
Contextualising the Study

1.1 INTRODUCTION AND RATIONALE

In 2001, the South African National Department of Education (DoE) released the Education White Paper 6: Special Needs Education (Department of Education, 2001). The paper reflects the dedication to develop an education and training system that is inclusive.

At its core, the paper promotes unified education wherein all role-players work in collaboration with one another and are supported by a learning community (Eloff & Ebersöhn, 2004). With the Education White Paper 6, there has also been a move away from only looking at the individual's difficulties, to considering other factors potentially affecting this individual. These factors could range from an inadequate or unsupportive curriculum, to the physical and psychosocial environment of learning and teaching; the conditions of the individual's home environment and the broader social context in which this individual operates. It suggests a more comprehensive approach to address barriers, as an individual's barriers do not work in isolation.

The adoption of the ideals expressed in the Education White Paper 6 expects educational psychologists to facilitate change within the education sphere and collaborate with many other professionals within the field. Such collaboration involves developing relationships with educators and the Institutional Level and District Based Support Teams, other health professionals, parents and the communities. The aim is to build an environment that meets the diverse needs of each individual to feel accepted, understood and supported within their educational setting (Engelbrecht, 2004; Walton, 2011).

Educational psychologists assess children who may have special educational needs (Farrell, 2004) and develop ways to support children's education. The changes that have taken place in education have encouraged educational psychologists to reevaluate their roles in supporting their clients with barriers to learning.

Attention Deficit Hyperactivity Disorder (ADHD) is a chronic neurological condition characterised by core features of inattention, impulsivity and hyperactivity. It is said to be one of the most prevalent disorders found among children (Venter, van der Linde, Plessis & Joubert, 2004) and may be associated with adverse outcomes through the lifespan with regards to the social, academic and emotional areas of functioning. These outcomes may

include challenges in academic performance as well as disturbances in relationships with parents, teachers, siblings and peers during childhood years, to delinquency and substance abuse in adolescent years (Harrison & Sofronoff, 2002; Wicks-Nelson & Israel, 2009).

The nature of ADHD is such that it places increased demands on family functioning and care giving responsibilities. Often, parents of children with ADHD feel incompetent, disillusioned and distressed about their parenting skills (Podolski & Nigg, 2001; Wicks-Nelson & Israel, 2009). My exposure to such parents, in particular the mothers, during my years within the teaching profession has led me to explore the support available to them. Having recently moved into the educational psychology profession, my interest focuses on the support provided by the educational psychologist in particular. Through an exploration of mothers' experiences, the study aims to provide insight into how to improve both our practices as educational psychologists as well as to identify key areas in which parents may need support. The choice to explore only mother's experiences is not to minimize the vital role that fathers play in parenting but rather due to the limited scope of this research study. Thus the main focus of this study is on the mothers' experiences of the role of educational psychologists in providing support to them as parents of children with ADHD.

There is much research describing the distress parents feel in parenting their children with ADHD. There seems to be a gap, however, in understanding how professionals, and in particular the role the educational psychologist within a South African context, can assist these parents. More research needs to be conducted on how an educational psychologist is able to collaborate with the schools, health care practitioners and other relevant role players to support the parents and maximise the success of the child with ADHD within an inclusive environment (Finzi-Dottan, Triwitz & Golubchik, 2011; Seabi & Economou, 2012).

1.2 PURPOSE OF THE STUDY

The purpose of the proposed study is to explore how mothers of children with ADHD experience the support provided by the educational psychologist. The study aims to provide insight into the current challenges faced by the mothers of children with ADHD and the role that the educational psychologist could play in assisting them. The study also aims to contribute to the literature base on the role of the educational psychologist in inclusive education and specifically in supporting families affected by ADHD.

1.3 RESEARCH QUESTIONS

This study was guided by the following research questions:

1.3.1 PRIMARY RESEARCH QUESTION

How do mothers of children with ADHD experience support from an educational psychologist?

1.3.2 SECONDARY RESEARCH QUESTIONS

- What do mothers understand about ADHD as it relates to their children?
- How do mothers experience parenting their children with ADHD?
- What are mothers' understanding of the role of the educational psychologist in supporting their child with ADHD?

1.4 WORKING ASSUMPTIONS

Through a review of the relevant literature, I approached the study with the following assumptions:

- That mothers experience intensified levels of stress when parenting their children with ADHD
- That mothers whose children have been diagnosed with ADHD experience positive support from educational psychologists
- That children with ADHD can and should be supported within an inclusive environment
- That educational psychologists play a vital role in implementing and improving inclusive education in our country through collaboration with educators, parents, communities and other professionals

1.5 CLARIFICATION OF CONCEPTS

In the following sections I provide clarification of the key concepts of the study.

1.5.1 INCLUSION

Inclusion focuses on a more comprehensive approach to learning, advocating the full participation of learners in all aspects of schooling. To be fully inclusive, and with particular emphasis on the inclusion of ADHD children in mainstream schools[1], one needs to draw

[1] Mainstream schools are general, regular schools

attention to factors potentially affecting this individual within the school curriculum, to the physical and psychosocial environment of learning and teaching; the conditions of the individual's home environment and the broader social context in which this individual operates (Swart & Pettipher, 2007).

1.5.2 INCLUSIVE EDUCATION

The foundation of inclusive education is that when a child experiences some form of barrier to learning, the educator strives to accommodate the learner within a mainstream schooling environment rather than pursue specialised schooling (Department of Education, 2001). Educational psychologists play an important role in supporting these educators to address the barriers the child may be facing.

1.5.3 ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention Deficit Hyperactivity Disorder (ADHD) is a chronic neurological condition characterised by core features of inattention, impulsivity and hyperactivity (Seabi & Economou, 2012). Intervention from an educational psychologist is necessary to support children with ADHD within an inclusive education system through the improvement of organizations and the development of collaborative relationships with parents, educators, other professionals and communities (Engelbrecht, 2004).

1.5.4 EDUCATIONAL PSYCHOLOGIST

According to the Health Professions Act, 1974 (Act no. 54 of 1974), the scope of an educational psychologist is stated as: "assessing, diagnosing, and intervening in order to optimise human functioning in the learning and development…; applying psychological interventions to enhance, promote and facilitate optimal learning and development." The role of the educational psychologist within a South African context will be discussed with regard to the support given to mothers' whose children have been diagnosed with ADHD. These experiences will be explored.

1.5.5 PARADIGMATIC PERSPECTIVE

In this section, I introduce the meta-theoretical paradigm and the methodological paradigm. Detailed discussions follow in Chapter 3.

1.5.6 META-THEORETICAL PARADIGM

I utilised an interpretivist paradigm using a phenomenological approach (Fouché, 2005). Within the interpretivist paradigm, the researcher aims to understand the phenomena through the meanings that the participants make of their situation. With a phenomenological approach I examined the essence of the mothers' experiences of the support provided to them with their child diagnosed with ADHD (Nieuwenhuis, 2007a).

1.5.7 METHODOLOGICAL PARADIGM

I conducted qualitative research for this study. Qualitative studies aim for depth and quality of information, seeking to understand phenomena within their natural settings. This form of research often studies people or systems through interacting with and observing them. As the researcher, I relied on the participants' views and concentrated on their meaning and interpretations (Creswell, 2007; Henning, van Rensberg & Smit, 2009; Nieuwenhuis, 2007a).

1.6 BRIEF OVERVIEW OF THE RESEARCH METHODOLOGY

Table 1.1 provides a summary of the research methodology used. A detailed discussion follows in Chapter 3.

Table 1.1: Summary of the Research Methodology

RESEARCH METHODOLOGY	
Research design	Multiple case study design
Selection of participants	Purposive and convenient sampling of five mothers whose children have been previously diagnosed with ADHD by an educational psychologist
Data collection methods	▪ Focus group ▪ One-on-one interview ▪ Reflective Journal
Data documentation	Audio recording and transcriptions
Data analysis	Thematic content analysis
Criteria to ensure rigour	Credibility, transferability, authenticity, dependability, confirmability
Ethical considerations	Informed consent, voluntary participation, confidentiality, anonymity

In a multiple case study design, the emphasis is placed on a phenomenon with identifiable boundaries (Henning et al., 2009) with an in-depth understanding of the status quo and meaning for those involved (Merriam, 1998; Nieuwenhuis, 2007b). This design gave me

greater insight into how five mothers whose children have been diagnosed with ADHD experienced the support provided by the educational psychologist.

The data generation strategy involved a focus group and one-on-one interview (Nieuwenhuis, 2007b) which were guided by my research questions (Appendix G). After transcribing the data, I used the systemic approach of content analysis which identifies and summarises message content. Content analysis involves looking at data from different perspectives in an attempt to identify preliminary codes and code headings through which I will be able to categorise the data (Creswell, 2007).

1.7 QUALITY CRITERIA

To ensure the trustworthiness of this study, I applied several strategies. The term 'trustworthiness' refers to the way in which the researcher is able to persuade the audience that the research is of a high quality and that the conclusions drawn are worth paying attention to (Maree, 2007). In order to establish the trustworthiness of my study, I ensured that my results were dependable, credible, confirmable, transferable and authentic. This was supported by a member checking session, reflective notes and supervision throughout the process. In Chapter 3, I further discuss the strategies I used to ensure rigour in this study.

1.8 ETHICAL CONSIDERATIONS

I followed strict ethical guideline to ensure participants were respected and well-informed. I gained written informed consent from each participant. All consent forms included a detailed description of the research providing a clear statement of purpose (Henning et al., 2009:73). Informed consent also explained that participation was voluntary and that were able to pull out at any time. By providing the participants with all the facts up front and disclosing all information necessary they were able to make an informed decision regarding their participation in the research (Glesne, 2006; Josselson, 2007). Participants' confidentiality and anonymity were of the utmost importance. A principle of trust was developed and therefore respect and care for participants were vital (Josselson, 2007).

1.9 LAYOUT OF THE STUDY

Figure 1.1 outlines the layout of this mini-dissertation.

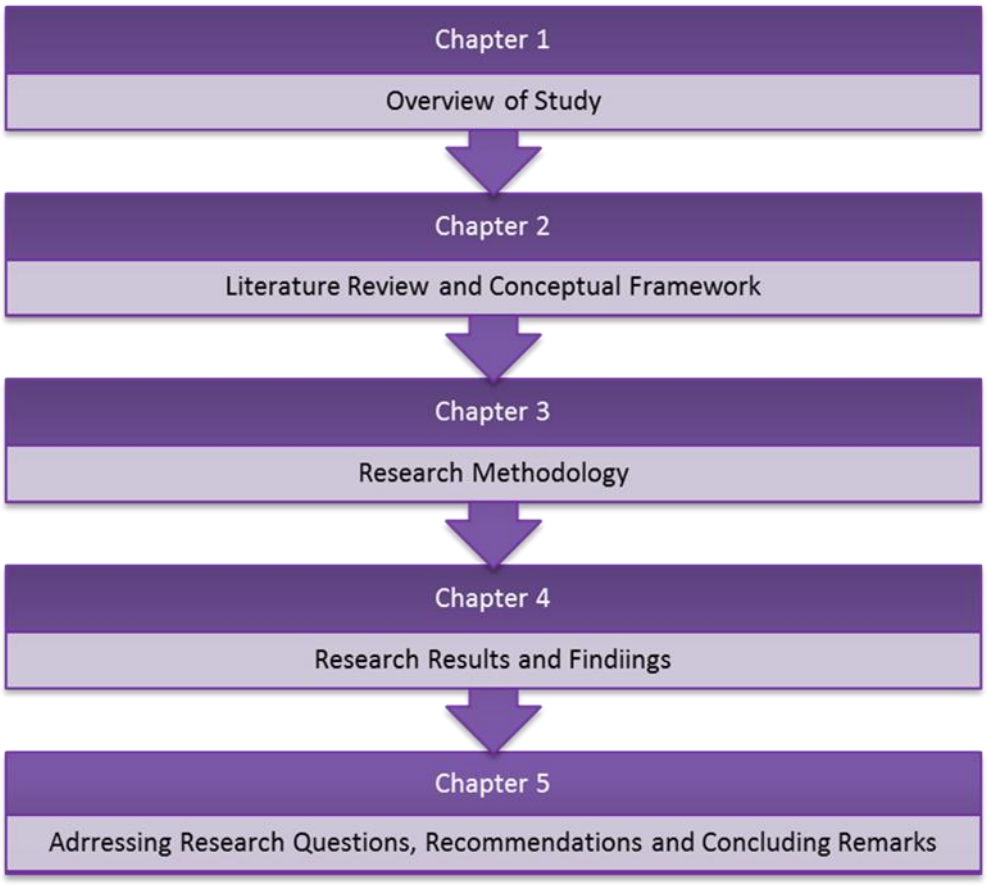

Figure 1.1: Layout of the study

1.10 CONCLUSION

In this chapter, I provided an overview and a rationale for undertaking the study. I discussed the purpose of the study according to the research questions. I clarified key concepts and outlined the assumptions I formulated. I briefly introduced the research design and methodology. I provided the ethical considerations and quality criteria that I adhered to in an attempt to enhance the rigour of the study.

Chapter 2 is based on a review of the current literature and research. I focus on the potentially supportive role an educational psychologist can play in an inclusive school community to mothers of children with ADHD. I also present my conceptual framework, guided by the literature review.

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CHAPTER 2
Literature Review and Conceptual Framework

2.1 INTRODUCTION

In the previous chapter, I introduced and presented the rationale for undertaking the study. I outlined the main and sub-research questions, I provided my assumptions and clarified key concepts. I then discussed the research design and the methodology that directed this study.

In this chapter, I explore literature on inclusive education in South Africa; Attention Deficit Hyperactivity Disorder; parenting a child with Attention Deficit Hyperactivity Disorder and the role of the educational psychologist in order to gain insight into the role educational psychologists play in supporting mothers whose children have been diagnosed with Attention Deficit Hyperactivity Disorder. I then present the conceptual framework, guided by my review of literature. I structure this chapter by discussing existing literature, as well as highlighting limitations in the recent knowledge base, thereby attempting to situate this study within these knowledge gaps.

2.2 INCLUSIVE EDUCATION

Internationally, the development of inclusion has been closely related to the shifting paradigms in educational support (Swart & Pettipher, 2000). The first significant recognition of an inclusive education approach was established at the World Conference in Special Needs Education 1994 in Salamanca, Spain (UNESCO, 1994). Acknowledgment was given to education as a fundamental human right and focus was placed on the policy shifts needed to enable education to serve all learners, including those with barriers to learning. The Salamanca Statement paved a pathway for the development of inclusive education systems and a benchmark for measuring learners' progress in schools (Swart & Pettipher, 2000:8).

International standards on human rights advocate full participation of all persons in society on equal terms and without discrimination (UNESCO, 1994, 2000). The Constitution of the Republic of South Africa, Act of 1996, includes a Bill of Rights which engrains the rights of all learners to an education within an environment that respects, values and accommodates diversity, regardless of: "race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth" (Republic of South Africa, 1996a:1247). The South African Schools Act, Act 84 of 1996 (Republic of South Africa, 1996b) recognises the Bill of Rights in that all learners have the

right of access to a learning environment within a single system of education. These documents provided the foundation and guidelines for implementation of inclusive education in South Africa.

Loreman, Deppeler and Harvey (2010:2) describe inclusion as: “the full participation of all students in all aspects of schooling. It involves regular schools and classrooms being responsive, willing to genuinely adapt and change to meet the needs of all students, as well as celebrating and valuing difference.”

In 2001, the South African National Department of Education (DoE) released the Education White Paper 6: Special Needs Education (Department of Education, 2001). The paper reflected the dedication to develop an education and training system that is inclusive. The ideals envisioned in the paper are to create a learning environment that is conducive to meeting the needs of all children, including those experiencing ADHD, into mainstream classes. The paper addresses barriers to learning and promotes maximum participation of all citizens within a community. It also emphasises the necessity for systems to be adapted to meet the needs of those individuals experiencing barriers to learning so that every child is able to learn. Focus is placed on developing the individual’s strengths to feel empowered to participate in the learning process.

Inclusive education in South Africa is intended as an educational approach that can contribute to a democratic society (Engelbrecht, 2006). Changes within our society, incorporating educational and contextual restructurings have had a negative influence on the implementation of inclusive education thus far. Therefore, to meet the ideals for inclusive schools as set out in the White Paper 6, are proving to be a challenge for schools. In particular, educators are finding it challenging to cope with the expectations placed on them by society to adapt and cope with the growing diversity of learners and learning needs in their classrooms.

2.2.1 Challenges Facing Educators in Implementing Inclusive Education in South African Schools

Educators cope with a large number of learners in their classes and in so doing they need to meet each child’s diverse learning needs. In order to practise inclusive education, educators need to identify the unique needs of each learner and then be able to accommodate these needs. Such a process requires that the educator be adequately trained and informed in addressing barriers to learning (Decaires-Wagner & Picton, 2009). According to Swart and Pettipher (2000) and Bothma, Gravett and Swart (2000), the challenge facing many South African educators is that there appears to be inadequate support and insufficient training

provided to educators on how to address the diverse needs of learners in mainstream classrooms.

While researching the implementation of differentiated learning activities in South African secondary schools, de Jager (2011) found that 97% of educators never, or rarely, use a differentiated curriculum to accommodate the diverse learning requirements of their learners. Managing a classroom environment so that it becomes an optimally healthy and inclusive learning atmosphere for all the learners, is a particularly complex responsibility. It involves an in-depth understanding of the curriculum and each and every learner in the classroom, and then the ability to adapt this curriculum to suit the unique needs of the individual learner. In an environment where classrooms are overcrowded and educational resources are lacking, it makes it more difficult for the educator to implement such an inclusive learning environment.

Educators cannot be expected to address this potentially challenging task on their own. Expertise of the specialised services including psychologists, occupational therapists, speech therapists and audiologists is essential. Nel, Müller and Rheeders (2011) state that this kind of support network should form part of the school environment in order to facilitate the development of an inclusive environment. Their services would not only extend to the educators, but to all learners experiencing barriers to learning, their parents, the Institutional Level Support Team (ILST), the District Based Support Team (DBST) and the wider community. The ILST is an internal support team working alongside the educators and is responsible for the identification of learners experiencing barriers to learning and development with the aim of designing intervention programmes (Department of Education, 2002). The DBST is defined as a “Group of departmental professionals whose responsibility it is to promote inclusive education through training, curriculum delivery, distribution of resources, identifying and addressing barriers to learning, leadership and general management” (Department of Education, 2008).

The adoption of the ideals expressed in the White Paper 6 allows educational psychologists to facilitate change within the education sphere and collaborate with many other professionals such as educators, health care practitioners and policy makers within the field of education, including members of the ILST and DBST. The aim is to build an environment that meets the diverse needs of each individual to feel accepted, understood and supported within their educational setting (Engelbrecht, 2004; Walton, 2011).

Educators are perceived to be some of the most valuable sources of information within the school environment with regard to identifying children with possible barriers to learning and referring them to the appropriate professionals for assessment, diagnosis and intervention

(Graham, 2008). As Attention Deficit Hyperactivity Disorder (ADHD) is considered to be the most predominant childhood disorder in South Africa (Mahomedy, van der Westhuizen, van der Linde & Coetsee, 2007; Perold, Louw & Kleynhans, 2010), educators should be well-informed of the identification, referral and treatment of ADHD. In a study conducted in the Western Cape of primary school teachers' knowledge and perceptions of ADHD, it was found in certain key areas of ADHD, educators had a substantial lack of knowledge (Perold, Louw & Kleynhans, 2010). The results also show that educators had minimal or no training in understanding ADHD and the management thereof. Three Australian studies also investigated educator knowledge of ADHD (Efron, Sciberras & Hassell, 2008). Overall the results showed that educators knew the most about the causes of ADHD, less about the characteristics of the disorder and the least about the treatment for ADHD.

