AN EXPLORATORY CASE STUDY AT A PRIMARY SCHOOL IN CAPE TOWN OF THE EXPERIENCES OF PARENTS OF CHILDREN WITH ADHD CONCERNING PARENTAL CHALLENGES, RESILIENCY AND THE ROLE OF THE SCHOOL

A minor dissertation submitted in partial fulfillment of the requirements for the award of the degree of Masters of Social Science in Clinical Social Work.

By

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2014

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced according to the Harvard-UCT 2014 guidelines.

Signature:  Date:
ACKNOWLEDGEMENTS

This study would not have been possible without the support, understanding and sacrifice of my husband and children as I juggled working life, academia and mothering. My grateful thanks must therefore go to my husband and family.

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Finally, my grateful appreciation is expressed to Mr. Ronald Addinall, my supervisor, who devoted considerable time and thought to guiding, challenging, and finally pruning, this study. I think I learnt more by what I did wrong, and it is the mark of an attuned supervisor to allow me to learn from these mistakes knowing that I will get it right in the end.

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ABSTRACT

This phenomenological study seeks to understand challenges and resilient adaptations of parents of children with ADHD at a Primary School in Cape Town, and to examine the role of the school and the school social worker in supporting parents not only in developing parental resilience, but also developing resiliency in their relationships with the school as an adjunct to forging effective parent-school partnerships.

The macrosystemic background to this study is the Department of Basic Education’s policy on Inclusive Education, which calls for parent-school partnerships in educating vulnerable children. Two theoretical frameworks guide this study: resiliency theory, given the increasing calls for resiliency research in resource-poor contexts; and Bronfenbrenner’s bio-ecological framework, as ADHD is a complex phenomenon in which parents and school, both micro-and meso-systemically, buffer the impact of ADHD.

The research methodology is an exploratory qualitative cross-sectional single case design with multiple respondents. Eighteen parents were the unit of study, selected according to a purposive and discriminant sampling design. Data was collected using a semi-structured interview schedule, and recorded during an in-depth interview.

This study confirmed chronic and overwhelming personal and parenting challenges, but also challenges around medication, and parent-school interaction. Participants struggled more than they felt they succeeded, as adaptations shadowed and were overshadowed by, challenges. Participants increasingly used the services of the school social worker, and preferred to access personal help via their children’s mental health provider, underlining the importance of the school as an intervention site. Participants indicated that school social work services should provide counselling, a support group for parents, advocacy and mediation between parent and teacher/school, and develop opportunities for parent-school partnerships. School social work services were valued because they were based on knowledge and experience. Relationships with the school were tempered by ambivalence and frustration; participants wanted proactive teachers providing in-depth and accessible contact and trained in ADHD classroom management. Implications of this study for the school, the social work profession and the Department of Basic Education are discussed.
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LIST OF ABBREVIATIONS

PS: Primary School (the site of the case study)
ADHD: Attention-Deficit/Hyperactivity Disorder
LMIC: Lower to Middle Income Countries
USA: United States of America
ILST: Institution-Level Support Team
EMDC: Education Management and Development Centre
APA: American Psychological Association
DSM V: Diagnostic and Statistical Manual, 5th Edition
UK: United Kingdom of Great Britain
CSTL: National Model for Action concerning the Care and Support for Teaching and Learning

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction

This study explores the perceptions and experiences of parents of children with ADHD at a specific primary school (PS) in the Southern Suburbs of Cape Town. The study concerned itself with parental challenges; coping strategies promoting parental resiliency; the role of the school and the school social worker in strengthening parental resiliency; and promoting resilient parent-school partnerships. It is in the format of a case study, but focuses specifically on parents as the unit of study.

Chapter One serves as an introduction to the study. The first section describes the research and school contexts in which this study is located. The second section introduces the study, and covers problem formulation, goals and objectives, and motivation. The third section defines key concepts. The fourth section describes an overview of the research design and concludes with a discussion on reflexivity and limitations. Finally, this chapter provides an outline of the chapters in this study.

1.2 Contexts

1.2.1 Research context

Attention-Deficit/ Hyperactivity Disorder (known as ADHD) can affect as many as three out of thirty children (Bester, 2006), making it the most common childhood Disorder (Biederman, 2005; Masse et al., 2006). It is a chronic disorder with key features of impulsivity, hyperactivity and distractibility (Carr, 2006), resulting in behavioral, relational or academic difficulties. The consequences of the disorder manifest within the school environment, making it one of the most common problems dealt with by a school social worker (Corcoran & Walsh, 2006).
Paradoxically, research shows that interventions targeting only children have limited value: Young and Amarasinghe (2010) argue that for young children, the intervention focus should be parents. There is a considerable body of literature aimed at helping teachers manage children in the classroom (DuPaul, Weyandt & Janusis, 2011), and helping parents improve parenting under conditions of chronic challenges (Daley & O’Brien, 2013), but less research has been generated on the school’s role in supporting parents, and indirectly the child.

Parents buffer the impact of ADHD on the child, thus parenting quality mediates ADHD severity and duration (Kaiser, McBurnett & Pfiffner, 2013). However, the impact on parents has been well documented: mental health problems (Margari et al., 2013), marital discord (Barkley et al., 1990; Margari et al., 2013), and personal and parenting stress (Lange et al., 2005). Many parents have ADHD (Biederman, 2005), adding a further layer of stress. Less well documented is how parents adapt to their challenges and develop resiliency. Interventions promoting resiliency, the concept of ‘struggling well’ (Walsh, 2003:1) which is a feature in managing chronic impairment, is particularly important in less well- resourced contexts such as South Africa (Bhana, 2010). Parents also respond better to interventions when their struggles are reframed more positively (Smith et al., 2014).

