

**THE EXPERIENCES OF MOTHERS WHOSE CHILDREN TAKE RITALIN FOR
THE TREATMENT OF ADHD (ATTENTION DEFICIT HYPERACTIVITY
DISORDER).**

By

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DECLARATION

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I declare that **THE EXPERIENCES OF MOTHERS WHOSE CHILDREN TAKE RITALIN FOR THE TREATMENT OF ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER)** is my own work and that all sources I have used or quoted from have been indicated and acknowledged by means of complete references.

Signature

MRS C.M. BURKE

Date 29/11/2004

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ABSTRACT

Attention Deficit Hyperactivity Disorder (ADHD) has become the disorder of the nineties. The name has been bandied about by experts, teachers, parents, lay people and specifically the media, however, when a child or children are diagnosed with this disorder, parents, and in particular for this study, mothers, are left feeling confused, frightened and uncertain. The method of treatment is the specific study of this research. Ritalin is the most popular form of treatment utilised for the alleviation of symptoms, yet mothers are afraid they are drugging their children or taking the easy way out. Constant media hype and ignorance exacerbate the mother's experiences and they are left in a quandary of which course to follow.

The purpose of this research was to investigate if mothers share similar experiences when administering Ritalin for the treatment of symptoms of ADHD. Literature indicates enormous controversy surrounding this disorder and in particular the treatment methods recommended to alleviate symptoms. There are two strongly opposed camps regarding the negativity or positivity toward utilising this schedule 7 drug. Media publicity intensifies the individual's uncertainty of administering this drug and suggests bad parenting as the reason mothers resort to Ritalin.

The goal of this study is to highlight the mother's experiences and to become aware of their feelings and isolation when being advised that their child or

children have ADHD. The lack of awareness and the uncertainty of which course to follow seems to have profound affects and cause mothers to have negative experiences.

The purpose of this research is to see if mothers share similar experiences regarding the administering of Ritalin as a treatment method for ADHD. The researcher is hopeful that the outcome of this small study will assist experts, counselors and lay people to empathize and recognize the mother's plight in this regard, and consequently for them not to feel as troubled and unaided without this knowledge. Finally, she expects that the research may help mothers to be aware that they are not alone with their predicament and sense of apprehension and uncertainty regarding the administering of a drug like Ritalin to assist in alleviating the symptoms presented.

KEYWORDS

ADHD

Attention Deficit Hyperactivity Disorder

Ritalin

Impulsivity

Behavioural Problems

Disruptive Behaviour

Children

Mothers

Methylphenidate

**The experiences of mothers whose children take Ritalin for the treatment of
ADHD (Attention Deficit Hyperactivity Disorder).**

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CHAPTER ONE

Introduction, Statement of the Problem, Concept Definitions and Procedures.

1.1 Introduction:

Attention Deficit/ Hyperactive Disorder (ADHD) consists of an ongoing, persistent pattern of inattention, and/or, over active and impulsive behaviour. The DSM-IV-TR diagnostic criteria for ADHD requires 6 or more symptoms of inattention, which have persisted for at least 6 months, and to a degree that it is classified as maladaptive and inconsistent with the developmental level. The individual must also have 6 or more symptoms of hyperactivity-impulsivity with the same criteria as above. Methylphenidate or Ritalin is a popular drug administered for the minimizing of symptoms for individuals suffering from ADHD. The psychostimulant drug Ritalin is the most widely prescribed psychoactive drug prescribed in children and highly effective in alleviating all three clusters of symptoms of ADHD, that is inattentiveness, impulsivity, and motoric hyperactivity. (Moll, G.H. Heinrich, H and Rothenberger, A in Acta Psychiatr Scand 2003:107: 69-72.)

1.1.1 Diagnostic Criteria for ADHD:

According to the DSM-IV-TR (2000)

A. Either (1) or (2):

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

Inattention:

1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
 2. Often has difficulty sustaining attention in tasks or play activities.
 3. Often does not seem to listen when spoken to directly.
 4. Often does not follow through on instructions and fails to finish schoolwork, chores or duties at the workplace (not due to oppositional behaviour or failure to understand instructions).
 5. Often has difficulty organizing tasks and activities.
 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
 7. Often loses things necessary for tasks or activities (such as toys, school assignments, pencils, books or tools).
 8. Is often easily distractible by extraneous stimuli.
 9. Is often forgetful in daily activities.
- (2) 6 or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:

1. Often fidgets with hands or feet or squirms in seat.
2. Often leaves seat in classroom or in other situations in which remaining in your seat is expected.
3. Often runs about or climbs in situations in which it is inappropriate (in adolescents or adults may be limited to subjective feelings of restlessness.)
4. Often has difficulty playing or engaging in leisure activities quietly.

5. Is often 'on the go' or often acts as if 'driven by a motor.'
6. Often talks excessively.

Impulsivity:

1. Often blurts out answers before questions have been completed.
2. Often has difficulty waiting turn.
3. Often interrupts or intrudes on others (such as butting into conversations or games).
 - B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
 - C. Some impairment from the symptoms is present in two or more settings (example at school, work or home).
 - D. There must be clear evidence of clinically significant impairment in social academic or occupational functioning.
 - E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder such as Mood Disorder, Anxiety Disorder, Dissociative Disorder or a Personality Disorder.

This dissertation investigates the feelings experienced by the parents, and in particular the mothers of children taking the Ritalin medication. By considering any negative feelings experienced by the mothers, the reader may feel empathy and understanding toward their plight. The mother needs to come to terms with her feelings regarding her child's diagnosis of this disease and ultimately the medication prescribed. Isolating her feelings and noting the similar experiences felt by the different mothers may assist to comparable findings elsewhere and ultimately to an understanding of the normalcy of these negative feelings. Further it may assist her in finding strategies to aid her in coping. These findings may

also support other mothers whose children are diagnosed with ADHD and the subsequent decision to take Ritalin. It might help her feel less guilty and realize that she is not alone in her plight.

However, one must keep in mind the broad and diversified topic of ADHD and the Ritalin drug. Therefore, the reader must keep in mind that this is only one aspect of the individual's feelings toward a vast subject matter. The research is aimed at an understanding of what such an experience induces, without trying to fit the experience into a preconceived framework. Finally one needs to bear in mind the subjectivity of this focus.

The researcher has chosen not to deal with the fathers or the family in this regard as this will require further extensive research that she would like to pursue at a later stage. The researcher would like to utilise a family systems approach for that particular research.

1.2 Awareness of the Problem:

In the researcher's circle of friends, as well as her interaction with other mothers, she has continuously become aware of how many children are suffering with ADHD. The researcher has spoken to teachers at primary schools and extended this communication with other parents whose children have this diagnosis, and a common theme seems to be apparent. The mothers in particular, have all resorted to administering the Ritalin drug to assist themselves and their children to cope easier with this disorder. It seems that most of them have tried the alternative diet procedure, as well as supplementing different prescribed vitamins, however, there appears to be little change, if any. In all the cases the researcher has been in contact with, the mothers eventually resorted to Ritalin in a final desperate attempt to assist them in their plight to overcome some of the symptoms the child is manifesting. They all claim that the Ritalin drug alters the

child's moods and this has a noticeable effect in the children. It appears that although the child does in fact cope better socially, academically and cognitively, the mothers are left with enormous feelings of guilt for having placed their child on a schedule 7 mind-altering drug.

1.3 Analysis of the Problem:

Diller (1999:103), states that in recent years research has shown a biological explanation theory for ADHD, which is embraced by parents and the medical practice. This allows parents to feel less blame, as it is a consequence of something they cannot be responsible for. He states that for many years psychotherapists implied to parents, especially mothers, that they were somehow to blame for the child's behaviour. There are numerous literatures supporting his viewpoint. Finally Diller (1999) warns parents to, "not feel guilty if they are certain their child is ADHD and Ritalin is prescribed."

Teeter (1998) states that there is mounting evidence to support the theory that ADHD is biogenetically based involving frontal lobes, basal ganglia and other networks of the brain. This research is supported by many researchers and is constantly being updated. She goes on to argue that acknowledging the biological etiology of this disorder does not mean that intervention efforts should not take place. She also states that although performance improves on Ritalin does not necessarily prove that ADHD is a neurological disorder because most people on a stimulant like Ritalin will perform better. She maintains that understanding that this disorder is neurobiological may help us avoid the misunderstandings that lead to mistreatment and misdiagnosis of these individuals.

Sadock & Sadock (2003) maintain that there is no single causal factor for the onset of this disorder. They argue that the causes of ADHD are not known, but

may include contributory factors such as, development factors, neurochemical factors, neurophysiological factors, psychosocial factors and prenatal toxic exposure, prematurity and prenatal problems with the fetal nervous system. Finally, they mention that food additives, colourants and sugar are also said to cause ADHD, however no scientific evidence is conclusive.

Research is divided regarding the necessary intervention and treatment. Some researchers feel that controlled diet and behavioural therapy is sufficient to counteract the symptoms of ADHD, while others are staunch in the belief that taking the prescribed Ritalin medication is the answer. Nevertheless, overall, it seems as though there is little research focusing on the mother's experiences.

According to Diller (1999), since 1990 the number of people diagnosed with ADHD has risen from 900,000 to 5 million. This in turn increases the amount of Ritalin produced in the United States and shows a 700 percent increase during that same period. He goes on to state that trying to sort the myth from fact about Ritalin is not easy, and in particular why so many physicians and parents utilize it. He contends that the general public all links ADHD with the drug Ritalin and mothers are keen to have their child accepted and to improve his/her schoolwork and ultimately make their decisions based on that. However, they all claim that they feel so guilty!

It seems that prior to ADHD being diagnosed, parents believed their children were naughty, while struggling with schoolwork and activities, as well as being unable to make friends. They believed they were somehow responsible and were bad parents. Research has shown that ADHD became extremely popular in the 90's, with most of the general population being aware what the condition is, as well as the medication used to suppress the symptoms. Furthermore, the diagnosis has also caused people to divide opinions regarding the diagnosis of ADHD. Medical doctors and researchers seem to agree that a neurological explanation may be one of the causes, yet on the other hand, alternative sources

maintain that it is bad parenting. Barkly (in Teeter 1998) argues that environmental or social factors such as bad parenting, poverty, family chaos, poor diet or poor parent management of children has little conclusive evidence proving this to be a causal factor.

The media are often at fault for the layman's ignorance on topics such as this, therefore enforcing guilt in the parents. If there were a clear-cut etiology, the parents of children suffering with this disorder would probably feel less anxiety and blame. According to Teeter (1998), it is unfortunate that the media report the rare cases of abuse, however she feels that the number of teens who do abuse medication is overgeneralised and overestimated. She states that articles or television reports that tell stories of stimulant abuse imply that stimulant medication such as Ritalin is the first step to serious drug abuse in adolescents. She goes on to argue that these articles are harmful as they often neglect to report on scientific research. This type of negative media attention exacerbates the experiences felt by mothers of children taking Ritalin.

Diller (1999) gives a case study of one of the many mothers whose child was diagnosed with ADHD. She allegedly had a son who displayed all the DSM symptoms and was prescribed Ritalin by the family doctor. She states that her hands shook the first time she administered the drug to her son as she was consumed by so many thoughts. She noticed a difference after a few days, the school stopped calling, and her son became more subdued, nonetheless, she was extremely concerned that he would lose his exuberant personality forever. Many other mothers administering Ritalin to their children in the hope to improve their child's lifestyle share the feelings of this woman in this case study.

Parents, and in particular mothers, often bear the brunt of raising a child who has been diagnosed with ADHD. These children are often extremely exhausting and demand attention. As infants they are usually poor sleepers and ultra sensitive to environmental changes, light or noise. Although ADHD may affect some children

in the complete opposite manner, that is, they are particularly placid and sleep most of the time, more commonly however, is the child that cries excessively and sleeps for short periods at a time. Sadock & Sadock (2003).

At school these children are disruptive, cannot sit still and answer questions before the teacher has started asking. They are often irritable, laugh or cry easily, and their moods are generally up and down. They are impulsive and unpredictable and furthermore may be accident-prone. These children often suffer with low self-esteem as they recognize that they are different and have problems. Learning difficulties and behavioural problems intensifies school performance. Parents, in particular the mothers, usually feel isolated, alone and extremely frustrated. Once the child has been diagnosed there seems to be some relief, however, this is short lived because now a decision is needed to seek treatment for the child. Usually the doctor will suggest and prescribe a central nervous system stimulant, such as methylphenidate (Ritalin), including short and sustained release preparations. A recent study showed that 75% of a group of ADHD children responded positively to Ritalin, and their school performance exhibited significant improvement. Sadock & Sadock, (2003)

Although most research supports the administering of drugs, there are still vast claims to alternative treatment and intervention, in particular, altering the child's diet in an attempt to alleviate the symptoms. This seems to be an ongoing debate and new research regarding these issues is endlessly discussed.

Bearing in mind the alternative strong views on treating the child with ADHD, the mother 's feelings of guilt are exacerbated as she may attempt amending the diet and finding that it does not work effectively which in turn induces more guilt. Popular public opinion regarding ADHD is that altering the diet is sufficient. Once more this places enormous pressure on the parents, because if this diet does not work sufficiently, it adds to her feelings of frustration and helplessness. A popular school of thought by the general population is that diet can "cure" the child's

symptoms. Unfortunately the general public is often ignorant of the researched facts and pass judgment based on limited facts and fiction. These biased opinions feed the mothers negative experiences and cause their feelings of uncertainty.

There are numerous books and journals on the subject of ADHD, the symptoms, the treatments, the clinical picture and so on, however, there does not appear to be a good deal of research on the mothers actual experiences on having to administer a schedule 7 drug to her child in an attempt to alleviate symptoms.

This research is an attempt to see what the mothers actually experience by resorting to administering this medication that is so contentious. It is beyond the scope of this dissertation to come to a remedy; however, it may reduce their negative experiences if they realize they are not alone in feeling this destructive reaction.

1.4 The Aim of the Study:

The aim of this research project is to enter the mother's world and obtain first hand experience of her feelings toward administering the Ritalin drug to her child in an attempt to improve or suppress the behaviours associated with ADHD. Furthermore, the goal is to pinpoint similarities in feelings and experiences between the mothers interviewed for this research. Once this is accomplished, it is hoped that other mothers, family members and individuals suffering with this disorder may realize the extent of the harmful and negative thoughts experienced.

1.5 Statement of the Problem:

The researcher would like to ascertain if mothers experience any emotional distress or upheaval because of administering Ritalin for the treatment of ADHD. There is an endless debate between the public and professionals on the justification of utilising this drug as a treatment for children diagnosed with ADHD, and parents, in particular mothers, appear to bear the brunt of the media hype that suggests they are drugging their children or finding the easy way out.

1.6 Goals:

The researcher hopes to see if the different mothers taking part in this research share similar feelings. The project is aimed at getting into the mothers world and her experiences to obtain an accurate account of her feelings. If this is a trend in the mother's thoughts, perhaps a study like this will assist in alleviating some of this negativity as they may realize that they are not alone in their plight. Subsequently, they may continue the treatment with less guilt, in the knowledge that others share their experiences. Thus the goal of this research is to pinpoint these feelings and understand the personal experiences and similarities shared by these mothers.

1.7 Definitions of the Concepts:

1.7.1 ADHD (Attention Deficit Hyperactivity Disorder)

ADHD consists of an ongoing, persistent pattern of inattention, and/or, over active and impulsive behaviour. The Diagnostic and Statistical Manual of Mental Disorder (DSM-IV-TR) requires 6 or more symptoms of inattention, which have

persisted for at least 6 months, and to a degree that it is classified as maladaptive and inconsistent with the developmental level. The individual must also have 6 or more symptoms of hyperactivity-impulsivity with the same criteria as above.

1.7.2 Ritalin:

Ritalin, or Methylphenidate (MPH), is the most widely prescribed psychoactive drug prescribed for children, and is highly effective in alleviating all three clusters of symptoms of ADHD, that is inattention, impulsivity and hyperactivity. It has been widely researched, and allegedly has few serious side effects. Empirical data consistently demonstrates the efficacy of this central nervous system (CNS) stimulant on the individuals academic, behavioural and social functioning of the individual. Ritalin is a short acting medication, thus its effects wear off in a fairly short time span.

1.7.3 Mothers interviewed

For the purpose of this study mothers interviewed were chosen randomly based on there having a child or children diagnosed with ADHD. All the mothers chosen have more than one child and are between the ages of 35 to 48. In each case the child or children in question are boys, although this was not intentional. Other than that there is no particular common denominator.

1.7.4 Treatment

For the purpose of this study treatment is defined as an alleviation of the symptoms prescribed in the Diagnostic and Statistical Manual (DSM –IV-TR).

1.7.5 Children

For the purpose of this study children are aged between 5 years and 14 years, with the majority being primary school age. The exception is one of the mothers interviewed whose child is 14 but was diagnosed late at age 10, and who is still suffering with symptoms of ADHD. In this study children may be defined as those who have been officially identified with ADHD according the Diagnostic Statistical Manual (DSM-IV-TR) and have been diagnosed by a professional who specializes in children with this disorder.

1.8 Plan of Study:

Chapter 1:

Chapter one is an introduction to the research and includes a discussion of how the researcher became aware of the issues at hand. She formulates and explores the research problem. The researcher explains relevant concepts pertaining to this research and also defines the aims and goals of the research.

Chapter 2:

The focus of this chapter is for the reader to understand Ritalin as a treatment for ADHD (Attention Deficit Hyperactivity Disorder), as well as the history, the pharmacological aspects, biological aspects and other significant information relevant to this investigation.

Chapter 3:

Chapter 3 deals with alternative views and interventions for the treatment of ADHD, and in particular diet as an intervention. The researcher also attempts to inform the reader of the many controversial public and professional opinions in this regard. She mentions cognitive behavioural therapy as another treatment method.

Chapter 4:

This chapter explores the research methodology, which includes the methods utilised in obtaining data, the analysis thereof and the phenomenological approach.

Chapter 5:

This chapter contains a discussion and analysis of the results of empirical research.

Chapter 6:

This chapter entails a discussion of the recommendations and implications that may be drawn from the relevant findings of the research. It includes a summary, conclusion and results

Chapter 7:

Recommendations

Chapter 2

Understanding Ritalin as a treatment for ADHD (Attention Deficit Hyperactivity Disorder).

2.1 Introduction:

This chapter will highlight the studies made regarding the stimulant medication methylphenidate (Ritalin) administered to children with ADHD. The history, the pros, the prevalence, recommended diagnoses, pharmacological aspects, family systems and children's views will be discussed. In this way a background on Ritalin as a treatment medication for ADHD sufferers will be discussed.

2.2 History of ADHD:

The enormous increase in research on hyperactivity characteristic of the 1970's continued into the 1980's making this disorder the most well studied childhood psychiatric disorder in existence. During the 1990's there have been further marked developments. Firstly the American psychiatric Association 1994, the DSM-IV amended their criteria. These included several improvements over the DSM-111-R. This is based on a much wider field trial than its predecessors, and the DSM-IV criteria are the most empirically based in the history of this disorder (Barkley, 1998). In the 2000's there is a clear shift viewing ADHD as neurological and genetic rather than looking at social factors to determine the cause of this disorder.

The United States Drug Enforcement Agency production quotas for Ritalin (methylphenidate) increased by more than 3000 kilograms between 1990 and 1995. More than 90 percent of methylphenidate is produced and prescribed for

adolescents and children with ADHD which represents an almost six fold increase in the manufacturing of this drug, and therefore an indicator of the marked increase in the diagnosis of this disorder. In addition, the Drug manufacturer Shire Richwood Laboratories reported almost a doubling in the number of prescriptions between June 1996 and 1999. He goes on to state that according to an article in the American Academy of Pediatrics journal "Pediatrics" the use of stimulant medication in preschool children has tripled, and the American Academy of Pediatrics (AAP) revealed that between 1990 and 2000 there was a sevenfold increase in the use of Ritalin and similar medications. Thus, ADHD has become the most prevalent neurobehavioural disorder to be found in children as well as one of the most common problems for the Public Health sector for children between the ages of six and twelve (Haber 2003.3 and 4). Understandably, parents have a very real fear of over diagnosis, which enhances any negative feelings they may experience.