2.3 ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder, usually present from infancy and characterized by developmentally inappropriate levels of impulsivity, hyperactivity and difficulty sustaining attention (Rogers, Hwang, Toplak, Weiss & Tannock, 2011; Danciu, 2011). Over one hundred years ago, Still and Tredgold (Barkley, 2006) were credited as being the first to focus attention on what is known today as ADHD. In the 1950's and 1960's, Minimal Brain Dysfunction was the term used to describe the disorder, ADHD. The first official diagnosis of Hyperkinetic Reaction of Childhood was made in the DSM II (Wodrich, 1994) as hyperactivity was thought to be the predominant feature. In 1980, the term was changed to Attention Deficit Disorder in the DSM III as inattention was argued to be the central deficiency. In 1987, a revision of the DSM III was published (DSM III-R) and both inattention and hyperactivity were recognized as equally important. The term changed to that which is known today as Attention Deficit Hyperactivity Disorder (Silver, 1993; Wodrich, 1994).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994) and the DSM-IV, Text Revision (American Psychiatric Association, 2000), the symptoms of ADHD need to be clinically evident and show a significant impairment in order for a diagnosis of ADHD to be made. There are 18 symptoms listed in the DSM-IV-TR that comprise the core features of ADHD which are indicated as nine symptoms of inattention and nine symptoms of hyperactivity and impulsivity. Specific criteria are defined in order to highlight the three subtypes of the disorder namely: ADHD-Predominantly Inattentive type, ADHD Predominantly Hyperactive-Impulsive type and ADHD-Combined type (McConaughy, Volpe, Antshel, Gordon & Eiraldi, 2011).

2.3.1 CHARACTERISTICS OF ADHD

In this section I use Figure 2.1 to provide a diagrammatical representation of the main characteristics of ADHD and related behaviour. I then review the prevalence of the disorder, the social and emotional difficulties a child with ADHD experiences, followed by the cognitive implications of ADHD.

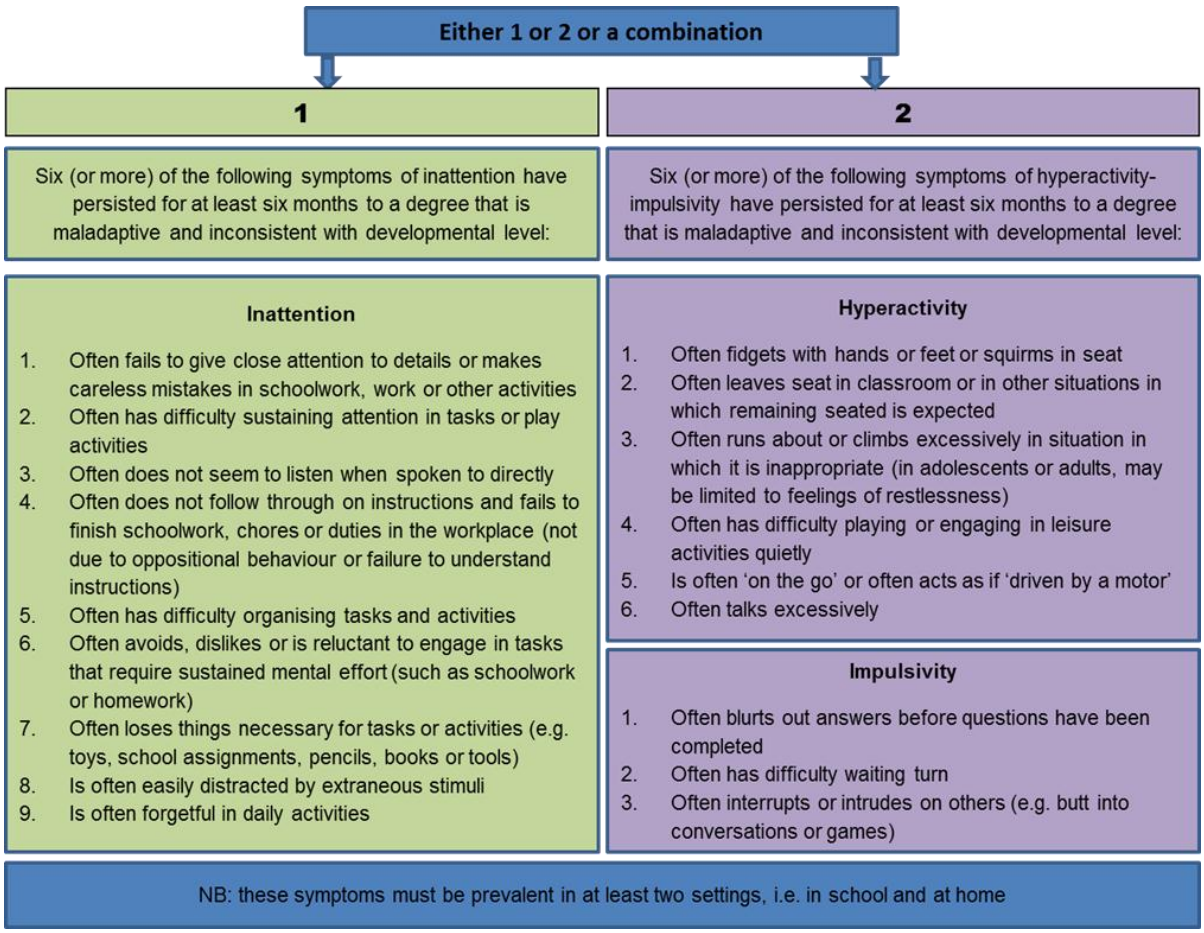

Figure 2.1: Features of ADHD (American Psychiatric Association, 2000:85)

2.3.2 FEATURES OF ADHD AND RELATED BEHAVIOUR

In this section, I discuss the prevalence of ADHD as well as the social, emotional and cognitive challenges of children with ADHD.

2.3.2.1 Prevalence of ADHD

Although ADHD is usually diagnosed in children, recent studies have shown that between 30% and 70% of children with ADHD continue to experience difficulties into adulthood. Although features of hyperactivity may decline over time, symptoms of inattention may persist (Rogers et al., 2011; Danciu, 2011).

In the United States, the prevalence of ADHD in school-aged children has been estimated at between 3% to 7% (Cubillo, Halari, Smith, Taylor & Rubia, 2011). The prevalence rates in Africa are reported to be just as high as in Western countries (Aase, Meyer & Sagvolden, 2006; Louw, Oswald & Perold, 2009; Seabi, 2010; van der Westhuizen, 2010) and remains consistent with studies done in South Africa, estimating that 4% to 5% of children are affected (Louw, Oswald & Perold, 2009). ADHD is considered as the most prevalent child psychiatric disorder in South Africa (Mahomedy et al., 2007; Perold, Louw & Kleynhans, 2010).

2.3.2.2 Social and emotional challenges of children with ADHD

Children with ADHD may find it difficult to integrate socially. Various perspectives on why children with ADHD have such social difficulties: they may find it challenging to process social cues or they are possibly unable to enact the appropriate behaviour even though they know what it should be, especially when they become eager or restless (Seabi & Economou, 2012).

Children with ADHD may talk excessively to themselves and others; display gross bodily movements and engage in tasks other than those at hand. Being impulsive is synonymous with the inability to inhibit behaviour, hold back or control certain behaviours. They tend to do such things as cut in front of others in line, interrupt others and possibly engage in dangerous situations (van der Westhuizen, 2010; Wicks-Nelson & Israel, 2009) and therefore such hyperactive and impulsive behaviours can make integrating socially more problematic. Peers may view these children as unpredictable and overbearing. Children with inattention may come across as withdrawn and distracted and therefore may be ignored or neglected by their peers (Wicks-Nelson & Israel, 2009:237).

2.3.2.3 Cognitive and learning challenges of children with ADHD

According to Barkley (2006), research has shown that children and adolescents with ADHD pay less attention to their work and do less well in such tasks that demand sustained concentration. Within the classroom environment, children with ADHD are perceived to be more disruptive and are reported to be less cooperative, as well as exhibiting more problem behaviours than other children (Wicks-Nelson & Israel, 2009).

Not being able to sit still, always on the run, fidgety, restless as if driven by a motor are characteristic of children with ADHD (Barkley, 2006). It is believed by Barkley (1994, in Mayes, Calhoun & Crowell, 2000) that rates of learning disabilities in children with ADHD vary considerably from 25 to 40%. In two separate studies conducted in America, (August &

Garfinkel, 1990; Willcutt, Olsen, Pennington, Boada, Ogline & Tunick, 2001), it was found that children diagnosed with ADHD had a coexisting reading disability. Inattention seems to have a larger impact on reading problems than hyperactivity as the child with inattention difficulties is more likely to be distracted and less likely to return to an activity once interrupted.

Children with ADHD tend to be more impaired in measures of executive functioning than children without ADHD (Lambek, Tannock, Dalsgaard, Trillingsgaard, Damm & Thomsen, 2011). Executive functioning can be described as those cognitive processes that are necessary for goal-directed behaviour (Stuss & Alexander, 2000). A deficit in this area affects one's ability to plan, organise and self-regulate. Another challenge associated with poor executive functioning is working memory. Working memory is the cognitive ability to store and manage information for a relatively short period of time. In other words, working memory is what allows us to keep several pieces of information active while also trying to do something with them. There is evidence showing that working memory is closely linked with academic achievement (Alloway & Cockcroft, 2012), including that of reading ability and poor mathematic achievement – in particular arithmetic, word problems and poor computational skills (Alloway & Cockcroft, 2012).

Considering the effects of child-related ADHD behaviour within the school environments, one of the ways in which educators tend to cope is by becoming directive and controlling. The outcome of which appears to be in line with Hutchins' (2005, in Seabi & Economou, 2012) view that learners with ADHD commonly experience humiliation and intense levels of stress as educators often expose their challenges. Elbaum and Vaughn (2003, in Seabi & Economou, 2012) point out that learners with ADHD often develop a low academic self-concept due to these frequent experiences of emotional, scholastic and social failures early on in their school career. It is therefore appropriate that educators, parents and other significant role players develop a greater understanding of such difficulties in order to support the child and the family.

2.4 PARENTING A CHILD WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD has many associated positive aspects. Children with ADHD can often be independent, decisive and non-conformist, making for good leaders. Their originality and creativity, and their ability to make new and interesting connections, often leads to unconventional and original solutions if these qualities are given the opportunity to flourish (Decaires-Wagner & Picton, 2009:250). Viewed differently, impulsivity as bravery may be regarded as quick wittedness. Hyperactivity could be interpreted as having endless energy, enthusiasm and determination. Keeping many projects going at one time and applying this questioning

attitude to things others miss can be an advantage of inattention. (Decaires-Wagner & Picton, 2009:250; Green & Chee, 1997).

However, the reality for many families with a child with ADHD on a day-to-day basis is that they experience difficulties in effective family functioning (Cunningham, 2007). The accumulation of problem behaviours and outcomes related to ADHD impact on various family relationships. These family difficulties may appear when the child is young and they often intensify during adolescence (Cunningham, 2007).

The nature of ADHD is such that increased caretaking demands exist and these disrupt the processes of parenting, having an adverse effect on the parents themselves (Harrison & Sofronoff, 2002:703). Families of children with ADHD need to cope with more behavioural, developmental, and educational challenges than those of children without ADHD. According to Finzi-Dottan, Triwitz and Golubchik (2011), parents of children with ADHD perceived parenthood as more of a threat in comparison to parents of children without ADHD. They are also reported to lack confidence in their parenting skills.

It appears that the mother-child relations are more strained than the father-child interactions, although, both parents are at risk for becoming more directive and negative (McLaughlin & Harrison, 2006). Where families have the traditional parenting roles, whereby mothers are engaged in much of the nurturing and fathers tend towards outside work activities, mothers are often responsible for the emotional health of all members of the family. Maternal perceptions of their use of inadequate parenting practices have been associated with an increase in parenting stress and feelings of failure. This strain may affect the capability of the parent to use positive parenting practices to produce co-operative conduct from their child (Cunningham, 2007). Recent family research recommends that nurturing roles should be shared, the advantage of which relieves the pressure on the mother and emphasises the need for a more present fatherly role (Prithivirajh & Edwards, 2011).

The added time, logistical problems, and energy necessary to cope with these challenges may be associated with increased marital conflict arising from possible inconsistent parenting practices or varying discipline perspectives. Parental conflict within the home environment has been shown to decrease the child's sense of safety and security (Cunningham, 2007) which can often exacerbate the child's problematic behaviour.

Furthermore, the financial implications of managing ADHD and its additional associated difficulties may also exacerbate family stress and further affect positive family functioning. The cost of additional therapies such as occupational therapy and learning support, follow up

visits to health care practitioners, medication and other interventions sought, as well as the number of professionals a child visits before a correct diagnosis of ADHD is made, can add financial strain to many families (Cunningham, 2007; Gerdes, Haack & Schneider, 2012; Theule, Wiener, Rogers & Marton, 2011).

2.5 SUPPORTING CHILDREN AND FAMILIES WITH ADHD

Difficulties with parenting a child with ADHD are often a reason for parents to seek professional help from an educational psychologist. Although there is limited research on this topic within a South African perspective, it has been shown that social support is a valuable resource in reducing the stress experienced by families of children with ADHD (Finzi-Dottan, Triwitz & Golubchik, 2011). Psychoeducation and parent training are acceptable means of supporting parents of children with ADHD. Such support may require assisting the parents with their daily tasks of managing their child with ADHD, in ways such as, implementing routine, effective discipline practices, and homework intervention strategies. Support would also include establishing their sense of belief in their parenting abilities and coping strategies, for example, through support groups with other mothers experiencing similar difficulties.

To date, over 30 years of research has been invested in the understanding of ADHD. Knowledge of the disorder, with particular reference to, diagnosis, management and treatment, is thus well-established and documented (Seabi & Economou, 2012). Without this significant body of work, educators and health professionals would not be in a position to intervene or treat the child who presents with this disorder (Seabi & Economou, 2012).

2.6 THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST

Educational psychologists assess children who may have special educational needs (Farrell, 2004:11) and develop ways to support children's education. According to the Health Professions Act, 1974 (Act no. 54 of 1974), the scope of an educational psychologist is stated as: “assessing, diagnosing, and intervening in order to optimise human functioning in the learning and development…; applying psychological interventions to enhance, promote and facilitate optimal learning and development.”

The Department of Education (1998:4) defines assessment as “the process of identifying, gathering and interpreting information about a learner’s achievement, as measured against nationally agreed outcomes for a particular phase of learning.” It is a way of understanding a child in order to make an informed decision about the child (Sattler, 2008:20). A diagnosis can be described by Sattler (2008:4) as: “determining the classification that best reflects the child’s level and type of functioning and/or assisting in the determination of mental disorder or

educational disabilities." Psychological interventions refer to the improvement of the child's functioning by: "the action of intervening, stepping in… so to affect its course or outcome" (Onions, 1950:1033).

The changes in the South African education system over the years have encouraged educational psychologists to re-evaluate their roles in supporting their clients. Consideration of parents' needs and the provision of a more consultative role within schools need to be taken into account (Love, 2009).

2.7 THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST IN SUPPORTING CHILDREN WITH ADHD AND THEIR FAMILIES

Much of the research conducted on the treatment of ADHD has focused on the child and improving the child's overall functioning (Gerdes, Haack & Schneider, 2012). More recently, research shows that a multimodal treatment approach to managing ADHD has the greatest outcomes. This includes medication, psychological and psychosocial therapies, and/or a combination thereof (Montoya, Colom & Ferrin, 2011). As discussed, many families of children with ADHD experience difficulties in family functioning and subsequently may seek the advice of a professional such as an educational psychologist. Educational psychologists need to ensure that families acquire sufficient information regarding the etiology of ADHD, the comparative benefits and risks of various interventions as well as factors such as parenting that may impact the course of the disorder, in order to make informed decisions about treatment. It has been shown (Cunningham, 2007), that parents with more knowledge about ADHD, for example, report to have a greater sense of competency and contentment in their parenting abilities, as well as more control over their child's behaviour.

Information shared with parents in this manner is referred to as psychoeducation. Psychoeducation is a treatment paradigm, which comprises information about the relevant disorder and its treatment, development of skills, and client empowerment (Montoya, Colom & Ferrin, 2011). Unfortunately, there is not yet a working definition of what ADHD psychoeducational interventions are or should be. However, in the last two years there have been three key studies exploring evidence-based psychosocial treatments for ADHD (Gerdes, Haack & Schneider, 2012). These reviews concluded that behavioural parent training has sufficient research to support the use of evidence-based treatment for ADHD (Gerdes, Haack & Schneider, 2012). Research on behavioural training for parents of children with ADHD (Gerdes, Haack & Schneider, 2012) highlighted how parental gender differences emerged resulting in marked reduction of parenting stress for mothers.

Prithivirajh and Edwards (2011) evaluated the experiences of parents of children with ADHD who participated in a stress management programme and found that the parents experienced the programme as bringing about cohesion, an ability to think in a different and more constructive manner, a sense of control, personal growth and changes in negative behaviours that they themselves were experiencing, These parents' children reported that they found their parents to be more relaxed, approachable and tolerant when interacting with them. The inclusion of such a stress management programme for parents of children with ADHD appears to be a valuable strategy in the overall comprehensive management of ADHD.

Educational psychologists can provide support through individual work with families or parent support groups. Furthermore, this may lead to more nurturing father-child interactions and more constructive father involvement in the child's learning (Gerdes, Haack & Schneider, 2012). In working closely with families of children with ADHD, an educational psychologist is able to advise the parents on the benefits of increased involvement in their child's education and school life. They are also able to play a critical role in helping to reduce barriers between the parent and school. This may possibly allow for improved relations between the school, parents and other professionals involved in the child's life (Rogers, Weiner, Marton & Tannock, 2009). Educational psychologists can advise parents and educators on the advantages of placing children in an inclusive school environment (Farrell, 2004) where it is expected that appropriate support will be provided to their child's needs academically and emotionally.

2.8 THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST IN AN INCLUSIVE EDUCATION FRAMEWORK

Educators play an important part in encouraging positive parental involvement. Thus, educational psychologists can likewise provide training for educators who may feel they lack such training to develop detailed and routine participation plans, which have proved to be effective (Rogers et al., 2009). Although to a lesser extent, there is evidence supporting the importance of psychoeducation of ADHD to educators (Cunningham, 2007; Montoya, Colom & Ferrin, 2011). Educational psychologists can consult with educators about how to effectively communicate with parents of children with ADHD. This would not only entail reporting on the child's difficulties or problem behaviours but also encouraging the educators to regularly contact parents about children's positive behaviour and school achievements (Rogers et al., 2009). Parent involvement has been shown to have a positive impact on children's schooling and has a significant role to play in the progression of inclusive schools. Engelbrecht, Oswald, Swart, Kitching and Eloff (2005), indicate that parents that have had a positive experience with inclusive learning environments place the success on shared

ownership and understanding among professionals, parents and learners for inclusive education.

Educational psychologists can also give advice and support to educators on how to develop and adapt the curriculum for individual children (Farrell, 2004; Gulliford, 1999). This can be done through working with the ILST who assist and guide the teaching and learning process by identifying and addressing learner barriers, and with district offices within the provincial departments of education, to help improve inclusive policies and practices (Farrell, 2004). Currently data suggests that there is little collaboration among the numerous professions involved in the diagnosis and treatment of learning difficulties. A closer working relationship between professionals such as classroom educators, psychologists, medical practitioners and the parents may enhance the outcomes for the intervention of ADHD (Walton, 2011).