The role of schools and school social workers assumes importance when considering that in resourced countries such as the United States of America (USA) schools meet 70% of children’s mental health needs (Franklin, 2005). In South Africa children’s mental health services are under-resourced (Robertson, 2010), and ADHD and Conduct Disorders are under-represented (Flisher et al., 2010). Discussing the role of schools as mental health promoting sites is necessary given Bussing et al.’s (2006a) findings that parents of children with ADHD are not forthcoming in seeking help for themselves, and Flisher et al.’s (2010) contention that in Lower to Middle Income Countries (LMIC) schools are important sites for systemic intervention in ADHD. Schools are accessible to parents and children, intervention is cost free, and school based intervention carries less stigma (Franklin, 2005). As ADHD is chronic, schools are in a better position to provide on-going support (Thomas & Corcoran, 2003). Children generalize gains across home
and school more effectively when interventions are coordinated by school mental health professionals such as social workers (Pfiffner et al., 2011).

In South Africa, the Department of Basic Education (DBE) (2001) expects schools to reach out, support parents, and develop school-parent partnerships to promote and operationalize Inclusive Education. Parent involvement is a key factor in children’s performance at school (Corcoran & Dattalo, 2006). However, research documents parents of children with ADHD avoiding school because of feeling stigmatized and labelled as bad parents (Austin & Carpenter, 2008) or struggling to navigate the school system to advocate for their children (Rogers et al., 2009).

1.2.2 The School (PS)

1.2.2.1 The school

PS is an ex model-C primary school located in a residential suburb to the south of Cape Town. It is bordered by two busy arterial roads, and is opposite a small but busy shopping centre and a local Day Hospital. Bordering the school to the north is a small sub-economic high density housing area. The area surrounding the school is characterized by blocks of flats.

The school is a double story brick structure with a tiled roof, hall, electricity and running water. Facilities include a library, computer lab, and a staff computer resource room. The school has two small playing fields and two netball courts. The school is contained by a wire fence around the perimeter, protected by a guard. A portion of the school is set aside for an aftercare facility.

Racial demographics have changed as less than 5% of children now enrolled are white. An increasing number of African immigrants are settling in the area. Medium of instruction is English, with Afrikaans offered as first additional language.

The school’s capacity is 712 children from grade R to grade 7, with an average class size of 32. There are 3 classes per grade, 5 assistant teachers, and specialized teachers for learning support, library, computers, and arts/culture. A music teacher is contracted by parents. ‘Learn
to Read’ has volunteers helping children with reading difficulties. The school runs a sandwich scheme.

Approximately half of the 712 children live in adjacent suburbs. The other half travel to school by car, taxi, train and bus from suburbs as far as Mitchell’s Plain, Khayelitsha and Muizenberg.

In 2013 monthly school fees were R685 per child, 72 families had fee paying exemption, and a considerable number of parents defaulted paying fees. The school prioritizes financial resources for staff as the Governing Body pays for the assistant teachers, specialist teachers, one extra teacher per grade, and the social worker.

The school partners with parents to fundraise and cater at events. Parents are invited to annual events such as sports days and concerts. Teachers communicate with parents via a diary that is signed daily. At the end of each term parents of children who have behavioral or academic difficulties meet with the teacher. Difficulties are discussed, and strategies documented. If there are continued problems the child is presented to the Institution-Level Support Team (ILST), who may decide that a full team meeting with the parent is necessary to find a way forward. Ad hoc meetings between parent and teacher are encouraged.

The school falls under the Educational Management and Development Center (EMDC) South district. The school can access the EMDC district support staff of psychologist and social worker, as well as the District’s health support of nurse and doctor, although they are in different locations.

1.2.2.2 The school social worker

The school has employed a social worker for 7 years, the researcher having been in the post for the past 2 years as the school social worker. The social worker offers emotional support services to children through case and group work. Preventative programmes are occasionally requested. Traditionally there has not been an emphasis on working with parents or developing school-parent partnerships. The researcher chose to join ILST, become involved in the
management of children with ADHD, and assist teachers in thinking about managing these children in the classroom. The school is not prescriptive how the social worker discharges her responsibilities.

1.2.2.3 ADHD and the school

Concerns are discussed with parents, and if warranted parents are asked to have the child clinically assessed. If a parent has medical aid or can afford it, the child is assessed privately, and medication is the parents’ responsibility although they may ask the school to administer the dose/s. The alternative is relying on State health services for diagnosis and management of medication and co-occurring disorders. Unfortunately, the Department of Basic Education and the Department of Health do not appear to have a coherent system for ADHD assessment and management (personal communication with other school social workers in the district). The Department of Child and Adolescent Psychiatry (DCAP) at Red Cross Children’s Hospital take referrals of children with a complex presentation (personal communication). The Day Hospital holds psychiatric clinics one afternoon a month, but focusses on adult psychiatric patients (personal communication). The onus to help these children has fallen back on the school.

Some schools fund raise to pay for private assessment; others develop a volunteer network of professionals (personal communication). Once a child has been assessed, medication management (only Ritalin is provided by the state system) devolves to the school health system and Ritalin is accessed via the state health service. Currently the school relies on the school doctor’s goodwill to do the assessment, as it is not part of the job description. At PS teachers refer children to the social worker via ILST. Parents are interviewed, and assisted in thinking about parenting strategies. Referrals are only made to the school doctor if the parent wishes to discuss medication as a treatment option. Given the skill set of the researcher, she interviews parents and provides a report for the school doctor, who visits once a term. All children on this

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1 An intersectoral district task team is currently (2015) compiling guidelines on the assessment and management of ADHD referrals from schools through the state health system
system are monitored by the researcher, who requests that teachers complete a Conner’s assessment every term. This is collated for the school doctor.