Because of the endless controversies regarding the diagnoses and ultimately the treatment procedures for ADHD, and because ADHD has produced so much interest in the general population as well as professionals it appears that an excessive amount of children are erroneously dubbed as having ADHD. The fear reverberating through the parents and the general public is that perhaps it's too easy to make a casual diagnosis, and furthermore the question of what happened before ADHD became a DSM disorder and a household name. People in opposition to the drug Ritalin are particularly quick to quote statistics and documentation slating the overuse and over diagnosis of this disorder. The researcher became aware of numerous articles, journals, books, and other media tools disclaiming the very disorder itself. In addition to this is the endless contentious debate on whether we are drugging our children to escape parenthood. The leaning of public opinion seems to emphasise that parents are unable to discipline their children satisfactorily and thus resort to quick fix solutions like Ritalin.

In the early 1960's researchers at John Hopkins University discredited the use of tranquillizers for children and recognized a new group of psychostimulant drugs called dextroamphetamine sulphate, known by its brand name of Dexedrine, and methylphenidate hydrochloride known as Ritalin which is an amphetamine-like drug originally approved by the Food and Drug Administration (FDA) in 1955 and used to control mild depression and senility in adults. Ritalin soon became popular for controlling hyperactivity. By 1987 Ritalin was taking 93% of the market while Dexedrine accounted for only 3% of the market (Armstrong, 1995).

2.3 Diagnoses and Ritalin as an Intervention:

There are two strong divergent schools of thought regarding the treatment and diagnosis of ADHD. We have radio broadcastings, newspapers reports, magazine articles and books written on the pros and cons of medication for the treatment of ADHD. Parents are torn between the powerful controversy regarding this topic: To medicate their child or children or to attempt alternative methods such as diet and/or behavioural therapy.

Ritalin is the most widely used drug for the maintenance of symptoms of ADHD and has been prescribed for over 60 years. It has been widely researched and is believed to be safe and effective for the treatment of ADHD. If ADHD has been properly diagnosed and it is used in the correct manner it has been prescribed it seldom results in any serious side effects. (Fowler, 1993). Ritalin is a short acting medication, thus its effects wear off in a matter of hours. Children often require an added dose after lunchtime, and some will even require a further dose in the evenings. The acting physician should monitor the child for the correct dosage and see to follow check ups at least twice a year. Frequently the parents will have an ongoing relationship with the physician. Usually the drug is administered for school times, however, many physicians believe in keeping up the medication throughout the holidays as well. (Fowler, 1993.) Doctor Goldstein (in Fowler,

1993) maintains that the decision to medicate, and the times of medication, whether to include holidays or not, should be made with serious consideration for each individual, and not in an arbitrary fashion based on some 'old wives tales'.

Haber, (2003) contends that the controversy surrounding the administering of Ritalin over holiday periods stems from the past, where clinicians thought that stimulant drugs caused severe loss of weight and lack of growth, therefore they recommended "drug holidays." The reasoning follows that if the child had breaks or time outs from Ritalin, they would resume their normal appetite and hence regain their heights and weights. He states that another viewpoint is that because ADHD is a pervasive disorder, medication should be used every day of the week and including holidays. He argues that neither point of view is entirely true and that treatment plans should be made to fit each child independently.

A physician should administer medical treatment such as Ritalin. Wender, (2000) claims that non-medical specialists, such as psychologists, educators and social workers need to provide useful information and the necessary assistance, but cannot assume primary responsibility for the treatment. It is also necessary for the parents to be aware of alternative courses of treatment should they wish to attempt it. One needs to be aware of a holistic approach to the treating of ADHD because often a teacher for example may suspect the child has a learning problem and recommends treatment for ADHD. In fact, the child may be experiencing emotional problems in the home which is affecting his learning abilities. It is wiser to consult experts in the field to ensure peace of mind for the child and the parents.

According to Fowler, (1993) the diagnosis should be made on the child's observable behavioural difficulties. She argues that although ADHD is a hidden disability, the problems caused are clearly visible. Although many different problem areas are manifested such as inattention, disinhibition, impulsivity and hyperactivity, the outcome of these characteristics are a multitude of tribulations

such as not completing tasks, losing things, disorganization, poor planning and many more. However, when a child shows these difficulties, parents and teachers may blame the child, not realizing that these difficulties stem from a neurobiological disorder. She goes on to stress that children must be properly assessed by a professional and this should include a battery of tests, a social and academic history of the child and family, as well as a medical history with up to date information. The medical information could discount auditory and visual problems the child may be suffering, causing similar outward symptoms to ADHD.

2.4 Pharmacological Aspects of Stimulant Medication:

According to Moll, Heinrich, and Rothenberger, (2003) the psychostimulant methylphenidate (MPH) or Ritalin, is the most widely prescribed psychoactive drug prescribed for children and highly effective in alleviating all three clusters of symptoms of ADHD, that is inattention, impulsivity and hyperactivity. Whereas its pharmacological action is thought to be related to its ability to increase levels of nonadrenaline and dopamine in the extracellular space, the exact mechanisms of the therapeutic actions are still unresolved.

Barkley (1998) contends that Central Nervous System (CNS) stimulant medications are the most commonly used psychotropic drugs used to treat the symptoms of ADHD. Substantial research has been conducted on the effects of this medication, while empirical data consistently demonstrates the efficacy of these stimulants on the individuals behavioural, academic and social functioning in about 50-90% of children treated, depending on other developmental disorders or the presence of any other co morbid psychiatric disorders. However, despite the tremendous amount of scientific research concluded regarding the use of stimulant medication, and in particular Ritalin, it continues to be controversial publicly and professionally.

Ritalin is a psychostimulant drug methylphenidate, which belongs to a group of amphetamines. In adults it acts as a stimulant, which may cause severe addiction, however, in children it has a calming affect and no one seems to know why? (Pozzi, 2000). Because ADHD is an uncertain syndrome and there is still no consensus among the world's leading psychiatrists and psychotherapists as to its treatment, diagnosis or etiology, its treatment interventions remain debatable and parents are left with ambiguity and uncertainty on all issues pertaining to this disorder. Teachers are quick to point out hyperactivity amongst their pupils, however that on its own is not a true or accurate diagnosis. Pozzi (2002) points out that in her experience Ritalin is often prescribed by psychiatrists and pediatricians who are over burdened. She maintains that it is often the parents or teachers who need a sedative because they can no longer stand their active and busy child, but they seek medication for the child.

Pelham, Pillow, Kipp, Greiner, Trane, Hoza, Gnagy, Waschbusch, Greenhouse, Wolfson, and Fitzpatrick, (2002) have raised the question regarding whether children perceive themselves differently while on psychostimulant medication. Do they believe and attribute the success in their daily lives based on the medication they are receiving or on their own efforts. They also question that children may perceive the need to rely on pills to succeed. A research was carried out with results showing that a low dose methylphenidate MPH (0.3mg/kg/dose) improved boys' behaviour in a summer treatment program and made them far more likely to meet daily behavioural goals compared to the placebo. The Expectancy regarding medication influencing the boys' behaviour had no effects on their behaviour. Their studies add to existing evidence that stimulant medications are an effective acute treatment for children with ADHD, and furthermore, they found that children with ADHD do not exhibit debilitating attributions regarding success when medicated.

Wender, (2000) holds that no other stimulant medication in psychiatry has the same response as an ADHD child taking Ritalin. At best, he claims that other treatments may restore a patient to his previous level of functioning, while Ritalin does much more. He claims that psychiatrists believe that the brain chemistry in people with ADHD is different from that of other people, because the medication seems to compensate at a basic level for this chemical difference, affecting behaviour in many diverse areas. He emphasizes that these effects are very different to the so called tranquilizing drugs which may slow the child down, but do not increase his attention span, personal sensitivity or reasonableness.

Bester, (2000) comments that the clinical histories of people with ADHD are unable to regulate their responses, owing to intrinsic neurochemical imbalance in certain areas of the brain. The result of this imbalance is that messages are not transmitted effectively from neuron to neuron. Current knowledge of this syndrome is the products of fifty years of intensive research, while a huge explosion of knowledge in particular has characterized the past decade.

She goes on to argue that the obvious conclusion of the intensive research is that ADHD is a definite neurochemical imbalance with a very strong genetic component, leading to specific dysfunction in specific individuals. Environmental factors often exacerbate the condition but are rarely the primary cause.

According to Barkley, (1997) a specific implication of the management of ADHD is a treatment that can result in improvement or normalization of the underlying neuropsychological deficit in behavioural inhibition and is likely to result in an improvement or normalization of the executive functions dependent on such inhibition. He claims that to date the only existing treatment that has any hope of achieving this end is stimulant medication or other psychopharmacological agents that improve or normalize the neural substrates in the prefrontal regions that are likely to underlie this disorder.

2.5 Myths and Facts regarding the administering of Ritalin?

Owing to the overwhelming controversies regarding ADHD, and the use of Ritalin as a medication, parents receive input from well-intentioned friends, family members and even strangers. Often people feel that these children are lacking discipline or are just plain naughty. Furthermore, these well meaning people carry on asking questions such as “Do you really think your child needs this drug?” or, “Have you seen that article in the newspaper with that child that died from taking Ritalin?” or “Have you heard that children who take Ritalin end up being drug addicts?” These comments and many others cause endless harm and uncertainty for the parents and the child. Often parents stop the medication because of ignorant “well-intended” statements made by others. These continual debates about medication cause ADHD children to feel ostracized and different, thereby causing social problems and a lack of self- esteem for the child.

Barkley, (1997.319) contends that the general public view of ADHD and self-control issues assists him in understanding the misconceptions related to this disorder. He states that the widespread social acceptance of ADHD has always been difficult to accept because the public finds it difficult to believe that such uncontrolled, poorly regulated and impulsive patterns of behaviour are anything else but willful misconduct. Furthermore he argues that they find it equally difficult to accept that it does not arise from simple bad parenting and a poor diet. Thus, if the aforementioned is what the general public contend, then it is little wonder that they find it reprehensible to give ones child a brain altering medication. He goes on to state that if society believes that family determines the causes of behaviour then it is scandalous and ethically blameworthy to give ones child this stimulant medication. He argues that, however, if his speculations regarding self-control are accurate, then it is perfectly understandable why medication can and should be used to assist with self-regulation, and why it would be ethically and rationally humane to administer.

Because of the vast controversy regarding the diagnosis and treatment of ADHD, and in particular the administering of stimulant drugs, much has been written and talked about in society and amongst professionals. The discrepancy between scientific and societal views means that society or its media, as a cause for alarm and scandal, should not take any initiation of the use of stimulant medication. Nor should the increase in the use of stimulant medication be similarly interpreted. Changes in prescribing practices should not be a reason for smearing the professionals and stating that they are drug pushers as has been the case in various countries. Such an attitude shows a scientific illiteracy of the nature, its effects and side effects of stimulant medications and their largely non-addictive nature if used properly, but also shows an ignorance of scientific literature (Barkley, 1997).

2.6 Alternatives to Ritalin:

The most popular alternative treatments for ADHD are diet and/or behavioural therapy. The most popular diet became the Feingold diet, which theoretically eliminates hyperactivity by restricting additives, preservatives, salicylates and sugar. The diet was developed during the 1960's by Ben Feingold, an American allergist who maintained that up to 50% of the hyperactive children he saw in his practice improved when placed on a diet excluding artificial flavourings, preservatives, dyes, and food containing naturally occurring salicylates (such as oranges, apples, grapes, berries and apricots, and other additives. Although his theory and organization (Feingold Association of the United States), helped thousands of families deal with hyperactive behaviour, it has become controversial during the past fifteen years. Critics suggest that the successes are primarily anecdotal and fail to meet meticulous standards and scientific research (Armstrong, 1995).

According to Schonwald and Rappaport from Children's Hospital Boston and Harvard Medical School (in Newsweek Sept., 2003), ADHD is not only about rambunctious boys wreaking havoc in the first grade, it may also affect girls or boys in a quiet dreamy like state. They argue that ADHD is treatable with stimulants such as Ritalin, and further maintain that the problem with stimulant medications is their inflexibility. Although they do concur that the medications have advanced substantially and the various short term and long term affects make it easier for parents and children to monitor. They mention a new drug in their article. This drug called Strattera allegedly offers a non- stimulant option for managing ADHD and should also be administered daily. However, like an anti-depressant it may take several weeks to be effective, as it is a new drug and still being tested for long term and short-term safety and efficacy. They conclude that most individuals benefit from medication, but one must assess if the benefits are optimal and the side effects tolerable. Most children, they believe will experience substantial improvement in their ADHD symptoms with minimal side effects.

Not surprisingly parents may feel bewildered when presented with a batch of ideas and strategies to assist their child. Therefore, whatever course one decides to use for the treatment of ADHD, one needs to equip themselves with the thorough knowledge and expertise of experts in the field. Psychiatrists, psychotherapists and/or pediatricians need to be consulted. One may also contact the ADHD Support Group (See Appendix A for this information)

2.7 Rise of Medication Therapy:

According to Barkley (1998) the development of ADHD and medication rapidly increased between 1970 to 1979. He claims that research on this disorder during this decade took a quantum leap forward with more than 2000 published studies existing by the time the decade was over. One of the huge developments pertained to the rapidly increasing use of stimulant medication and the research

on the effects of this medication on hyperactive children. Another reason was the general use of rigorous scientific methodology in drug studies. This treatment approach was the most well studied therapy in child psychiatry, however, despite the proven efficacy of this approach, public and private misgivings about its increasingly widespread use emerged.

Conrad, Schrag & Divoky (in Barkley 1998) stated that at this time there were also claims that hyperactivity was a myth arising from intolerant teachers and parents as well as inadequate educational systems. Barkley (1998) goes on to argue that at this time there was also a huge rise in the United States regarding the use of natural foods, health consciousness and the extension of life expectancy through manipulations of the environment. Thus the extremely popular view introduced by Feingold was that allergic or toxin reactions to food additives such as dyes, preservatives and salicylates caused hyperactivity behaviour. It was maintained that more than half of all hyperactive children had developed these symptoms because of diet.

Copeland & Love (1995) have written a teachers handbook guide to treating children with ADHD. They do not advocate medication alone. They insist that the whole child should be treated to ensure the best results, that is psychological, educational and medication. They further maintain that educating the parents of ADHD children is essential as they are often negatively influenced and refuse treatment based on their lack of knowledge and understanding. They do however contend that for the last fifty years professionals and parents have been treating ADHD children with numerous approaches, and yet consistently stimulant medication comes out as the most successful. This approach is also the most difficult one for parents to have to choose. The goal of this stimulant medication, and Ritalin in particular, is to help the brain function efficiently and effectively; they argue, "Just as glasses correct vision, medication corrects the neurochemical imbalances that cause ADHD symptoms." (Copeland & Love, 1995.74/75). Ritalin is the most popular stimulant medication used for ADHD and has been approved for children since 1961.

Haber, 2003 claims that in the United States alone, an enormous amount of children have been diagnosed with ADHD and subsequently medicated with Ritalin that there has been a 6-fold increase in manufacture since 1990. He does not negate the use of stimulant medication by any means, however he feels that maximum benefits are obtained when this medication is used in conjunction with other approaches, such as educational remediation and modifications, behaviour modifications and counseling for both parents and child alike. He further argues that to neglect the other aspects is the same as placing a band aid on a severely festering sore, and then do nothing else, this short term gain is null and void by the long term problems.

2.8 Family and social issues:

ADHD is a family problem; helping either the parents only, or the child in isolation is only an attempt to solve a portion of the problem. Wender, (2000) argues that often ADHD is hereditary and therefore their own symptoms may exacerbate the child's feelings making it doubly difficult to cope. Treating the parents will enable them to carry out the psychological and behavioural management of the child, but frequently ADHD is not recognized as a medical symptom. Until recently all behaviour was recognized as psychological, and almost all ADHD children have psychological problems. Some of these problems may be helped with psychological treatment, but according to Wender, (2000) as long as temperamental problems remain, the psychological problems will continue to grow. He postulates that if an ADHD child has temperamental problems psychotherapy may be necessary, but medical treatment must be administered. Once the child has received medical treatment, he may then seek help from other professionals.

John Werry, MD, Professor Emeritus of Child Psychiatry (in Barkley, 1997:341) states that in any other medical or psychiatric condition where the evidence of drug efficacy is this substantial, and for the side effects to be this benign, the failure of a physician to consider medication treatment for this disorder would be considered tantamount to malpractice. And yet, so many people in our society believe that withholding this medication for ADHD children is the ethical noble and humane way to approach this disorder. Barkley argues that this is ignorance and naiveté and perhaps a misunderstanding of the scientific literature on ADHD and its medications.

An interesting point of view is made by Hoza et al 2000. They maintain that if the parents of children with ADHD are implementing the treatment, it is likely that their thinking will influence the success of the intervention for their child indirectly, that is influencing their compliance with the treatment. That is to say that whatever the parents find as the cause for children's problems will be related to the types of treatment the parents find acceptable which in turn relates to how well the treatments are implemented. Therefore, they feel that parents cognitions regarding ADHD in their children, as well as their parenting, and themselves have not been previously studied as predictors of children's responses to treatment. Hence if parents believe that the child can control his misbehaviour, they will more likely pursue behavioural intervention strategies. On the other hand if parents believe that their child is incapable of altering his/her behaviour because of reasons beyond their control, they will be more likely to offer medication as a treatment to control their behaviour.

Hoza et al, 2000 continue to state that in addition to cognitions about their children or their parenting ability, their cognitions about themselves may influence the efficacy of the treatment for their children. They give an example of parents with low self-esteem who feel less confident about themselves, who may find it difficult to enforce medication, especially when faced with resistance from the child. As we are aware, there is ongoing public and media resistance to

medication and one may debate the feelings associated with the administering of this stimulant to ADHD children.

In another study undertaken by Johnston et al 2000, they too maintain the importance of the parent's feelings regarding the understanding and managing of this disorder. In particular the way the parents and children think and feel about the causes of the behaviour and the effects of the treatment. They question the child's attribution of causality to the medication and argue that tests have been conducted to ascertain if this is likelihood. Milich, Licht, Murphy and Pelham 2000, compared the attributions that boys with ADHD offered for their performance on a continuous task performance in placebo and medication conditions. Results showed no significant differences in attributions made on placebo versus medication. Carlson, Pelham, Milich and Hoza (1993) and Lalongo, Lopez, Horn, Pascoe and Greenberg (1994) also reported no significant effects of medication or placebo on the attributions or perceived competence reported by ADHD children. Finally, Pelham, Hoza, Kipp, Gnagy, and Trane (1997) used a balanced placebo design, crossing expectations for placebo versus medication with actual versus placebo medication and found no effects of either active medication or expectancy on the attributions boys with ADHD offered for their performance on academic puzzles. Regardless of medication or expectancy, boys attributed their success to effort and ability, and failure to task being difficulty, with no difference in pill attributions across success and failure. These newer studies indicate fewer adverse affects of medication on the generally self-esteem enhancing attributions of children with ADHD.

2.9 Biological Aspects:

It is thought that stimulant medication acts by affecting the catecholamine neurotransmitters, especially dopamine in the brain. Some people believe that

ADHD develops from a dopamine deficiency, which a stimulant drug can treat (Martin, 1992).

Amen (2001), claims that ADD affects many areas of the brain, primarily the prefrontal cortex which is the brain's controller of attention span, concentration, judgment, organization and planning, and impulse control, the anterior cingulate gyrus which he terms the brain's gear shifter, the temporal lobes where the brain houses the memory and experience, the basal ganglia which produces the neurotransmitter dopamine that drives the prefrontal cortex and the deep limbic system which is the brain's mood control center. He maintains that there are 6 different types of ADD, which need to be diagnosed properly. A comprehensive questionnaire will assist people to identify which type of ADD they or their children may be suffering with.

The pioneering work of David Comings, Florence Levy and others has demonstrated a genetic component to this disorder claims Amen (2001). He states that specific gene sites implicated include the HLA on chromosome 6, the dopamine transporter gene on chromosome 5 and the D4 receptor gene on chromosome 11. Furthermore he mentions a research from Australia that found 81% of identical twins, which share identical genetic material had ADHD, while fraternal twins who have sibling genetic material share ADHD only 29% of the time.