According to Engelbrecht (2004), educational psychologists need to question how and why their working contexts have transformed in South Africa, in order to be more aware of the challenges that have arisen from the implementation of inclusive education. Collaboration could be acknowledged as a vital feature for success in this approach which should aim to be inclusive and emphasise the need for joint decision making in governance, planning, delivery and assessment in education (Hariparsad, 2010).

In summary, the key findings of this literature review demonstrate a need for educational psychologists to act collaboratively with all role players to promote an inclusive school community which could support children with ADHD and their families. I now outline the conceptual framework adopted for this study.

2.9 CONCEPTUAL FRAMEWORK UNDERPINNING THIS STUDY

Arising from my review of existing literature and theory, key constructs were identified and developed into a conceptual framework. Thus, this conceptual framework allowed me to plot the territory being studied and anchored my findings with the various key concepts (Athanasou, Mpofu, Gitchell & Elias, 2012).

Considering that inclusive schools welcome diversity and in order for diverse perspectives to be understood and incorporated, collaboration within and between all systems is essential. Therefore this study draws from a systems theory perspective. It is increasingly recognized that there are multiple influences on learners' outcomes, or in Bronfenbrenner's (1979) terms, that the microsystem for learners, typically comprised of home or school, affects achievement and long-term educational outcomes and psychological well-being (Reschly & Christenson,

2012). Figure 2.2 is a diagrammatic representation of the conceptual framework utilised for this study.

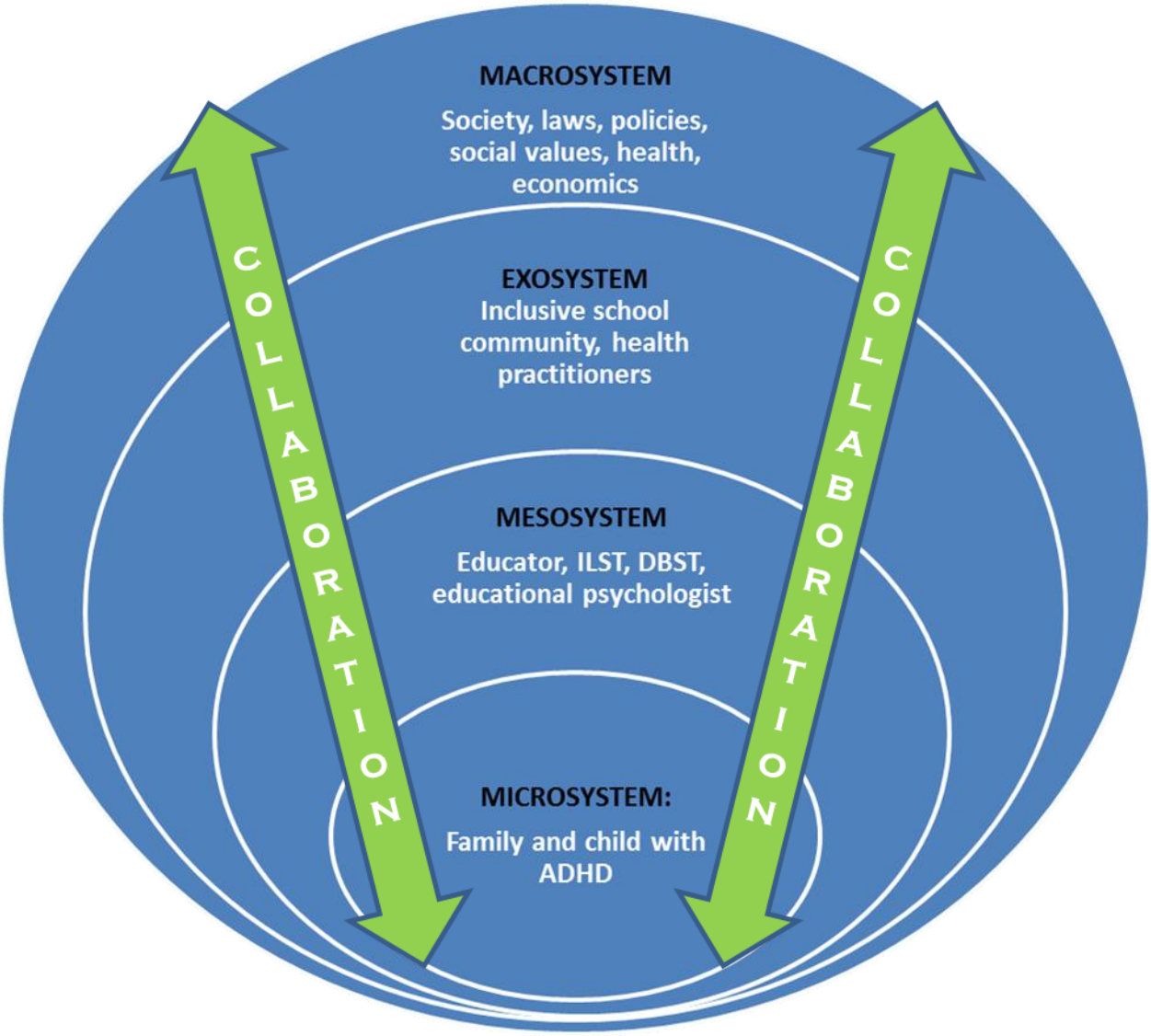

Figure 2.2: Diagrammatic representation of the underpinning conceptual framework

The systems theory underscores the multiple and recursive influences of immediate contexts in which individuals develop such as the home, school, and community, as well as the interactions of these contexts and individuals over time (Reschly & Christenson, 2012). Donald, Lazarus and Lolwana (2009:32) define the ecosystemic perspective as "a blend of ecological and systems views of interaction between different levels of the social context and the individuals within them." Bronfenbrenner's ecological model consists of the microsystem, mesosystem, exosystem and macrosystem which all interact with the chronosystem (Swart & Pettipher, 2000).

2.9.1 BRONFENBRENNER'S ECOLOGICAL MODEL

This section provides further detail about Bronfenbrenner's ecological model. Each system: the microsystem, mesosystem, exosystem, macrosystem and chronosystem is described in the context of this study.

2.9.1.1 The microsystem

According to Swart and Pettipher, (2000:10) the microsystems are the activities, roles and interpersonal relations that individuals experience, face to face with other relevant people. A family is a system which interacts with other families, with schools and with the community in which it lives. There are also subsystems within a family system that interact and impact on each other and thus on the system as a whole (Donald et al., 2009).

2.9.1.2 The mesosystem

The mesosystem refers to the linkages and processes that take place between these microsystems (Bronfenbrenner, 2005). In relation to this study it includes the collaborative partnerships formed between the child, the family, the educational psychologist and the school.

2.9.1.3 The exosystem

The exosystem refers to an environment in which the individual is not directly involved as an active participant, although they may be influenced by the happenings and relationships around them. In relation to this study, the way a mother experiences the support provided by an educational psychologist for her child diagnosed with ADHD, may influence her own development as a mother, as well as her attitude towards and ability to support her child. This may in turn have a positive impact on the family functioning as a whole; the marital status and sibling relationships.

2.9.1.4 The macrosystem

The macrosystem describes the attitudes, beliefs, values and ideologies in the systems of society and culture in which the individual lives (Swart & Pettipher, 2000). For example, the implementation of inclusive education policy at government level has an impact on the education system and the way society perceives barriers to learning. This in turn has a significant influence on the learning experience for a child with ADHD by ensuring that their needs are met through the state providing the necessary resources and infrastructure.

2.9.1.5 The chronosystem

The changes that take place in the individual's lifetime is referred to as the chronosystem (Swart & Pettipher, 2000). These experiences include environmental events such as the impact of apartheid on individual learners' education, as well as major transitions in life such as the death of a caregiver.

The collaboration between and within the various systems are such that change at one level has an effect on other levels (Engelbrecht & Green, 2001) in a multiple and recursive manner. It is thus imperative to work with the whole system in a collaborative manner, not just with one individual within it. Therefore, although this framework is embedded in systems theory, it requires collaborative relationships in order for positive change to occur.

2.9.2 COLLABORATION ACROSS SYSTEMS

Within a collaborative systems approach, educational psychologists constitute one component of the web of significant players forming collaborative relationships with the subsystems of the inclusive school community, the family and the child with ADHD. Collaboration is a powerful resource that allows for diverse views to be heard (Loreman, Deppeler & Harvey, 2010). Role players such as the School-Based Support Team, parents, children and educational psychologists, see their experiences through different lenses, and contribute different meanings to the system (Engelbrecht & Green, 2001), therefore each view adds value and meaning.

For collaboration to be an integral part of the school environment, all role players need to reflect, debate and discuss how to build on the collective knowledge and current practices within their school environment. Shared ownership and collaboration between learners, parents, educators and the relevant school community are critical elements of inclusive education (Engelbrecht & Green, 2001). At the microsystem level, parents should be involved in their child's education and well-being. The child must take responsibility for his or her actions and work with the assistance given. At the mesosystem and exosytem levels, it is necessary for educators, Institutional Level and District Based Support Teams, educational psychologists and other health care practitioners to take responsibility for their role in supporting the child and family. Each role player needs to act in a collaborative manner, sharing knowledge and keeping the clients best interests in mind.

Research shows that educational outcomes for learners vastly improves when there is collaboration with home, school, and community working together to support learners'

learning and development (Epstein & Sanders, 2006; Peacock & Collett, 2010). There is a shift emerging where schools are starting to find that they can no longer function effectively as an isolated and separate institution outside of the community and therefore rely on collaboration with the wider school community (Loreman, Deppeler & Harvey, 2010).

A central problem in the development of collaborative partnerships globally is a failure to create trusting, empowering relationships (Loreman, Deppeler & Harvey, 2010). In South Africa, inequality of power and authority in the relationship amongst parents and educators, and the failure to establish collaborative, trusting and empowering relationships, has posed a major challenge (Engelbrecht et al., 2005). However, where there has been a positive experience with inclusive education, such parents report that the disparity of power can be overcome by shared understandings of the significance of communication, dedication, fairness and respect for collaborative relationships. As discussed earlier, there is a growing consensus that educators need more training to manage the growing diverse needs of learners in this country. Training could also focus on the characteristics of effective collaborative school communities and how these can be implemented in our education system. There is also a great need to expand understandings of family structures and actions, and work out how to be responsive to learners and their families, who present a multiplicity of unique needs.

According to Peacock and Collett (2010), where this philosophy of collaboration in the school community is the norm, parents and learners are then more likely to feel comfortable with this approach. Therefore, the Institutional Level Support Teams, including educational psychologists, may find it easier to engage parents in such collaborative interventions. An educational psychologist working within an inclusive school environment should focus on developing collaborative relationships in the subsystems and systems within which the child operates. Such collaborative relationships may enhance, promote and facilitate optimal learning and development of the child (Engelbrecht & Green, 2001).

2.10 CONCLUSION

In this chapter, I explored literature on inclusive education in South Africa; Attention Deficit Hyperactivity Disorder; parenting a child with Attention Deficit Hyperactivity Disorder and the role of the educational psychologist in order to gain insight into the potentially supportive role educational psychologists play in supporting mothers whose children have been diagnosed with Attention Deficit Hyperactivity Disorder. I presented the underpinning conceptual framework, guided by my review of relevant literature.

In the next chapter, I discuss the research methodology and paradigmatic perspectives utilised in this study. I detail the research design implemented, as well as the data collection and documentation strategies applied. Furthermore, the data analysis and interpretation is discussed, followed by the quality criteria and ethical considerations that were taken into account.

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CHAPTER 3
Research Design and Methodology

3.1 INTRODUCTION

In Chapter 2, I explored existing literature relevant to the research focus. I highlighted parents' challenges when parenting a child with Attention Deficit Hyperactivity Disorder, and the vital role that the educational psychologist plays in inclusive education in South Africa.

The aim of this chapter is to discuss the research methodology and paradigmatic perspectives utilised in this study. I outline the research design implemented as well as the data collection and documentation strategies applied. The data analysis and interpretation is then discussed, followed by the quality criteria and ethical considerations that were taken into account.

3.2 PURPOSE OF THE STUDY

The purpose of the proposed study is to explore how mothers, whose children have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), experience the support provided by the educational psychologist. The study aims to provide insight into the challenges faced by the mothers of children with ADHD and the role the educational psychologist could play in assisting them. It also aims to contribute to the literature based on the role of the educational psychologist in inclusive education and specifically in supporting families affected by ADHD.

3.3 PARADIGMATIC PERSPECTIVES

A paradigm is a way of making sense of complexities in the world. A research paradigm may be viewed as an essential framework from which a researcher is able to categorize observations and give meaning to them (Babbie & Mouton, 2002; Patton, 2002). In this section, I discuss the meta-theoretical and methodological paradigms that informed this study.

3.3.1 META-THEORETICAL PARADIGM

I followed an interpretivist paradigm using a phenomenological approach. Within the interpretivist paradigm, I aimed to understand the phenomena through the meanings that the participants made of their situation and everyday lives. According to Smith (2004), throughout

the interpretivist phenomenological process the participant tries to make sense of their own world, whilst the researcher tries to make sense of the participant trying to make sense of their own world. Such a process leads to the construction of broad research questions resulting in expansive data collection methods (Smith, 2004). By using interpretivism as a meta-theoretical paradigm, I gained insight into how mothers experience the support provided to them by an educational psychologist when their child had been diagnosed with ADHD. The key to working within this paradigm is to understand the subjective experiences of each participant and therefore I remained aware of the fact that each person's context was unique. My subjective interpretation of data was another area I needed to remain cognisant of. I attempted to negotiate potential bias and subjectivism by reflecting in a research journal, and by ensuring that I debriefed with my supervisor.

I asked the question "What is the structure and essence of experience of this phenomenon for these people?" (Henning et al., 2009:16). Phenomenology places an emphasis on understanding a person's experience of a problematic situation where the people tell their own story, in their own terms, through having lived through and experienced the situation (Wilson, 2002). By listening to the mothers, I examined the essence of their experience of the educational psychologist's support to their child diagnosed with ADHD with a phenomenological approach (Nieuwenhuis, 2007b).

3.3.2 METHODOLOGICAL PARADIGM

I conducted a qualitative research study. Qualitative studies aim for depth and quality of information, seeking to understand phenomena within their natural settings. This form of research often studies people or systems through interacting with and observing them. Qualitative research aims at examining the construction of meaning, making sense of the predominant features of peoples' lives or their frames of reference and then at reflecting on the role of the researcher in the generation of data (Gibson & Brown, 2009:8). One of the main advantages of using a qualitative approach is that I was able to gain an in-depth perspective on what was being studied. I observed the participants as fully as possible and captured the attitudes and inner meanings they ascribed to the experiences they had had with the support provided to them by the educational psychologist. I relied on the mothers' views and concentrated on their meaning and interpretations of the support given (Creswell, 2007; Henning et al., 2009; Nieuwenhuis, 2007b).

The limitation of the qualitative approach lies in the possibility of attaching my own meanings and interpretation when analysing the data (Henning et al., 2009). I addressed this challenge by recording these in a reflective journal throughout the research process. This is discussed

in detail under Section 3.4.3.1. I confirmed the results with the participants concerned and had ongoing supervision with my supervisor to ensure I remained objective in my approach.

3.4 RESEARCH METHODOLOGY

3.4.1 RESEARCH DESIGN

The chosen research design for this study is a case study. In a qualitative case study design the emphasis is placed on a phenomenon with identifiable boundaries (Henning et al., 2009). From an interpretivist paradigm this form of research design strives towards an in-depth understanding of the status quo and meaning for those involved (Merriam, 1998; Nieuwenhuis, 2007b) by collecting various forms of data. I conducted a collective case study using multiple cases (Creswell, 2007). This means that I described more than one case in order to bring greater depth and insight by illuminating the commonalities and dissimilarities from one case to the next.

The advantages of using a case study design are that it offers a multi-perspective analysis of participants' experiences within their context, which can be summed up by a metaphor from the social science world (Nieuwenhuis, 2007b:76) stating that a: "… well-selected case constitutes the dewdrop in which the world is reflected." By gaining in-depth perspective of the mothers' experiences, this study yielded rich and personal data. Criticism of this approach is that generalisations are seen to stem from a small number of participants. However, case studies aim rather to give the holistic and deep understanding that the participants attach to the phenomena under study (Fouché, 2005; Nieuwenhuis, 2007b). Specific to this study, a limited number of five participants were interviewed. Therefore, I needed to be cautious in making generalisations and oversimplifying their experiences. Rather, I concentrated on the richness of the data and the deeper understanding of the participants' experiences that align with an interpretivist approach. In Table 3.1, I present a summary of the research methodology followed.

Table 3.1: Research methodology

RESEARCH METHODOLOGY	
Research Design	• Qualitative Case Study
Selection of participants	• Sampling procedure: Purposive and convenience sampling • Five mothers whose children had been diagnosed with ADHD by an educational psychologist
Data collection	• Focus group discussion • Semi-structured one-on-one interview • Reflective journal

Data documentation	• Audio recording and transcriptions
Data analysis and interpretation	• Transcriptions of interviews • Qualitative content analysis • Triangulation of data
Quality Criteria	• Dependability • Credibility • Confirmability • Transferability • Authenticity
Ethical Considerations	• Informed consent and voluntary participation • Anonymity and privacy • Protection from harm

3.4.2 SELECTION OF THE PARTICIPANTS

When selecting the participants, I applied purposive and convenience sampling procedures. In this form of sampling participants are selected with the intention that they will be able to help the researcher better understand the central phenomenon (Creswell, 2007). This type of sampling lends itself to information rich cases, highlighting the questions under study (Patton, 2002). Convenience sampling involves the selection of the most accessible participants (Marshall, 1996). By purposively and conveniently selecting the mothers in this study, I gained insight and in-depth understanding of their experiences.

The strategy to select mothers to participate in this research was that of maximal variation sampling, as I intended to present multiple viewpoints of mothers within the Johannesburg north area from different contexts. I chose mothers from this area for reasons of convenience as I live in the Johannesburg north area and it saved on travel costs for myself and the participants. In doing so, I hoped to be able to compare their perspectives and establish whether there were similarities and differences between their views on educational psychology support. During my years of teaching, I taught many children who were diagnosed with ADHD and subsequently I had a considerable amount of interaction with their mothers. The interaction ranged from identifying possible difficulties their child was experiencing to referring the child to an educational psychologist for an assessment. I communicated with the mothers on an ongoing basis throughout the year and I provided feedback on how their child was coping at school. I also suggested interventions they could use at home to assist their child's progress, following up on where they felt I could offer further support and recommended additional supportive intervention where possible. These in-depth interactions allowed me to gain insight into the challenges the mothers were experiencing. Some of the mothers expressed a need for more support in understanding their

child with ADHD which led to my interest in understanding how the educational psychologist was possibly able to support these mothers with their child with ADHD.

I identified potential participants from my workplace, which is an independent and mainstream school. In order to gain richer and more diverse opinions, I approached one of my previous colleagues who is now the head of an independent, special needs school. I asked her to identify mothers within her school environment who would possibly be able to participate in this study. All focus groups and individual interviews took place at my workplace. Due to my background in education and the interaction I have had with many parents and children with ADHD, I was aware of any biases I might have had as I moved into the role of a researcher. I was careful not to use information obtained through my previous interactions with the participants. I was also cautious when I negotiated being an active participant in some of the children's lives, as a teacher, to being an objective researcher. I discuss these role differences in detail in Section 3.6. Participants' details and their child/children with ADHD are given in Table 3.2.