Until the researcher joined the staff, if a parent did not have access to medical aid the child was discussed at an ILST meeting, and placed on a waiting list for the school doctor to assess when she did her termly visit. Children can remain on this waiting list for a considerable period of time.

1.3 Problem formulation

Within the context of ADHD, this study focusses on exploring parental challenges and resilient parenting adaptations, with a view to examining the role of the school and the school social worker in supporting parents not only in developing parental resilience, but also in developing resiliency in their relationships with the school as an adjunct to forging effective parent-school partnerships. Developing resiliency means understanding challenges as well as protective adaptive strategies that parents experience and employ in their relationships with their children, and the school on behalf of their children. Singer (2002) argues that effective interventions can only be a ‘goodness of fit’ when they are based on what parents say they need and want. Ditrano and Silverstein (2006) and Ho (2002) describe similar collaborative research between parent and school.

There is an increasing call for research on resiliency, particularly in resource poor contexts (Singer, 2002; Brown, Howcroft & Muthen, 2010). However, whilst it is necessary to examine challenges, families cannot only be defined by their problems; acknowledging resources and skills in adapting to challenges is important especially when families are resistant to seeking and maintaining supportive intervention (Silberberg, 2001; Smith et al., 2014).

There is a paucity of South African ADHD research from a family resilience perspective (Brown, Howcroft & Muthen, 2010), and Flisher et al. (2010) caution interpreting research conducted in First World settings to LMIC such as South Africa. There is little published research on ADHD in
South Africa from the social work profession as evidenced by a search of South African social work research publications. Very little research has been conducted in South Africa on operationalizing inclusive education with respect to children with ADHD and their parents, and no research has been generated on the role of the school social worker in this respect. This study therefore seeks to contribute to the body of knowledge concerning parenting challenges and resilience in a South African context, with specific reference to the role of the school and the school social worker in supporting resiliency in families as well as resiliency in parent-school relationships. Furthermore, given the paucity of research in a South African setting, this study hopes to prompt further research, as well as suggest recommendations for the Department of Basic Education and the social work profession.

Using a bio-ecological framework (Bronfenbrenner, 1986), the researcher expects that what happens at home will also affect what happens at school: this research explores both contexts in terms of parental challenges and adaptive coping strategies. This interconnected complexity generated considerable data which could not be separated or reduced for the requirements of a minor dissertation. This presented a considerable challenge in trying to meet the academic requirements of this course.

PS is the site for this research as the researcher is the school social worker who will apply recommendations to generate the ‘goodness of fit’ between expressed need and intervention. Although it would be advantageous to consider a broader population, this is a minor dissertation so parameters had to be useful yet manageable.

1.4 Goals and objectives

The research framework is twofold: how do parents perceive and experience their challenges and adaptive coping strategies (resiliency) in parenting a child with ADHD; and what are their perceptions concerning the role of the school and the school social worker in strengthening parental resiliency and promoting resilient parent-school partnerships.
The research objectives:

1. To explore the challenges perceived by parents in coping with a child with ADHD
2. To explore how parents successfully adapt to and cope with ADHD (resiliency)
3. To explore parental perceptions of how the school and the school social worker can strengthen resiliency
4. To explore parental perceptions of parent-school partnerships to promote resiliency

The research questions:

1. What are the challenges perceived by parents in coping with a child with ADHD?
2. How have parents successfully coped with and adapted to the impact of ADHD?
3. How do parents perceive the role of the school and the school social worker in strengthening resiliency?
4. How do parents perceive parent-school partnerships to promote resiliency?

1.5 Motivation for the study

Firstly, the researcher was unable to find ADHD published research in the field of South African school social work on the experiences of primary school children’s parents and the link with parent-school partnerships and the services that parents would find most empowering. There are a few studies on resiliency in South African parents of children with ADHD from allied professions (Brown, Howcroft & Muthen, 2010). The researcher’s motivation is to contribute to the clinical knowledge of the social work profession, and more specifically to the field of school social work, which is less well represented in South African social work research publications.

Secondly, the researcher is a school social worker. In the course of her work, through discussions with the school nurse, school doctor, teachers, parents and other school social
workers, it has become apparent that management of children with ADHD is of concern, and guidelines have been requested by other school social workers (personal communication). Children are able to access limited resources through the school system and considerable research has been generated on managing the child with ADHD in the classroom (DuPaul, Weyandt & Janusis, 2011). However, the researcher has been curious about parents’ experiences in parenting a child with ADHD and their experiences with, and perceptions of, how the school can help support them in coping with their child. Parents of children with ADHD do seem to be more vulnerable to stress, and parenting can be more challenging hence books and support groups aimed at assisting parents (Bester, 2006; Kutscher, 2008). Quality of parenting is a key indicator in the course of a child’s ADHD, thus developing clinical social work insight into parents’ experiences and needs, with the aim of enhancing resiliency and collaborative parent-school strategies, is warranted. This becomes particularly important in the South African context of limited resources.

Thirdly, the researcher is motivated by the post-modern concept of social constructionism, where the meaning people make of their experiences directs behavior. Understanding and working with this meaning creates opportunities for developing personal, relational and institutional resiliency.