Hinshaw, a child psychologist at the University of California in Berkeley (in Newsweek, Sept, 2003), stresses that bad parenting is not the cause, but parents may be the cause, because ADHD is largely from genes passed on by the parents. Many researchers share this viewpoint; Wender (2000) argues that the majority of cases of ADHD appear to be genetically and chemically transmitted. That is, he feels that this disorder is hereditary, and what is inherited is the abnormal chemical functioning in the brain. He maintains that stimulant drugs normalize the effects while correcting the imbalances that are believed to

produce ADHD. He continues to state that although the method in which the child is raised and treated may affect the symptoms and the severity of this disorder, it cannot actually cause it. He explains the chemical workings in the brain as each nerve cell releases a small amount of chemicals, which are picked up by the next cell causing it to 'fire'. These chemicals are neurotransmitters and if there is too little of a particular neurotransmitter, the second cell will not fire because not enough of the neurotransmitter has been released by the first cell. Although the nerve cells themselves are intact, it's as if the connections are broken. These presumed chemical differences are generally thought to be inherited, that is, part of the individual's genetic make-up.

Johnston et al, 2000 supports the claim that evidence is accumulating to support a biological basis for ADHD, and the use of psychostimulant medication such as Ritalin. However, they argue that this does not negate the crucial aspects of the psychosocial context surrounding the child with ADHD. They maintain that the treatment of ADHD is inextricably linked to how parents and children think and feel about the disorder as well as the effects of the treatment. It has been speculated that the psychostimulant treatment may transmit cognitive-motivational messages regarding the child's behaviour and his or her inability to control it, which may encourage the attribution to causality of the medication, however, further studies have indicated no significant differences in attributions made on placebo versus medication. They sum up by stating that these newer studies indicate hardly any adverse effects of medication on the self-esteem enhancing attributions of children with ADHD.

According to Amen (2001), Cocaine and Ritalin work in the basal ganglia where dopamine is produced in the brain. He maintains that the reason that cocaine is addictive and Ritalin is not is related to how each drug is metabolized. Cocaine has a powerful immediate effect that stimulates an enormous release of the neurotransmitter dopamine. The pleasure this brings to the individual rapidly fades leaving the person craving for more. Ritalin, however, works more slowly

inducing no high, or pleasure, and its effects stay around for a long time. He gives the example of what video games do to the workings of the brain. Video games bring pleasure and focus by increasing the dopamine release, but the problem is that the more dopamine is released, the less neurotransmitter is available later to accomplish other tasks such as homework.

Sears & Thompson (1998), also refer to the puzzlement of the medications used to control ADHD actually being a stimulant. They explain the neurobiology by stating that every time one thinks or acts, messages travel from one nerve to another telling the brain what to do. These messages are carried by neurotransmitters, and chemicals such as norepinephrine, dopamine and serotonin, which are secreted at the junction between brain cells to facilitate the transmission of messages. Stimulant drugs are thought to increase or stimulate the secretion of neurotransmitters, which inhibits behaviour and helps the individual to stick to what he or she is doing.

2.10 ADHD Children and their responses to Ritalin:

Quinn & Stern (1991:42) quote what some ADHD children have to say about their medication:

“It helps me think one thought at a time.”

“It’s like glue – before my thoughts were in pieces. The medicine stuck them all together.”

“I feel more organized.”

“It helps me to calm down.”

“It helps me not to climb the walls or ‘spaz out’ or get into trouble.”

“It helps me to pay attention better.”

“My brain was cloudy, and now it’s cleared up.”

“It lets me show how smart I am.”

“It helps me get my work done.”

“After 30minutes, the ADHD just packs up and moves out.”

“It’s my memory or concentration pill.”

“It is my brain-aid, just like a band-aid for my brain.”

They claim that parents must be well informed about the medication and ADHD as a whole to truly understand this disorder.

2.10 Conclusion:

It is clear from the above literature that Ritalin is the number one treatment administered to children with ADHD. Although there is overwhelming controversy regarding the treatment, undoubtedly it has the most positive results. However, the constant flow of media negativity continues to confuse and exasperate the general public, and in particular parents of children suffering with this disorder. The next chapter looks at alternatives for the treatment of ADHD.

Chapter 3

Alternative views and interventions for the treatment of ADHD.

3.1 Introduction

In order to understand the challenges the parents, and in particular the mothers, have regarding the treatment for their ADHD children, one first needs to understand the alternatives to Ritalin, and specifically diet as an intervention to treating ADHD children. There is no cure for ADHD, however various interventions may be administered or attempted to alleviate symptoms and enable the child to function optimally. Diet has been seen as a popular alternative, although the efficacy is controversial.

3.2 Doctor Feingold's diet

Friedman & Doyal (1992) mention the writings of Doctor Benjamin Feingold, a pediatrician who in 1974 wrote a book entitled "Why your child is hyperactive." Based on his clinical experience he recommended a diet, free of artificial flavours and colours, refined sugar, preservatives and natural salicylate. He argued that this helped a large number of children with ADHD. There are Feingold societies throughout the United States of America and Canada, and cookbooks have been published describing additive-free diets, however, there is no scientific evidence that this does in fact help ADHD in children. However, Friedman and Doyal (1992) mention that many parents have noticed a difference in their children's behaviour when they have too many sweets and fizzy cold drinks. They continue to state that although these sugary items filled with refined sugars and additives may exacerbate your child's behaviour, it is not a cause for it. People may be sensitive to large amount of refined sugar. They claim that there is mixed and

contradictory research on the relationship between eating too much refined sugar and behavioural changes.

Dr Benjamin Feingold was the first to popularize a special diet for the treatment or alleviation of symptoms for ADHD sufferers, and specifically aggression and hyperactivity. The diet he recommended is still used today, however, it has suffered harsh criticism because people maintain that it is not effective “all” of the time. The critics argue that there are a possible number of reasons for this failure that is an allergic reaction to certain food types; a mineral deficiency, a spinal misalignment, or the instructions simply weren’t followed correctly. (Bell & Pieper, 2001).

According to Carson (1987) after the child has been correctly diagnosed, it is necessary to try him on a special diet for a minimum of three months. It is interesting to note that this book was published sixteen years ago, and yet opinions do not seem to have varied much. Carson (1987) maintains that there is an ongoing major dispute regarding diet as the management of ADHD. He claims that the dispute is mainly between health professionals and parents, as the health professionals are very suspicious of diets. As we are aware, there does not appear to be much of a change in attitude even though all these years have passed? He does however add that tests have shown that there is a causal link between hyperactive behaviour and diet. However, he goes on to argue that the research on diet is not only restricted to overactive behaviour but to several other ailments such as headaches, tummy aches, epileptic fits, asthma, eczema and limb pains. Nevertheless, he does state that the foods responsible for the overactive behaviour seem to include preservatives and artificial colourants, which today have become popular as foods to avoid for children.

Carson (1987) also refers to Doctor Ben Feingold when discussing the diet alternative to ADHD treatment. He believes that it is far more than a couple of food groups that exacerbate the hyperactive symptoms. He claims that there are

an “astonishing” number of foods involved, and thus, the Feingold diet alone could not be completely effective. Furthermore, he argues that Ben Feingold placed much emphasis on the role of salicylate containing foods and artificial food additives as reasons for over activity in children. He claims that as important as these substances are, there are many other foods involved in the condition, which the Feingold diet does not exclude. In addition he also recommended a higher dose of some foods to make up for the restrictions already imposed by the diet. Consequently, he claims, many children were only partially treated by this diet method and did not improve significantly for other diet options to be considered.

3.3 ADHD Support Group of Southern Africa’s Views

According to Pooley (n.d.) of the ADHD Support Group in South Africa, although there is mounting evidence than what we eat has no effect on our behaviour, there are still doctors who believe otherwise. She maintains that not all children respond to diet, however she believes that most respond to some extent. Some do well enough that medication is not necessary, and some show no change at all. She argues that perhaps the children that show no difference may not be adhering to the eating program sufficiently or that their dietary requirements are slightly different from the usual diet recommended for ADHD children. She does however state that as a child gets older and schoolwork becomes more formalized, the child may require some medication even if it is only for academic reasons.

There is currently tremendous interest in Atomoxetine, or Strattera, a new medication on the market, which differs from Ritalin in that it is not a central nervous system stimulant. The Support Group maintains however, that medication is not the only route, diet and supplementation is an invaluable path to follow. That is, a vitamin and mineral supplementation and the correct diet.

They argue that people have tremendous results using either supplementation or diet; however, the best results obtained are the use of both simultaneously. Improvements have been noted in learning ability, behaviour, social interaction and health coordination, while Ritalin is a stimulant, which makes certain neurotransmitters such as dopamine more available in the brain. Thus the child becomes calmer and less impulsive, active or/and destructive. Concentration usually improves, resulting in Ritalin being the number one choice for ADHD sufferers. On the whole they support the use of both solutions, that is Ritalin and diet. They argue that people do not have to choose between the two interventions, but can use both. Understanding ADHD combined with informed use of the different therapies available they believe will undoubtedly yield the most favorable results. (Picton, 2003)

3.4 The Drug Companies

According to Stein (2002), pharmaceutical companies have been waging a successful campaign to market psychiatric drugs. He maintains that they have been successful in persuading the public the need for these drugs in curing a multitude of problems. He argues that they make life appear simple – if we feel anxious, they have a tablet, if we feel depressed, they have a tablet, and if our children are diagnosed with ADHD, there is a tablet! He poses a forceful argument against psychiatric drugs and asks if it matters where drugs come from: drug dealers or medical doctors, the effects he believes are the same. He maintains that during the 1990's we merely switched pushers. His dispute is that, " we shifted from Colombian and Mexican cartels to the pharmaceutical cartels." (Stein, 2002: xii)

Stein (2002) claims that the Children and Adults with Attention Deficit Disorder (CHADD) organization in the United States is mostly funded by the monies received from Novartis, the company that actually manufactures Ritalin. He

argues that the majority of research on ADHD and Ritalin is funded by one of two sources, that is, the pharmaceutical companies or The National Institutes of Mental Health (NIMH), which he claims has been pro disease and pro drug for many years (Breggin and Valenstein in Stein 2002).

In the 1980's there was a steady output of approximately 1,700 kilograms of Ritalin with slight annual increases or decreases, but at the beginning of 1991, the production of Ritalin rose sharply and has grown significantly ever since. The amount of Ritalin produced in 1993 was 5110 kilograms, while the quota for 1996 11,775 kilograms. The emergence of ADHD children began to emerge in full throttle and this is made apparent by the group of parents whose children had ADHD. In 1987 in the United States of America, they formed an organization called CHADD, which was an acronym for Children with Attention Deficit Disorders. By 1993 CHADD had grown to thirty five thousand members and changed its name to Children and Adults with Attention deficit Disorder. In 1993 newspapers and television were reporting an apparent national shortage of Ritalin. It was alleged that through a bureaucratic oversight Ciba-Geigy 's (the manufacturer's) request for an increase in the Ritalin quota sat on a desk at the DEA, Drug Enforcement Administration for several months. However, the production quotas for this drug have continued to soar. In 1997 the DEA authorized 13,824 kilograms, which is an increase of more than 700% since 1990 (Diller, 1999).

According to Diller (1999) the Ritalin boom has created an extraordinary growth in pharmaceutical profits and is up an estimated 500% since the start of the 1990's. He also argues that it is not only the pharmaceutical companies that are making vast amounts of profit but spin offs for nonmedical entrepreneurs both legitimate and illegitimate. Advertisements in professional journals regularly promote tools for assessing and treating ADHD individuals, or ADHD Clinics. Furthermore professionals in the fields are besieged with mail, phone calls, emails and faxes selling various products and services for ADHD. There are

vitamins, herbal preparations, homeopathic remedies, different therapies, videos, computer software and even special camps for children with ADHD to attend. Zimmerman (1999) postulates that the United States consumes five times more Ritalin than the rest of the world. This is according to the United States Drug Enforcement Agency. DeGrandpre (2000) also claims that the United States consumes 80 to 90 percent of the total Ritalin consumption in the world. He also speaks of the financial benefits for the manufacturer Novartis, previously CIBA Pharmaceuticals. Thus, we are left wondering why this particular nation has such excessively large diagnoses of this disorder? Once again this confirms or reaffirms parents concerns over the validity of the diagnosis firstly, and secondly the treatment prescribed. These factors exacerbate and confuse parents who are already uncertain and dubious regarding the administering of Ritalin.

3.5 Is there proof that ADHD exists?

There are literally thousand of literature articles, books, publications, video's documentaries and discussions on the controversial topic of ADHD. The main questions are "Is there proof that ADHD exists?" "Are the pharmaceutical companies promoting their drugs as treatment for this diagnosis, in an effort to make more money?" "Is diet an alternative to medication for the treatment of ADHD?" "Are parents unable to cope with children who are feisty, spirited, energetic and a handful?" "Are we making our children drug addicts?" and many more. Selikowitz (2001) argues that it is not a condition that parents can possibly help without some form of medication or treatment. He maintains that it results from insufficient quantities of certain chemical messages to the brain. He believes that certain medicines used to treat ADHD act by restoring these chemical messengers to more levels thus enabling the child to behave more like other children in his/her age group.

Selikowitz (2001) acknowledges that bad parenting has often been blamed for children who display symptoms of ADHD. He mentions different traditions that have played a part in the way people think about children with behavioural difficulties. One of these is the terms people use, such as “lazy”, “naughty”, and “spoil” without being aware of the parents or child’s background. Sigmund Freud’s beliefs also contributed to the way people think as he maintained that children’s behaviour might be attributed to the earlier experiences. Another popular myth, he believes, is that this century has seen many behavioural psychologists emerge, and they emphasize that behaviour is learned, thus dispelling the belief that one is born with ADHD symptoms. It has only been fairly recently that people are questioning this and considering that behaviour may also be determined by external factors.

Are we labeling our children with ADHD because it is convenient and an easy way to put down natural creativity and exuberance or is there a real medical condition? asks Zimmerman (1999). She claims that one needs to ask the parents of a child suffering with these symptoms relative to ADHD. As casually as people bandy around the term, it is in fact a reality. Attention deficit disorders are serious neurological disorders that can and do result in severe behavioural dysfunctions. The American Psychiatric Association (APA) has compiled a list of symptoms most commonly associated with this disorder. These criteria are used by doctors and medical practitioners to assist them in making accurate diagnoses of people who present with symptoms. The criteria is listed and published by the APA in the Diagnostic and Statistical Manual of Mental Disorders (DSM). It is the most commonly diagnosed psychiatric condition found among young people.

DeGrandpre (2000) poses the question – “Is our society too hurried?” He refers to the American culture and the endless obsession with speed. He argues that everything must be quicker, better, sooner, faster. He quotes a primary school teacher as saying that it is no wonder that our children today are all diagnosed with ADHD, because children constantly seek entertainment and stimulation and

don't know how to listen. DeGrandpre argues that we want the best of two contradictory worlds, that is fast, technological advancements, materialism, a world filled with endless excitement and adventure, and yet we yearn for a social world that is secure and tranquil.

3.6 Is the diagnosis of ADHD comprehensive and sufficient?

The use of the word ADHD or Attention Deficit Hyperactivity disorder, or Ritalin is bandied about with relative ease. Are people sufficiently aware of the symptoms and the medication to pass credible judgment? Only a medical practitioner trained in this field, who is interested and experienced in the field of developmental and behavioural difficulties in children, should be allowed to consider an accurate diagnosis. This "expert" should also work in close liaison with an educational psychologist who should play a role in this diagnosis. This diagnosis should take a number of crucial steps when making a decision that may alter a child's life, including the parents and siblings. Firstly, a history of the child should be taken. This may include a questionnaire from the teacher as well as the parents. Secondly the pediatrician should examine the child carefully to ascertain that there are no other conditions interfering with his/her learning and behavioural problems. Thirdly, an educational psychologist who is trained in this field should carry out specialized psychometric testing. Finally, a neurologist should carry out tests for measures of brain function (Selikowitz, 2001).

Breggin (2001), postulates that the over diagnosis of ADHD is out of control. He maintains that teachers want well-behaved children who can easily be taught, while parents are eager to see their children succeed. Medical Health Professionals are quick to diagnose ADHD and seek drug treatment. Children who are creative, have a different learning style, are depressed or angry are all being diagnosed as having ADHD (Collins in Breggin, 2001).

Breggin (2001) is in total opposition to the diagnosing of ADHD, he claims that most physicians spend a few moments making a “quickie” diagnosis of ADHD. The physicians, he suggests, are using a mental checklist of behaviours to make this diagnosis. He feels that children are being diagnosed and medicated on the basis of personal, subjective feelings offered to the physician, who he maintains, makes their own personal subjective impression. He argues that the process is too arbitrary and imprecise to have true objective validity, and goes on to claim that the drugging of the child is therefore being justified on the basis of medical science. He is a strong opponent of there being a syndrome, diagnosis or condition called ADHD that should be treated with stimulant drugs. He argues that ADHD covers a relatively meaningless list of behaviours that may manifest in almost anyone, and may pop up almost anywhere, and, he believes especially in creative bright children. He declares that no child should ever be labeled as ADHD as it is extremely harmful and declares the child as the source of the problem. He considers that it labels the child as incorrigible making him/her unreachable by any adult, which is a very harsh and negative viewpoint to bring to a child. He argues that its main purpose is to justify the use of drugs.

Finally, Breggin (2001), states that ADHD is not a disorder, disease or condition and does not believe that it is biological. He quotes the November 1998 NIH Consensus Development Conference panel and the 2000 American Academy of Pediatrics official guidelines documented claims saying that there is no evidence of brain scan abnormalities in children labeled with ADHD.

The diagnosing, the syndrome, the treatment, and medication pertaining to ADHD are a continuing debate amongst professionals, parents, and the public at large. There does not seem to be a general consensus as far as anything to do with this disorder is concerned. There are ongoing debates in the media, television programs and professionals who have taken the time to write books, articles and journals arguing their point of view. On the whole, the argument against the medication and in particular, Ritalin, appears to be against the

pharmaceutical companies, as well as professionals diagnosing this disorder without sufficient evidence.

3.7 The Biological Controversy.

There is even debate amongst experts regarding the biological aspect of determining if ADHD is present as a disorder or not. Is it genetic? Is it biological? Is it inbred? These are the questions individuals and experts alike are asking. Should there be a clear-cut biological explanation, it would put parents at ease regarding the diagnosis and perhaps the treatment. However, there does not appear to be a general consensus in this regard and experts in this field seem to be divided about the neurological workings of a person diagnosed with symptoms of ADHD.

De Grandpre (2000) argues that despite all the efforts of the American Psychiatric Association (APA) to define ADHD as a well-established disorder of the brain, three decades of science have yet to prove or substantiate evidence to support this claim. He maintains that psychiatrists, general practitioners and pediatricians rely on observation and case histories to make medical diagnoses. They cannot differentiate between the biological disorders of ADHD and normal fluctuations of behaviour that we see in children every day. This he believes makes physicians overlook other possibilities when diagnosing children. Thus they are jettisoning their very basic tenet, that is family, social and cultural issues that often manifest themselves as psychological ones. If an individual presents with persistent problems with attention and/or hyperactivity, he/she becomes a candidate for an ADHD diagnosis, without the medical practitioner looking for other possibilities such as developmental ones.

Armstrong (1995) states that he does not find any one particular biological factor to explain ADHD, however, he feels that there is a biological predisposition that

needs to interact with cultural, social, educational and/ or psychological environments that may trigger and erupt into ADHD symptoms. He acknowledges that most proponents of ADHD are acutely aware that there are no biological factors evident and yet they find a place for them in their models so that they can maintain the ADHD myth, and particularly its existence as a medical disorder to enable society to preserve it.

The exact etiology of ADHD is unknown, but current research supports a neurobiological base (White, 2003). She argues however that the National Institute of Health (NIH) responsible for biomedical research concluded that too much television, food allergies, excess sugar, poor home life and poor schools do not cause ADHD. She too confirms that diagnosis is empirical, with no objective confirmation available to date (Kidd in White 2003). The diagnosis is primarily based on the child's and family's histories, interviews, physical examination, and developmental and psychological evaluations.