Table 3.2: Details of participants and their child/children with ADHD

Participant	Age	Socio-economic background	Age of child with ADHD	Gender of child with ADHD	Grade of child	Language	Household type
1	37	Middle class[2]	8	Female	3	English	Intact[3]
2	44	Middle class	7	Female	1	English	Intact
3	45	Middle class	13	Male	8	English	Intact
4	51	Middle class	22	Female	N/A	English	Intact
			28	Male			
5	39	Middle class	7	Male	2	English	Intact

3.4.3 DATA GENERATION AND DOCUMENTATION

For this research, data was generated by means of focus groups and one-on-one interviews. The aim of both these forms of data collection was to obtain rich descriptive data to assist me in gaining a deeper understanding of the participants' construction of knowledge about the central phenomenon (Greef, 2005). Kvale (in Greef, 2005:287) defines qualitative interviews as "attempts to understand the world from the participant's point of view, to unfold the

2 Middle class refers to average to above average income, education further than a matric.
3 Intact refers to both parents living together with their child.

meaning of people's experiences [and] to uncover their lived world prior to scientific explanations." I also made use of a reflective journal in order to engage in a deeper form of thinking, remaining aware of any biases and to triangulate the data I received from the interviews. The focus group discussion and the one-on-one interview took place at my workplace and I kept a reflective journal throughout the process to document my thoughts and observations.

3.4.3.1 Focus group discussion

Focus groups are described as group interviews and participants are selected as having some characteristic in common, relating to the topic of study (Greef, 2005). In this case, the five participants are female and their children have been diagnosed with ADHD by an educational psychologist. I chose this number of participants to increase the chance for depth of information and any more participants might have decreased the opportunity for them to voice their experiences. I ensured that the children represented various age groups and genders so as to add to the richness of the data.

In a focus group, the participants may be able to build on and make comparisons of their own and others' perspectives, experiences, concerns, desires and comments providing detailed information that may otherwise be difficult to attain with other research methods. This process may release inhibitions of respondents in disclosing information as the environment is seen as non-threatening as well as to assist in activating forgotten details of their experiences (Greef, 2005; Nieuwenhuis, 2007b.). It may also aid in the investigation of multiple perspectives within a defined area of interest.

Another advantage of using focus groups for data generation is that new and unexpected perspectives might arise which are easy to explore in a focus group interview thereby possibly adding value to the study. Furthermore, focus groups are also considered less time consuming than individual interviews. A strength of the focus group discussion lies in the concentrated amount of data gathered on precisely the theme under study (Greef, 2005; Nieuwenhuis, 2007b).

Limitations of focus groups are that they are typically small and therefore may not be representative of the population at large. It can also be difficult for the participants to congregate in the same place at the same time especially if they live in geographically distant places. With regard to the current study, all the participants lived within the Johannesburg region which facilitated easier access for me, the researcher. Another challenge is that information can be seen to be biased if one participant dominates the discussion which in

turn means that the less assertive participants' viewpoints may not be considered. I was aware of the risks of one participant dominating the focus group so I emphasised the importance of turn- taking to all participants at the beginning of the process and encouraged the quieter respondents to give their opinions so as to gain all viewpoints across all topics raised. The sensitive and personal nature of the topic meant that confidentiality was another aspect that presented as a challenge for the focus group discussion. I asked that all participants respect the privacy of one another and refrain from using names or discussing confidential information with others (Nieuwenhuis, 2007b).

3.4.3.2 One-on-one interview

Through the focus group interview process I identified a key participant who I believed could possibly add value to this research in a one-on-one interview. The mother highlighted certain relevant issues in the focus group interview that I felt I needed to explore further in a space where she was given more time to express her views in detail. I made use of a semi-structured interview with a set of pre-determined open ended questions arising from the focus group interview (Rapley, 2004; Creswell, 2007). A semi-structured interview is more time efficient in that it guides both the researcher and the participant and allows time for probing and clarification of answers. A semi-structured interview is also better focused than an unstructured interview, while still allowing for depth and flexibility. I ensured that I was attentive to new and emerging lines of inquiry. Another strength of the one-on-one interview is that it is a useful way of gaining large amounts of rich data in a fairly short space of time (Greef, 2005).

One of the disadvantages of one-on-one interviews is that participants might provide information they feel the researcher wants to hear (Creswell, 2007). I attempted to overcome this issue by addressing it with my participants at the start of the interview, emphasising the importance of honesty and transparency. One-on-one interviews can be time consuming and costly for the researcher. The interviews took place at my workplace and therefore travel time and petrol was minimal. Another caution of this form of data collection is for the researcher to be aware of not allowing the interviewing relationship to become a therapeutic one. In the focus group interview the mothers became emotional and I therefore needed to be cognisant of my role as a researcher.

I gained permission from the participants to digitally record all interviews as this provided a more complete record than merely taken notes. It also allowed me to observe both the verbal and non-verbal cues and focus on how best to guide the interview (Greef, 2005). In order to overcome the possibility of experiencing technical difficulties, I made use of more than one

recording device. I also made handwritten notes to support the recordings. I then transcribed the interviews, taking note of any non-verbal observations. I ensured that I listened to the recordings soon after finishing the interviews in order to reflect on and identify gaps that possibly needed to be followed up in another interview (Nieuwenhuis, 2007b).

3.4.3.3 Reflective journal

According to Morrow (2005), keeping a reflective journal is considered one of the most valuable ways a qualitative researcher is able to maintain a reflexive approach throughout the research process. Reflexivity can be defined as: “self-awareness and agency within that self-awareness” (Rennie, 2004, in Morrow, 2005:254).

The ability to reflect on one’s behaviour and intentions is said to necessitate some time in order to reflect and feel supported within an environment by those with reflective ability (Ahern, 1999). I kept a record of my experiences, my thoughts and reactions during the research process, as well as any assumptions and biases that I became aware of (Addendum F). I was able to share this with my supervisor in order to remain objective in my stance. Reflexivity also offers an opportunity for the researcher to recognise how understandings of the world and personal experiences might affect the research process (Morrow, 2005).

Ahern (1999:408) writes that: “The ability to put aside personal feelings and preconceptions is more a function of how reflexive one is rather than how objective one is because it is not possible for researchers to set aside things about which they are not aware.” Making use of my reflective journal allowed me to engage on a deeper level of cognitive thinking, that is, to think about what I was thinking. As I reflected on the observations I made of the mothers, I focused on their non-verbal behaviour in an attempt to gather richer and more meaningful data.

3.4.4 DATA ANALYSIS AND INTERPRETATION

Once all the data had been transcribed I read and listened to the recordings in their entirety in conjunction with my handwritten notes in order to gain a comprehensive overview. Literature guided me in my data analysis and interpretation process, particularly that of Creswell (2007), Marshall and Rossman (2006) and Nieuwenhuis (2007b). Qualitative data analysis is an on-going and iterative process which tries to establish the meaning the participants make of the central phenomena by analysing their perceptions, values, experiences and understanding thereof. This allowed for the emergence of themes inherent to the raw data (Nieuwenhuis, 2007b). It is a search for general statements about

relationships and underlying themes (Marshall & Rossman, 2006) and systemic procedures followed so that important features and relationships were identified (Wolcott, 1994).

I implemented the systemic approach of content analysis which identifies and summarises message content. This approach involved looking at data from different perspectives in an attempt to identify preliminary codes and code headings through which I was able to categorise the data (Creswell, 2007). Through doing so, commonalities emerged which I was then able to cluster into themes. By using content analysis, it assisted me in triangulating the data. Triangulation involves the clarification, verification and validation of meaning through the collection of data from numerous sources (Gibson & Brown 2009). I collected data in diverse ways in order to home in on the different perspectives required to understand the phenomenon under study.

3.5 QUALITY CRITERIA

The term 'trustworthiness' refers to the way in which the researcher is able to persuade the audience that the research is of a high quality and that the conclusions drawn are worth paying attention to (Maree, 2007). In order to establish the trustworthiness of my study I ensured that my results were dependable, credible, confirmable, transferable and authentic.

3.5.1 DEPENDABILITY

Dependability looks at the stability of the results over time, demonstrating the consistency of the findings. It also focuses on the degree to which the findings can be repeated in other studies (Sinkovics, Penz & Ghauri, 2008). Dependability was ensured by monitoring the quality of the recordings and transcriptions of interviews as well as the documentation thereof. I also provided rich descriptions of my data to strengthen the dependability (DiFabio & Maree, 2012). I then used triangulation and crystallisation (Janesick, 2003; de Vos, 2005) together, which contribute to the overall trustworthiness of the study in various ways.

Triangulation allowed me to cross-reference my results and findings against each other from my different sources of data (Gibson & Brown, 2009), namely focus groups, the one-on-one interview, document analysis and reflective journal. By way of triangulation, I was more likely to see all aspects of the results from different perspectives and feel more confident that I had not missed anything (de Vos, 2005). Like triangulation, crystallisation also adds to the degree of trustworthiness of the study. However, crystallisation also incorporates many aspects of the social world, contributing further insight and perspectives (Janesick, 2003; Henning et al., 2009). In order to address both triangulation and crystallisation I consulted with my

supervisor during the analysis and interpretation phases to gain another perspective on my findings.

3.5.2 CREDIBILITY

Credibility focuses on finding a match between the constructed realties of the respondents and those realities represented by the researcher (Sinkovics, Penz & Ghauri, 2008). To ensure maximum credibility is reached the researcher explores the triangulation of the multiple data sources and then uses member checking which involves examining the identified themes with participants to guarantee their accuracy (Creswell, 2007).

I kept a reflective journal, documenting my thoughts and emotions throughout the study and ensured that I debriefed with my supervisor to increase the credibility of my study. I also made use of member checking (Creswell, 2007) with my participants to clarify my understanding of the emerging themes. This proved to be a useful exercise as not only did all the participants confirm that the themes were an accurate reflection of what they had shared, some used the reflection inherent in member checking to provide further clarity to the themes.

3.5.3 CONFIRMABILITY

Confirmability is the need for the researcher to confirm that their data and interpretations are grounded in real conditions and circumstances and refers to the degree of neutrality and objectivity of one's findings (Sinkovics, Penz & Ghauri, 2008). It also refers to the absence of research errors. Confirmability can be monitored by an external researcher who has not participated in the study. This involves assessing whether the methods and procedures of study have been described adequately and that enough detail has been provided for data verification purposes (DiFabio & Maree, 2012).

In order for a logical, sequential process to be carried out, I needed to ensure that my chain of evidence was well documented. In other words, all my data, methods, documentation, interviews, transcriptions, observations, data analysis and my decisions were recorded and provided an audit trail to be checked by my supervisor (Maree, Ebersöhn & Vermaak, 2008). Confirmability also relies on the researchers own self-awareness. This was done through reflectively journaling my thoughts, values, beliefs, emotional state and biases. I also intend to keep the data collected for an acceptable period of time for the possibility of further analysis by other researchers (DiFabio & Maree, 2012). I expressed the interpretations drawn from the data based on the participants' views by including direct quotations in the research report from the interviews and focus groups. Data interpretations were discussed

and verified with the participants in order to ensure that correct interpretations and conclusions were drawn.

3.5.4 TRANSFERABILITY

The degree to which striking conditions match or overlap and how dependable and generalizable the findings are, is referred to as transferability (Sinkovics, Penz & Ghauri, 2008). In other words, are the findings representative of the greater population and can they be 'exported to other contexts (DiFabio & Maree, 2012).

The study looked at a small sample (i.e. five mothers) of the population and therefore will not necessarily be representative. However, the aim of a case study is to provide deeper insight into the perceptions and experiences of the mothers around a central phenomenon providing rich descriptions for the audience to decide whether the findings can be applied to similar contexts.

3.5.5 AUTHENTICITY

Authenticity refers to the acquisition of a balanced and fair view of all perspectives (Morrow, 2005; Patton, 2002). I aimed to attain authenticity by gaining insight into each and every one of the participants' experiences and by acknowledging their views and input. I also reflected on the influence of my own views in my reflective journal and through discussions with my supervisor, in order to process and address any biases and assumptions I may have had.

3.6 ETHICAL CONSIDERATIONS

Researchers must be vigilant in maintaining high standards of ethical standards as one plans, thinks about and discusses each aspect of the research (Glesne, 2006).

3.6.1 INFORMED CONSENT AND VOLUNTARY PARTICIPATION

I conducted all of the individual interviews at a private school and therefore I needed to gain permission from the school's board of directors (Addendum B). I gained written informed consent from each participant (Addendum C). Informed consent means that participants know the purpose of the research, what is required of them and the possibility of harm from participating in the research study (Ryen, 2004). All consent forms entailed a detailed description of the research providing a clear statement of purpose (Henning et al., 2009). Informed consent also explained that participation was voluntary and that participants could withdraw from the study at any time. They were also informed that they may also refuse to answer a question at any time.

The participants in this study were made aware of the on-going research process and their attention was brought to any possible effects on their well-being. By providing participants with all the facts up front and disclosing all information necessary they were able to make an informed decision regarding their participation in the research (Glesne, 2006; Josselson, 2007).

3.6.2 ANONYMITY AND PRIVACY

Participants' confidentiality and anonymity is of the utmost importance. In a focus group situation, anonymity may not be possible and records can be subpoenaed if a court suspects unlawful practice. Participants were informed of these aspects and were asked to protect the names of fellow participants from others. I assigned codes for each participant so that it decreased the risk of their being identified to others. All data collected during the research process was treated confidentially and I asked that the participants do the same. I informed the participants that no one else would have access to the material other than my supervisor and myself (Josselson, 2007).

3.6.3 PROTECTION FROM HARM

Due to the nature of qualitative research, a relationship is built between the researcher and the participants. A principle of trust is developed and the researcher becomes seen as more of a friend and less of a researcher. At this point the richest data is said to be collected, but the researcher is most ethically vulnerable (Ryen, 2004). It is important that the researcher does not betray this trust by deceiving the participants for personal gain during the research process. Respect and care for participants is vital. I was aware of the fact that every aspect of how I treated the mothers would be reflected in the way I conducted my research to ensure no harm was done to the participants (Josselson, 2007). By keeping a reflective journal and consulting with my supervisor throughout the research process, I was able to reflect on my role as the researcher which assisted me in ensuring my behaviour as a researcher was ethical at all times and that no part of the process was deceptive or doing harm to the participants.

3.7 REFLECTING ON MY ROLE AS THE RESEARCHER

During the time of my data collection, my role at the school was that of a part-time mathematics educator and the Learning Centre coordinator. Throughout my years in education, I had encountered many children who experienced barriers to learning; in particular those with ADHD. In facilitating these children's learning processes, I worked

closely with their mothers and thus was exposed to many of the challenges they faced in parenting a child with ADHD and the support provided to them by various professionals. On deciding to research this particular area, I had to become aware of the shift I had made from being an educator to that of an educational psychologist and delineate my role as a researcher from that of a staff member. This required that I no longer see myself as an integral member of the staff but rather an outsider: someone removed from the system and able to gain an outsider's perspective of the phenomena being studied. I was explicit in my relationship with my participants in that my role as a researcher was clearly explained to them at the outset of the process. I was also constantly aware of any biases I had carried through with me in my years as an educator as well as any views I had already assembled through my interactions with mothers. The mothers were known to me and therefore I made it clear to them that their participation was completely voluntary. I did not coerce them into participating in any way.

My role as a researcher shifted according to the needs of the research process. I acted as a facilitator and observer in the focus group and one-on-one interview (Creswell, 2007; Greef, 2005). I was a critical reader and reviewer in the triangulation process of content analysis and member checking, and ensured quality criteria were employed. I became a reflective researcher by keeping a journal to monitor my own actions, biases, responses and thoughts. Throughout the entire process my role as a researcher was embedded in ethical behaviour so that no intentional harm was done the participants (Ryen, 2004).

3.8 CONCLUSION

In this chapter I discussed the research methodology and paradigmatic perspectives utilised in this study. I explained the research design implemented as well as the data collection and documentation strategies applied. The data analysis and interpretation were then discussed, followed by the quality, criteria and ethical considerations that were taken into account. In the following chapter, I present and discuss the integrated findings of the study.

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CHAPTER 4
Research Results and Discussion of Findings

4.1 INTRODUCTION

In the previous chapter I discussed the research methodology and paradigmatic perspectives utilised in this study. I explained the research design, as well as the data collection and documentation strategies applied. The data analysis and interpretation were then discussed, followed by the quality criteria and ethical considerations that were taken into account.

In this chapter, I provide an overview of the results and findings of the current study. I use direct quotations from the participants as well as reflective notes from my journal to support the emergent themes. At the end of each sub-theme, I substantiate my findings with a discussion embedded in existing literature.

4.2 RESULTS OF THE THEMATIC CONTENT ANALYSIS

In this section, I discuss each of the two main themes that emerged following thematic content analysis of the interview transcriptions (Addendum D & Addendum E), namely *How mothers experience their children with ADHD* and *How mothers experience support of their children with ADHD.* These themes are supported by statements made by participants during the focus group discussion and the individual interview (Addendum D & Addendum E) as well as reflective notes from my journal (Addendum F). Table 4.1 outlines the themes, sub-themes and categories.

Table 4.1: Themes, subthemes and categories

THEME 1: How mothers experience their children with ADHD	
Subtheme 1.1	**Children with ADHD**
Category 1.1.1	*Behavioural challenges*
Category 1.1.2	*Academic challenges*
Category 1.1.3	*Emotional challenges*
Subtheme 1.2	**Management of ADHD with medication**
Category 1.2.1	*Types of medication*
Category 1.2.2	*Negative experiences for the child and family*
Category 1.2.3	*Positive experiences for the child and family*

Subtheme 1.3	Effects of ADHD on family
Category 1.3.1	*Emotional challenges experienced by the mother*
Category 1.3.2	*Homework challenges for the child and the family*
Category 1.3.3	*Need for additional interventions*
Category 1.3.4	*Effects on parents: marital conflict*
Category 1.3.5	*Effects on siblings*
THEME 2: How mothers experience support of their children with ADHD	
Subtheme 2.1	Support from an educational psychologist
Category 2.1.1	*Assessment, diagnosis and recommendations*
Category 2.1.2	*Mothers understanding of the role of the educational psychologist*
Category 2.1.3	*Mothers experiences of support from an educational psychologist*
Subtheme 2.2	Support from other professionals
Category 2.2.1	*Support from the school*
Category 2.2.2	*Negative experiences for the child and family*

THEME 1: How mothers experience their child with ADHD

Theme 1 discusses the results relating to the features of ADHD as reported by the mothers[4]. Three subthemes emerged namely, **Subtheme 1.1 Children with ADHD, Subtheme 1.2 Management of ADHD with medication** and **Subtheme 1.3 Stress on the family**. Table 4.2 outlines the inclusion and exclusion criteria that categorised the data for Theme 1.