1.6 Definition of key concepts

1.6.1 Attention-Deficit/ Hyperactivity Disorder (ADHD)

Attention-Deficit/ Hyperactivity Disorder is commonly shortened to ADHD, the format used in this study (American Psychiatric Association (APA), 2013). Although diagnostic labelling is not encouraged in a post-modern paradigm, a diagnosis of ADHD is required for pharmacological intervention (Corcoran & Walsh, 2006). For the purposes of this research ADHD also needs to be defined. A clear description of behaviors associated with ADHD sets a context for challenges facing parents.
ADHD is a persistent pattern of frequent and severe developmentally inappropriate behavior that lasts longer than 6 months; is present across at least two settings such as home and school where it causes impairment in functioning; and behaviors are clustered around inattention, hyperactivity and impulsive behavior. Presentation can be categorized as Inattentive, Hyperactive/Impulsive or Combined (APA, 2013: 60).

For the purposes of this research, only parents of children diagnosed with ADHD and receiving stimulant medication were sampled, irrespective of Presentation type.

1.6.2 Parents/family

The term parents and family is used interchangeably in literature (Swart & Phasha, 2011; Walsh, 2002). Walsh (2002:130) provides a developmental and ecological systems definition of families as “…an open system that functions in relation to its broader socio-economic context and evolves over the multi-generational life cycle”. This perspective takes into account complexity of families, in that problems and their solutions are affected on many levels, over time. In this study the parent is the adult who has parental responsibility.

Although ‘parents’ and ‘family’ is used interchangeably in literature, this study uses the terms more specifically. When discussing captured data, the parent is referred to as the ‘participant’. When discussing data more broadly, ‘parent’ is used. If discussion included the child, siblings or extended family, ‘family’ is used.

1.6.3 Resiliency

Doll and Lyon (1998: 2) define resiliency as “…successfully coping with or overcoming risk and adversity or the development of competence in the face of severe stress and hardship” and Walsh (2003: 1) defines it more colloquially as “struggling well”. In this study, resiliency is considered within and across two domains: home and school.
1.6.4 Parent-school partnerships

Epstein (1995: 701) describes parent – school partnerships as ‘recognizing their shared interests in and responsibilities for children’ and through this partnership collaborating to create better programmes and opportunities for students. Swart and Phasha (2011:231) note that as society and family structure becomes more complex it is appropriate to consider more broadly family-school connectedness than the more narrowly defined parent – teacher relationship.

1.6.5 School social work

Germaine, quoted in Broussard (2003:212), describes the school social worker as “stand (ing) at the interface not only of child and school, but family and school, and community and school ... (and is) in a position to help children, parents and community develop social competence and, at the same time, to help increase the school’s responsiveness to the needs and aspirations of the children, parents and community”. Torres (2006: 1123) cites a definition of school social work by the USA Department of Labour, as “providing social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and academic functioning of children”, which highlights the importance of school social work in the interface between school and families. From an ecological and resiliency perspective, Early and Vonk’s (2001:10) definition is appropriate: “school social work services may be seen as promoting desirable mental health outcomes through reducing risk and enhancing protective factors”.

1.7 Research methodology

This study is phenomenological and qualitative as it examines perspectives and experiences of parents. It is also exploratory given the paucity of similar research in South Africa.
1.7.1 Research design

The research design is a qualitative cross-sectional exploratory single case study with multiple respondents. The defining feature of a case study is that it explores in depth a single unit that is affected by, and interacts with, multiple variables within a specific context (Gilgun, 1994; Fouche & Schurink, 2011). This research design was chosen for the following reasons:

- This is a qualitative case study design as it explores parents’ lived experiences
- It explores perceptions of parents at a specific point in time
- It is exploratory given no prior research within this specific context
- The unit of study is the parents of children with ADHD and the specific context is the school
- Eighteen participants took part in the research
- It provides detail on practice issues in a context in which the practice is embedded, making it a useful social work research technique (Strydom, 1996)
- It fits well with an ecological perspective (Gilgun, 1994)

1.7.2 Sampling

In order to be credible and generalizable, the sample should reflect a range of parental perceptions and experiences. This entailed finding a balance between participants who would reflect this range, whilst ensuring that selected participants could honestly share valuable data (Shenton, 2004). Therefore a purposive and discriminant sampling design was used (Leedy & Ormrod, 2010; Yin, 2009).

Of the 57 families known to the school, 18 parents participated: 3 fathers and 15 mothers.
1.7.3 Data collection

The data collection strategy was in-depth interviews using a semi-structured interview schedule. The interviews were audio recorded for data capturing accuracy, and were transcribed into written format for data analysis.

A pilot interview was conducted to test the interview schedule and the operationalization of the research.

1.7.4 Data analysis

This study used Tesch’s (1990) method of coding data. The analyzed data was verified in a presentation and group discussion with participants. Twelve of the eighteen participants voluntarily participated in the verification process.

1.8 Reflexivity

As this is the researcher’s first experience of research at this depth, the process was a steep learning curve. An attitude of reflexivity before, during, and after the process, combined with supportive supervision, enabled this research to take shape in a trustworthy manner. The researcher was also guided by the ethical code (Strydom, 2011a) discussed in Chapter Three.

The final challenge was managing the quantity of data within the framework of a coursework minor dissertation. The tension between compromising data and the trustworthiness of the study against the researcher’s own inexperience in whittling down data required considerable reflection and supportive and critical supervision.
1.9 Limitations

This study has a number of potential limitations, which have to be understood within the context of a minor dissertation. Researcher subjectivity has been discussed, but there were also design limitations. The research was conducted and analyzed by one person, using one research method, having only one source of data obtained in one session (Rubin & Babbie, 2011). The researcher is employed by the school and is thus embedded in the research context.

1.10 Outline of chapters

Chapter One provided an introduction to the study. It discussed the context for the study, the problem formulation, goals and objectives, and motivation. Key concepts were defined, the research design summarized, and it concluded with challenges and limitations.