Williams (2002), states that although ADHD is described as a neurobiological disorder that prevents children focusing on a specific task, there is no scientific method for diagnosing this ailment. Leo (2002), points out that although ADHD is one of the most thoroughly investigated and well studied pediatric disease, and has had millions of dollars, countless hours and tremendous resources pumped into it, fundamental questions are still unanswered. He maintains that there is no proof underlying a neurobiological deficit.

3.8 Cognitive-Behavioural Therapy

Because of the disadvantages of using a single approach, and more often medication as treatment, the focus has moved to alternative interventions. Cognitive –Behavioural therapy models share a few basic tenets:

- Individuals are proactive, independent, and thus capable of influencing their environment.
 - Cognitions affect the individual's behaviour and his/her feelings of well-being. It is claimed that not only are cognitions related to behaviour, but there is also a causal relationship between the two.
 - Cognitions can be monitored, assessed and altered.
 - Any changes in cognitions will lead to changes in behaviour.
- (Schwebel & Fine 1994).

According to Dryden & Ellis (in Schwebel & Fine 1994), Ellis's Rational Emotive Therapy, the root of an individual's psychological disturbances lie in the tendency to make absolute evaluations on their perceived situations in their lives. These perceived beliefs stop individuals pursuing their life goals and may lead them to have distorted beliefs about themselves.

Beck et al (in Schwebel & Fine 1994), cognitive model of emotional disorders maintains that inaccurate and maladaptive cognitions lead to the development and maintenance of many negative emotions.

The above two therapists believe in assisting clients in identifying and changing their distorted and maladaptive cognitions. The common assumption of cognitive-behaviourists is that the individual's cognitions, emotions and behaviours are shaped by how their cognitions view the world. Thus, their therapy would include assisting the individual in becoming aware of, and correcting the negative and unhealthy cognitions. The therapists help the clients identify and replace inaccurate and maladaptive cognitions that if eliminated, would enable them to live happier lives.

According to Braswell & Bloomquist (1991), interventions using cognitive-behavioural therapy with samples of mild to moderate behaviourally disordered children have achieved successful outcomes, what's more, these approaches

have been increasingly successful to remediating deficits in academically impaired children. However, they have not achieved much success with children meeting the full diagnostic criteria of ADHD, and they have failed to show incremental benefit beyond outcomes achieved by utilizing psychostimulant medication.

Thus, the cognitive-behavioural model emphasizes the breaking of negative thoughts using cognitive and behavioural interventions. An individual is influenced by his beliefs about himself in relation to the environment in which he is part of; therefore this approach is to relieve the emotional disturbance by helping the individual change their maladaptive beliefs and behaviours. (Scott and Dryden in Woolfe and Dryden 1996).

3.9 Conclusion

Although Ritalin appears to be the number one treatment of ADHD, there are many people in authority as well as the general public and the media who disclaim the validity of this medication. Consequently the endless uncertainty of parents who seek help to assist their child suffering with symptoms of ADHD is never ending. As long as the public and experts discredit Ritalin as a treatment of ADHD, parents will be torn in their decision to treating their children with this intervention. It seems that the more people that utilise this drug, the more skepticism surrounds the credibility of it. The endless barrage of uncertainty permeates the parent's viewpoints and causes uncertainty and blame. However, there is one aspect that most experts on ADHD agree upon and that is a multifaceted approach is of paramount importance in the treatment of ADHD.

Chapter 4.

Research Methodology

4.1 Introduction

The aim of this chapter is to discuss the research methodology and the research process that will be implemented. Qualitative research will be defined, and the phenomenological approach will be discussed. The data collection, method and analysis are stated and clarified. The researcher outlines her hypotheses and concludes the chapter with descriptions of the validity and reliability of this research, as well as the ethical considerations.

4.2 The Aim of the Research

In this research project, the aim of the researcher will be to enter the world of the mothers whose children have been diagnosed with ADHD and investigate the feelings experienced by the parents, and in particular the mothers of children taking the Ritalin medication. By considering any commonalities of feelings experienced by the mothers, the reader may feel an understanding and awareness toward their plight. The mother needs to come to terms with her feelings regarding her child's diagnosis of this disease and ultimately the medication prescribed. Isolating her feelings and noting the similar experiences felt by the different mothers may assist to comparable findings elsewhere and ultimately to an understanding of the normalcy of these feelings, particularly if they are negative. Further it may assist her in finding strategies to aid her in coping.

Understanding the mother's experiences may lead to easier adjustments for other mothers and also a more positive acceptance of this disorder. This may

therefore prevent any secondary problems to which the family may be predisposed.

4.3 The Phenomenological Approach

The researcher decided to use the phenomenological approach because this approach aims to understand the meaning of human experience as it is actually lived (Barrell, in Sherman, 1997). This approach explores the commonalities and uniqueness of the individual's experiences. Phenomenological research places an emphasis on the descriptions of the people being interviewed, rather than on the researchers report. It concentrates on descriptions of experience, and is concerned with how a phenomenon is experienced by the individual.

The aim of the phenomenological method is to achieve valid and inclusive descriptions of the way in which a person experiences events.

According to Woolfe & Dryden (1996), the task of the researcher is to become immersed in the subject's world until the real implication, or essential meaning becomes apparent. The researcher needs to attempt to hold back his/her worldviews and preconceived notions to search for new and hidden meanings. Thus it is essential that the interview take place with the interviewer continuously being aware of his/her own prejudice or tolerance of the subject at hand.

"The subject matter of phenomenology began with consciousness and experience, was expanded to include the human world by Heidegger, and to include human action by Sartre." (Kvale, 1996:52, 53). Phenomenology is interested in clarifying both what appears, as well as the manner in which it appears. It studies the subject's viewpoint of the world and attempts to describe in detail the content and structure of the persons consciousness. In a nutshell phenomenology likes to make the invisible visible! (Kvale, 1996).

This research method is descriptive and qualitative, thus the researcher attempts to receive a neutral, unbiased, and accurate account of the subject matter discussed without any prejudices and pre determined thoughts and ideas. She will instead attempt to search and discover essential information of the phenomena being researched and to formulate and express unconditionally and without discrimination. The qualitative perspective focuses on the human experience (Valle & Halling in Sherman, 1997).

According to Kvale in Willig (2001:52), “Phenomenology is interested in elucidating both which appears and the manner in which it appears. It studies the subjects’ perspectives of their world; attempts to describe in detail the content and structure of the subjects consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meaning.” Willig (2001) argues that although phenomenological analysis aims to explore the subjects’ experiences from his or her perspective, one must be mindful that the researchers own worldview will be implicated. Therefore, she states that the result is always, only an interpretation of the subjects’ experience.

Tesch (1990) explains phenomenological research as commencing almost immediately as the data is collected from the interview. She claims that the first task is a conceptual task, which includes the clarifying of the researchers own preconception of the phenomenon she is studying. She calls this “bracketing” and simply stated, means attempting to put aside ones own meanings and explanations and attempting to enter the world of the individual she is interviewing.

4.4 Motivation for using Qualitative Research:

It was decided that interviews with subjects would be most beneficial for this study. Interviews shall be semi-structured, meaning that the questions posed are

open-ended and non-directive. However, the researcher will have certain questions requiring her to enter the life world of the subject (Willig, 2001). The interview will be informal but in depth attempting to understand the meanings of their experiences, and to feel the emotions they feel.

The purpose of the qualitative research interview is to obtain descriptions of the subjects "lived world," and her relationship towards it. The interview seeks to interpret meanings of central themes that may arise. The interview will focus on Ritalin as a treatment for ADHD, but will attempt to allow the subject to speak freely about her experiences regarding both the diagnosis and the treatment. There will be no prompting of any negative experiences the mother may have. The subject will be encouraged to speak freely about her everyday world as well as her child diagnosed with this disorder. She will be gently encouraged to share her conceptions of her life world, while the researcher aims to obtain any nuances in her descriptions.

4.5 The Unstructured Interview:

An informal, unstructured interview will be utilised to gather descriptions from the subjects being interviewed. A Qualitative method will be used in an undirected conversation with the participants, allowing for the free flow of experience from each subject. The researcher, however, will attempt to steer the conversation around the question at hand. Because qualitative research is a holistic process that attempts to explore the entire phenomena under study, it requires the researcher to discover the essence of the experiences studied (Human, 2002).

The researcher will also be mindful of the standardized objections utilising Qualitative Interview Research to obtain information. Kvale (1996), mentions the ten standard reactions which is listed hereunder:

- Not scientific, only reflects common sense
- Not objective, rather subjective
- Not trustworthy but biased
- Not reliable as it rests upon leading questions
- Intersubjective, as different readers find different meanings
- Not a scientific method as it is too person-dependent
- Not scientific hypothesis testing, it is only explorative
- Not quantitative, only qualitative
- Not generalized as there are too few subjects
- Not valid as it relies on subjective impressions

The researcher will be mindful of the negativity and criticism surrounding qualitative interviewing research and will thus attempt to make certain she examines the essence of the experiences in order to gain insight and a better understanding of the subject at hand. Naturally, one must be acutely aware of the subjectivity of the research questions and the interpretation of the data, as well as the challenge to obtain a hypothesis that suits the study she is attempting to discuss. One is never able to be completely objective, as each individual's meaning of reality is different. Each individual comes with a set of world experiences and preconceived notions thereby making it extremely difficult to be totally impartial, however, the researcher will attempt to maintain an unbiased, genuine and fair outcome to this study.

Because the researcher is aware of the multiple meanings that one may find in the analysing of the data, she will search for clues to these meanings in the discourse, she will attempt to make sense of the subject's reality. She will be actively aware of their backgrounds, their communities, their society and their cultures, as well as any other dynamics that may influence the outcome she is searching to find. The researcher will continually be mindful of the different discourses and the relevance therein (Henning, 2004).

4.6 Data Collection Process

4.6.1 Choice of Subjects for this study:

The researcher will chose 4 mothers, which should be chosen randomly from schools in the area. The principals will be approached to ensure a fair and random selection takes place. The researcher would prefer a mother that is married and has more than one child, to ensure a similar sharing of experiences in this small selection. The gender of the child is of no significance. The age of the mother is not a factor, nor will the age of the child be of importance, however, a necessary stipulation will be that the child has been officially diagnosed with ADHD.

4.6.2 Method of Data Collection

The Data will be collected by means of unstructured interviews with the 4 mothers in question. The researcher will act as interviewer and record the interview on a Dictaphone tape recorder. The subjects will be advised of the confidentiality of the information and their anonymity. The essential characteristics of an interview are that they should be neutral and the questions posed should not be leading.

The interviewer will familiarize herself with the basic background information of each subject and ensure that the above stipulations have been adhered to. The interviews will be approximately 1 hour per subject in which the researcher will attempt to gain some further biographical information and to build a comfortable rapport with the mothers. There should be a relaxed ambience in which the mothers can speak candidly and freely. The researcher shall inform the mothers that they should share their subjective views and not say what they may think is expected of them. They will also be informed that the researcher has no

particular viewpoint on the subject matter as she personally does not have a child diagnosed with ADHD

The researcher chose interviews as it allows for a rich and detailed description of the subjects experiences. By making use of open-ended questions, the researcher obtained detailed descriptions of the interviewee's perspectives and experiences. The interview as a research method was chosen over and above pre constructed questionnaires, as it is less structured and allows the subjects freedom to respond according to their own personal experience and understanding of the phenomenon at hand.

4.7 Data Analysis

The data shall be collected through unstructured interviews and the analysis will include reducing the collected data to manageable sized proportions, and seeking or identifying any emerging patterns and themes. The process of analyzing the data requires the researcher to have an open mind and when attempting to format the findings is mindful of all possibilities and explanations she may unearth. Interpretation, shown in Chapter 5 refers to the actual research process where the researcher attempts to collate the data by categorizing the various findings to attempt to discover if the hypotheses are accurate or false; or by formulating a new hypothesis that would best suit the relevant findings (Phadi, 2003).

The researcher's approach and subjective feelings plays an important role in the process of analyzing the interviews. However much one attempts to remain neutral, the human element plays a role. One is influenced, and influences by the questions asked and the responses made. Therefore, with this in mind, one attempts to analyze the data collected in context of the mothers' story.

The researcher will categorize various experiences she feels are pertinent to this study and decide which experiences relate to this particular research. She will scrutinize the content for similar experiences and meanings and cluster these together on the matrices. (See Appendices D and E). Finally after repeated reading and categorizing, the researcher aims to tie the various notions together, connecting elements and thereby identifying emerging themes, patterns and experiences (Tesch 1990).

4.8 Validity and Reliability

4.8.1 Reliability

Reliability pertains to the consistency of the research findings. This would primarily apply to the interviewer posing leading questions, or inadvertently influencing answers. The objective would be to ensure that if a later interviewer conducted an interview with the same subjects, they would find an almost exact response and the researcher would discover similar findings and conclusions. It would be almost impossible to maintain this type of consistency of reliability in qualitative research, as each person is unique and could not possibly come to the exact same conclusion (Phadi 2003).

This research incorporated data being collected via means of semi-structured interviews, which were transcribed verbatim. According to Silverman (1998), data that is collected by tape recording has strengths in terms of accuracy; however, he asserts that “single-encounter” interviews may be at a risk of not capturing reliable data. Thus, with the 4 subjects intended for this research, the researcher hopes to achieve accuracy in reliability. The data will be analysed repeatedly, and themes shall be deduced from the respondents. An example of several pages of one of the transcripts is included in Appendix B. (Lazarus, 2002)

4.8.2 Validity

“Ascertaining validity involves issues of truth and knowledge” (Kvale, 1996:236). Validity involves both truth as well as the correctness of a statement; it is in essence the extent of capturing the descriptions of events accurately. One can check validity in an interview situation by checking “Am I measuring what I think I should be measuring?”(Kvale, 1996).

In this study, the researcher will attempt to ensure the validity of the data which will be obtained from an in depth interview. She will make the subjects feel comfortable and at ease throughout the interview, thereby encouraging genuine communication and the sharing of their different experiences (Lazarus, 2002).

4.9 Hypotheses

The Hypotheses for this study is as follows:

1. The researcher hypothesizes that the four subjects will share similar experiences by administering Ritalin to their child or children diagnosed with ADHD.
2. Although Ritalin appears to help a high percentage of children suffering with this disorder, the mothers are afraid of the side effects of this treatment, and feel guilty about having to administer it.
3. The mothers feel negative regarding the treatment method and would prefer an alternative approach.
4. Although Ritalin has a very positive effect on the symptoms of ADHD, mothers experience anger or denial when they are first approached by a teacher, principal or caregiver recommending they have their child tested, and prescribed Ritalin as a treatment method.

5. Is there a difference in experiences of negativity or helplessness in mothers who work full time; to mothers who work part time; to mothers who stay at home all day or mothers who work flexible hours?
6. Is there a difference in experiences from full time working mothers, to part time working mothers, to mothers who stay at home all day or mothers who work flexible hours?

4.10 Ethical Considerations

Weber in Silverman (2001) points out that all research is contaminated to a lesser or greater degree by the values of the researcher. With this in mind the researcher will commence her interviews. Willig (2001:18) mentions the following considerations when dealing with both qualitative and quantitative research. These include:

- Informed Consent whereby the researcher ensures that the subjects are fully informed about the research procedure and have given their consent to participate in the research prior to the interview taking place. (A copy of the letter given to each participant is shown in Appendix C).
- No deception of subjects.
- Right to withdraw, without the fear of being penalized.
- Debriefing – the researcher must ensure that the subjects are informed of the aims of the research.
- Confidentiality regarding any information shared in the interview.
- The researcher must ensure that no harm or loss should arise because of the interview process. She shall aim to preserve her subjects' psychological well-being and dignity at all times.

The subjects were assured of their confidentiality when signing the consent form.

4.11 Conclusion

This chapter outlined the prerequisites for the interview that are identified as being qualitative in nature. The phenomenological research model will be utilised bearing in mind the various negative aspects of measuring the data collected. The criteria of choosing the different subjects are discussed. The researcher's responsibilities regarding the measuring instruments and analyzing the data are stated. The hypothesis of the research project is briefly mentioned; the researcher will keep all the above in mind when analyzing the final data as well as during the interviews to ensure a just and dependable outcome.

Chapter 5

5. Results of Empirical Research

5.1 Introduction

This chapter outlines the research findings and themes that were revealed in the interviews and subsequent analysis.

5.2 Criteria for the selection of these particular subjects

The researcher chose 4 mothers based on their experience of raising children with ADHD and attempting to find an intervention that works best. All 4 of the subject's chosen have more than 1 child, and they are between the ages of 35 – 48 years old. One of the mothers does not work and stays at home with her children, another mother works part time and works from home, the third mother works full time, while the fourth mother has a business away from the home but only works mornings. The researcher chose this intentionally in order to have four different groups, that is:

- Mothers that don't work
- Mothers that work part time
- Mothers that work full time
- Mothers that have their own business

This selection was to ascertain if being at home, or working made any significant difference in their experiences in dealing with their ADHD child. The researcher is aware that the prejudice surrounding the administering of ADHD includes slating the parents who are unable to discipline their children adequately and seek

medication in an “easy way out” to cope effectively. She hoped that choosing mothers with different working routines would nullify that option.

In searching for the appropriate subjects, school principals were approached to enable a fair and random selection to take place. Prior to the final selection, which involved biographical information from each of the interviewees, she purposefully chose mothers from the four different working groups.

All mothers were married and had several children. Two of the mothers have more than one child officially diagnosed with ADHD. The children in question were diagnosed between 5 years and 11 years old. The researcher has tempted to keep the variables similar in an attempt to relay their shared experiences as accurately as possible. In her attempt to obtain mothers with similar backgrounds, she hopes to ensure further reliability to this study.

None of the mothers knew about the other mothers and each interview was personal and exclusive. The confirmed diagnosis of ADHD, the child’s ages when diagnosed, the mothers working background and a basic high school education served as the criteria for the choice of subjects. No specific gender for the child was required and the fact that it turned out to be all boys is merely coincidental. A description of the individual subjects is listed hereunder. Their real names were not utilised to protect their identity.

5.3 Mothers Interviewed

5.3.1. Subject no. 1

Subject no. 1 is 36 years old, her son who has been diagnosed with ADHD is 14 years old and his name is Michael. He has a brother of 17, and a sister of 12. Subject no. 1 and her husband Wayne

divorced 6 years previously and she is now living with a man and his three children whom she intends marrying in the not too distant future. The divorce was messy and unpleasant, however the new relationship is settled and calm. The “new” family have 6 children between them, while Michael’s biological father has remarried and has a new baby. They are all living in the upper class financial bracket with no issues regarding money.

Michael was diagnosed with ADHD after numerous attempts to sort out problems he had with his schooling. He was only tested at age 10, in 2001 by a paediatrician who diagnosed him with ADHD. Prior testing started in 1999 but was put down to emotional problems due to the divorce.

Subject no. 1 had always been concerned about Michael and found him to be a handful, however, she put this down to “boys will be boys” behaviour. She never pursued the ADHD line of thought as no one mentioned this to her. It seems as though she blamed Michael’s behaviour solely on her disruptive and traumatic divorce. This was a time of enormous emotional upheaval for the whole family and she naturally assumed that this was attributed to the divorce. She felt that Michael’s manifestations of problem actions were a response to the family’s rejection of the parting of her and her husband.

Subject no. 1 does not appear to find Ritalin a huge source of help in alleviating the ADHD symptoms he appears to portray. Indications suggest that Michael has other problems that Ritalin is unable to assist. She mentions that he was diagnosed with oppositional disorder. However, it was interesting to hear her experiences of administering the Ritalin and subsequently removing it.

She did not seem to experience any particularly negative feelings, except that she was certainly averse to giving a child drugs to change his personality. Her sense of helplessness seems to come from the ADHD itself rather than the administering of the Ritalin. Michael's symptoms were typical of ADHD sufferer's but because he displays other more serious symptoms it seems to shadow the concentration and impulsivity. Subject no. 1's awareness was seriously uninformed regarding this disorder as well as the medication used to alleviate the symptoms. She did attempt alternative remedies, such as diet, however, she did not monitor the effects consistently and seemed unimpressed with the results.