Table 4.2: Inclusion and exclusion criteria for Theme 1

THEME	INCLUSION CRITERIA	EXCLUSION CRITERIA
Subtheme 1.1: Children with ADHD	Any reference to children with ADHD behaviour, academic challenges, poor self-image and anxiety	References to current behaviour displayed by the participant's children where the children are now adults, as well as signs of ADHD in parents of children with ADHD
Subtheme 1.2: Management of ADHD with medication	Any reference to medication prescribed to children with ADHD, the negative and positive experiences of medication for children and their families	References to dosage of medication and the particulars of professionals prescribing medication to children with ADHD

4 The term mother and participant are used interchangeably throughout this chapter.

THEME	INCLUSION CRITERIA	EXCLUSION CRITERIA
Subtheme 1.3: **Effects of ADHD on the family**	Any references to emotional challenges experienced by mothers, homework difficulties experienced by the mother and the child with ADHD, additional stress experienced by child/children and mother with additional therapies, marital conflict and sibling rivalry	References made to fathers' challenges with their child diagnosed with ADHD

Subtheme 1.1 Children with ADHD

I discuss this subtheme in terms of the following categories: *Category 1.1.1 Behavioural challenges, Category 1.1.2 Academic challenges* and *Category 1.1.3 Emotional challenges*

Subtheme 1.1 Children with ADHD

Category 1.1.1 Behavioural challenges

Children with ADHD exhibit various behaviours, which may be described as challenging by their mothers. In this study, mothers firstly described how they experienced their children's behaviour and then discussed their children's challenges. One participant described her child as having a predominantly inattentive type of ADHD: "*She wasn't, well she's not one of these children that bounces off the walls you know uhm, you know, and is sort of physically disruptive. But she was, the teacher was saying she's like she'll look around and she will be all over the class room, very distracted by everything"* (P2, Focus Group, L30). This mother also described her child as being impulsive at times and found it difficult to get her to focus on the task at hand: "*She's the sweetest thing but just sjo, just to get her to, the impulsivity and the like being able to say to her uhm, 'can we just focus and get this done'*" (P2, Focus group, L81). Another participant reported that her child is both hyperactive and inattentive, as opposed to being impulsive. She described her daughter as energetic, talkative, easily distracted and not able to maintain effective concentration: "*She just really can't keep still but not, not impulsive like hitting and jumping. She just moves and chats and stuff like that, yeah. And then someone will walk past the sliding door, she looks up and that's the end of her work. I mean it would be ten minutes and then that's gone you know"* (P3, Focus group, L95). Participant 4 also described her child as having difficulties with sustaining attention: "*You know in class he's never been that bouncy hyperactive child. It's been the daydreaming and inattentive"* (P4, Focus group, L156). In addition to the mother's observation, educators also pointed out certain types of behaviour to the mothers. For example, one teacher had told participant 4 that her son displayed inattentive behaviour: "*he spaces out in class, just you*

know, will stare into space and he's gone" (P4, Focus group, L272). Participant 1 described the behaviour of her son, suggesting that he was hyperactive and impulsive: "*hectically active and climbing burglar bars at the age of a year and all of you know what it's like. And uhm, he was just unbelievable"* (P4, Focus group, L357). "*Ah and the impulsiveness"* (P4, Focus group, L824)

In addition to hyperactive, impulsive and inattentive behaviour, their children have also been described as sociable, endearing and engaging*: "So when she was in pre-school we, she was uh, the bell of the ball. Miss Social you know, always hopping around and her teacher said "uhg, you know, she, she comes to school and then she's off to visit the next class." And at that stage it was just sweet because she was young and friendly and she loved uhm, participating in everything that was going on" (P2, Focus group, L25).* Other participants found that their children were also very sociable and well-liked: *"Uhm, she was fine at nursery school, she was happy uhm, very popular, social. Everyone thought she was perfect, she was absolutely fine. She sailed through everything you know, no issues, I mean there was nothing"* (P3, Focus group, L91), as well as "*a very likeable child"* (P1, Focus group, L424). Both statements indicate that their children's sociable and endearing ways seemed to mask certain ADHD behaviour and were therefore overlooked from a young age. It was in Grade R that the difficulties become more apparent: "*But then she got to Grade R and it became clear that she wasn't actually concentrating, able to focus" (P2, Focus group, L30),* and *"Then we got to Grade 0* [R] *and yeah, she, the teacher said she just really can't keep still"* (P3, Focus group, L95).

Mothers in this study noticed that their children found difficulty in sustaining attention to tasks; were more active than other children their age and appeared to have difficulty in impulse control. These descriptions indicate that mothers were aware of the main features of ADHD and how they presented as challenges to their children as well as to themselves. Such behaviour was recognised by the educators as well.

Subtheme 1.1 Children with ADHD

Category 1.1.2 Academic challenges

All participants reported on the academic difficulties their children faced. These academic difficulties included challenges in reading, spelling and written expression. Children either repeated a grade or were asked to consider doing so. This mother spoke of her child's difficulty in finishing work timeously: *"Mommy I'm the last in class, I can never finish my work. Never… everybody else is finished and they can play games and I'm still trying to finish*

sticking my collage" (P4, Focus group, L249). The word 'struggled' is mentioned by the mothers on a few occasions: *"He was like struggling through Grade R because you know, we were worried if he should repeat or not"* (P4, Focus group, L220). "*She's struggled a lot at school"* (P2, Focus group, L48). "*I mean in Grade R because he was struggling, he was doing so terribly"* (P4, Focus group, L851). These children seemed to experience difficulty with spelling, written work: *"Spelling and written work was like a nightmare"* (P4, Focus group, L581), as well as with the ability to express themselves adequately: "*They still can't get it together in the classroom to actually produce what's expected in terms of the grade you know* (P4, Focus group, L548)… *saying you know, 'it doesn't help that I know in here you know'"* (P4, Focus group, L555).

A consequence of not identifying the children's' difficult behaviour at a young age is that the child starts struggling academically and larger gaps in knowledge and skills increase with time: "*Meanwhile she's lost, all these gaps now and they're just now building up"* (P3, Focus group, L106). Participant 1's child was battling to learn to read due to gaps in her learning that had developed: "*she was not learning to read very well*" (P1, Focus group, L367) and participant 2's child was not feeling as though she could cope with the increased academic demands: *"She wasn't, now wasn't coping. She wasn't able to do the work*." (P2, Focus group, L464).

Repeating a grade, or the consideration thereof, due to academic difficulties seemed to be a common theme experienced by these families: "*He had to repeat Standard 8" (P1, Focus group, L403)*. One of the participants felt that it would have been advantageous for her son to have repeated a grade earlier on in his schooling career: *"I think it would have done him the world of good because he was young, he's small, nobody would've noticed if he repeated Grade R. That would have been the time to repeat for me."* (P4, Focus group, L862). However, one of the participant's experience of her child repeating a grade at school was not positive and she felt it was a waste of time for her child: *"We repeated Grade 3, no 4 or 5, I think it was Grade 5 uh, it did nothing. It was just a waste of time"* (P1, Focus group, L429). This same mother was also asked to consider placement at a special needs school for her second child: *"They wanted her to go to a remedial school for Grade 3, after Grade 3 and I said no, I'm not doing this again"* (P1, Focus group, L425). She had not had a positive experience at a special needs school with her first child as she found that his behaviour became more difficult to manage. This mother was therefore opposed to the request made by the school to consider placement at a special needs school for her second child: "*My little daughter in a school where there are boys with lots of uhm, emotional problems and uhm, I'm not doing it. So I kept her at Brescia*" She did not want her daughter to be placed in a school environment where the majority of her classmates would be boys with 'emotional' problems.

Subtheme 1.1 Children with ADHD

Category 1.1.3 Emotional challenges

Mothers in the study commented on the emotional challenges their children experienced. What emerged as a shared experience among all mothers is that as a result of constant academic struggles their children started to feel inadequate: *"He said mommy, I got no talents, nothing, nothing"* (P4, Focus group, L243); *"He feels inadequate"* (P4, Focus group, L947). Feelings of constant failure and incompetency led to a low self-esteem: *"And then she got to school and her self-esteem just plummeted because I think she just saw that she wasn't, now wasn't coping"* (P2, Focus group, L463). The children told their mothers that they were not clever: *"But she constantly tells us she's not clever"* (P2, Focus group, L545) and then started comparing themselves with their siblings: "*Why aren't I as clever as my brother?"* (P5, Interview, L66). One mother echoed how she believed her daughter felt: *"I'm something that somebody is trying to fix, I'm broken"* (P2, Focus group, L267). This mother was concerned that her child felt as though she was 'broken' and people needed to fix her.

Mothers reported that possible consequence of the children's low self-esteem was that they were reluctant to persevere and gave up with work that was too challenging. Participant 4 believed her daughter tells herself that: *"Well I'm not going to be able to do it, so I'm not gonna try. It's very difficult."* (P4, Focus group, L573) and how it seemed that the start of each new year was experienced as a constant struggle for the child: *"They feel such terrible self-esteem and then my son to feel a little better and we're back to term one and then they're knocked down again"* (P4, Focus group, L859). She felt as though her child's confidence grew in the second and third term of every school year, but that it did not carry him through to the start of a new school year.

Another mother noticed signs of high levels of anxiety in her child: *"He's a very anxious little guy, he doesn't want to break the rules. He gets very scared, he's like too scared to ask to go to the toilet in class even up till recently and he's now in Grade 7"* (P4, Focus group, L279). "*The start of the next year was always a very high anxiety time. He didn't handle change very well and he was getting nervous*… *And so he started wetting himself a little bit"* (P4, Focus group, L523, L525). Her child felt anxious about asking to go to the toilet and his anxiety seemed to be exacerbated by the start of a new school year (P4, Focus group, L427).

4.2.1 DISCUSSION OF FINDINGS FOR SUBTHEME 1.1

ADHD is the most prevalent child psychiatric disorder in South Africa with estimates of 4% to 5% of children affected (Mahomedy et al., 2007; Perold, Louw & Kleynhans, 2010). With regard to the participants' views on the behaviour of their child with ADHD, the results are in line with current literature and diagnostic criteria for ADHD (American Psychiatric Association, 2000). The children in this study who have been diagnosed with ADHD show signs of hyperactivity, inattention and impulsive behaviour (Louw, Oswald & Perold, 2009). Literature reviewed speaks synonymously of children with ADHD showing signs of not being able to sit still, being fidgety and restless, and appearing distracted, inattentive, forgetful and impulsive (Wicks-Nelson & Israel, 2009). This behaviour of a child with ADHD is reported by the mothers in the study. Although children with ADHD may find it difficult to integrate socially, two of the participants commented on the sociable nature of their child and their ability to integrate with their peers whilst the rest of the participants did not comment otherwise (Seabi & Economou, 2012).

Many reviews have reported the functional impairments experienced by children diagnosed with ADHD. Reviews focusing on academic difficulties report that up to 80% of those diagnosed with ADHD struggle academically (DuPaul, 2007; Loe & Feldman, 2007; Raggi & Chronis, 2006; Rogers et al., 2009, in Resnick & Reitman, 2011). As reported by some of the mothers (i.e. Participant 3 and 4), their children seem to struggle with reading, spelling and writing. Research shows (August & Garfinkel, 1990; Willcutt et al., 2001), that children diagnosed with ADHD were found to have a coexisting reading disability as well as that of the written expression. Another participant felt that because ADHD was diagnosed relatively late for her child, the gaps in the child's academic knowledge appeared to increase. Repetition, or consideration of repetition, had been a common occurrence in the education of the participants' children. One participant's child was placed in a special needs school. Literature suggests that children diagnosed with ADHD also have a greater likelihood of repeating a grade, being placed in a special needs school, and requiring individual support (DuPaul, 2007; Faraone et al., 1993; Raggi & Chronis, 2006; Silverman et al., 2009, in Resnick & Reitman, 2011).

Academic difficulties and behavioural challenges in the school environment have been found to make educators more demanding of children with ADHD (Wicks-Nelson & Israel, 2009). Thus, the children's challenges are highlighted and they are also subject to frequent failures, both emotionally and scholastically. This has been shown to cause intense levels of stress for the child, often resulting in humiliation, anxiety and a low self-image (Hutchins, 2005; Elbaum & Vaughn, 2003, in Seabi & Economou, 2012). All of these were reported by the participants in this study.

On average, 25-35% of children with ADHD have been found to experience anxiety disorders. Research suggests that if anxiety disorders are present then children appear to be less impulsive and hyperactive than those children with ADHD but without an anxiety disorder (Schatz & Rostain, 2006). With the comorbidity of an anxiety disorder, children with ADHD may display higher levels of inattention and fewer conduct problems (Wicks-Nelson & Israel, 2009:241).

Subtheme 1.2 Management of ADHD with medication

The categories forming the basis of the discussion for this subtheme are: *Category 1.2.1 Types of medication, Category 1.2.2 Negative experiences for the child and family, and Category 1.2.3 Positive experiences for the child and family*.

Subtheme 1.2 Management of ADHD with medication

Category 1.2.1 Types of medication

For many parents of children with ADHD, the decision to manage their children's behaviour with medication may be a difficult one. The participants spoke of the different types of medication their children have tried: "*She was on Ritalin"* and *"We're trying Concerta"* (P2, Focus group, L58; L63); *"We were first on Concerta… then it was Ritalin… so then we're on Ritalin LA"* (P3, Focus group, L125; L128; L130), *"He went on Ritalin… okay let's try Strattera… so the Strattera was like a no-go… so then we tried the Concerta"* (P4, Focus group, L282; L300; L310; L318). "*He went on Strattera"* (P5, Interview, L77), "*onto the Ritalin"* (P1, Focus group, L423). The types of medication the children were prescribed included the stimulants (i.e. Ritalin and Concerta) which alter the chemicals dopamine and noradrenalin in the brain, and non-stimulants (i.e. Strattera) which primarily effects noradrenaline in the brain, without directly affecting dopamine levels.

Subtheme 1.2 Management of ADHD with medication

Category 1.2.2 Negative experiences of medication for child and family

The participants explained the difficulties their children experienced with the taking of medication. These challenges ranged from disliking the pills to having difficulty swallowing the pills, as well as the emotional state they would find themselves in possibly as a result thereof: "*He hates taking pills*" commented one mother (P5, Interview, L75) and another spoke of the challenges her child experienced with swallowing of the pill. The child found the

pills too large to swallow and would be anxious in trying to swallow them: *"Never mind that she couldn't swallow a pill you know, she'd refuse, say "they're too big for me… Crying and couldn't, I mean hysterical at home till 10 in the morning. We couldn't get the pill down her throat, awful"* (P3, Focus group, L136; L139). This mother reiterated the challenge by saying: *"Well even the, even taking the pill was a huge thing and I was like, I poor her, was like how is she gonna swallow this thing, for weeks"* (P3, Focus group, L596). Another participant agreed that her child had difficulty swallowing the pills up until he was in Grade 4 "*So also swallowing tablets was a huge thing… he couldn't swallow anything bigger and then in his Grade 4 year, he finally was able to swallow bigger things"* (P4, Focus group, L217; L298). The same mother spoke of the emotional state he would be in over swallowing the pill: *"They would get in a state about it"* (P4, Focus group, L598). Participant 3 continued by describing the measures they would have to take with her daughter in order to overcome this difficulty: *"I mean she'd cry and get frustrated and she'd go to the head mistress and it was just terrible try, everyone trying to squash it in food and that kind of thing. It seems so small but it's huge. It takes over their whole lives"* (P3, Focus group, L599). They tried to break the pill into smaller bits and place it in food. The headmistress would even try to assist her in taking the pill at school.

The participants went on to speak of the side-effects of the medication their children experienced as well as the impact it had on themselves as parents. Participants spoke of how the effects of the medication wore off in the afternoons and that it was not necessarily effective: "*We would find it wasn't lasting into the afternoon* (P4, Focus group, L297); *"She was on Ritalin which was working but she, because it wears off uhm, the afternoons wasn't so great I mean"* (P2, Focus group, L59), *"This isn't working for us and honestly it did nothing for his concentration"* (P4, Focus group, L311). As the medication wore off, participant 4's child became moody and irritable in the afternoons and the child's behaviour became difficult to manage: *"As soon as it wears off, he was moody and miserable and ugly at home, you know. It's just like his emotions were doing this"* (P4, Focus group, L321). One mother felt that because her child was not eating his lunch, his blood sugar levels would decrease and his emotions would be affected: *"They wouldn't eat their lunch, it would come home in their lunch box and low blood sugar and grumpy and shouting and ah no, terrible"* (P4, Focus group, L821). The effects of not eating would lead to conflict at home in the afternoons.

Mothers were concerned about their child's loss of appetite possibly due to the effects of medication. This mother spoke of how they needed to monitor their daughter's eating habits day and night as she was not gaining weight: *"It affects her appetite. We have to make sure she eats well at night as well and try and almost force her to have something during the day so how can I say, she's grown but she's not putting on weight uhm, so that's the concern"*

(P2, Focus group, L67). Participant 4 also found her son lost his appetite: "*I would say it did take his appetite a little bit"* (P4, Focus group, L284). Participant 1 commented that her child battled with a loss of appetite possibly from the effects of Ritalin and was often nauseous, which resulted in his being underweight: "*Also we did the Ritalin thing which just did took his appetite away completely and he didn't eat, also a tiny little thing and thin and nauseas and ah, it just was a battle, went on and on"* (P1, Focus group, L391). This participant felt that the struggle with medication was never-ending.

Some of the children found it difficult to fall asleep at night possibly due to the side-effects of the medication: *"Then she couldn't fall asleep at night; she always battle to fall asleep so nine o'clock, half past nine every single night she's like this and she can't fall asleep. Ah, it's terrible"* (P3, Focus group, L125). Participant 4 found the same for her child: "*Struggle a little bit falling asleep"* (P4, Focus group, L295) and if the dosage was increased or was taken later in the day then falling asleep would become even more problematic for the child: *"If we take it later then he's gonna be up all night bouncing off the walls"* (P4, Focus group, L334).

Some mothers chose not to give their child the medication on the weekends and over the holidays as they had heard that the medication negatively affected growth: *"We don't give it to her consistently during the weekends and holidays* (P2, Focus group, L84). *"We'd stop during the holidays"* (P4, Focus group, L293), Participant 4's child showed signs of adjustment to the medication when resuming it after the breaks. He would get headaches and have slight difficulties in falling asleep: *"the first week or two back on it he would get a little bit head-ache and struggle a little bit falling asleep and then it was fine"* (P4, Focus group, L293).

Participants spoke of how awful their child felt in general on certain medications and the mothers feared it was changing their child's personality: *"The Ritalin is a, is a swear word"* (P1, Focus group, L812). There were times when the child refused to take the pills: *"Mom, I am not taking that, it makes me feel awful"* (P4, Focus group, L815). Participant 1 comments how much her child detests taking the medication and that her personality alters when on it: *"They absolutely hate it. It makes them feel terrible, changes their personality"* (P1, Focus group, L817). One participant said that her child became withdrawn from taking the medication: "*He seemed to be withdrawn and had no appetite. I hated the thought of his personality changing"* (P5, Interview, L77). Another mother reported that her child became depressed on the medication: *"It was an absolute disaster for him. Actually he became clinically depressed. He was on it for six weeks"* (P4, Focus group, L300). *"Mommy I'm so sad all the time, I don't know what's going on. I don't know why I feel like this, I just, I'm so unhappy"* (P4, Focus group, L308). The same participant's child was confused as to why he

constantly felt sad and lethargic; they soon realised that it was possibly a side effect of the medication.