Chapter Two provides the literature review, an important element in a case study as the literature review provides the theoretical context for the research questions and data analysis. This study is approached from a social constructivist perspective, and rests on two theoretical frameworks that lend themselves to being adapted within the school context: the bio-ecological model of Bronfenbrenner (1979; 1986) and resiliency theory. Current research and literature around parental challenges, adaptations and the role of the school and the school social worker in supporting family and family-school partnerships is explored with reference to these two models.

Chapter Three presents the research methodology in detail. This chapter charts the course of the research from the rationale for choosing the case study design, the trustworthiness of the design strategies, the data collection implementation and Tesch’s (1990) method for data analysis. The pilot study and the data verification process are included. The chapter concludes with a discussion of ethics and the researcher’s process of reflexivity.

Chapter Four presents the research data. It begins by addressing demographic factors, before outlining the Framework for Analysis. Data is presented in four themes: challenges facing
parents; their adaptations; the role of the school and the school social worker in helping
develop resiliency; and parents’ perceptions of parent-school partnerships. Significant trends
are compared to existing theory, and examples from narratives are provided.

Chapter Five gathers together the conclusions derived from Chapter Four and presents them,
together with recommendations, for key role players.
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The case study relies on the literature review to generate context for the research questions (Yin, 2009) and the data (Gilgun, 1994). This literature review relies on research generated outside South Africa given the paucity of South African research, as has been done in other South African ADHD resiliency studies (Brown, Howcroft & Muthen, 2010), but is mindful of Flisher et al.’s (2010) words of caution about applying external research to LMICs such as South Africa.

This study is approached from a social constructivist perspective, and rests on two theoretical frameworks that lend themselves to being adapted within the school context: the bio-ecological model of Bronfenbrenner (1979; 1986), and resiliency theory. Current research and literature concerning parental challenges, adaptations and the role of the school in supporting family resilience is explored with reference to these two models. This chapter briefly discusses social constructivism and social work, and describes Bronfenbrenner’s bio-ecological model and resiliency theory. The bio-ecological model is then used as a framework for managing information relevant to this study.

2.2 Post –modernism

2.2.1 Background

Post- modernist epistemology gathered force towards the end of the twentieth century, moving away from an ‘objective’ perspective of knowledge that was the hallmark of the ‘modern’ epoch of epistemology, to take the stance that truth is subjective and relative, that thinking and behaving is linked to beliefs and assumptions and the meaning that is made of them, which in turn is rooted in increasingly wider contexts of family, community, culture and
society (Payne, 2005). Knowledge is thus constructed rather than discovered, and rooted in social contexts. Given this concept of ‘construction’ post modernism has also been called social constructionism.

The post-modern epistemological framework has found expression in a range of models within psychology, sociology and social work. Bronfenbrenner’s (1979; 1986) developmental bio-ecological model sees the individual as “nested” within gradually widening contexts. Social constructivism, based on neurobiological discoveries, argues that the brain is templated to filter information in particular ways; a concept of ‘feedforward’ rather than ‘feedback’ (Carpenter, 2011:123), which finds similarities in Bronfenbrenner’s (1986) later work where he acknowledges the biological element, but considers it mediated by nested contexts.

Post modernism espouses two key principles, collaboration and empowerment. These are enabled through the belief that individuals are experts in their own lives; and with support solutions can be found and sustained. Resilience, described as adaptation under stressful conditions, falls within this paradigm.

### 2.2.2 Social work and post-modernism

Social work came into being with its focus on the individual within the environment. Payne (2005:6) describes social work as “practical action in a complex world” and considers one of social work’s key tasks interpreting this social and cultural complexity to other professions.

Social work is well placed within a post-modern paradigm, given the profession’s acknowledgement of the interdependence between people and their contexts, and social work values of empowerment, client self-determination, working at the client’s pace and within the client’s frame of reference. Wulff (2011: 356) says of post-modern social work practice that it “… deliberately focuses on the complex situation of persons in their environments. A strategy that stands against simple or circumscribed understanding and interventions … a single preferred way of understanding any given human situation is automatically limited”.


2.2.3 Research and post modernism

Research has its own flavor within the post-modern paradigm. Causality is complex and circular, and constantly changing within nested contexts. Perceptions and stories of experience, the outward evidence of meaning making, are considered valid data. Singer (2002) argues for ‘a goodness of fit’ between clients’ needs, what is offered and how it is offered, and this can only be assessed by collaboratively researching these needs with a focus on the particular client group requiring services. Research evolves from the bottom up, and is contextually rich.

Given that social work is a “practical” profession (Payne, 2005), research that guides practice, within specific contexts, operationalizes Singer’s (2002) ‘goodness of fit’ between perceived needs, and solutions offered.

2.3 Bio-ecological Model

Although ADHD is universal, how it is understood and managed is within a social context that takes into account psychological, social, economic and cultural influences and interactions. Bronfenbrenner’s (1979;1986) bio-ecological theory of child development has proven to be a useful framework for understanding systemic influences on children’s development, and has been applied and adapted to the school setting (Pianta & Walsh, 1998; Downer & Myers, 2010; Frey & Dupper, 2005; Department of Basic Education, 2010), within the South African context (Dawes & Donald, 2000), and particularly in understanding barriers to learning in South Africa (Donald, Lazarus & Lolwana, 2006; Swart & Pettipher, 2011; Swart & Pasha, 2011; Du Plessis, 2012). It therefore has value as a model for thinking about the complex ramifications of ADHD within a school-home perspective. Bronfenbrenner’s work has been used to develop a way of thinking that combines his ecological concepts with systems theory, often referred to as an ecosystemic model (Donald, Lazarus & Lolwana, 2006).