Subject No 1 was clearly negative towards administering Ritalin, and she pointed out that she is adverse to any form of medication, particularly in the case of her children. She repeatedly mentioned that the strength of Ritalin and its mind-altering consequences made her afraid. Although she felt this negativity toward Ritalin she was prepared to try this form of treatment because she was at the end of her tether regarding his behaviour. She admitted to feeling guilty and blamed herself for issues at home and in particular her tumultuous divorce. She afforded herself blame over the appalling circumstances of the marriage dissolution and was thus prepared to try almost anything to alleviate the problems she had with Michael and his behaviour.

On the whole, Subject No 1 did not find Ritalin to be sufficient a treatment for her son's behavioural problems and thus took him off the medication. Teachers had initially recommended Michael be checked and assessed by an expert to assist him with his conduct. Subject No 1 took him to a psychologist she was seeing for his behavioural problems and they suggested she try Ritalin because he

appeared to have all the ADHD symptoms. She claimed that if the teachers had liked him more, perhaps they would not have suggested Ritalin in the first instance. Although she was angry toward the school and the teachers she seems to have felt overwhelmingly helpless about the disorder and negativity toward the medication of Ritalin. Initially she was hopeful that Ritalin would finally be the remedy to alleviate Michael's symptoms of negative behaviour. This hope was soon dispelled when she became aware that there was not much difference in the way he responded.

5.3.2. Subject no. 2

Subject no. 2 is 35 years old; her son who has been diagnosed with ADHD is 10 years old. He has a younger sister of 7. Subject no. 2 and her husband are married and have been living in Johannesburg for the past 4 years. Prior to that they lived in Cape Town where both their extended families reside. They are financially comfortable and live in the middle to upper class financial bracket. After numerous tests and meetings between teachers, practitioners, paediatricians and other experts they were informed that their son Gavin has ADHD. This diagnosis was made at preschool at age of 6. Their home life is settled and they appear to be happy and content.

Subject no. 2 and her husband were both extremely distressed to be told that their son is ADHD. It appears that she accepted it easier than her husband David who seemed to regard it as a weakness. David's disappointment became an added burden for his wife, as she felt responsible and guilty.

It is clear that Subject no. 2 has tried everything she possibly can to assist her son with this diagnosis. She does not seem to leave any stone unturned regarding treatment or ongoing information. Her knowledge of the subject is profound and she is very realistic regarding the prognosis. Although she is not happy administering Ritalin, she has not found an alternative source to alleviate Gavin's symptoms. She has found a huge improvement in his behaviour since taking Ritalin. He works diligently and quietly; he does not have the need to jump up and down repeatedly. His concentration shows a dramatic improvement, he does not pick on his younger sister constantly.

She continues seeking knowledge on this subject to keep herself informed and to attempt to alleviate any guilt feelings she may experience. Subject no. 2 seems to have come to terms with the fact that her son is unable to cope without Ritalin, until something better comes onto the market. However, she keeps a constant watch on his progress and behavioural activities. She maintains that she would recommend Ritalin to other mothers, but only if they are prepared to go for constant monitoring by a qualified person. She has satisfied herself that no other intervention she has attempted, has had the positive effect that Ritalin has. It still concerns her that the medication is mind altering and a schedule 7 drug, but consoles herself with the thought that his behaviour on medication is far preferable to without medication. Furthermore, it helps her son to cope with his schooling and homework.

Subject no. 2 seems to have experienced enormous guilt, negativity and fear towards administering Ritalin, however, she accepted the challenge and was able to find hope to continue. This has changed her negative experience to a positive one. This seems to be due to

her extensive learning and educating herself regarding Ritalin and ADHD.

Subject no. 2's experience definitely started as negative and appeared to continue that way until she had exhausted every avenue of treatment. It seems that the dramatic improvement in her son's behaviour has forced her to acknowledge that there is some good to this drug. She tackled Gavin's diagnosis with a steely determination, set out to treat it as a challenge and finally reached a tranquil compromise. Because her son's behaviour has improved so much it has removed the initial bad experience from her. She looks at Ritalin in a positive way and does not suffer with any feelings of helplessness or guilt anymore. Thus Subject 2's initial feelings of negativity and fear of this unknown drug became optimistic when she finally attempted to prove to herself the effectiveness of its worth.

5.3.3. Subject no. 3

Subject no. 3 is 49 years old; her son Dudley was diagnosed with ADHD is now 15 years old. He has two older brothers, one is 21 years old, and the other is 19 years old. They are financially very well off and live in the upper financial bracket. Subject no. 3 does not work for a living and has been at home raising her boys since she was married. Her husband is a very high-powered businessman and hands on father at all times.

Dudley was diagnosed at the age of 8 after numerous meetings with teachers, doctors and psychologists. Subject no. 3 was informed that Dudley had serious concentration and distraction issues; however, she did not pay too much attention as she felt that all her boys had

been rather active. Furthermore, the family had suffered some trauma where the father's life was in danger, involving very powerful members of a conspiracy whose business dealings had gone sour. They subsequently threatened his life, and intimidated him and the family. Subject no. 3 thought that perhaps this was the reason for his ongoing hyperactivity and other symptoms. She assumed his behaviour was a consequence of this tumultuous event. Therefore the family did not agree to have him tested at that time.

However, when this behavioural pattern persisted, the family decided it was time to have Dudley tested; he was immediately diagnosed as hyperactive and distracted, and that he required Ritalin to alleviate the symptoms and assist him in coping with his concentration. Subject no. 3 claims that she is unable to recall that Dudley was given a label of ADHD, but she was informed that he was extremely hyperactive and inattentive and therefore they recommended he be treated with Ritalin. It was my sense that Subject no. 3 and her husband struggled to come to terms with there being anything "wrong" with their son. The label appeared to be difficult for them. Quote from the interview: *"Yes, so I don't know if there was a problem in the first place? I really don't?"*

Subject no. 3 denied any diagnosis of her son Dudley. It seems that she and her husband were reluctant to believe teachers when they mentioned that their son needed testing. She does not mention her husband's feelings much, but continues to claim that he had concentration issues which she seemed to accept more and more as the interview progressed. She also had behavioural issues with her older son Patrick whom she also treated with Ritalin. The same psychologist recommended she medicate Patrick with Ritalin in an attempt to alleviate the symptoms of his hyperactivity, lack of concentration and impulsivity. She appeared to let him decide if he

wanted to take Ritalin and was not really a part of that choice. She also kept Dudley on Ritalin for a substantial amount of time, but eventually decided that he too could end off taking the drug. She mentions having felt guilty about administering Ritalin to such a young child and had a fear of it having lasting side effects. She commented on side effects being liver damage as she felt that any medication could damage the liver. This was her own assumption which she was afraid may manifest. Dudley was in Standard one when he started taking Ritalin, which she felt was very young. She felt more comfortable when the older son was in Standard 7 and began administering Ritalin. It seemed that she was more comfortable because the older son made his own decision, but she was forced to make the decision for Dudley because of his age. This seemed to be a problem for her.

Subject no. 3 expressed helplessness and struggled to contain her anger and sadness at having to administer Ritalin to enable her son to cope sufficiently. She was very concerned regarding the effect that Ritalin might leave on Dudley. She was afraid of long-term damage to other organs as well as his “out of space” personality when on the drug. It did not appear that she had much faith or hope in the drug, but merely treated him because of school pressure. It was also clear that when her older son took Ritalin she did not face the same fears and negative experiences because she felt that he was older and thus could be in charge of his own future.

Subject no. 3's experience with Ritalin was not a positive experience as she felt it changed her son's personality. She agreed that it did assist Dudley to concentrate but the price was too high to pay. Initially in the interview she was angry regarding the apparent diagnosis and the suggestion that her son had a problem. She had a different

experience with her older son Patrick who she felt could make his own decision regarding the administering of this drug. She was not happy at having to make this same choice with her younger son and took blame for this.

5.3.4 Subject no. 4

Subject no. 4 is 42 years old and has two sons diagnosed with ADHD. Jason is 9 years old and Dylan is 6 years old. Subject no. 4 and her husband Stephan struggle to earn a living, however, they are not impoverished. Both their sons, Jason and Dylan, were suspected of being ADHD at preschool at the respective ages of 5. Psychologists confirmed this diagnosis at age 6. The family is extremely close and appear to be happy.

Subject no. 4 was strongly opposed to her sons taking Ritalin and fought this as a treatment method for as long as she was able. However, she eventually succumbed to this treatment because nothing else had much effect. She voiced her extreme negativity regarding administering the Ritalin but acknowledged that it did improve Jason's concentration and his schoolwork. However, she noticed that he lost weight and as he is a particularly small child, it bothered her, she also commented that he was "spaced out."

She was not prepared to continue administering the drug and made alternative arrangements to their life style. She recruited an au pair girl and had both the boys shown one on one treatment, which helped their schoolwork. She was not particularly concerned about their symptoms over weekends and in the evenings as she felt boys should

be boys. She was, however, deeply concerned about their schoolwork.

She is adverse to Ritalin as a treatment for her children but is quick to mention that each parent should assess their own child and make a decision based on their individual experience. Both her and her husband feel that although Ritalin improved their sons' concentration at school the benefits did not outweigh the negatives. She saw a dramatic difference in his personality and was not prepared to continue this as a source of treatment. She found that one on one undivided attention worked better and eased her conscience regarding the administering of this drug.

Subject no. 4 feels strongly that Ritalin is a "drug" which should be treated with extreme caution and is also afraid that her son could become an addict later in life. She opted not to place her younger son on Ritalin; instead she hired an au pair girl who assists him with his homework and after school activities. She is comfortable with this decision as she feels she is doing the best for her children without resorting to the extreme measure of administering a schedule 7 drug to her boys.

Subject no. 4 handled the entire experience as a challenge. Firstly she claimed that she was in denial and felt helpless at the diagnosis, however, she opted to educate herself regarding the disorder and the treatment. After attempting various treatments and finding them lacking in symptom relief, she opted for one on one education. She felt this made the difference, and clearly gave her hope. Overall she emphasised that anything she was able to accomplish to assist her boys, was better than the option of administering Ritalin. Her personal experience about administering Ritalin was fraught with fear and

negativity. This comes about through media coverage, friends talking and her son's symptoms while he was on the medication.

Subject No 4 expressed anger at teachers and the schooling environment and felt that it is an easy way out for teachers to suggest to children that are active and boisterous, to take a drug like Ritalin. Once she overcame her initial fear and helplessness she tackled the issue as a challenge and obtained any information she could regarding this disorder and the treatment on hand. Her primary feelings of guilt were replaced by anger and ultimately hope as she found ways to overcome her boy's behavioural problems. Her awareness of the condition and the different treatments have afforded her a sense of peace although she sticks by her assumption that it is really the teachers who are lazy and inept when it comes to dealing with hyperactive children. Finally she argues that one on one teaching and attention is what alleviates the issues surrounding ADHD and not Ritalin.

5.3.4.1 Appendix B:

A Verbatim extract from subject No. 4's interview:

R + Respondent

I = Interviewer

I: Good Morning, as I discussed with you, I'm going to interview you about your son Jason, and also about Dylan... if there is anything.... And to give me some background. Would you please tell me how old you are, where you live, your children's ages, and just some general background?

R: Ok, Um, I'm 42... almost, live in Victory Park. My kids go to King David, Jason is in Grade 5, he is 10 years old, and will be 11 in September. And Dylan is 6 and will be 7 in July.

I: Ok... ok... and you only have the two children?

R: Only the two children.

- I: *Ok... when were you aware there was something with Jason?*
- R: *Um, in pre primary...*
- I: *Nursery school?*
- R: *In Grade 00, before he went to grade one.*
- I: *Was that at King David?*
- R: *King David. They do these assessments every couple of months.*
- I: *On all the children?*
- R: *On all the children, um, normally on the children who have the problems, so they (the school) try and keep the parents involved. They try letting them know what is going on with their kids, and they picked up that... early in the year... that his concentration level was very bad. He was fidgety, he couldn't sit still, he couldn't focus, he couldn't finish his tasks, and um he was very fidgety.*
- I: *Ok, how old was he at that time?*
- R: *I think he was 5.*
- I: *Five ok. Grade 00?*
- R: *Yes.*
- I: *Ok, and they did the tests after how many months?*
- R: *Well, they (the school) give me a report saying that they were worried about his lack of concentration, lack of completing his tasks, lack of, um, he was fidgeting in class, so um...*
- I: *Ok...*
- R: *So, they (the school) then decided that I should then take him for an assessment*
- I: *Ok...*
- R: *So, before that they (the school) advised that I should maybe take him for OT – occupational therapy because he needed more fine motor coordination, he needed to work on that...*
- I: *Ok...*
- R: *His...um... they (the school) weren't very happy with that, so, they then said that his concentration was a problem so then I took him for a proper assessment.*
- I: *It doesn't matter if you can't remember the name, but was it a psychologist?*
- R: *It was a child psychologist*
- I: *Ok, ok – Did they (the psychologists) do tests, or what did they do?*
- R: *What she did was um... she... I left him there. It was a Saturday morning and I left him there for the morning. I had to leave him there. It was all morning.*

I: Mmm...

R: And then I had to go back a few days later and get the report from her.

I: Ok...

R: And the report was that he was definitely a Ritalin case, they (the psychologists) suggested that he be on Ritalin.

I: Did the psychologist say that you should take him to a neurologist or any other specialist...to confirm her findings?

R: No, no...

I: Or did she do it on her findings?

R: No, she did it on her findings. The report was that he should be... that he would benefit greatly on medication. That was what the report said.

I: Ok...

R: She was a forensic psychologist, that's what she did, so she was quite high up, she was pretty well recommended.

I: Ah ha...

R: She came very highly recommended

I: Ok, what did you do when you found out about that, what did you feel.

R: I...I...I... was pretty sad, but I wasn't in denial, definitely not. I thought well where do I go from here. And I thought there is no ways I am putting my kid on Ritalin. Let me tell you there's no ways, so I took him to a Professor, he's an herbalist, what do you call it?

I: Ah...um...

R: What do you call it, a homeopath?

I: Oh Ok, a homeopath

R: He's a professor of homeopathy, and he gave me a whole bunch of suggestions. So, I changed his diet, I got books out, I went onto the internet I... you know I read up on it, I spoke to parents, I got quite involved and they said that maybe I should change his diet which I did.

I: And did you see a difference?

R: No not really, very mild. Um... look the kid... I found him very active, hyperactive, but for me that was normal because he's always been like that so it wasn't like do I see a difference, yes, I sort of watched what I bought, so I thought keep an eye on MSG and all those colourants and all that stuff but you cant block it out completely, the kid's got

birthday parties and they go ballistic, so I couldn't... I tried to control, but I couldn't do everything?

I: Mmm...

R: And I wasn't obsessed with it, if you know what I mean.

I: So what did you do... did you just leave it?

R: So I just kept him on this medication cause they said salmon oil is very good so we tried to keep him on it, but the tablets were too big, so he was very small, so I wasn't stressing myself out, and I wasn't stressing my child out and we did as much as we could we kept on with the homeopathy, we did as much as we could but we didn't see much difference. But for me, he wasn't a failure at school. He wasn't failing outright, he was passing, he wasn't doing brilliantly but he wasn't a total failure.

I: How did he feel about being diagnosed?

R: I don't think he understood, it wasn't something we sat down at his stage and discussed, I mean I said to him that you can't have sugar every day, we have to watch stuff because you are hyperactive. On the weekends you can whatever you like, but during the week try not to have this that and the other. I mean 6 years old, 5 years old...

I: And your husband Stephan how was he?

R: Stephan was... look he was um...um...he wasn't really, um...he left it to me...um Stephan wasn't sort of... um...

I: There were no big feelings?

R: No, No...

I: One way or the other?

R: NO, No...

I: And from your side either?

R: No, No, because I think I was pretty hyper as a child

I: Ok...

R: I definitely, guaranteed was hyperactive, and Stephan reckons he was pretty hyperactive at his age – he didn't excel at school, neither did I, um... we are both pretty fidgety people who cant keep still, we... I think because we are like that, its, um...

I: ...no big deal?

R: No big deal!

I: And the school? What did they...

R: *The school made a huge big deal out of it. Oh no he must go on Ritalin and you must medicate him, and you must do this, and you must do that, and, you know... and I thought... No! Not yet! I wasn't ready to medicate him yet!*

I: *And then what was your next step, did you leave him in Grade 00 with nothing?*

R: *Grade 1 nothing, Grade 2 nothing, Grade 3... I can't remember, um... I can't, um... yes, Grade 3 yes.*

I: *Was the work becoming more difficult?*

R: *The work... Ya... I thought you know what, maybe I should give it a bash, um... because of all...*

I: *mmm...*

R: *So, I took him to Gillian De Vos*

I: *OK...*

R: *I took him to Gillian.*

I: *Is she a psychologist?*

R: *She's a psychologist specializing in ADHD*

I: *OK... ok.*

R: *So I took him to Gillian and we did another assessment and she said to me. "Look, lets give it a try", and I felt... I mean I had exhausted all those avenues, and I couldn't really see a difference I mean the homeopathy, the medicine the this the that I couldn't see a difference, I mean I thought this is my last resort let me give it a bash, so I did. And, um... I found that yes, I did see an improvement in his marks, I saw a huge improvement in his marks he focused better in class, but I wasn't happy, with him being on medication...*

I: *Why?*

R: *Because, um... he lost a lot of weight, I would talk to him and he would seem spaced out. To me he looked like totally on drugs.*

I: *So you saw a difference in his behaviour?*

R: *I saw a huge difference*

I: *In his behaviour?*

R: *He was... he wasn't my child, the kids were...I mean... you wouldn't mistake that my kids weren't around, they are so loud and noisy, and all of a sudden I had this quiet little child who didn't have a sense of humour any more, I mean...he wouldn't smile any more, I mean he was so withdrawn. And I was not happy with that hey.*

I: *So, just to recap. After your tried for about 4 years of diet and ...*

R: *Everything...*

I: *Homeopathy and vitamins and everything...*

R: *Melatonin and...*

I: *You decided, ok now you'll try the Ritalin?*

R: *Yes*

I: *How did it feel now that you decided to do the Ritalin? Did you have any great feelings or did you just go into it thinking...?*

R: *I thought miracles... miracles are going to happen now that he was onto this medication that I had heard so much about, and...*

I: *Were you kind of expecting a miracle?*

R: *And I was scared, I had tried so long not to put him on it?*

I: *Why?*

R: *I did a lot of research and watched a lot of programs and heard that children that take Ritalin often have drug problems later in life. I didn't want my child to be a drug addict... I suppose I was scared...*

I: *mmm.... How long was he on it for?*

R: *We did it for almost a year.*

I: *What did he say about it?*

R: *He hated it. He hated it.*

I: *Why?*

R: *He didn't want... because he... he couldn't eat, he would say "Mommy this medication ... I don't feel hungry.*

I: *Ok...*

R: *And he was lethargic and he wasn't... he wasn't himself, and he could see the change in himself*

I: *So he could see his personality was different... was he pleased that his marks were better?*

R: *He was pleased that his marks were better but they, it wasn't... there was definitely an improvement in his marks.*

I: *Homework?*

R: *Homework was done, but he wasn't happy, Jason hated being on that medication, he hated taking that tablet in the morning*

Further on in the interview:

I: How did you feel now that you had tried it but it didn't work for you? Were you relieved, happy, sad, what did you feel?

R: You know what –I was happy that I had tried it cause at least I could at least say I did try and I could say that I didn't block it, because I think at the beginning I did block it, I blocked it totally because it was more, it was more that I didn't want to medicate the kids at such a young age – you know for me, I didn't want the kids on medication, and yet, I'm glad I tried it because I had proof that I wasn't happy and my son wasn't happy

I: Ok, so what would you recommend, I know its an unfair question but, would you recommend, "Try it, or don't try it" or...

R: Try it, because I mean there is no harm in giving it a bash because you know kids react differently. Maybe when he's a bit older, like now...

5.4 Interpreting the data

When interpreting the data, the researcher needs to be acutely aware of the actual experience of the interviewee, if any, as subjectivity may be a danger. The analysis should be over a substantial period of time to allow the researcher to develop an awareness of any phenomena that may occur while examining the transcripts of the interview. The author is conscious that different people may depict their experiences differently making subtle innuendos more difficult to trace. Qualitative research emphasizes the uniqueness of the human state, so that disparities and/or similarities in experience, rather than substantiation are required.