Subtheme 1.2	**Management of ADHD with medication**
Category 1.2.3	***Positive experiences of medication for child and family***

Despite challenges experienced with medication, some mothers reported positive effects of the medication for their child, which was also acknowledged by the educators. Participant 2's child was able to concentrate and listen to the educator: "*So I mean I remember the day that she started* [her medication]. *First of all, her teacher said to us 'Oh my God, she said, 'I couldn't believe that this child, she's sat there the whole day like this just listening to everything I said, lapping it up'. And I said to T, 'So how do you feel today?' She says, 'Mommy I could listen to my teacher'"* (P2, Focus group, L469). Another mother had a similar experience after lowering the dosage and the educator had also noticed a positive change in the child: *"The paed has since lowered the dosage as he is a small boy for his age and it seems to be better. Uhm the teacher says she has noticed a change"* (P5, Interview, L79). This is echoed in Participant 4's experience in that her son's concentration improved: *"*[the doctor] *prescribed the medication and we started on it and concentration was a lot better"* (P4, Focus group, L519). Participant 2 was relatively sure it was helping with her child's concentration in the afternoons: "*I think that does help because it gets her through the afternoon activities better"* (P2, Focus group, L64). Participant 3 switched to Ritalin LA which had a more positive outcome as the medication released more slowly and was effective for longer: "*So then we're on Ritalin LA now and it has been better"* (P3, Focus group, L128). I made the following comment in my reflective journal:

After listening to the mothers speak about their difficulties with medication, it made me think about the controversies surrounding medication and my own biases towards them. It must be an incredibly hard decision to make initially as to whether to medicate or not…and then to deal with the side-effects even harder. I wonder if there is a sense of guilt for the mother that also comes with the relief of your child's behaviour improving (October, 2012).

The positive impact that the medication appeared to have had on the children with ADHD, also seemed to have resulted in mothers being better able to cope. *"I hate saying it but it* [medication] *makes my life so much easier"* (P2, Focus group, L77); "[the child is] *More manageable*" (P4, Focus group, L80). Both participants appeared to have found relief from their child's more manageable behaviour when taking their medication.

4.2.2 DISCUSSION OF FINDINGS FOR SUBTHEME 1.2

Every child is unique and therefore treatment of ADHD will differ from child to child (Wicks-Nelson & Israel, 2009). Participants spoke of the different types of medications they tried in order to suit the changing needs of their child with ADHD. There has been extensive research on medication to treat ADHD (van der Westhuizen, 2010; Johnston, Fine, Weiss, Weiss, Weiss & Freeman, 2000; Castle, Aubert, Verbrugge, Khalid & Epstein, 2007). Literature states that the most frequent types of medication used to treat children are categorised into two groups, namely: stimulants and non-stimulants.

Methylphenidate is the most common stimulant used to treat children with ADHD, available as Ritalin and Concerta. Dopamine and noradrenalin, the two chemicals in the brain that play an important role in expression and behaviour, are altered by the stimulant. Methylphenidate begins working thirty minutes to an hour after being taken. Two forms of the stimulants are available – shorter acting formulations lasting between two and four hours, and longer acting formulations, which can work for up to twelve hours. It is a schedule six medicine in South Africa and has been used for children for over 45 years. Non-stimulant medication primarily effects noradrenaline in the brain, without directly affecting dopamine levels. The most commonly used non-stimulant medication is atomoxitine, known as Strattera (van der Westhuizen, 2010; Wicks-Nelson & Israel, 2009).

Mothers commented on the negative side-effects their child experienced when taking medication. According to Green and Chee (1997) and van der Westhuizen (2010), the most common side effects of stimulant medications include headaches, decreased appetite, troubled sleeping, irritability, depression and stomach aches most of which were reported by the participants. Side effects are of non-stimulant medication are similar to stimulant medication, and include sleepiness, nausea and vomiting, slight increases in blood pressure and heart rate and dizziness (van der Westhuizen, 2010; Wicks-Nelson & Israel, 2009).

Positive effects of the medication were also discussed by the participants. They noticed a change in their child's behaviour and the relief it provided them as a parent in terms of less conflict in the house, the child being easier to manage and less emotional demands on them as mothers. In a study conducted by Hansen and Hansen (2006) several families reported that the medication's behavioural effects produced a welcomed change for the entire household. Reportedly, family relationships improved, there was a reduced level of parenting stress, and daily routines of the child with ADHD were easier to manage. Several parents spoke of an improved one-on-one interaction with their child. Due to the sense of relief the participants in Hansen and Hansen's (2006) study found they felt they were able to parent

their child in a more positive manner. According to Dosreis, Zito, Safer and Soekon (2003) parents were satisfied with the behavioural and academic improvement related to the positive impacts of the medication and the relative improvement in their child's self-esteem.

Subtheme 1.3 Effects of ADHD on the family

Subtheme 1.3 is comprised of the following categories: *Category 1.2.1 Types of medication, Category 1.2.2 Negative experiences for the child and family* and *Category 1.2.3 Positive experiences for the child and family.*

Subtheme 1.3 Effects of ADHD on the family

Category 1.3.1 Emotional challenges experienced by mothers

Participants reported that they experience high levels of frustration and stress related to parenting their child with ADHD. The tension seemed to consume the entire family and often resulted in conflict. Participant 1 states: "*It's stressful and a whirlwind. It's like a rollercoaster ride with a kid like her"* (P2, Focus group, L53;81). "*It's so hard when you're the parent"* (P2, Focus group, L502); "*but it can be so hard"* (P2, Focus group, L930). The mothers spoke of how the pressure and tension affected the whole family: *"It creates a different sort of tension in the house that you got to deal with the whole time and try be aware of and as a parent you have to try to understand what they are going through yet it is very frustrating dealing with it as a parent"* (P5, Interview, L54). This mother added that is has placed enormous pressure on the entire family: *"It has placed a lot of pressure on our family* (P5, Interview, L43). One mother felt it overwhelmed her and added strain to the whole family: "*It takes over your life and it causes strain in your whole family"* (P4, Focus group, L603). As a result of the pressure relating to parenting their child with ADHD, conflict arose in the family: *"blood, sweat and tears and lots of fighting at home"* (P4, Focus group, L328). Participant 5 agreed and commented that: *"It actually becomes your problem you realise how huge the whole thing is and what an impact it can have"* (P5, Interview, L45).

The parents' frustration from the difficulties in parenting a child with ADHD often resulted in outbursts: *"But you get to the point where you just push, push, push, push till you snap"* (P2, Focus group, L397); *"But when you're in the situation, in the heat of the moment, sometimes that child and you're just butting heads and it's hard for you"* (P4, Focus group, L796). These outbursts left the parents feeling guilty and judging themselves for doing so: "*You judge yourself"* (P1, Focus group, L936); "*Ah I feel like a terrible mother"* (P5, Interview, L71); *"So from that aspect the mornings are always quite hectic and then obviously the guilt that goes*

with it because once you are in the car you feel so guilty for shouting or getting irritated" (P5, Interview, L50). One mother felt guilty about waiting so long to take her child to an educational psychologist as she felt they then could have intervened earlier: *"Oh, now I say why did we wait"* (P2, Focus group, L476). With feelings of guilt also came feelings of desperation and concern for their child with ADHD: *"I mean I just, I just want to sob"* (P2, Focus group, L474); *"It is absolutely soul destroying"* (P1, Focus group, L475). The focus group session appeared to be emotional for the participants and it brought tears to some: "*Uhm, sorry I am gonna just cry"* (P4, Focus group, L243). In my reflective journal I commented on how emotional the mothers became in the focus group session:

These mothers desperately needed to offload today in this focus group. I was completely taken aback by the emotional impact ADHD has on the mothers themselves. It was difficult seeing them so emotional (August 2012).

Participants also spoke about their loneliness as they appeared to struggle, unsupported, in their roles as parents. They felt overwhelmed by the reality of the challenges they faced in parenting their child with ADHD: "*I promise you, I felt so alone last year. I've been in tears more often than not"* (P4, Focus group, L675) and *"realising how you are just left on your own and the challenges you face and the reality of everything"* (P5, Interview, L14). I made the following comments in my reflective journal about the loneliness these mothers seemed to experience in parenting a child with ADHD:

Some of the comments the mothers made today about their loneliness really touched me. These mothers felt so alone and they remarked on how the focus group had been so helpful to them to be able to talk about their experiences and hear how other mothers are handling things. This was something I really had not expected (August, 2012).

This mother spoke of how she felt so alone after the diagnosis was made. It has really made me think about the role of an Ed Psych[5] *and at what point our services end- or begin for that matter!* (October, 2012).

The direct quotations in this category emphasize the extent of the stress and emotional strain the mothers experience while parenting their child with ADHD. The mothers reported feeling alone in dealing with their child and stressed about how they were going to cope. A common theme was how overwhelming the experience was and this appeared to create doubt in the minds of the mothers about their ability as parents.

5 Ed Psych is an abbreviation for the term educational psychologist.

Subtheme 1.3 Effects of ADHD on the family

Category 1.3.2 Homework challenges for the child and family

Difficulties monitoring and helping their children with homework was something the participants found a challenge. The participants reported that in trying to assist their children with their homework, it would result in conflict and tension in the house, adding strain to the mother-child relationship: "*I mean her homework, well I can't even do it with her. I just can't. Our helper does and that's not ideal. But she, we just fight, she doesn't want to do it… I can't do homework at all with my child."* (P2, Focus group, L703; L786). The next participant spoke of the tension it created in the house and the frustration she felt: *"So this creates tension as well in the house. Ag especially when it comes to homework time. Ah I could tear my hair out"* (P5, Interview, L63). One of the participants, an educator, found it easier to do homework with children other than her own: "*I'm a teacher too and I don't know if you find, I mean I did extra lessons for years and other people's children will work for me without problems"* (P4, Focus group, L705). She realised that she was unable to be both his teacher and mother as these roles required separate identities. The conflict over homework was affecting their relationship: "*I can't be his mother and his teacher because it's like damaging our relationship* (P4, Focus group, L709). Participant 4 agreed with her as she had a similar experience with her two children: *"The sooner you can back off, the better because, because it's just destroying* (P1, Focus group, L712) and advised the mother to take a step back.

Participant 4's oldest child went onto boarding school. It seemed like the mother found relief in this arrangement as there was supervised homework time every afternoon: *"Uhm, he then went to St. Alban's College for high school because it was, they decided that the boarding aspect was the best where there's structure in the afternoon and could supervise his homework… He just had to stay there and also to save my sanity. He was incredibly difficult in the afternoons, incredibly hard*" (P4, Focus group, L385; L390). This child eventually moved back to another school where he was no longer boarding and the idea of conflict with her child over homework was daunting for the mother. This time the mother was advised to let her child be if there was no homework given: *"It was just a nightmare to get homework done and eventually the educational psychologist said 'Leave him, leave him in the afternoons if there is no homework'."* (P4, Focus group, L403). It turned out that this new school environment was much less pressured: *"Absolutely marvelous and took the pressure off me. I didn't have to be at him the whole time"* (P4, Focus group, L409) and therefore there was less need for the mother to implement structure for her child at home in the afternoons. It was a relief for this mother after all the years of conflict that had arisen over homework.

Subtheme 1.3 Effects of ADHD on the family

Category 1.3.3 Need for additional interventions

The presence of ADHD increases the existence of associated difficulties and therefore different intervention is needed for each difficulty (Green & Chee, 1997). The participants spoke of the type of intervention and therapies that have been recommended for their children. These ranged from speech and language therapy, occupational therapy, remedial therapy, physiotherapy, visits to the neurologist and optometrists, as well as a therapy called 'So Listening' to improve auditory processing skills: *"Yeah so now we're also doing speech therapy also" We're stopping the OT*[6]*. We're done with the 'So Listening', don't know if you heard of the new therapeutic listening therapy?"* (P3, Focus group, L143; L146). This participant's son had similar therapies: *"I mean we had the neurological assessment and the EEG and we've done it all. He went to OT for a while, he went to speech therapy because he had uhm, it was his processing that was a problem"* (P1, Focus group, L360). *"We had him assessed for low muscle tone and then we started physio… so it was physio, OT, eyes"* (P4, Focus group, L205, 229). I made the following comment in my reflection journal:

I have learnt so much about the various comorbid difficulties a child with ADHD can have. Such as sensory and auditory processing difficulties, social behaviour problems, academic problems, and on top of that the amount of therapists they see for these difficulties. Where do they have time for these? And the cost must be huge (August, 2012).

With all the additional therapy, mothers found that they had very little extra time for play dates for their children. They also found that their children were exhausted at the end of the day. Any additional therapy came at an additional cost: *"When do you have time for play dates and things?"* (P2, Focus groups, L782) *"Sjo because like you know they're, they're so bogged down with all these therapies"* (P2, Focus group, L266), "[therapy] *for two hours in the day after her school and after a 4 extra hour a day, all that stuff, yeah" (P3, Focus group, L170).* The mothers commented on how expensive all the therapy became: *"Ah the expense of these things"* (P3, Focus group, L113). With the added exhaustion, time constraints and expense that the therapy adds, more stress is placed on the parents and children.

6 O.T. is the abbreviation used for occupational therapy.

Subtheme 1.3 Effects of ADHD on the family

Category 1.3.4 Effects on parents: Marital conflict

In terms of the emotional challenges parents experienced, marital conflict seemed to be a common thread: "*It has been difficult for my husband and me*" (P5, Interview, L59) and *"It's put huge strain on my marriage, massive"* (P4, Focus group, L645), at which point all participants uttered: *"Of course yes, oh yes!"* (All, Focus group, L646). Different parenting styles where participants felt as though they were the disciplinarians seemed to add conflict in their marriage: "*I can't do it all anymore and it, it's only in recent times that I said to him 'Jeffrey I feel like a policeman in this household. I cannot just do the homework stuff. I can't do all this. I need you to step up and help"* (P4, Focus group, L651) which is echoed in Participant 5's comment: *"I often feel like the disciplinarian. And then my son will say, 'Mom why are you always shouting at me'. Ja it has been very difficult"* (P5, Interview, L59). These statements made by the mothers infer the need for their partners to assist with the discipline of their children as it seems to place more strain on the mothers' relationship with their children through constant disciplining.

Subtheme 1.3 Effects of ADHD on the family

Category 1.3.5 Effects on siblings

The participants found that their child with ADHD often compared him or herself to their sibling/s. Participant 5 spoke of how her son felt less competent academically: "*He is always comparing himself to his younger brother and saying things like, you know, uhm, 'Why aren't I as clever as my brother?"* (P5, Interview, L64). Another two mothers spoke of the jealousy that emerged between the siblings: *"He feels jealous of the younger son because he thinks things come easier to the younger son"* [without ADHD]" (P4, Focus group, L763) and participant 2 felt that the younger sibling gets jealous of the older sibling with ADHD: "*She gets very jealous"* (P2, Focus group, L944).

The participants with younger children fear that their child's awareness of their own difficulties is only going to increase as they get older: *"I just fear that it is only going to get worse as they get older and more aware of their abilities you know."* (P5, Interview, L67). Participant 2 comments: "*The little one is still at pre-school. My husband and I talk about this a lot, that if we look at her, it's not gonna be long before she in a sense overtakes, because she's focused. I mean she can, she would sit here and just concentrate. And when she starts school uh, you know… you don't want the older sister to feel that she's being overtaken by*

the little one" (P2, Focus group, L948). They expressed concern over the younger sibling/s without ADHD possibly progressing more quickly academically than the child with ADHD:

4.2.3 DISCUSSION OF FINDINGS FOR SUBTHEME 1.3

Participants described the stress in parenting their children with ADHD. They spoke of emotional strain, guilt, loneliness, the emotional effects of having to attend additional therapy, conflict in their marriage and sibling difficulties. Literature suggests that increased caretaking demands exist with children diagnosed with ADHD, which can have a negative impact on the parent and their parenting abilities (Harrison & Sofronoff, 2002). Thus parents may feel inept, frustrated, and helpless.

Research supports how participants in this study felt and confirms that that mothers feel less competent than fathers in their ability to parent their child with ADHD and the mother-child relationship is often more strained than the father-child one (Green & Chee, 1997; McLaughlin & Harrison, 2006). This may be due to the fact that, traditionally, mothers are the primary caretaker and may be left exhausted and void of hope. With little emotional resources left, positive parenting and optimal child conduct proves challenging (Cunningham, 2007).

The participants spoke of the difficulties they have with regard to carrying out homework with their child with ADHD. Studies show (Resnick & Reitman, 2011) that children diagnosed with ADHD tend to show more numerous and intense homework problems than their peers. For example, children with ADHD have been noted for forgetting to write down or bring home assignments, struggling to sit down and work, not keeping to allocated time frames, becoming easily distracted, engaging in conflict with their parents, and working in a careless fashion (Green & Chee, 1997; Resnick & Reitman, 2011). Firmin and Phillips (2009) conducted a study on families and children diagnosed with ADHD and found that homework periods in the afternoons are the most challenging and stressful for the parents. Despite the important role that homework difficulties play in the lives of families and their children diagnosed with ADHD, there has been limited research on homework interventions for ADHD-diagnosed children (Resnick & Reitman, 2011).

As reported by the participants, the associated difficulties and costs of treating ADHD add major stress to family functioning. Research shows (Cunningham, 2007; Gerdes, Haack & Schneider, 2012; Theule et al., 2011) that financial strain is often experienced by families with children diagnosed as ADHD, with the additional therapy; visits to health care practitioners; medication and other interventions required, as well as the number of professionals a child sees before an accurate diagnosis of ADHD is made. The added costs, time and energy

necessary to manage these challenges may likewise be associated with marital conflict as reported by participants indicating the need for different levels of support (Cunningham, 2007).

THEME 2: How mothers experience support of their child with ADHD

Theme 2 highlights the way mothers experience support of their child with ADHD. This theme is divided into **Subtheme 2.1 Support from an Educational Psychologist** and **Subtheme 2.2 Support from other Professionals**. Table 4.3 outlines the inclusion and exclusion criteria considered for Theme 2.

Table 4.3: Inclusion and exclusion criteria for Theme 2

Theme	Inclusion criteria	Exclusion Criteria
Subtheme 1.1: **Support from an educational psychologist**	Any references to the assessment, diagnosis and recommendations made by the educational psychologist, the mother's understanding thereof and their experience of the support provided to them by the educational psychologist to their child diagnosed with ADHD .	References to opinions of other professionals and the mothers' experiences of support provided to them by other professionals.
Subtheme 1.2: **Support from other professionals**	Any references to the schools involvement in the referral process, educators lack of understanding of ADHD and the interaction between professionals.	References to educators lack of understanding to other disorders and particulars of other professions.

Subtheme 2.1 Support from an educational psychologist

Subtheme 2.1 is comprised of the following categories, namely: *Category 1.2.1 Assessment, diagnosis and recommendations, Category 1.2.2 Mothers understanding of the role of the educational psychologist and Category 1.2.3 Mothers experiences of support from an educational psychologist*

Subtheme 2.1	**Support from an educational psychologist**
Category 2.1.1	***Assessment, diagnosis and recommendations***

All mothers consulted with an educational psychologist for a complete educational psychology assessment of their children. *"We took her for a full Educational Psychology assessment this year"* (P1, Focus group, L44) *"Now is the time to get him fully assessed, let's go to the education psychologist*" (P4, Focus group, L263). *"That's when we took him for the educational assessment"* (P1, Focus group, L369).

Overall the participants found the assessment process a positive experience*: "My husband and I found the support during the whole assessment process very good and uhm all the information from the report we agreed with"* (P5, Interview, L4). "*I think the assessment for me was incredibly useful* (P2, Focus group, L490). "*She* [educational psychologist] *was amazing. Assessment was, she gave report back at her office, lots of things to recommend"* (P3, Focus group, L508). They felt that the support during the assessment process was adequate.

The diagnosis of ADHD was made by the educational psychologist. Participant 4's child was initially diagnosed as the inattentive type *"He had his whole assessment diagnosed with inattentive type and possibly later on we've discovered he might even have the combination but more the inattentive"* (P4, Focus group, L277). "We had been given the diagnosis" (P5, Interview, L6) "*She said yeah, he's ADHD"* (P4, Focus group, L269) and the mothers felt satisfied with the diagnosis.