The model lends itself to an exploration of resiliency. Pianta and Walsh (1998) argue that resiliency is best understood from a contextual systems perspective: they believe that
stemming risk in a system is more effective for the majority. Pianta and Walsh (1998:6) state that “risk and resilience are not characteristic of a child or a family or a school but are characteristics of a process involving the interactions of systems”. Developing home-school collaborations is thus critical in terms of promoting family resiliency.

Bronfenbrenner’s bio-ecological theory (1979, 1986) is based on the constructivist perspective that knowledge is actively and continuously constructed by individuals, groups and societies (Donald, Lazarus & Lolwana, 2006). How people perceive their environments impacts on their response; people are active rather than passive participants in their own development; and changes in one part of the system will have an impact on other parts of the system (Swart & Pettipher, 2011).

Bronfenbrenner’s (1986) model of child development takes as its point of departure that children’s development is shaped by the interaction between their biological attributes and social contexts. The dynamic interaction between these contexts then fosters or disrupts development. These biological attributes, which Bronfenbrenner called person characteristics, include the child’s temperament, ability to use resources, and personal capacity to invoke reactions that impact on development (Swart & Pettipher, 2011). Interactions build up repetitively over time through close contact, which Bronfenbrenner called ‘proximal processes’ (Swart & Pettipher, 2011).

Bronfenbrenner (1979; 1986) used the term “nested” to illustrate that social contexts are embedded within each other, and are inextricably linked so that an impact in one context will have an impact in other contexts. He constructed a model of nested systems: micro, macro, meso, exo and later, as his theory evolved, the chrono system, which takes into account the developmental impact of these nested systems over time (Bronfenbrenner, 1986). At the heart of these nested systems is the child. It is not enough to understand the influences within each system as much as the reciprocal influences between the systems, and considerable attention is given to the importance of relationships as systems in their own right when the ecological model is applied to school contexts (Christenson, 2003; Epstein, 1995; Downer & Myers, 2010).
A brief explanation and contextualizing of these systems is as follows:

**Microsystem:** This includes all the proximal contexts vital for child development, such as parents, siblings, peers, teachers, family members and the school, all of which tend to be affected by ADHD behavior. “The microsystem is made up of the roles, relationships and patterns of everyday life that both shape and are shaped by the child in terms of cognitive, emotional, social, moral and spiritual development” (Donald, Lazarus & Lolwana, 2006:41).

**Mesosystem:** These are the connections and relationships between the individual microsystems in the child’s world. For example, a child who is impaired by ADHD will have an impact at home and at school; what happens at home will impact on what happens at school. There is considerable literature around how the home context or the school context affects child development, but it is generally recognized that less work has been done understanding how development is impacted by the intersection of home and school contexts, i.e. the realm of parent-school partnerships (Lohman & Matjasko, 2010) despite an increasing awareness that this partnership can be critical to a child’s success at school (Downer & Myers, 2010; Chavkin, 2005). A well-functioning school attempts to develop reciprocal mesosystemic relationships between as many of the microsystems as possible (Swart & Pettipher, 2011).

**Exosystem.** These systems have an indirect effect on the child, such as parents’ decisions concerning intervention e.g. therapy, support groups, parenting training or the decision whether or not to medicate their child.

**Macrosystem:** This system reflects social, cultural and economic factors, values, beliefs and practices that can affect the child’s development, such as the policy of Inclusive Education (Department of Education, 2001).

**Chronosystem:** Systems continuously evolve over time, and interact with the child’s stages of development. There is a reciprocal relationship between a child’s development and the social context.
2.4 Resiliency

Resiliency is in the balance between stressors/risks and protective factors, and developing coping skills in the face of adversity (Donald, Lazarus & Lolwana, 2006; Doll and Lyon, 1998; Climie et al., 2013) and is encapsulated in Walsh’s definition of ‘struggling well’ (2002: 132). Resiliency fluctuates, and is a process that develops over time (Walsh, 2002).

Donald, Lazarus and Lolwana (2006:172) define protective factors as “those that compensate for, shield, support or strengthen a person’s responses to stress”. These protective factors can be individual such as the ability to relate, communicate, effectively problem solve, and have a strong sense of self (Donald, Lazarus & Lolwana, 2006; Gitterman, 2011; Walsh, 2003) or family based such as consistent family values and the encouragement of competence (Donald, Lazarus & Lolwana, 2006); kind and effective parenting (Doll & Lyon, 1998); and the ability to reframe crises, pull together, and seek help (DeFrain, quoted in Silberberg, 2001:56). Acceptance and identity within the peer group, access to positive role models, and a wider circle of trusted and accessible adults are characteristics of protective support networks for children (Donald, Lazarus & Lolwana, 2006:172), and the same is true for adults (Bussing et al., 2003a). Many individual protective factors are challenged by ADHD, resulting in risk factors outweighing protective elements. Fostering resiliency in families and the wider community thus becomes an important strategy in managing the chronic impact of ADHD.

Theories concerning stress are often linked with resiliency e.g. how a family recognizes, thinks about and reacts/adapts to stress (Walsh, 2002). Hill’s ABCX formulation of family stress (as cited in Kadesjo et al., 2002; Prithiviraj, 2007) states that event (A) interacts with coping/resource network (B) interacts with how the family think about or interpret the event (C), resulting in the stressful crisis (X).