Dependability and constancy are primary criteria's for the outcome of this research. They are essential elements for the credibility of this research project. Therefore, the author is seeking a consistency in her findings. She will describe, classify and interpret her findings, which involves identifying the salient themes.

Categories of meaning emerge from these interpretations and this shall be portrayed in her results (de Vos 2002).

Giorgi's (1997) description of the methodological steps used in the phenomenological research analysis is helpful in the interpretation of the collected data. His approach is holistic and includes the researcher reading through the transcripts repeatedly before commencing with any interpretations, to enable her to get a sense of the whole. He recommends a search for themes, which is essential for any phenomena being scrutinized or studied (Human, 2002). This process will be repeated for each subjects interview material. It is important to do this several times, with decent intervals in between to allow one to reassess the common themes. This will also enable the researcher to pick up any frequent ideas, if any, that emerge between each of the different subjects experiences and feelings. Only then will it be possible to select any common experiences or emotions the mothers may have experienced.

The researcher will conduct the interviews in an appropriate and confidential manner and transcribed the oral information into a written text. Thereafter, she shall approach the analysis phase which incorporates discerning the meanings of the interviews and bringing the subjects own understanding into the forefront while seeking relevant essentials pertaining to her hypotheses.

The researcher will find it essential to read and re read the transcribed interview until a sense of totality is obtained (Taylor & Bogdan, 1984). It is important to be aware of intuition, hunches, themes and interpretations when listening and transcribing the material. The analysis of research data does not necessarily provide the answers to the research question; an interpretation is essential, and to this end one needs to find explanations and meanings within the narrative (De Vos, 1998). The researcher will at all times be aware that in analyzing the data and even during the interview process, she will still be informing her "truth" as it is

not possible to give an uncontaminated “truth” without including her own ideas, experiences and world view.

Data analysis involves reducing the information to manageable proportions and attempting to identify the different themes and patterns that may emerge. According to Miles and Huberman (1994:10) and Denzin and Lincoln (1998:180) data reduction is a part of the data analysis.

The data in this research will be processed as follows:

- Data will be collected through interviews and transcribed verbatim
- The transcribed data will be read through numerous times to gain a sense of the subjects’ experiences.
- The main themes as well as patterns, similarities and hunches shall be noted. According to Miles and Huberman 1994, clustering the information allows for a better understanding of a phenomenon as it allows for grouping and conceptualizing the data with similar characteristics.
- The themes that emerge from this data will be displayed in matrices with raw data quotes from each subject to support the validity of the category that in turn will allow for hypotheses and recommendations to be inferred (Lazarus 2002).

5.5 Analysis Procedure

Henning (2004:127-128), describes the way various authors’ progress with the analysis procedure:

- Qualitative analysis takes place throughout the whole data collection process. The researcher must be aware of impressions, relationships, and connections between stories while collecting the data. She must reflect all

the while she is interviewing the subject. Furthermore, she must check for similarities, differences, categories, themes, concepts and ideas that form part of this process.

- An analysis begins with reading the data and then dividing the data into smaller units that become more meaningful
- Data segments are organized into a system that predominantly results from the data, which suggests that the analysis is inductive.
- The researcher must use comparisons to obtain and refine categories and to define similarities and seek patterns that emerge.
- Categories are at all times flexible, and may be amended or modified during the analysis process.
- Most important is that the analysis is as true a reflection of the respondent's perception as is possible.
- Ultimately, the result of the analysis should be a sort of higher order synthesis in the form of eloquent pictures, patterns, themes or rising or substantive theories.

According to Henning et al (2004:128) “ Meaning is inherently ambivalent and context dependent; hence, you cannot rely on the respondents' intentions as an incontestable guide to interpretation.” The researcher will be watchful of her own personal world view, her discourses, her intentions and consequently the outcome of the analysis being as fair and objective as is truly possible when dealing with the human element. The classification of data is an integral part of the entire process because it makes the entire interview process more meaningful. Without the classification, there can be no evident way of making true meaning of the data. Patterns need to be sought, and any variations need to be examined. Therefore, the aim of the collection of the data is to categorize the information, and to code the data into more meaningful descriptions.

5.6 Mothers Experiences:

5.6.1. Theme 1 (See Appendix D) Mothers Initial Emotions Experienced:

After the researcher interviewed each mother and began analyzing the data, which included reading and rereading over the transcripts numerous times she made lists of the various emotions experienced and arrived at different themes. The first theme that emerged is listed in a matrix in Appendix D. She identified the initial emotions experienced by the mothers as 'helplessness', 'guilt', 'anger' and 'negativity and/or fear', which appear to be the core elements of their early reaction to their child or children being diagnosed with ADHD and having to administer Ritalin as a treatment method. The matrix gives an indication of how the feelings emerged and how each individual mother dealt with her experience. The mother's responses are quoted verbatim to assist the reader in sharing her profound experience.

5.6.2 Theme 2 (See Appendix E) Mothers experiences after awareness:

Matrix E shows different experiences such as 'hope', 'awareness and/or denial', 'challenge' and 'warning signs' that emerged after the mothers became aware of the disorder and had obtained some information regarding the disorder and the various options of treatment. Once again, these themes emerged only after the researcher had repeatedly analysed the transcripts and sought comparable findings in the mother's experiences. These themes were captured and quoted verbatim in Appendix E in a matrix with suitable headings for ease of reference.

5.7 Conclusion:

This chapter dealt with the interpretation of the data and the emerging themes were discussed. The results and overall findings are summarized in this section. A detailed matrix of the different feeling experienced by the mothers appears in Appendices D and E. The researcher included several pages of one interview in its entirety showing the subjects own language and descriptions. This appears in Appendix B.

Chapter 6.

Findings, Recommendations and Conclusions

6.1 Introduction

In this chapter the researcher will discuss the findings from the literature study and the empirical research. The hypotheses as stated in Chapter four would be accepted or rejected. The shortcomings or limitations of this study will also be discussed. In conclusion, recommendations will be made.

6.2 Literature Study of main findings of the study done in Chapter 2 and Chapter 3 – The role of Ritalin

Ritalin is the number one intervention for the treatment of ADHD. However, Ritalin is a schedule 7 drug that has mind-altering properties. Parents are afraid of administering this drug to their children, as they are fearful they will become addicted or cause them to become substance abusers at a later age. In many instances children have a personality change whilst taking Ritalin. It appears to make some children apathetic, quiet, “spaced-out” withdrawn and also a loss of appetite. The media play a profound role in the experiences that the mothers undergo. Privately they may long to administer this drug to assist themselves and their children in coping, however, with the hype and publicity surrounding Ritalin it makes people uncertain and places parents in a quandary.

There are countless articles, journals, books, videos and radio shots exposing the negative effects of this drug. Experts in the field also have entirely diverse outlooks and attitudes about this disorder and the ways it should be treated. Lay people often forward their advice knowing very little about the profundity of this

syndrome. This is a relatively new disorder and accordingly has many complexities and uncertainties pertaining to the diagnoses and the treatments thereof. As can be noted from previous chapters and the literature studies, Ritalin is the number one treatment available for ADHD sufferers; however, the ambiguity surrounding this disorder, as well as the severity of the treatment causes the general population endless dilemmas.

The following findings were evident from the Literature Study:

All the mothers experienced negativity and helplessness regarding the administering of Ritalin as a treatment method. Mothers were afraid of placing their child or children on Ritalin. They were afraid for a number of reasons being:

1. The mind altering effects of the drug – 4 out of 4 mothers
2. The schedule 7 factor which makes it a profoundly strong medication – 3 out of 4 mothers
3. The 'spaced out' or listless behaviour of the child – 4 out of 4 mothers
4. That perhaps the child would become a drug addict later in life because of this dependency on Ritalin – 1 of the mothers
5. Not being able to alleviate the symptoms without taking Ritalin - 4 out of 4 mothers
6. The fear of the after effects of this drug – 3 out of 4 mothers.

6.3 Findings from the Empirical Research

The findings in the literature compares with the findings of the empirical research, and the matrices found in Appendices D and E categorize the various experiences that seemed to have emerged across the 4 subjects. These experiences of emotion have been quoted and documented verbatim from the audiotapes from the interviews in question. These following themes emerged:

- Feelings of Helplessness

- Feelings of Guilt
- Sense of Anger
- Feelings of Negativity and/or Fear
- Sense of Hope
- Deeming the diagnosis and treatment method as a Challenge
- Having an awareness, or being in denial regarding symptoms, diagnosis and treatment
- Noticing the warning signs.

Almost all the mothers seemed to feel helpless and guilty initially, however, this did not appear to last long. 3 of the 4 mothers experienced guilt, while 4 of the 4 mothers experienced helplessness when faced with the diagnosis and subsequent treatment methods available. The mothers who took it upon themselves to seek further information and assistance tackled the issue as a challenge. 2 of the 4 mothers treated the experience as a challenge once the initial realisation had been accepted; they sought information and knowledge regarding the disorder and all the options that may be available. 4 of the 4 mothers attempted alternative treatments before administering Ritalin. They all agreed that the diet recommended did not have an affect of alleviating the symptoms. It seemed that the awareness rather than denial was a factor in becoming more positive, because as one mother claimed, she was at first in total denial but after grappling with the diagnosis she opted to arm herself with knowledge on the disorder and treated the whole experience as a challenge. Another mother maintained that she always had an inkling that something was 'wrong' but after being advised that her son had ADHD, she decided to find out all possible means of treating the disorder. She went forward gaining all the facts she could obtain regarding the disorder and treatment methods. This awareness encouraged her to be more positive regarding the treatment and thus her experience became more optimistic. All four of the mothers were negative and fearful because of having to 'drug' their child. All the mothers voiced concern regarding the administering of a schedule 7 drug, which they were afraid could

have long-term serious repercussions. The symptoms and warning signs experienced by all the mothers were similar, as was the negativity and/or fear. This experience was almost the same for each of the mothers concerned. The symptoms included hyperactive behaviour, inability to concentrate, fidgety, can't sit still, and in two of the four cases aggression.

Anger was not a large factor, as this seemed to be an experience that was more fleeting, that is, the mothers did not initially want to place their child or children on Ritalin, and was linked to their feelings of denial. 3 of the 4 mothers experienced anger but apart from one of the mothers this soon disappeared and was replaced by hope. One of the mothers was still angry when she was interviewed. She felt that teachers were lazy and not doing their jobs properly.

Hope was experienced fairly equally by all the mothers; they hoped that firstly the diagnosis was incorrect and then they hoped that they would be able to treat the symptoms without Ritalin. Every mother shared that "hope" that her child would not need to have Ritalin administered as a treatment method. They all tried alternative measures which did not prove successful, thus they all resolutely resorted to administering Ritalin as a final measure to attempt to alleviate the symptoms.

6.4 The Mother's Experiences:

The researcher interpreted the findings after clustering the similarities in experiences together. She went back and forth between the data to achieve a relevant theme that is unbiased and impartial, but being aware of the difficulty of keeping her own presuppositions at bay (Tesch,1990).

The researcher set out to discover if mothers who administer Ritalin to their children share similar experiences, because in her world she had come across many mothers who voiced negativity and fear in this regard. She sought to

distinguish if mother's experiences of Ritalin being administered were riddled with pessimism as she had believed when confronted with the literature, the media and also one to one in private.

According to her findings, it appears that mothers do find the experience of administering Ritalin to be a negative one, however in this small study one of the four mothers experience turned out to be positive as she experienced a dramatic constructive change in her son, which altered any negative feelings, she originally experienced. Nevertheless, she was extremely opposed to utilising Ritalin initially and also experienced emotional turmoil at the prospect. Thus all the mothers' experiences of Ritalin caused emotional upheaval and various disturbing feelings as expressed in the attached matrices in Appendices D and E.

Willig (2001:55) contends that the theme titles should capture something about the essential quality of the heading that is represented in the matrix. She argues that the researcher's decision of which themes to capture and which to be abandoned will inevitably be influenced by the phenomenon under investigation. The aim of this interpretation is to capture the mother's experiences and to unravel the meanings, bearing in mind the limitations of language, and the awareness that one is seeking to understand the actual experience, that is, 'what it is like' to live in a particular situation (Willig 2001: 62).

The data collected from the unstructured interviews allowed the researcher to pinpoint the different and similar experiences and emotions the mothers went through when being advised that their child was diagnosed with ADHD and Ritalin was the recommended treatment method. The issues that became clear from this study, were that all the mothers in this selection shared similar experiences. Focus was placed on their experiences regarding administering of Ritalin rather than the diagnosis of the disorder itself, although they are interlinked and one cannot help mentioning one without the other. According to the mothers, subtle innuendoes, the patterns of the interview, the observations, the spoken and unspoken words, the following themes emerged:

6.4.1 A Sense of Hope:

The information revealed from the data collection showed mothers as feeling hopeless initially when they are summonsed concerning their child's behaviour. This hopelessness is exacerbated when they are informed their child is suffering with ADHD, and will require long-term medication, and specifically Ritalin. Thereafter various emotions are experienced, but they all seemed to feel hope when they finally accede or consent to administering Ritalin. Subject No. 2 postulates, "And we gave it to him for 2 weeks and there was such an improvement the next day – it was unbelievable, even his hand writing."

Interestingly, the researcher became aware that each mother tried alternative methods before resorting to Ritalin, and some were more hopeful than others that a lower dosage of Ritalin would be sufficient treatment. There seemed to be a hope that these alternative treatments might help in assisting their child with the symptoms at hand. Finally, it seemed that overally the hope was that the first diagnosis may be incorrect, or that the teacher, or caregiver was mistaken in describing the signs. Some mothers felt almost relieved that Ritalin may assist their plight with the doubt and uncertainty they were going through regarding their child's behaviour.

6.4.2 Having awareness, or being in denial regarding the symptoms, diagnosis and treatment.

Two of the four mothers were clearly in denial or had no knowledge of ADHD, Ritalin, or anything related. Subject No 3 states "Yes, so I don't know if there was a problem in the first place? I really don't?"

The two mothers that were aware had very different outcomes but made certain that they armed themselves with knowledge regarding the disorder, the symptoms and the treatments. Subject No. 4 stated “So, I changed his diet, I got books out, I went onto the internet, you know I read up on it, I spoke to parents, I got quite involved...”

It seemed that in general it was a difficult realization for all of them. When gaining information, they once again had different reactions. All of them were opposed to Ritalin as a treatment; however, they all succumbed to this as a last resort. One of the mothers claimed that perhaps her son never really had ADHD, two of the moms was relieved that something was diagnosed and the fourth mom tried repeatedly to disprove that her son was ADHD instead of merely lacking in concentration.

6.4.3 Deeming the treatment and diagnosis as a Challenge

The researcher is aware that raising children is already a huge challenge, and particularly in our society today where everything is hectically fast paced and frenetic. Thus, a problem of this nature affects the entire family and needs careful consideration regarding management and outcome. With all the media hype and well-intentioned friends and family, the parents are afraid to be seen as taking the easy way out and resorting to an easy fix to modify the child’s behaviour. Therefore, this exacerbates the challenge each mother is faced with regarding this disorder and ultimately the management of the child, as well as the consequences and effects to the entire family.

Initially all the mothers found both the diagnosis and the treatment method as a challenge, however, some more than others. Subject No. 2 asserted “Um... I was initially anxious, maybe not even a strong enough word, and now I’m really happy – It’s a relief!” This mother was almost relieved that something might help

her son with his behavioural problems, the second mother was extremely concerned regarding an addiction to Ritalin and made it her business to watch him at all times. The third mother treated the entire diagnosis, treatment and prognosis as a challenge. She armed herself with knowledge and tackled the issue with determination, while the fourth mom tried every available alternative option. Although she ultimately conceded to administering Ritalin, she was constantly dubious and unconvinced, and finally came up with different solutions that worked for her and her family.

6.4.4 Noticing the warning signs

With regard to the child's symptoms, each mother voiced similar stories. The child in question was lacking in concentration, fidgety, impulsive, can't sit still and so on. Quotes from the four different subjects:

Subject No 1 states "... um he wasn't concentrating, he wasn't coping let's say that"

Subject No. 2 affirms, "...He was becoming like the class clown because he knew he wasn't coping."

Subject No. 3 postulates "Total lack of concentration..."

Subject No. 4 cries, "...His concentration level was very, very bad."

However it seemed that the different mothers took different views to the symptoms their child displayed. Three of the mothers felt that "boys will be boys" and this behaviour is normal. The fourth mother was totally aware, and felt that something was amiss. At this point it is fair to say that the researcher is not aware of the profundity of ADHD in each child, or if there is differing "depths" that one can diagnose? Certainly, with any disease or disorder, people manifest symptoms differently, thus the mothers attitudes regarding the behavioural symptoms may be at variance.

The data also showed the symptoms of each child after he had been taking Ritalin for a substantial amount of time. Two of the four mothers described very similar symptoms, that is, glazed eyes, very quiet, loss of personality, lack of appetite and general apathy. One of the moms found a huge improvement in her child's behaviour and this encouraged her to continue with the drug. The fourth mother noticed very little difference in her child's behaviour but did not seem to administer Ritalin consistently. The teachers however noticed an improvement in his marks and his behaviour; in reality, the teachers noted a change in all the children under study. They all improved their marks and their concentration. Thus one can safely contend that there is a dramatic change in the child's symptoms while he is on Ritalin. The difference is how these symptoms or behaviours are displayed or manifested. Clearly in the case of this study it is mixed reaction and a diverse display of symptoms after administering Ritalin.

6.4.5 Feelings of Helplessness

All the mothers experienced enormous feelings of helplessness. This experience was across the board. Subject No. 2 states helplessly, "And I was scared, I had tried so long not to put him on it?"

The researcher was aware of the deep feelings of sadness while the mothers were being interviewed. Their quotes are expressed in the Matrix in Appendix C, where one is able to perceive their absolute helplessness, and vulnerability.

The mother's experiences of helplessness and even disappointment appear to be reinforced by the thought of administering a schedule 7 drug such as Ritalin. They seemed to feel that the need to medicate their child is a drastic measure to facilitate a behavioural change. They did not necessarily voice this opinion, but it was gleaned from their tone and attitude of their dialogue within the interview. Only in the case of one mother did this turn out to be a positive measure,

although she too was extremely opposed to using Ritalin as a form of treatment. Often they would gaze past the interviewer and pause as if searching for a word or meaning. There was a general sense of sadness over the diagnosis and the ultimate treatment thereof, hence each mother's attempt at alternative strategies prior to giving in to Ritalin. In each case Ritalin was a last resort and ultimately one that they hoped would make enough of a difference to justify the use.

Only one mother felt that Ritalin changed her and her family's life in a positive manner. Her experiences after trying every alternative approach and arming herself with knowledge and countless means of information was that this decision supported her and the entire family in coping with the situation. She appears to have handled the circumstances responsibly and fervently meeting the challenge head on, consequently her acceptance of the medication. Certainly the positive outcome aided her and validated her judgment.

6.4.6 Feelings of guilt

Feelings of guilt were not experienced in a large way. One mother experienced no guilt as she justified her actions as supporting her child and the entire family. This mother accepted the ADHD and the medication as a challenge. Further, it proved to have a positive effect and thus she did not experience any form of guilt.

The guilt experienced by the other mothers was regarding the actual medicating of a young child with such a strong prescription drug, and not unequivocally acknowledging that the child is an ADHD sufferer. One mother also felt guilty that it was her fault that her child displayed behavioural problems because of her traumatic divorce and for that reason felt blame that he was prescribed a medication that has mind-altering consequences.

6.4.7 Sense of Anger

This emotion was predominantly expressed toward the teachers. Three of the mothers felt the teachers were to blame because they were not doing their jobs properly. There was definite anger in this regard. Subject No. 4 voices her anger as follows, “And for me, that is an excuse. An excuse from the teacher, because as far as I’m concerned we pay the teacher to teach the children and its not a clean slate. “

The mother that had a positive outcome from the medication did not afford any blame to anyone and did not experience feelings of anger at anytime. One of the mothers was angry that the teachers and/or authorities kept insisting that she have her child assessed and ultimately medicated. She voiced outrage at this outlook and went so far as to say teachers are lazy and looking for short cuts. Another mother said the teacher insisted that her child be assessed and medicated, while the third mother said she was at the end of her tether with her child and the teachers and had finally given up the anti Ritalin stance.