The participants were given the recommendations for their children after the diagnosis was made. The educational psychologist recommended they see a neurologist as well as start remedial therapy. It was also advised that their children visit an optometrist and continue with occupational therapy: *"She diagnosed ADHD and recommended to go see a neurologist and maybe remedial therapy and maybe an eye test and maybe carry on with OT"* (P3, Focus group, L108). Participant 4 felt as though the educational psychologist did not have many recommendations for her son other than to accept the diagnosis of ADHD and to start with the medication: "*See, she had no recommendations for L other than ok well he's ADD and get on with on it"* (P4, Focus group, L640), This seemed to be a similar experience for participant 1 who was also advised to medicate her child with no recommendations for additional interventions: "*Yeah and get your child medicated*" (P1, Focus group, L595).

Some of the children engaged in therapy with the educational psychologist after the diagnosis of ADHD was made: *"We took him to counseling* (P4, Focus group, L530); "*I think that for us it's been, my daughter has been for therapy, how many, six and now eight yeah"* (P2, Focus group, L538).

Participants spoke of both their positive and negative experiences with therapy. Participant 2 reported that her child loved therapy and especially the one-on-one attention she was receiving. The educational psychologist worked on the child's self-esteem in therapy: "*and uhm, it's been good* (P2, Focus group, L538); "*The educational psychologist is working on the esteem and stuff and that, I don't know. I mean she loves going, it's fun she loves it because she thrives on the one-on-one attention… She goes for uhm, you know, support lessons with the teacher once a week and she just loves going to, loves the educational psychologist"* (Participant 2, Focus group, L554; L777).

Participant 4 did not think the therapy was particularly beneficial for her son: *"But she never volunteered anything you know, unless you specifically say 'okay, this is the issue I'm having, please can you help me with this?' and it wasn't very play therapy oriented. She sort of was very formal about it and I like, for me I don't think it was great, a great experience for him"* (P4, Focus group, L530). She went on to comment that her child did not like going to therapy: "*I didn't like going at all. He didn't form a bond with her at all"* (P4, Focus group, L561). In this instance, the educational psychologist was found to be too formal and her son did not bond with her. Participant 4 also felt that the educational psychologist did not necessarily initiate any assistance unless the mother asked for it specifically.

Subtheme 2.1	**Support from an educational psychologist**
Category 2.1.2	***Mothers' understanding of the role of the educational psychologist***

I needed to gain insight to how participants understood the role of the educational psychologist and their scope of practice to be, with regard to support provided by the educational psychologist for them and their ADHD child. In listening to each participant, I found their responses varied.

Some participants were unsure about exactly what the scope of practice of an educational psychologist was, while others appeared well informed. Participant 5 had a good understanding of the role and saw benefits of the educational psychologist working together with the school to provide more support to parents and teachers: *"It is quite a broad role of the educational psychologist, like uhm you know testing, play therapy, diagnosis of different*

learning areas and learning problems and your whole ADHD aspect. Uhm I think a lot of parents maybe only feel that an educational psychologist is only used for identifying of problems especially ADHD and I think it is something actually as a school need to work on. Because you know they offer so much more support to the staff and parents from that aspect… well they could offer so much more to the staff and parents but I don't think that role is fulfilled at the moment" (P5, Interview, L19). Participant 2 also made the following comment with regard to what she understood the scope of practice to be. She felt it was unethical of an educational psychologist to only make a diagnosis of ADHD without following up with the parents or making further recommendations for them: *"An educational psychologist to just diagnose and then to leave you alone. I think they need to recommend and suggest and talk and say okay let's have a session and this is what I, what the options are. Then you make a decision, do you want that support. But she should be saying this is what I can offer, this is the kind of things that we, that are within our scope. I mean you know, they can pretty much do everything"* (P2, Focus group, L967).This participant felt it should be the parents' choice as to whether or not they feel they need ongoing support. She also made a comment on the necessity of the educational psychologist to be explicit about their role.

The other participants were not as clear in their understanding of the role of the educational psychologist. They were unsure how far their role extends to the client: *"I don't know how far the job must go"* (P3, Focus group, L515) and felt that the educational psychologist could be more explicit at the outset of the process about their role: *"The scope for an educational psychologist is very broad so they need to tell you that. Because you're going in there as a parent for the first time, you don't know this"* (P4, Focus group, L975). In my reflective journal I said the following:

I realised today how important it is for an ed psych to speak about his/her role and scope of practice at the outset of the process so that the clients have a better understanding of what they can and should expect (August, 2012).

The participants expected more emotional support from the educational psychologist: *"I went in there expecting she's going to do the assessment but then she's also going to provide the support* (P2, Focus group, L632); *"The educational psychologist, you feel they're there for the emotional stuff, provide you with support"* (P4, Focus group, L634). The same participant went onto to reiterate: *"Once the child has been diagnosed by the educational psychologist, is just to have a little bit more of a supportive role in helping the family to manage"* (P4, Focus group, L753).

This category shows the mothers' varying degrees of understanding of the role of the educational psychologist and depicts a need for the educational psychologist to be more explicit about their role at the outset of the process as well as to provide the family with more emotional support.

Subtheme 2.1	**Support from an educational psychologist**
Category 2.1.3	***Mothers' experiences of support from an educational psychologist***

I asked the participants how they experienced the support from the educational psychologist after their child was diagnosed with ADHD. Participants had strong and detailed opinions and expressed how they believed better support could be provided for them.

Some participants felt that the educational psychologist just gave the diagnosis of ADHD and did not provide any further information as they had expected: "*My experience has been a diagnostic one. She's diagnosed him and that was it"* (P4, Focus group, L960); *"Nothing, nothing. Nothing at all. This is the diagnosis*" (P3, Focus group, L613). They also felt that there was little follow up after the diagnosis of ADHD had been made: *"There wasn't much follow-up at all"* (P5, Interview, L7).

The participants all felt that they did not have sufficient support from the educational psychologist. The support was not constant and ongoing. The parents felt they were isolated and left to deal with their children on their own. These feelings of insufficient support from the educational psychologist were echoed in the following statements made by the mothers: *"We didn't have a constant support*" (P3, Focus group, L590), to: *"And they're, they're not supportive of you through that, they don't sort of say you are going to need support through this"* (P4, Focus group, L604), *"We would have appreciated a bit more support from the psychologist… so ja we didn't get much more support than that"* (P5, Interview, L8; L15); "*She hasn't actually offered any parental support to us"* (P2, Focus group, L636); *"She's focusing on the child and that's good but not really enough because we needed the support. No matter how much experience and what I know theoretically about this ADHD and related symptoms. It's so hard when you're the parent"* (P4, Focus group, L698).

The type of support the participants felt they needed was varied. Areas in which they felt support could be provided, ranged from the management of expectations; facilitation of support groups; normalisation of experiences and feelings; to follow up, referrals and ongoing assistance.

Participants felt they needed more reassurance and emotional support from the educational psychologist in terms of normalising their fears. In other words they wanted to hear that what they were feeling and experiencing was normal: *"Just someone to reassure you to say that actually okay you are gonna lose it someday. Things are gonna fall apart some days and actually it's okay,"* (P4; Focus group, L798); "*Someone who knows who has worked with others to say, just to be able to say you're there is nothing unique about you actually"* (P4, Focus group, L926).

Participants felt the educational psychologist needed to tell them what to expect as parents of a child with ADHD: *"Just say well this is what's gonna happen and these are the steps you know"* (P1, Focus group, L606); *"I just think if we had that support in the beginning and they, the educational psychologist perhaps could say look the family experienced problems because of the issues that their child has"* (P4, Focus group, L661); "*And you may not feel it right this minute, you may, but down the line and you know, we're here if you need any kind of…"* (P1, Focus group, L666); "*Just to vent a little bit"* (P4, Focus group, L925), *"I just wish she had maybe warned me about how things would be and I am sure there is so much more still coming my way"* (P5, Interview, P37).

The participants felt strongly that they would like the educational psychologist to facilitate support groups for mothers of children with ADHD. They expressed a need to hear what other mothers were experiencing so that they would not feel alone in their struggles and to provide that additional emotional support: *"Even also like a group, a group like this, it would be so nice you know"* (P4, Focus group, L669); *"I like the idea of the educational psychologist uhm, forming or helping to for advice and recommending support groups"* (P2, Focus group, L878); "*I don't know if it is within the scope of a psychologist, uhm an educational one, but I think support groups would be beneficial"* (P5, Interview, L31); *"Yeah, they got one going at Bellavista which is definitely helpful. Incredibly helpful"* (P1, Focus group, L672); *"I think it would just make a huge difference, even just support in that form* [parent support group] *would be good too"* (P4, Focus group, L901); *"I just feel if they could have a support group for the parents that you use to say look this is what my child's doing, yes mines doing the same. This is what I would you know, this is how you could possibly deal with it, don't worry about it,"* (P4, Focus group, L964). "*Sometimes I feel so alone and would like to chat to other mothers about how they handle it all cos it can all be so hard… And I think that would also be helpful you know like to hear it from the other parents as well"* (P5, Interview, L33; L40).

Follow up and offering assistance where possible was another area the participants felt they needed more support from the educational psychologist. The mothers expressed the need for the educational psychologist to make contact with them, to enquire about their child and

to find out if they need assistance with anything relating to parenting their child: *"Even just say like in say three months' time I just wanna touch base again you know, what's happening just to see where you are"* (P2, Focus group, L692); *"Ongoing, to meet once every few months and say listen how are things going through you know, what issues are you to change? Is there anything you know, that you want to discuss that could help? That would be a huge, huge thing* (P4, Focus group, L757); *"It would be nice I think if someone would just follow it through you know* (P1, Focus group, L606); *"Surely as an educational psychologist you also want to see what's happening with your* [client]" (P3, Focus group, L696); *"Uhm then maybe some follow up phone calls or appointments to find out how it is going with the family and where we need help and what challenges we are facing you know I think I would really find that useful"* (P5, Interview, L34). The comment I made in my reflective journal about having their fears normalised reads as follows:

Many of the mothers felt that they needed to be warned about what they should expect. They needed to hear that what they had been experiencing at home was normal and that their feelings of guilt, exhaustion, frustration and doubt are common when dealing with a child with ADHD (August, 2012).

Participants also commented on the need to be given names of other professionals or be directed to other sources of information that could possibly help in other areas such as with family therapy, information booklets, useful websites, and books to read as a couple: *"If they just recommend somebody and say look this person is good at the family life* (P2, Focus group, L687); *"You know, you may hit these issues you know, give you a list of support"* (P1, Focus group, L690). "*I would appreciate maybe right from the beginning when the diagnosis was made and the report was given back uhm maybe some assistance with regards to some websites to look at, information booklets or books we could read as a couple"* (P5, Interview, L28).

After the focus group, I reflected on the following in my journal:

I realised today that these parents desperately need more support. I felt so inspired after the focus group session to become a better educational psychologist- one that does not merely assess, diagnose and refer. I want to be more involved, giving advice where possible to family members of what to expect, how to handle it and normalise any fears (August 2012).

This category shows support for a closer involvement of the educational psychologist in the lives of children diagnosed with ADHD and their mothers. Participants in the study expressed

frustration at the level of support from the educational psychologist and at the consistency in the support provided. Many of the participants noted that the educational psychologist merely provided them with the ADHD diagnosis and then provided no further support. Support that the mothers felt would be helpful included the management of their expectations by the educational psychologist, facilitation of support groups, normalisation of experiences and feelings and providing referrals and ongoing assistance.

4.2.4 DISCUSSION OF FINDINGS FOR SUBTHEME 2.1

The participants' understanding of the role of the educational psychologist was varied. As stated in the literature review in Chapter 2, the scope of an educational psychologist (Health Professions Act, 1974: no. 54 of 1974): "assessing, diagnosing, and intervening in order to optimise human functioning in the learning and development…; applying psychological interventions to enhance, promote and facilitate optimal learning and development." Educational psychologists assess children who may have special educational needs and develop ways to support children's education (Farrell, 2004:11). Due to the varying understandings the participants in this study portrayed, it is essential that the educational psychologists are explicit about their scope of practice at the outset of the consultation process.

As discussed in Theme 1.2, ADHD places strain on family functioning and the participants in this study reported high levels of stress in parenting a child with ADHD. Participants expressed the need for the educational psychologist to play a more supportive role for them as a family, as parents and for the in child with ADHD. Participants spoke at length about the need for the educational psychologist to provide support groups for individual work with families and possibly parent support groups. They felt the need to know more about the disorder and, as part of the scope of the educational psychologist, it is therefore vital that psycho-education on the disorder is given. This comprises information about ADHD, its treatment and consequential stressors discussed with the parent (Montoya, Colom & Ferrin, 2011).

Parents with in-depth knowledge about the disorder have been shown to have a greater sense of competency and satisfaction in their parenting abilities, as well as more control over their child's behaviour (Cunningham, 2007). Studies also show (Prithivirajh & Edwards, 2011) that parent stress management programmes improve cohesion; an ability to think in a different and more constructive manner; a sense of control, personal growth and changes in negative behaviour that they themselves were experiencing. Reportedly parents are more relaxed, approachable and tolerant.

Subtheme 2.2 Support from other professionals

The following subtheme is discussed in terms of two categories, namely: *Category 2.2.1 Support from the school* and *Category 1.2.2 Knowledge and interaction between professionals.*

Subtheme 2.2	**Support from other professionals**
Category 2.2.1	***Support from the school***

The case with many of the participants in this study was that initially the educator recommended that the mother take the child for an educational psychology assessment in order to identify possible barriers to learning and provide the family with recommendations for intervention: *"So she recommended that we uhm, take her for an assessment and I uhm, she gave us recommendations"* (P2, Focus group, L35); *"In May of Grade 1 uh, the teacher said no she must have full assessment"* (P3, Focus group, L105).

Participants felt that the school placed pressure on them: *"There was a lot of pressure on us to, to get it done. We found that the school has put a lot of pressure on us saying 'sort this out',"* (P2, Focus group, L38); *"Then after Grade 2 or 3 uhm, the school said look we, he needs a different environment"* (P1, Focus group, L361); *"Last year we were under a lot of pressure to keep her back in Grade R… But I think the pressure is also from the school"* (P2, Focus group, L548; L722). As these mothers reported, the pressure placed on the parents was to take their child for a complete educational psychology assessment, repeat a grade or to move the child to a different school environment.

Subtheme 2.2	**Support from other professionals**
Category 2.2.2	***Knowledge and interaction between professionals***

Participants expressed that the educators they dealt with often lacked understanding of ADHD and its challenges for the child and family. This mother felt that the educator believed the medication would solve all the child's problems: *"I still feel like she doesn't completely get it. She still says okay, so she's on her medication now, she must just get on and catch up"* (P2, Focus group, L727).

Participant 5 is a teacher and realises that she did not fully understand ADHD until her own child was diagnosed with it: *"You know being a teacher myself uhm I don't think I really*

understood the whole process uhm as much as when you get involved when your own child is diagnosed… as teachers to say your child has ADHD, just deal with it" (P5, Interview, L12; L45). In my reflective journal I made the following comment about the lack of understanding some educators have on the ADHD and its impact on the family.

I think one of the pertinent topics that emerged in this interview, and which added to what participant 2 said in the focus group, is how teachers don't have a holistic understanding of the impact a child with ADHD has on the family and often teachers can give advice that may come across as insincere or lack empathy. Some of it may be a lack of knowledge on the educators' behalf possibly from a lack of training (October 2012).

Additionally, participants felt that the educational psychologist should be interacting with other professionals in order to better support them with their child with ADHD. Participant 3 and participant 1 expressed the desire to have a school based educational psychologist. *"I'm saying that it is a pity that the schools like our school doesn't have the support [of an educational psychologist], is to be able to have uh, somebody who can really interact with the teachers because I feel like as much as our teachers are supporting, they don't really get it"* (P3, Focus group, L502) *"Uhm, whereas if there was someone at the school uhm, it may be a bit easier"* (P1, Focus group, L748).

Participant 2 felt that the educational psychologist needed to interact more with the educator: *"So there's not enough interaction between, I would have liked the educational psychologist maybe to come and meet the teacher"* (P2, Focus group, L729). This is echoed in participant 4's comment: *"I mean just to speak* [to the teacher]" (P4, Focus group, L735). The mothers felt it was important that the educational psychologist spoke to the educator to gain more insight into their child.

4.2.5 DISCUSSION OF FINDINGS FOR SUBTHEME 2.2

As educators are considered to be some of the most valuable sources of information within the school environment with regard to referral and diagnosis of barriers to learning, it is essential that educators be well-informed of the identification, referral and treatment of ADHD (Decaires-Wagner & Picton, 2009). In a study, discussed in Chapter 2, which was conducted in the Western Cape Province of South Africa by Perold, Louw and Kleynhans (2010) of primary school teachers' knowledge and misconceptions of ADHD, it was found in particular key areas of ADHD, that educators have a substantial lack of knowledge. This was reported

in the results of the findings of this study where participants spoke of their frustration at the educators' lack of understanding and knowledge of ADHD.

According to Swart and Pettipher (2000) and Bothma, Gravett and Swart (2000), South African educators have not been trained to cope with the increasing diversity of learners entering mainstream classrooms and there is a lack of support provided to them in this regard. Thus, educational psychologists can provide training for educators, who may feel they lack knowledge of ADHD in particular and consult with educators about how to effectively communicate with parents of children with ADHD (Rogers et al., 2009) as was desired by the participants in this study.

Literature suggests that the role of the educational psychologist should extend to all learners experiencing barriers to learning, their parents, the Institutional Level Support Team, medical practitioners, and the wider community (Walton, 2011) in order to create a more inclusive school environment

4.3 CONCLUSION

In Chapter 4, I discussed the results of the current study based on the themes, sub-themes and categories which had emerged. I presented the results and findings of the current study in an integrated manner in order to position the findings within the literature base.

In the next chapter, I give a brief overview of each chapter. I then answer the secondary questions as well as the primary research question. I provide a discussion on the contributions and limitations of the current study. Furthermore I discuss silences in the data and make recommendation for future research, practice and training.

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CHAPTER 5
Conclusions and Recommendations

5.1 INTRODUCTION

In Chapter 4, I integrated the results and findings of the study by interpreting the themes, subthemes and categories in terms of existing literature and the underpinning conceptual framework. In this chapter, I conclude my study by first providing an overview of the previous chapters and revisiting the conceptual framework. I then answer the secondary research questions as well as the primary research question. Furthermore, I discuss possible silences in the data, and the potential contributions and limitations of the study. Finally, I conclude the chapter with recommendations relating to further research, training and practice in the fields of education and educational psychology.

5.2 OVERVIEW OF PREVIOUS CHAPTERS

The purpose of this study was to explore how mothers whose children have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) experience the support provided by the educational psychologist. The study aimed to provide insight into the current challenges faced by the mothers of children with ADHD and the role the educational psychologist could play in assisting them. It is intended that this study could contribute to the literature base on the role of the educational psychologist in inclusive education and specifically in supporting families affected by ADHD.

CHAPTER 1

In Chapter 1, an overall view of the study was provided. I introduced and presented the rationale for undertaking the study and then outlined the main and sub-research questions. I provided my assumptions and clarified key concepts. Finally, I discussed the research design and the methodology that directed this study.

CHAPTER 2

In this chapter, I explored literature on inclusive education in South Africa, Attention Deficit Hyperactivity Disorder, parenting a child with Attention Deficit Hyperactivity Disorder and the role of the educational psychologist in order to gain insight into the potentially supportive role educational psychologists play in supporting mothers whose children have been diagnosed with Attention Deficit Hyperactivity Disorder. I then presented the conceptual framework, guided by my review of literature. I structured the chapter by discussing existing literature, as

well as highlighting limitations in the recent knowledge base, thereby situating this study within these knowledge gaps.