This can be stated in an equation as \[ \frac{A+C}{B} = X \]
McCleary (2002) analyzed the literature around parenting and ADHD from a social work perspective and found most useful Lazarus and Folkman’s (Lazarus & Folkman, 1984, as cited in McCleary, 2002:287) theory that focuses on the process of adaptation in the face of stress. Stress begins as a psychological experience of being overwhelmed, is cognitively appraised (it is only stressful if it’s perceived to be stressful), coping behaviors are employed that are linked to resources and constraints, this is reappraised, and thoughts and behaviors are adapted. Acute or chronic stressors need to be seen within the context of other stressors, as well as within the life cycle context (Gitterman, 2011), and this theory finds credence in Brannan and Heflinger’s (2001) contention that stress is normative when raising children with ADHD; it becomes psychological distress when other stressors are present.

A key feature of resiliency theory is that it is aligned with a post-modern strengths based perspective (Silberberg, 2001; Walsh, 2002; Climie et al., 2013) that promotes the values of empowering families through paying attention to resources and strengths as well as problems, and by working collaboratively. Climie et al. (2013) state that it’s not about asking what is wrong so much as asking what can make it right; and Walsh (2002) contends that it’s about seeing people as challenged rather than troubled. This finds an echo in ADHD literature that challenges the perspective of labeling children with ADHD and their families as damaged (Lench, Levine & Whalen, 2013; Austin & Carpenter, 2008; Travell & Visser, 2006), and that psychological stress when raising more difficult children is normative rather than pathological (Brannan & Heflinger, 2001).

Although it is important to understand resiliency within specific microsystems, resiliency studies are also concerned with mesosystemic interactions (Doll & Lyon, 1998). Pianta and Walsh (1998) believe that resiliency programmes must be flexible, designed for specific communities, and support and sustain intervention over time. Schools are considered ideal sites for promoting resiliency based interventions for vulnerable families, with good reason (Doll & Lyons, 1998; Pianta & Walsh, 1998; Donald, Lazarus & Lolwana, 2006; Dawes & Donald, 2000; Bussing et al., 2003a; Bhana, 2010). School-based programmes can be sustained over time (Doll & Lyon, 1998); potentially more children and their parents can be reached at school than
community clinics (Franklin, 2005); schools provide smaller more integrated systems for the most vulnerable children (Pianta & Walsh, 1998); and most importantly, schools can be used more effectively, especially within a context of limited resources such as South Africa (Bhana, 2010). Schools are also often the original source of referral for diagnosis and treatment (dosReis et al., 2003; Department of Basic Education, 2010).

2.5 An application of the bio-ecological model

The following section uses the bio-ecological framework to organize literature relevant to this study.

2.5.1 Microsystemic factors: the child

2.5.1.1 Description of ADHD

ADHD describes a severe and pervasive condition in which three core symptoms of impulsivity, hyperactivity and inattention predominate (APA, 2013: 61). It is considered a developmental, neurobiological and chronic condition that is first diagnosed in childhood (APA, 2013). ADHD is a condition that has been found worldwide (Remschmidt, 2005), including South Africa (Meyer et al., 2004). Prevalence rates are generally between 5% and 10% for children, and 4% for adults (Faraone, cited by Biederman, 2005:1215). In South Africa this can translate to 3 out of a class of 30 children affected (Bester, 2006). Three times more boys than girls are identified, possibly because more boys are affected by co-occurring disruptive behavior disorders (Biederman, 2005) or by non-compliance (Corcoran & Walsh, 2006). Girls present with higher levels of inattentiveness (Sciutto & Eisenberg, 2007). This could mean that girls are under-identified (Sciutto & Eisenberg, 2007), or the disorder is more marked before it is diagnosed in girls, as Meyer et al. (2004) notes that it is more prevalent in boys but more severe in girls.
The DSM V (Diagnostic and Statistical Manual, 5th Edition), (APA, 2013: 59-66) diagnostic criteria differentiate between three types of ADHD: ADHD combined presentation; ADHD predominantly inattentive presentation, and ADHD predominantly hyperactive/impulsive presentation. Six or more designated symptoms interfering with development need to be present within the past six months in order to be diagnosed with one of the presentations of ADHD. In addition, ADHD can be in partial remission, or its current severity recorded in terms of mild, moderate or severe. Symptoms must be present before the age of 12, and across at least two settings, such as home, school, peers, and other activities (APA, 2013: 60). It is noteworthy that a deepening understanding of ADHD is demonstrated in the DSM V’s re-categorization of ADHD from a disorder in children to a neurodevelopmental disorder with a childhood onset (Dalsgaard, 2013). From an educational perspective, inattentive rather than hyperactive presentation is considered more of a risk factor (Daley & Birchwood, 2010). For a list of the DSM V diagnostic criteria, see Appendix 1.

Of particular concern are co-occurring disorders, which are the norm rather than the exception (Becker, Luebbe & Langberg, 2012). Corcoran and Walsh (2006:132), citing work done by Langstroem, note that 44% of children with ADHD have another disorder, 33% have two disorders and 10% have three co-occurring disorders. The most common are the behavioral, mood and anxiety disorders (Biederman, 2005), but Carr (2006) comments that virtually all children with ADHD struggle to achieve academically. Daley and Birchwood (2010) argue that inattentive presentation correlates strongly with persistent reading impairment. Anxiety and alcohol abuse are the most frequent co-occurring disorders seen in adults with ADHD (Biederman, 2005). Co-occurring disorders have implications for greater impairment, poorer outcomes, increased chance for risk taking behavior, and higher costs of treatment (Becker, Luebbe & Langberg, 2012).

A summary of the clinical features of ADHD, as compiled by Carr (2006: 427) can be found in Appendix 2.
2.5.1.2 Aetiology

With the advent of neuro-imagery techniques of brain mapping, ADHD is now understood to be a complex brain disorder with no single underlying cause or presentation (Biederman, 2005; Kieling et al., 2008; Carr, 2006). Structural differences in the brain and a dysregulation of the neurotransmitter systems in the prefrontal and subcortical structures of the brain have been identified (Fleming & McMahon, 2012). This means that symptoms could be a combination of different and separate neurological impairments (Fleming & McMahon, 2012); Tannock (2013) contends that Inattentive presentation could be seen as a separate disorder in its own right.