6.4.8 Feelings of Negativity, and/or Fear

This was an area that the mothers all agreed upon. They all felt completely negative towards administering Ritalin. They were all afraid of the long-term affects, the addiction, the mind-altering nature of the drug, the damage to organs in the body, the side effects and the symptoms. Each mother expressed a very real fear of what she may be doing to her child in an attempt to alter his behaviour. Subject No. 3 states this concisely, “Yes, yes and I was terrified because it was a mind-altering drug. ”They all agreed that all they had ever been told, or read, or viewed was of a negative nature.

6.5 Testing the Hypotheses:

In chapter four the researcher mentioned 4 hypotheses that she attempted to prove or to reject. For ease of reference, the hypotheses are repeated below:

1. The researcher hypothesizes that the four subjects will share similar experiences by administering Ritalin to their child or children diagnosed with ADHD.

Hypothesis No 1 is accepted as all the mothers seemed to feel ‘hope’ when they finally acknowledged or consented to administering Ritalin. In general it was difficult for them to accept the symptoms and treatment. All the mothers found both the diagnosis and the treatment method a challenge. The mothers displayed a mixed reaction and a diverge display of symptoms after administering Ritalin. All the mothers experienced enormous feelings of helplessness. Three out of four mothers experienced guilt and anger but the fourth mother experienced neither. All the mothers experienced negativity and/ or fear and also each child showed symptoms prior to being diagnosed with ADHD. The mothers were aware of the symptoms but had not placed any emphasis on it until pointed out by a teacher or teachers. Their awareness of something being amiss seemed to come after the diagnosis was formed.

2. Although Ritalin appears to help a high percentage of children suffering with this disorder, the mothers are afraid of the side effects of this treatment, and feel guilty about having to administer it.

Hypothesis No 2 is accepted as all the mothers were afraid of the effects of Ritalin, that is the strength of the medication, its side effects and its mind-altering

consequences. However, guilt was not experienced in a large way by any of the mothers.

3. The mothers feel negative regarding the treatment method and would prefer an alternative approach.

Hypothesis No 3 is accepted because all the mothers experienced complete negativity and fear with regard to treating their child or children with Ritalin as they had all been exposed to negative viewpoint and opinions. All four mothers attempted alternative measures before succumbing to Ritalin as a treatment method.

4. Although Ritalin has a very positive effect on the symptoms of ADHD, mothers experience anger or denial when they are first approached by a teacher, principal or caregiver recommending they have their child tested, and prescribed Ritalin as a treatment method.

Hypothesis No 4 is rejected because one of the mothers did not experience anger. She appeared to be resigned to the fact that something was wrong with her child and although she attempted every imaginable alternative to Ritalin, she never experienced feelings of anger at having to administer this drug. The anger experienced from the other mothers was predominantly experienced towards the teachers.

5. Is there a difference in experiences of negativity or helplessness in mothers who work full time; to mothers who work part time; to mothers who stay at home all day or mothers who work flexible hours?

Hypotheses No 5 is rejected because there seems to be no difference in mother's negativity or helplessness toward Ritalin based on their working hours.

6.6 Conclusions drawn from this study

All four of the subjects experienced feelings of hope and hopelessness. Initially they all experienced a sense of hopelessness at the diagnosis, and again when they were informed that their child should be treated with Ritalin. All of the mothers attempted alternative treatments prior to commencing the administering of Ritalin. They also shared the experience of hope in that the initial diagnosis was incorrect or mistaken.

The mothers were all against the utilising of Ritalin initially, but all succumbed when they realised that the alternative treatments were not working. To varying different degree each of the mothers experienced the diagnosis and treatment as a challenge. This was different for each of the mothers.

The symptoms of each child prior to being diagnosed was very similar in nature, for each of the mothers, however, the symptoms while on Ritalin differed. Two of the mothers shared similar stories regarding the affects from Ritalin, one mother noticed very little and the fourth mother saw a huge improvement. All the teachers noted an improvement in each of these children under discussion.

Helplessness was voiced very strongly from all of the mothers. They all expressed this emotion and were clearly experiencing sadness and disappointment in the diagnosis and eventual treatment method. Guilt was not particularly noted except as far as the medication of a drug that has mind-altering consequences was concerned. Only one mother felt guilt regarding her private life that she thought might have caused her son's behavioural problems.

Anger was expressed by 3 of the 4 mothers; however, this anger was vented upon the teachers who had first pointed out the behavioural effects of the child. These three mothers felt that the teachers were not doing their jobs properly and

hence they blamed the child's feisty behaviour. All four mothers expressed the negativity and/or fear experience. They all shared deep feelings of fear relating to addiction, long term side effects, damage to organs, personality changes and so on. They all unconditionally agreed that they had only read and heard negative stories regarding Ritalin as a treatment method.

Overall, it seems that the experiences of mothers toward administering Ritalin to their child or children was a feeling of helplessness, hope or hopelessness, negativity and/or fear. Clearly they all felt hopeless about the diagnosis and as each one-attempted alternative methods one became aware of the fear of administering Ritalin.

6.7 Limitations of the Study

From different perspectives, one may be able to perceive different viewpoints of limitations in this research study. There are several flaws and deficiencies in this study, namely:

- One of the most important limitations is the size of the sample. Undoubtedly, four people are not enough to ascertain if there is indeed the negativity that appears to surround the mothers' experiences.
- Most books and journals arise from the United States and very little material from other countries world wide, therefore this limits the outcome of the study insofar as a 'general' experience in mothers feelings toward administering Ritalin.
- The sample utilised only mother's experiences and did not take into account the fathers experiences. This could significantly affect the

outcome of the negative experiences because the fathers may have a totally different viewpoint, which may affect the results considerably.

- The interview being conducted only once may have a detrimental affect toward the credibility of the study, although the researcher did attempt to read between the lines and to read and reread the transcripts with an open mind. She endeavored to make this research as credible as possible by submerging herself in the data while searching for themes, subtleties, links and innuendoes. The interpretation was not made without repeated readings and analysis.
- Culturally, the group was from a westernized white culture that could also slant the outcome. It does not necessarily apply to other race groups.
- Finally, experiences may differ considering all the variables that affect ones life or lives. Different influences such as divorce, trauma, poverty and so forth may affect the experience that each mother shared, even though the researcher was aware of this prior to interviewing and pointed out these facts when giving background information on each subject in Chapter 4. Behaviour is a complex process, and while the researcher was aware of some of the variables affecting the mothers' lives, it is by no means sufficient to answer the research question fully.

6.8 Recommendations

The recommendations are based on the findings of the study.

A larger focus group is required to obtain a more accurate picture of mother's experiences regarding administering Ritalin to their child.

Based on the findings, the researcher recommends mothers obtain knowledge on the topic of ADHD and Ritalin. Mothers need to empower themselves and their families by obtaining knowledge from as many sources as possible. The researcher recommends the following sources:

- ADHD Support Group – See Appendix A for details
- Internet, being careful to avoid articles that are not written by experts in the field
- Medical Doctor, Neurologist, Pediatricians, Psychologists and/or psychiatrists
- Teachers, Principals of schools or guidance counselors
- Parents of other children suffering with diagnosed ADHD
- Books from Libraries written by experts in the field
- Talk show tapes from radio or television shows
- Journal articles or medical journals

Mothers need to strengthen their support group and feel free to discuss the topic with other parents. They must avoid the negativity surrounding this syndrome and the treatment and attempt to judge for themselves. However, they must at all times have their child or children under the care of a professional in the field. The medication should be monitored constantly, being aware of the child's changing needs and different developmental phases.

All the mothers in this small research project were afraid to try Ritalin. They all opted to trying alternative treatment methods in the hope that they could avoid the child being treated with Ritalin. In addition, they all found that the alternative methods did not make a difference, and finally each mother resorted to Ritalin as a final measure. However, they each experienced many differing emotions and only one mother found the experience to be positive. One mother discovered that her best friend had been medicating her child

with Ritalin and never discussed this with her. It seems that many mothers may suffer with feelings of inadequacy and negativity regarding this disorder and the available treatment offered. Thus, it would improve negative experiences if more mothers came forward about their positive experiences.

Perhaps psychologists should be made aware of the sensitivity surrounding this disorder and assist the parents, especially as far as administering a schedule 7 drug. They could attempt acknowledging the helplessness and grant the mothers awareness by giving them more information.

6.9 Conclusion

In this final chapter, the researcher dealt with the interpretation of the data and her findings. The researcher discussed the themes that emerged, which were supported by the raw quotes mentioned in the Matrices in Appendix D and E. She endeavored to answer the hypotheses as stated in Chapter 4. The chapter concludes with recommendations and limitations resulting from the various findings.

The researcher is hopeful that the various issues discussed and questions that were answered will assist mothers in their plight when being informed that their child has ADHD. She is encouraged by the outcome of this study and anticipates that many other mothers may feel familiar and recognize the different experiences that emerge, and consequently not feel as troubled and unaided without this knowledge. And, finally she expects that the research may help mothers to be aware that they are not alone with their predicament and sense of apprehension and uncertainty regarding the administering of a drug like Ritalin to assist in alleviating the symptoms presented.

APPENDICES

Appendix A:

ADHD Support Group of Southern Africa
P O Box 3704,
Randburg
2125

Tel: 011 793-2079 Sandy
011 805-7899 Marina
Fax: 011 793 4790 Margie
Email: rscox@icon.co.za

Appendix B:

A Verbatim extract from one of the subjects interviews:

Subject no. 4 Interview:

R + Respondent I = Interviewer

R: Well, they give me a report saying that they were worried about his lack of concentration, lack of completing his tasks, lack of, um, he was fidgeting in class, so um...

I: Ok...

R: So, they then decided that I should then take him for an assessment

I: Ok...

R: So, before that they advised that I should maybe take him for OT – occupational therapy because he needed more fine motor coordination, he needed to work on that...

I: Ok...

R: His...um... they weren't very happy with that, so, they then said that his concentration was a problem so then I took him for a proper assessment.

I: It doesn't matter if you can't remember the name, but was it a psychologist?

R: It was a child psychologist

I: Ok, ok – Did they do tests, or what did they do?

R: What she did was um... she... I left him there. It was a Saturday morning and I left him there for the morning. I had to leave him there. It was all morning.

I: Mmm...

R: And then I had to go back a few days later and get the report from her.

I: Ok...

R: And the report was that he was definitely a Ritalin case, they suggested that he be on Ritalin.

I: Did the psychologist say that you should take him to a neurologist or any other specialist...to confirm her findings?

R: No, no...

I: Or did she do it on her findings?

R: No, she did it on her findings. The report was that he should be... that he would benefit greatly on medication. That was what the report said.

I: Ok...

R: She was a forensic psychologist, that's what she did, so she was quite high up, she was pretty well recommended.

I: Ah ha...

R: She came very highly recommended

I: Ok, what did you when you found out about that, what did you feel.

R: I...I...I... was pretty sad, but I wasn't in denial, definitely not. I thought well where do I go from here. And I thought there is no ways I am putting my kid on Ritalin. Let me tell you there's no ways, so I took him to a Professor, he s an herbalist, what do you call it?

I: Ah...um...

R: What do you call it, a homeopath?

I: Oh Ok, a homeopath

R: He's a professor of homeopathy, and he gave me a whole bunch of suggestions. So, I changed his diet, I got books out, I went onto the internet I... you know I read up on it, I spoke to parents, I got quite involved and they said that maybe I should change his diet which I did.

I: And did you see a difference?

R: No not really, very mild. Um... look the kid... I found him very active, hyperactive, but for me that was normal because he's always been like that so it wasn't like do I see a difference, yes, I sort of watched what I bought, so I thought keep an eye on MSG and all those colourants and all that stuff but you cant block it out completely, the kid's got birthday parties and they go ballistic, so I couldn't... I tried to control, but I couldn't do everything?

I: Mmm...

R: And I wasn't obsessed with it, if you know what I mean.

I: So what did you do... did you just leave it?

R: So I just kept him on this medication cause they said salmon oil is very good so we tried to keep him on it, but the tablets were too big, so he was very small, so I wasn't stressing myself out, and I wasn't stressing my child out and we did as much as we could we kept on with the homeopathy, we did as much as we could but we didn't see much difference. But for me, he wasn't a failure at school. He wasn't failing outright, he was passing, he wasn't doing brilliantly but he wasn't a total failure.

I: How did he feel about being diagnosed?

R: I don't think he understood, it wasn't something we sat down at his stage and discussed, I mean I said to him that you can't have sugar every day, we have to watch stuff because you are hyperactive. On the weekends you can whatever you like, but during the week try not to have this that and the other. I mean 6 years old, 5 years old...

I: And your husband Stephan how was he?

R: Stephan was... look he was um...um...he wasn't really, um...he left it to me...um Stephan wasn't sort of... um...

I: There were no big feelings?

R: No, No...

I: One way or the other?

R: NO, No...

I: And from your side either?

R: No, No, because I think I was pretty hyper as a child

I: Ok...

R: I definitely, guaranteed was hyperactive, and Stephan reckons he was pretty hyperactive at his age – he didn't excel at school, neither did I, um... we are both pretty fidgety people who cant keep still, we... I think because we are like that, its, um...

I: ...no big deal?

R: No big deal!

I: And the school? What did they...

R: The school made a huge big deal out of it. Oh no he must go on Ritalin and you must medicate him, and you must do this, and you must do that, and, you know... and I thought... No! Not yet! I wasn't ready to medicate him yet!

I: And then what was your next step, did you leave him in Grade 00 with nothing?

R: Grade 1 nothing, Grade 2 nothing, Grade 3... I can't remember, um... I can't, um... yes, Grade 3 yes.

I: Was the work becoming more difficult?

R: The work... Ya... I thought you know what, maybe I should give it a bash, um... because of all...

I: mmm...

R: So, I took him to Gillian De Vos

I: OK...

R: I took him to Gillian.

I: Is she a psychologist?

R: She's a psychologist specializing in ADHD

I: OK... ok.

R: So I took him to Gillian and we did another assessment and she said to me. "Look, lets give it a try", and I felt... I mean I had exhausted all those avenues, and I couldn't really see a difference I mean the homeopathy, the medicine the this the that I couldn't see a difference, I mean I thought this is my last resort let me give it a bash, so I did. And, um... I found that yes, I did see an improvement in his marks, I saw a huge improvement in his marks he focused better in class, but I wasn't happy, with him being on medication...

I: Why?

R: Because, um... he lost a lot of weight, I would talk to him and he would seem spaced out. To me he looked like totally on drugs.

I: So you saw a difference in his behaviour?

R: I saw a huge difference

I: In his behaviour?

R: He was... he wasn't my child, the kids were...I mean... you wouldn't mistake that my kids weren't around, they are so loud and noisy, and all of a sudden I had this quiet little child who didn't have a sense of humour any more, I mean...he wouldn't smile any more, I mean he was so withdrawn. And I was not happy with that hey.

I: So, just to recap. After your tried for about 4 years of diet and ...

R: Everything...

I: Homeopathy and vitamins and everything...

R: Melatonin and...

I: You decided, ok now you'll try the Ritalin?

R: Yes

I: How did it feel now that you decided to do the Ritalin? Did you have any great feelings or did you just go into it thinking...?

R: I thought miracles... miracles are going to happen now that he was onto this medication that I had heard so much about, and...

I: Were you kind of expecting a miracle?

R: And I was scared, I had tried so long not to put him on it?

I: Why?

R: I did a lot of research and watched a lot of programs and heard that children that take Ritalin often have drug problems later in life. I didn't want my child to be a drug addict... I suppose I was scared...

I: mmm.... How long was he on it for?

R: We did it for almost a year.

I: What did he say about it?

R: He hated it. He hated it.

I: Why?

R: He didn't want... because he... he couldn't eat, he would say "Mommy this medication ... I don't feel hungry.

I: Ok...

R: And he was lethargic and he wasn't... he wasn't himself, and he could see the change in himself

I: So he could see his personality was different... was he pleased that his marks were better?

R: He was pleased that his marks were better but they, it wasn't... there was definitely an improvement in his marks.

I: Homework?

R: Homework was done, but he wasn't happy, Jason hated being on that medication, he hated taking that tablet in the morning

Further on in the interview:

I: How did you feel now that you had tried it but it didn't work for you? Were you relieved, happy, sad, what did you feel?

R: You know what –I was happy that I had tried it cause at least I could at least say I did try and I could say that I didn't block it, because I think at the beginning I did block it, I blocked it totally because it was more, it was more that I didn't want to medicate the kids at such a young age – you know for me, I didn't want the kids on medication, and yet, I'm glad I tried it because I had proof that I wasn't happy and my son wasn't happy

I: Ok, so what would you recommend, I know its an unfair question but, would you recommend, "Try it, or don't try it" or...

R: Try it, because I mean there is no harm in giving it a bash because you know kids react differently. Maybe when he's a bit older, like now...

Appendix C

Copy of Informed Consent from the Participants:

INFORMED CONSENT:

DATE:

PARTICIPANT NAME:

CONTACT NO:

RE: INTERVIEW REGARDING THE DIAGNOSIS OF ADHD WITH YOUR CHILD, THE MEDICATION, AND YOUR FEELINGS REGARDING TREATMENT

The interview will be conducted in a safe environment between yourself, and the interviewer being Christine Burke who is a student of the University of Pretoria, completing my Masters Degree in Counselling Psychology.

I shall be the researcher in this project and ensure that all matters obtained within this interview will remain private and confidential. You will be encouraged to share your details of the experience regarding your child's diagnosis, his/her treatment and your feelings regarding the issue. I will seek to describe and understand the meaning of the central themes of the experience being investigated. Furthermore, I will seek descriptions of the experience itself without theoretical explanations.

My objective during the interview is to therefore remain non-directive and avoid being interpretative. All information gleaned from this interview shall be held private and confidential and your name will be anonymous.

Thank you for your time given during this interview.