CHAPTER 3

Chapter 3 provided a discussion on the research methodology and paradigmatic perspectives utilised in this study. I outlined the research design implemented as well as the data collection and documentation strategies applied. The data analysis and interpretation was then discussed, followed by the quality criteria and ethical considerations taken into account.

CHAPTER 4

In this chapter, I discussed the results of my findings. I recorded direct quotations from the participants as well as reflective notes from my journal to support the emergent themes. At the end of each sub-theme, I integrated my findings with a discussion supported by existing literature.

5.3 REVISITING THE CONCEPTUAL FRAMEWORK

A conceptual framework was developed in Chapter 2, after a review of relevant literature and theory. Collaboration within and between all systems is essential in order for diverse perspectives to be understood and incorporated in an inclusive school environment. Therefore this study was embedded in a systems theory perspective. The systems theory underscores the multiple and recursive influences of immediate contexts in which individuals develop. Bronfenbrenner's ecological model consists of the microsystem, mesosystem, exosystem and macrosystem which all interact with the chronosystem (Swart & Pettipher, 2000).

The collaboration between and within the various systems are such that change at one level has an effect on other levels (Engelbrecht & Green, 2001) in a multiple and recursive manner. It is thus important to work with the entire system in a collaborative way, not just with one individual within it. Therefore, although this framework is drawn from a systems theory, it requires collaborative relationships in order for positive change to occur.

Within a collaborative systems approach, educational psychologists constitute one component of the web of significant players forming collaborative relationships with the subsystems of the inclusive school community, the family and the child with ADHD. Role players such as the School-Based Support Team, parents, children and educational psychologists, see their experiences through different lenses, and contribute different meanings to the system therefore each view adds value and meaning.

A child with ADHD operates within a family system which interacts with other families; with schools and with the community in which it lives. The way a family experiences the support provided by an educational psychologist, may have a positive impact on the family system; the state of the marriage and sibling relationships and therefore have a recursive influence on the systems within which it operates. On a mesosytem level, such relationships could be formed with the educators and the Institutional Level and District Based Support Teams. On an exosystem level, the educational psychologist could collaborate with the inclusive school community and other health care practitioners, such as speech and language therapists, occupational therapists and neurologists. Operating within the macrosystem, an educational psychologist advising on the implementation of inclusive education policy at government level, has an impact on the education system and the way society perceives barriers to learning. This in turn has a significant influence on the learning experience for a child with ADHD.

An educational psychologist working within an inclusive school environment should focus on developing collaborative relationships with all role players in the systems and subsystems within which the child operates. Such collaborative relationships may facilitate and advance optimal learning and development of the child.

5.4 ADDRESSING THE RESEARCH QUESTIONS

In this section, I address the research questions that guided this study. In an attempt to understand and support the primary research question, the secondary research questions will be answered first.

5.4.1 ADDRESSING THE SECONDARY RESEARCH QUESTIONS

The purpose of this research study was to explore and describe how mothers experience the support of an educational psychologist for their child diagnosed with ADHD. In Chapter 1, I posed research questions to guide this inquiry. In the following sections, I answer the secondary research questions.

5.4.1.1 Secondary question 1: What do mothers understand about ADHD as it relates to their children?

In this study, the mothers described their understanding of ADHD in relation to their child's behavioural, academic and emotional difficulties. The mothers described their children's behaviour as inattentive, hyperactive or impulsive, or a combination thereof. Their children's hyperactive behaviour was evident in their inability to sit still, their energetic and lively ways

and their sociable and chatty nature. Mothers found their children to be distracted and unable to focus on the task at hand. They described them as daydreamers. Their children's impulsive behaviour was evident in their spontaneity. The child would not necessarily think before they acted and showed little constraint in their actions.

Like other studies, the findings of this study, show that children with ADHD often face academic challenges. The mothers reported that their children experienced difficulties with reading, spelling and the ability to express themselves in writing. ADHD affects the executive functioning and working memory of an individual. This means that they have difficulty planning, organising, self-regulating and mentally working with information. With difficulties in areas of executive functioning and working memory, the reasons these children experience academic challenges is evident. Mothers spoke of their child's inability to attend to their work and complete given tasks. The children's educators reported these same difficulties to the mothers. Thus with consistent behavioural problems of inattention, hyperactivity and impulsivity, the academic development of children with ADHD may be negatively impacted. Hence, the mothers reported that they found their children to be struggling academically.

Mothers reported that their children had developed gaps in knowledge over the years, which they found to be cumulative, thus interfering with their academic progress. One mother regretted not having identified her child's difficulties at a younger age. If she had the child's academic progress would probably have been positively affected. Out of the six children reviewed for the purpose of this study, three of them have repeated or are currently repeating a grade. The accumulation of gaps in knowledge is a possible reason why these children either repeated a grade or were asked to consider doing so at some point in their schooling career. Mothers had varying opinions regarding whether repeating a grade had been beneficial to their child's progress. There was also often pressure on the participants to consider placement of their children at a special needs school in order to assist them academically.

Emotionally, the mothers found that their children experienced a low self-image possibly through the constant failures and difficulties they faced academically. The children believed they had no talents; that they were not clever and started to compare themselves with their siblings. Mothers noticed that their children's self-image decreased with every academic failure. The children were reported to experience high levels of anxiety towards school which is found to be a common associated disorder with children diagnosed with ADHD. One participant's child felt anxious about asking to go to the toilet and his anxiety seemed to be exacerbated by the start of a new school year.

The participants spoke of the different types of medication their children had been prescribed, including both stimulants and non-stimulants. They appeared knowledgeable about the types and effects of medication prescribed to treat symptoms of ADHD. Methylphenidate is the most common stimulant used to treat children with ADHD, available as Ritalin and Concerta. It is a schedule six medicine in South Africa and has been used for children for over 45 years. The most commonly used non-stimulant medication is atomoxitine, known as Strattera. Stimulant and non-stimulant medication primarily affects noradrenaline in the brain. Stimulant medication also affects the dopamine levels (van der Westhuizen, 2010; Wicks-Nelson & Israel, 2009).

Both negative and positive outcomes were reported by the mothers regarding their children's experiences with medication. Mothers commented on the negative side-effects their children experienced when taking medication. The majority of the children experienced great difficulty in swallowing the pills. This often resulted in the child becoming emotional and anxious about taking the medication. The participants reported their children as being moody and irritable in the afternoons, possibly due to the medication wearing off. Another possible negative side-effect the mothers reported, was the lack of appetite and nausea their children experienced. Some of the children would not eat during the day and mothers were concerned about the children being underweight. Participants believed that one of the side-effects of the medication was related to their children's inability to fall asleep at night. Children being underweight and having difficulty falling asleep was a reason the mothers would not administer the medication to their children on the weekends and during the holidays.

However, participants also found that there were positive effects of the medication. Children were reported to be able to concentrate better and were less impulsive and hyperactive. Educators had also noticed these positive changes at school. The mothers also reported finding that there was less conflict in the house, possibly due to the child being easier to manage and that there were fewer emotional demands on them as mothers.

5.4.1.2 Secondary question 2: How do mothers experience parenting their children with ADHD?

The findings of this study, suggest that mothers experience parenting children with ADHD stressful. They appear to experience high levels of frustration with increased tension at home which seemed to affect the entire family. Some mothers found themselves using their children as a conduit for venting their frustration, leaving them with feelings of guilt.

One of the major areas of concern expressed by the mothers was that of the academic difficulties their children have faced and the difficulties in monitoring and helping their

children with homework. The participants reported that trying to assist their children with their homework often resulted in conflict and tension in the house, and often added strain to the mother-child relationship. One mother found relief in supervised homework time at school as it took the pressure off of her and resulted in less conflict in the home.

The presence of ADHD increases the existence of associated conditions and intervention is needed across all problem areas. The mothers reported that it was recommended they take their children to a variety of different forms of therapy such as speech and language therapy; occupational therapy; remedial therapy and physiotherapy. They were also advised to visit a paediatric neurologist and optometrist and one was advised to engage in a therapy called 'So Listening' to improve auditory processing skills. The findings of this study suggest that with all the additional therapy the child with ADHD is involved in, the family is often exhausted and has less flexible time in the afternoons. The mothers also reported on the expense of therapy. All this led to extra stress being placed on the families.

Mothers reported the additional financial strain often led to conflict in their marriages. Conflict also occurred from the different parenting styles employed. Mothers commented that they felt like the disciplinarians, which added strain to the mother-child relationship and they expressed a need for the fathers to be more involved.

5.4.1.3 Secondary question 3: What do mothers understand about the role of an educational psychologist?

The mothers' understanding of the role of the educational psychologist varied. While some mothers were unsure about the exact role of an educational psychologist, others seem to have a fair knowledge of it. Mothers agreed that they felt the educational psychologist should assess, diagnose and intervene to support the child and family.

The assessment process should consist of an initial intake interview with the parents, followed by a battery of cognitive, scholastic and emotional assessments tailored to the child's needs. Parents are then invited to a feedback session where the educational psychologist reports on the findings of the assessment. A diagnosis is usually made in order to understand the child's difficulties and to make informed recommendations for intervention. The assessment findings guide the recommendations to the parents. Psychological interventions aim to improve the child's overall functioning. The participants' children engaged in therapy with the educational psychologist, which focused on improving child's self-esteem. Some mothers felt that therapy was beneficial for their children as the child thrived on the one-on-one attention. Another participant found that the educational

psychologist was too formal for her son and did not think it was a particularly useful experience.

Participants view the educational psychologist as being able to work collaboratively and systemically with many other professionals in the school community, These professionals include the educators, the Institutional Level and District Based Support Teams and various health care practitioners such as occupational therapists, speech and language therapists, optometrists, neurologists. The mothers felt that through a collaborative relationship and the sharing of knowledge with other professionals, an increased understanding of their child's difficulties would arise. Thus, interventions could possibly be more inclusive and the child feel more supported.

The findings suggest that the educational psychologist could be more explicit at the outset of the process about their role with regard to the parents. Mothers felt they needed to be sure of what they could expect from the educational psychologist in terms of the support provided to them. Being more explicit would assist in clarifying any misconceptions about the role of an educational psychologist and put the parents' minds at ease knowing that they are receiving an ethical service.

5.4.2 ADDRESSING THE PRIMARY RESEARCH QUESTION: HOW DO MOTHERS OF CHILDREN WITH ADHD EXPERIENCE SUPPORT FROM AN EDUCATIONAL PSYCHOLOGIST?

Overall the findings of the study indicate that mothers of children with ADHD expect a deeper level of support from an educational psychologist. I answer the primary research question by looking at the support for the child with ADHD and then the support for the mothers.

5.4.2.1 Support for the child with ADHD

The participants' children had been referred to an educational psychologist by the educator as they were experiencing scholastic difficulties. The educational psychologist conducted an educational psychology assessment in order to explore and understand the difficulties identified by the educator and parents. The participants agreed that the actual assessment and feedback process was a positive experience for them. They felt the educational psychologist was attentive throughout and provided a professional service. The mothers expressed that the educational psychologist accurately recognized their child's problematic behaviours as being ADHD and they agreed with this diagnosis.

Through constant failures and the difficulties they faced academically, the mothers believed their children developed a low self-image. The children were also reported to experience high

levels of anxiety towards school. Some of the children therefore engaged in individual therapy with the educational psychologist after the diagnosis of ADHD was made in order to address their emotional needs. Therapy with the educational psychologist consisted of a 45 minute session, once a week for an average of six to eight weeks. Therapy focused on improving the child's self-esteem and overcoming anxiety. Overall, therapy was found to be beneficial for the children, although one participant disagreed and found the educational psychologist to be too formal and did not find the experience to be valuable to her child.

The participants felt that recommendations suggested by the educational psychologist were adequate but that the support from the educational psychologist ended at this point. The majority of the recommendations made by the educational psychologist were for the child to attend additional therapy, such as occupational therapy and speech and language therapy. They were also advised to visit other health care practitioners, such as the paediatric neurologist and optometrist.

5.4.2.2 Support for mothers

The mothers felt they needed more reassurance and emotional support from the educational psychologist. One such area of support required was that of the normalisation of their fears. The mothers expressed the need to hear that what they were feeling and experiencing was normal. The participants found the focus group session helpful as they were able to share their challenges and hear from the other participants that what they were experiencing was typical of families with children with ADHD. Thus, they believed that support groups for parents would be beneficial to them and expressed a need for the educational psychologist to facilitate more support groups on an ongoing basis for mothers of children with ADHD.

Participants wanted the educational psychologist to tell them what to expect as parents of a child with ADHD. The findings suggest that the educational psychologist could provide the parents with more information on the disorder and possible interventions available to them. Mothers also felt that the educational psychologist should follow up with them and offer assistance to them in the form of additional advice, therapy and guidance where possible. Participants also commented on the need to be given names of other professionals or be directed to other sources of information that could possibly help in other areas such as family therapy, information booklets, useful websites, and books to read as a couple.

Mothers found that the educators were generally lacking in knowledge and an understanding of ADHD. They recognised a need for the educational psychologist to share their knowledge of barriers to learning, with the educators. The mothers also felt it would benefit the educational psychologist to work in collaboration with other professionals within all systems

of the school community such as the educators, the Institutional Level and District Based Support Teams and the various health care practitioners such as occupational therapists, speech and language therapists and neurologists to provide support for the parents.

5.5 SILENCES IN THE DATA

Loreman, Deppeler and Harvey (2010:2) describe inclusion as "the full participation of all students in all aspects of schooling. It involves regular schools and classrooms being responsive, willing to genuinely adapt and change to meet the needs of all students, as well as celebrating and valuing difference." With regard to the current study, there was a reference made to a child being placed in a special needs school; however, no references were made to inclusive education and inclusive school communities. Participants did not speak of how this type of environment might have been beneficial to their child with ADHD. Furthermore, no references were made to the way the school could possibly become more inclusive other than reporting a need for the educational psychologist to interact with educators and other health care practitioners.

Prithivirajh and Edwards (2011) found positive outcomes from parents of children with ADHD who participated in a stress management programme. Such programmes were also found to benefit the father-child relationship. Although references were made by the mothers for increased emotional support and involvement of the partners in parenting their child with ADHD, participants did not speak of the possible benefits of engaging in couple therapy as an additional support structure.

5.6 POTENTIAL CONTRIBUTIONS OF THE STUDY

This study aimed to offer rich descriptions and in-depth understandings of the mothers' experiences of the support provided to their children with ADHD by an educational psychologist. Thus, this study contributes to existing knowledge on how educational psychologists can best support parents after a diagnosis of ADHD has been made for their children. This study highlights, and can further contribute to the body of knowledge on the challenges faced by mothers whose children have been diagnosed with ADHD.

The findings show the need for a more inclusive school environment and it may therefore serve as a guide to all role players to work collaboratively to assist one another to include children with ADHD. It highlights the importance of the role of the educational psychologist sharing knowledge and working collaboratively with educators, the Institutional Level and District Based Support Teams and the various health care practitioners such as occupational

therapists, speech and language therapists and paediatric neurologists to provide support to the child and family.

The study contributes to the knowledge base of how educational psychologists can better support families with ADHD on a practical level. It suggests that educational psychologists should provide the mothers with information on the disorder as well as what challenges they can expect as parents of children with ADHD. The study highlights the need for the educational psychologist to provide the mothers with emotional support that is ongoing, in the form of individual, couple and group therapy.

In reviewing existing literature, I experienced a lack of research which focused on the parents' experiences of the educational psychologist with regard to supporting their children with ADHD and other learning barriers. It is my hope that this study may contribute to this possible gap in existing literature.

5.7 POSSIBLE LIMITATIONS OF THE STUDY

One of the limitations of this study relates to the lack of generalisabilty of the findings as the views are only representative of a small number of participants within a specific area. However, I set out to gain an in-depth understanding of the mothers experiences of the support of an educational psychologist and the findings may be transferred to a similar context which is in line with an interpretivist approach.

The participants in this study are all mothers which could imply bias towards mothers being the primary caregivers. The choice of only including mothers in this study was due to the limited scope of the study. The significant role that fathers can play in parenting a child with ADHD is acknowledged.

I sometimes experienced difficulty in maintaining a balance in my roles as a researcher; my past profession as an educator and my future profession as an educational psychologist. It was challenging to refrain from becoming emotionally involved when the participants spoke of their own difficulties. I was able to be aware of these problematic encounters through supervision and reflection in my journal.

5.8 RECOMMENDATIONS

Based on the findings of this study, I make recommendations for training, practice and future research in the fields of education and educational psychology.

5.8.1 RECOMMENDATIONS FOR TRAINING

I recommend that training at a postgraduate level in the field of educational psychology, include the families' experiences of living with ADHD as well as other barriers to learning that the child might experience. The findings suggest that training needs to be given to educational psychologist at postgraduate level on how best to provide support to families with ADHD. Training could focus on how the educational psychologists can work collaboratively with other professionals within an inclusive school community. I recommend that educators are provided with more training in barriers to learning and on how best to assist such learners. This training for educators could extend to parental guidance and the involvement and collaboration with professionals and so enhance learner's development at school.

5.8.2 RECOMMENDATIONS FOR PRACTICE

Based on the findings of the study, I recommend that educational psychologists work more closely with families with ADHD to support their ongoing needs. Educational psychologists could explain more clearly to the parents at the outset of their services, the scope of their practice. I recommend that they collaborate with other professionals in the school community to enhance an inclusive learning experience for learners with ADHD. Educational psychologists could work together with schools to provide a more inclusive school environment for all learners, both with and without barriers to learning. I recommend that the services of an educational psychologist be made available to the school community to share knowledge on barriers to learning, to consult and advise on the management of diverse classroom and school settings, and provide emotional support to enhance well-being within the educational setting.

5.8.3 RECOMMENDATIONS FOR FUTURE RESEARCH

Based on the findings that mothers experience insufficient support from educational psychologists for their children diagnosed with ADHD, future research projects might focus on the following:

- How educational psychologists can best support parents after the diagnosis of ADHD has been made across all cultural and socio-economic backgrounds, in order to add to the existing knowledge base and close gaps in research
- Inclusive education in South African schools in order to facilitate the positive development of education for all

⌘ Collaboration between all role players involved in an inclusive school community to further enhance the learning experience for learners with barriers

5.9 CONCLUDING COMMENTS

For the purpose of this study, I explored how mothers of children with ADHD experience support from educational psychologists. What emerged from the study was that there is a lack of adequate support from the educational psychologist.

This study highlights the challenges the mothers face in parenting their children with ADHD and the need for greater support for these families. The findings suggest the need for collaborative relationships within the school community to be forged in order to share knowledge of barriers to learning and focus on supporting these learners in an inclusive school environment. It is evident that educational psychologists play a vital role in promoting these collaborative relationships to support both learners and families living with ADHD. Furthermore, this study highlights the role educational psychologists can play in facilitating the successful development of inclusive education in South Africa.

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ADDENDA

Addendum A:
Ethics Clearance Certificate

Addendum B:
Informed Consent from Principal at Research Site

Addendum C:
Example of Informed Consent from Participant

Addendum D:
Sample of Transcriptions of Audio Recording and Coding

Addendum E:
Sample of Thematic Analysis

Addendum F:
Extracts from my Reflective Journal

Addendum G:
Interview Schedule

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ADDENDUM A

Ethics Clearance Certificate

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ADDENDUM B

Informed Consent from Principal at Research Site

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ADDENDUM C

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