Yours faithfully,

CHRISTINE BURKE
RESEARCH MASTERS STUDENT

APPENDIX D

Matrix

APPENDIX D

MATRIX OF RAW DATA:
EXPERIENCES:

THEME 1

MOTHERS

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 1	<p>“He was always blamed, and that was always what he would come home and say.”</p> <p>“I was still going constantly into the principals office um... his arrogance, his defiance his...”</p> <p>“um... he just wasn't himself.”</p> <p>ME: “So, even on the Ritalin his behaviour was still there...”</p> <p>“Still there...”</p>	<p>“I felt, um... its been going on for so many years maybe I was wrong and I was too blame because I always fought against it. Because maybe if I had done it earlier I could have given him a chance. I felt um... guilty, but I felt ok, lets try it.”</p> <p>“ Felt um... guilty, but I felt ok, lets try it,”</p>	<p>“And if he felt better, he wouldn't feel a reason to run around the class frustrating the teacher who in turn would be negative towards him, because whatever happened in class he would be blamed even if it wasn't him.”</p> <p>“I was actually at the end of my tether, because I had done everything, I had avoided the Ritalin with a passion.”</p>	<p>“ I always had a problem giving him pills, I felt that it was wrong to give a child pills.”</p> <p>“I just felt... I just felt that, that pills could not make a behaviour right, like making him into a zombie, making him something he wasn't.”</p> <p>“He didn't want to – he didn't want to take the tablets, and I explained to him that after 4 years I was dead against it but he should try because it might make him cope better at school and if he coped better he would feel better”</p> <p>“My older son</p>

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 1				<p>when he</p> <p>was young, he's 17 now also went through a stage where he was an absolute nightmare, they actually diagnosed, no they didn't diagnose but mentioned Ritalin which I absolutely refused!"</p>
Subject 2	<p>"...he would just joke around and become the class clown so that he didn't have to answer anything cause he inside knew he didn't know what to do."</p> <p>"... and the psychologist even said that he picked it up and realized how difficult it was for me."</p> <p>"Deep down, I knew, I think I knew already because he only started speaking at 2 and say his first words. Deep down I knew what they were going to say. But I didn't want to</p>			<p>"...so when I just heard the word Ritalin I just switched off and straight away I said No. I didn't even give it a chance or anything."</p> <p>"...they said to me, one of the side effects is that the kids become withdrawn and very quiet and Gavin was such an outgoing bubbly little boy and he was rough and he was a bit wild and I was frightened about the effect it would have on him..."</p>

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 2	<p>know and I was upset and I felt really bad and my husband was devastated. I had to sort of be strong for the, for David and for Gavin was scared he would have a personality change and even though he was rough and tough I was scared, I thought how would this drug change my child, and his personality..."</p>			<p>"...I never heard good things about it." (Ritalin)</p> <p>"...because deep down you think of everything, there heart rate going up, um...everything."</p> <p>"I tried other methods: I never heard anything positive about it."</p>
Subject 3	<p>"He was feeling different and outside from the rest of us."</p> <p>"Anti it! Angry! – Not angry, I think more disappointed than that..."</p> <p>"I was terrified of them taking a schedule 7 drug, kidneys, maybe liver.. Yeah terrified."</p>	<p>"Because we felt guilty to put him on."</p> <p>"I think guilty in a way... I don't know – that I had to give my child heavy dosage drugs. I think that somewhere along the line I always just felt bad – I did! I did! I just felt really bad!"</p>	<p>"It was the teachers insistence not mine."</p>	<p>"...I think it was more anti-Ritalin because of the side effects."</p> <p>"...but I was terrified that it would stuff up his liver, or something bigger."</p> <p>"I took him off in Standard 4 or 5 because he always had this glazed look? He always looked out of it."</p> <p>"It was devastating to</p>

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 3				<p>see..."</p> <p>"This child had no energy, this child would walk and then he would have to sit down, it was shocking! Shocking!"</p> <p>"Ya, ya, because to me, he always looked like he was spaced out –</p> <p>always..."</p> <p>"Yes, yes and I was terrified because it was a mind-altering drug"</p>
Subject 4	<p>"I...I...I... was pretty sad, but I wasn't in denial, definitely not. I thought well where do I go from here. And I thought there is no ways I am putting my kid on Ritalin. Let me tell you there's no ways."</p> <p>"He was... he wasn't my child."</p> <p>" And I was scared, I had tried so long not to put him on it?"</p>	<p>" but I wasn't happy, with him being on medication..."</p> <p>"Stephan wasn't happy, we both weren't happy about medicating the kids..."</p> <p>"I was never ever, you now, I've never ever been happy about medicating"</p>	<p>" No! Not yet! I wasn't ready to medicate him yet!"</p> <p>"... but I didn't go down that road again, so I thought there is no ways I'm medicating this one as well."</p> <p>" and I decided that was it! I wasn't going"</p>	<p>" Because, um... he lost a lot of weight, I would talk to him and he would seem spaced out. To me he looked like totally on drugs."</p> <p>"...and all of a sudden I had this quiet little child who didn't have a sense of humour any more, I mean...he wouldn't smile any more, I mean he was so withdrawn. And I was not happy"</p>

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 4	<p>“...and heard that children that take Ritalin often have drug problems later in life. I didn’t want my child to be a drug addict... I suppose I was scared...”</p> <p>“... he was losing weight he was lethargic. He is a tiny little thing as it is, he had no energy, he wasn’t smiling. It almost seemed like he had no motivation.”</p> <p>“I blocked it totally because it was more, it was more that I didn’t want to medicate the kids at such a young age – you know for me, I didn’t want the kids on medication, and yet, I’m glad I tried it because I had proof that I wasn’t happy and my son wasn’t happy.”</p> <p>“And, and I wasn’t happy, I wasn’t happy with the fact that he wasn’t eating he had no appetite he was lethargic</p>	<p>medicating children. I’ve just had a block, a mental block about that –“</p> <p>“I mean I had this child that wasn’t running around me 24 hours and was loud and, and spinning, you know, but he had, you know, it was great but he a wasn’t my child, he had no sense of humour, he wouldn’t laugh and... and...”</p> <p>“...so now if I have to medicate him, maybe that enthusiasm will go away...”</p>	<p>to put him back on.”</p> <p>“I’ve told them straight. There is no ways I’m medicating him!”</p> <p>“I cant! I cant justify the fact that I put my children on a drug, because that’s what it is - a drug!”</p> <p>“And for me, that is an excuse. An excuse from the teacher, because as far as I’m concerned we pay the teacher to teach the children and its not a clean slate. I think the teachers today are</p>	<p>with that hey!”</p> <p>“And he was lethargic and he wasn’t... he wasn’t himself, and he could see the change in himself.”</p> <p>“...we were not happy putting our kids on drugs. And that’s what it is for me, Ritalin is a drug! And, if you drug children at this age what about cocaine and all those things at a later stage. And they say that children on Ritalin have a higher percentage of becoming drug addicts. (I don’t know where this research comes from but...I read it somewhere), then children who are not on Ritalin.”</p> <p>“I would rather recommend extra lessons; spend more time, one on one. Rather spend my money wisely there then spend my money on buying Ritalin and</p>

	HELPLESSNESS	GUILT	ANGER	NEGATIVITY / FEAR
Subject 4	<p>he was lethargic and he had no sense of humour I mean I had this child who was almost a zombie.”</p> <p>“Ya, the price was too high... ya.”</p> <p>“You know... I mean, I was sad. I mean do you know for me, it was...I’ve got two children, it now meant... a lot extra, but because of the fact that this Ritalin was not for me, it was just...after Jason, there was no option for me I will do anything, I will try anything that needs to be done...to help the kids...”</p> <p>“I mean I was devastated, I didn’t... in fact when Jason was diagnosed – I didn’t know what it was, I mean that’s how...I didn’t know ADD, ADHD... I didn’t know what it was... I had to learn about it”</p>		today are lazy!”	<p>and psychologists.”</p> <p>“I needed to educate myself about it... there was definitely no shame – for me, and that was the best thing for me...”</p> <p>“They were on Ritalin but they weren’t talking about it...”</p> <p>“Why? Why?”</p> <p>“ I think they were ashamed..”</p> <p>“I think it was like a huge, um, I don’t know.. a failure, a failure from within – that’s how the mom’s... and all of a sudden , like my best friend said “oh my son’s on Ritalin” and I’m thinking... “I’ve known you for so long I’ve spoken about my problem and you’ve never actually mentioned it and it came out when I decided I’m, going to try the Ritalin.”</p>

APPENDIX E

Matrix

APPENDIX E

MATRIX OF RAW DATE: THEME 2: MOTHERS EXPERIENCES AFTER AWARENESS

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 1	<p>“...they just kept him on the Ritalin, which seemed to make a difference then, but they put him on a higher milligram.”</p> <p>“I cant explain because I never really felt it at home.”</p> <p>“ I tried Calmolin which was herbal I even tried boarding school which I would never have done because there was no reason for me to make him be away</p>	<p>“...but there was nothing out of the ordinary except that he was a naughty little shit if I can put it that way?”</p> <p>“...he was more a D or E but once again we blamed something else.”</p> <p>“We thought he was young, he hadn’t had the same grounding as others. It was never thought that he had ADHD we pushed it to the side if it was a possibility until long... um... long after that.”</p> <p>“But again we put it down to... they called us in and they said this is what he’s doing, this is what he’s not doing... um... we put it down to due to the divorce...”</p> <p>“Even then we did not think of ADHD.”</p>	<p>“He didn’t want to – he didn’t want to take the tablets, and I explained to him that after 4 years I was dead against it but he should try because it might make him cope better at school and if he coped better he would feel better. And if he felt better, he wouldn’t feel a reason to run around the class frustrating the teacher who in turn would be negative towards him...”</p> <p>“So I</p>	<p>“He started displaying behavioural problems...”</p> <p>“...he started playing up at school, he could absolutely not concentrate, he started being aggressive...”</p> <p>“He was very dissatisfied with everything...”</p> <p>“He was very dissatisfied with everything...”</p> <p>“... um he wasn’t concentrating, he wasn’t coping lets say that?”</p> <p>“Um... no, no I cant say he ever walked around like a zombie, ever, No I cant</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 1	<p>from his own family?"</p> <p>"I did cut out like very sugary things, um..."</p> <p>"So I don't know how fair the diagnoses would be because the teachers that don't like him will say negative things about him so I don't know. Its so hard, if ever I could, I would get one teacher to teach him everything. I think there are too many that don't like him."</p>	<p>"And they also didn't pick up anything and said he just wasn't interested with his work, behavioural..."</p> <p>"I don't think he displays enough symptoms to justify taking anything. I'm sure some of his teachers would disagree ..."</p>	<p>explained to him and he took the Ritalin without fighting about it."</p> <p>"Because I knew he would just do it behind my back, so I would never go with the diet story with him because I never knew, cause even at home..."</p> <p>"He needed to be active all the time otherwise he would start... He had a need to be busy all the time."</p>	<p>ever say that!"</p> <p>"Certain work improved..."</p> <p>"Then from there they found a lot of things wrong – lots of things below average the part of the brain that the Ritalin worked on was above average."</p> <p>" He does well at school but he can't just sit down either..."</p>
Subject No. 2	<p>"They said he is having a concentration problem, learning difficulties... but they certainly didn't label it!"</p>	<p>"I think he knew something, he knew he had a problem with his speech and the way he would pronounce words, he knew there was something wrong. I think he was afraid."</p> <p>"Deep down, I knew, I think I knew already..."</p>	<p>"Um, he wasn't happy and I had to really kind of bribe him with Pokemon cards..."</p> <p>"And then he struggled and he struggled."</p>	<p>"...he had a learning problem and he was becoming like the class clown because he knew he wasn't coping."</p> <p>"And then he was quite ..."</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
<p>Subject No. 2</p>	<p>“I started with the eating methods and cutting out sweets and chips and which sweets are good and which are not...”</p> <p>“...and I went to a talk by Doctor Levine and um...he is a pro Ritalin doctor and he gives you all the benefits...”</p> <p>“...and I came to the conclusion myself, it is a high schedule drug, it is a schedule 7 drug but it has to be administered properly and I decided if I give Gavin the trial on Ritalin and it does work, the promise I made to myself is that I will take him</p>	<p>“Deep down I knew they were going to say. But I didn’t want to know and I was upset and I felt really bad and my husband was devastated. I had to be strong for both of them...”</p> <p>“In knew absolutely nothing, then I started doing all my research for myself because they did suggest that Ritalin would help him and the first thing my reaction was ‘Absolutely Not!’ – he’s not going to have Ritalin.”</p> <p>“...I dint know anything specific about it but just from what I’ve heard from the press and the media and other parents, so when I just heard the word Ritalin, I just switched off and straight away I said No! – I didn’t even give it a chance or do anything.”</p> <p>“There is definitely a huge difference ...” (If he does not take Ritalin)</p>	<p>“We took him to a remedial school and I didn’t tell him that it is like a special school or something like that...we just said we found a new school which is really great and there are far less students in the class...”</p> <p>“And, um... I went to talks on Ritalin and for Ritalin and against Ritalin, we went on the Internet, started reading up on the drug, and then I started making a whole lot of notes for myself and I did a list on the good things and the bad things.”</p> <p>“...and we’ve never ever looked back, never!”</p>	<p>aggressive, like on the school play ground – he used to bully the kids and all of that...”</p> <p>“Ya, so he was at a bad place and kept saying that he cant do it...”</p> <p>“Ya, he gives up before he starts...”</p> <p>“they never said ADHD, they just said he had a learning difficulty but when he went for testing they saw he was easily distracted and he hears any little noise in the background and his attention is gone and his attention is totally gone and you have to repeat a question to him.”</p> <p>“...he did calm down but he wasn’t drugged or numb and he was still a real</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 2	<p>to the pediatrician every single month and administer the Ritalin properly.”</p> <p>“And we gave it to him for 2 weeks and there was such an improvement the next day – it was unbelievable, even his hand writing.”</p> <p>“It was prescribed for him it was like he was just the perfect little model for Ritalin.”</p> <p>“...they said that in 2 years there has been such an improvement with him, and the emotional improvement has been huge.”</p> <p>“...they said he is not the desperate</p>		<p>“I was happy, I was nervous because I thought if this wonder drug that they say will help him doesn't help what then? I was afraid...”</p> <p>“I was starting to think of home schooling or what other alternatives I might have...”</p> <p>“I was nervous of the side effects...”</p> <p>“Because of the side effects I was scared he would have a personality change and even though he was rough and tough I was scared... I thought how this drug might change my child, and his personality, and...”</p>	<p>little boy which is what I wanted.”</p> <p>“...he was great, its just that he wasn't as wild as he once was ...”</p> <p>“...he stopped teasing her (his sister) which was great on the whole family, and his school work – it was just amazing.”</p> <p>When he was not on Ritalin “he would start teasing his sister from the minute he would wake up until he went to bed on a Saturday and a Sunday and he would be impossible and we would speak to him and he wouldn't listen and he would laugh...”</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 2	<p>little boy they met when he first went there...”</p> <p>“That’s the big difference, because in the past he would say ‘I cant, I cant, I don’t know’ Now he wants to learn and he wants to know...”</p> <p>“Emotionally we are much happier now, he can cope so he is a happier child...”</p>		<p>“...I was frightened about the effect it would have on him...”</p> <p>“Um... I was initially anxious, maybe not even a strong enough word, and now I’m really happy – Its a relief!”</p>	
Subject No. 3	<p>“...he believed in smaller dosages over a longer period of time which I was much happier with.”</p> <p>“Possibly because I thought he might be ok, and he’s done well...”</p> <p>“Not really,</p>	<p>“We went to an educational psychologist – they did come back and say that it was a lack of concentration...”</p> <p>“Anti it - angry... not angry. I think more disappointed than that. I think I knew in myself that they were right. I knew - it got to a stage that we were fighting a losing battle. Everyone was telling us he was not doing well in class, and we were doing him</p>	<p>“I watched him, I watched him in case he got hooked or whatever...”</p> <p>“...I would say try and stick it out.”</p>	<p>“Total lack of concentration...”</p> <p>“...but I was terrified that it would stuff up his liver or something, something bigger...”</p> <p>“... they kept calling me and saying that he is naughty and distractible...”</p> <p>“They said</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 3	<p>no, I would listen and try for a positive somewhere.”</p> <p>“That definitely made a difference. It did improve. But I don’t believe Dudley was a long term Ritalin case which is what they wanted?”</p>	<p>a disservice by not putting him on... because we felt guilty to put him on.”</p> <p>“So I know my child had it, it’s just that he was so easily distracted.”</p> <p>“Yes, so I don’t know if there was a problem in the first place? I really don’t?”</p> <p>“I never knew what it was, but I did know he had concentration problems, I knew there was something because if he had to do something, by the time he got there he would forget what it was that he had to get?”</p>		<p>purely lack of concentration...”</p> <p>“ because he always had this glazed look?? He always looked out of it...”</p> <p>“... yes... he did concentrate a bit better but he also became very introvert. Very, very introvert, he almost became the outcast of the family.”</p> <p>“He was feeling different and outside from the rest of us.”</p> <p>“...look he did eat less, he never ate, he had a loss of appetite...”</p> <p>“This child had no energy, this child would walk and then he would have to sit down, it was shocking! Shocking! We would be out for an hour and we would find him sitting on the</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 3				<p>floor in a department store. He just had no energy.”</p> <p>“Ya, Ya... because, to me he always looked like he was spaced out...always...”</p> <p>“I was terrified of them taking a schedule 7 drug, kidneys maybe liver .. Yeah terrified..”</p> <p>“Ya, and I took him off purely because he seemed to be concentrating and maturing, so that pituitary or whatever it is, had matured.”</p>
Subject No. 4	<p>“I sort of watched what I bought, so I thought keep an eye on MSG and all those colourants and all that stuff...”</p> <p>“ And I wasn’t obsessed</p>	<p>“Well, they give me a report saying that they were worried about his lack of concentration, lack of completing his tasks, lack of, um, he was fidgeting in class, so um...”</p> <p>“And the report was that he was definitely a Ritalin case, they suggested that he be on Ritalin.”</p> <p>“I...I...I... was pretty</p>	<p>“ I thought well where do I go from here. And I thought there is no ways I am putting my kid on Ritalin. Let me tell you there’s no ways...”</p> <p>“... we did as much as we could</p>	<p>“...his concentration level was very, very bad. He was fidgety, he couldn’t sit still, he couldn’t focus, he couldn’t finish his tasks, um, he was very fidgety.”</p> <p>“Um, look the kid, I found him</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 4	<p>with it, if you know what I mean?"</p> <p>"So I took him to Gillian and we did another assessment."</p> <p>"I mean I thought this is my last resort let me give it a bash, so I did."</p> <p>"I thought miracles... miracles are going to happen now that he was onto this medication that I had heard so much about, and..."</p> <p>"You know what –I was happy that I had tried it cause at least I could at least say I did try and I could say that I didn't block it, because I think at the</p>	<p>sad, but I wasn't in denial, definitely not."</p> <p>"So, I changed his diet, I got books out, I went onto the internet I , you know I read up on it, I spoke to parents, I got quite involved..."</p> <p>"I did a lot of research and watched a lot of programs and heard that children that take Ritalin often have drug problems later in life. I didn't want my child to be a drug addict... I suppose I was scared..."</p> <p>"I didn't want the kids on medication, and yet, I'm glad I tried it because I had proof that I wasn't happy and my son wasn't happy..."</p> <p>"I am grateful that he was diagnosed; yes I'm grateful that we found out at an early age I'm grateful that I tried it – but – not for me!"</p> <p>"I mean I was devastated, I didn't... in fact when Jason was diagnosed – I didn't know what it was, I mean that's how...I didn't know ADD, ADHD... I didn't know</p>	<p>but we didn't see much difference?"</p> <p>"The school made a huge big deal out of it. Oh no he must go on Ritalin and you must medicate him, and you must do this, and you must do that, and, you know... and I thought, No! Not yet! I wasn't ready to medicate him yet!"</p> <p>"I mean I had exhausted all those avenues, and I couldn't really see a difference."</p> <p>"And I was scared, I had tried so long not to put him on it?"</p> <p>"...but now I've got two ladies who come home with him one on one, I've had that for</p>	<p>very active, hyperactive, but for me that was normal because he's always been like that..."</p> <p>"And, um... I found that yes, I did see an improvement in his marks, I saw a huge improvement in his marks he focused better in class, but I wasn't happy, with him being on medication."</p> <p>"Because, um... he lost a lot of weight, I would talk to him and he would seem spaced out. To me he looked like totally on drugs."</p> <p>"He was... he wasn't my child, the kids were...I mean... you wouldn't mistake that my kids weren't around, they are so loud and noisy, and all of a sudden I had this quiet little child who didn't</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 4	<p>beginning I did block it, I blocked it totally...”</p> <p>“I still have the two au pairs who come to the house and do one on one extra lessons with him and I found for me, that is the biggest help.”</p> <p>“I wasn’t happy about it, but I thought let me give it a bash I’ve got nothing to lose, let me try it now because if I wait too long it might be too late”</p>	<p>what it was... I had to learn about it.”</p> <p>“Yes, I’m glad I tried it – I have no regrets, I don’t regret because I now know its not the right thing for my children.”</p>	<p>two years now and I think that has helped a great deal.”</p> <p>“... I was never ever, you know, I’ve never ever been happy about medicating children. I’ve just had a block, a mental block about that –“</p> <p>“And we have a speech therapist, the OT that comes to the house, plus he has OT at school, so I’ve got all these people working with him rather than medication.”</p> <p>“...there was no option for me I will do anything, I will try anything that needs to be done...to help the kids...”</p>	<p>have a sense of humour any more, I mean...he wouldn’t smile any more, I mean he was so withdrawn.”</p> <p>“And, and, it was the same reaction. I saw an improvement only in his marks, but nothing else, he was losing weight he was lethargic.”</p> <p>“I wasn’t happy with the fact that he wasn’t eating he had no appetite he was lethargic and he had no sense of humour I mean I had this child who was almost a zombie.”</p>

SUBJECTS	HOPE	AWARENESS/DENIAL	CHALLENGE	WARNING SIGNS
Subject No. 4			<p>“I needed to...find out about it...”</p> <p>“I think it was like a huge, um, I don’t know.. a failure, a failure from within – that’s how the mom’s...”</p>	

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