The impact of these differences in the structure and functioning of the brain manifests in terms of response inhibition and delay aversion. Impairment in response inhibition results in the core symptoms of distractibility, impulsivity and emotional dysregulation, which in turn leads to impairments in higher order executive brain processes such as organization, planning and working memory (Fleming & McMahon, 2012). Children increasingly struggle with more complex tasks, often evoking a more punitive response, and a pattern of task avoidance ensues (Fleming & McMahon, 2012). As neural structures continue to develop until the mid- twenties, practice is an important intervention. With the relatively recent surge of research into adult ADHD it is now known that executive impairment continues into adulthood, is possibly more marked, and is associated with lower academic achievement and lower socio-economic status (Spencer, Biederman & Mick, 2007). This has implications for interventions with parents of children with ADHD.

Delay aversion is a result of impaired signaling of long term reward, resulting in low boredom tolerance and avoidance of being bored (Fleming & McMahon, 2012). Sonuga- Barke (cited in Fleming & McMahon, 2012: 2) describes it as the preference for smaller immediate rewards over larger, delayed rewards. Daydreaming and fidgeting are interpreted as behaviors that generate instant reward, thus fending off boredom.

ADHD has a 77% chance of inheritability, making it the most inherited condition after height (Biederman, 2005). ADHD can also be caused by anything that potentially alters the brain during critical periods of in utero and post birth development. Maternal stress; smoking during
pregnancy; prematurity and low birth weight; birthing procedures such as forceps delivery; and attachment problems have, amongst others, been considered as causal or exacerbating factors (Spencer, Biederman & Mick, 2007; Corcoran & Walsh, 2006).

As ADHD is a chronic condition, intervention is not one of cure, but of management across all systems that impact on the child (Kadesjo et al., 2002). Biederman (2005) warns that medication manages the symptoms of this early alteration to the brain, but cannot cure. Also, intervention aimed at the child alone has not proved to be effective over time (Harrison & Sofronoff, 2002), and in fact is not considered an option at all for young children (Young & Amarasinghe, 2010).

2.5.1.3 Impact on the child

These children are often in conflict with parents, family members, teachers, and their peer group because they struggle to manage behavior and emotions due to impulsivity, distractibility and poor tolerance of boredom (Carr, 2006). Although some studies seem to suggest that the child is less aware of these problems than those impacted by them (Evangelista et al., 2008), secondary problems can arise such as poor self-esteem, anxiety, problematic ability to both make and keep friends, and worsening behavioral problems (Carr, 2006).

Kos, Richdale and Hay (2006: 149) describe these children as being socially inept, controlling, aggressive, and trouble prone. In considering peer relationships, Law, Sinclair and Fraser (2007:106) found that children with ADHD were avoided by other children because they were seen as ‘careless, lonely, crazy and stupid’. Bell et al. (2011) noted that children with ADHD had the highest social rejection rate compared to other psychiatric or illness categories, and that children internalize and act out these negative labels.

These children have significantly more academic difficulties (Carr, 2006; Frazier et al., 2007; Daley & Birchwood, 2010; Loe & Feldman, 2007) and are 4 – 7 times more likely to need remedial education (LeFever, Villiers & Morrow, 2002: 67) with Bester (2006) estimating that
80% of South African children with ADHD underachieve. Inattentive symptoms are more problematic for academic performance (Daley & Birchwood, 2010).

Most ADHD research looks at problems rather than protective factors, and narratives around ADHD can impress as problem sodden rather than solution driven. However, a resiliency perspective looks at both risk and protective factors, and it should be noted that the presence of symptoms does not necessarily imply impairment (Biederman, 2005). Other micro and meso-systems, particularly the family (Becker, Luebbe & Langberg, 2012), and the school (Bell et al., 2011), have the potential to mediate the effects of ADHD.

The ability to reframe behavior positively can be a key protective factor (McIntyre & Hennessy, 2012; Lench, Levine & Whalen, 2013). Whilst not underestimating how challenging these children can be, it is also important to consider what they can offer. A South African website describes these children as spontaneous, creative and able to hyper-focus when their attention is captured (The ADD Lab).

### 2.5.2 Microsystemic factors: the family

Although the aetiology of ADHD is neurobiological, severity and persistence is buffered by parenting quality (Kaiser, McBurnett & Pfiffner, 2013; Hinshaw, 2007; Johnston & Mash, 2001; Cunningham, 2007; Harrison & Sofronoff, 2002; Corcoran & Walsh, 2006). However, a vast body of research has documented the adverse impact on parents from mental health disorders to high levels of personal and parenting stress. Effective interventions therefore need to include parents (Hinshaw, 2007; Harrison & Sofronoff, 2002).

Early research on the impact of ADHD on parenting focused on mental health problems. Parents (particularly mothers) were considered to be more at risk of mental health problems such as depression (Biederman et al., 1990; Biederman, Kerim & Knee, 1987; Cunningham & Boyle, 2002; Hinshaw, 2007; Margari et al., 2013); increased use of alcohol (Margari et al., 2013; Biederman, Kerim & Knee, 1987) and were three times more likely to separate or
divorce (Barkley et al., 1990) although Wymbs et al. (2008) noted that this was more prevalent in families with adolescents. Given the strong inheritability factor, a large percentage of parents themselves have ADHD, which conflates difficulties, particularly in emotional regulation and family organization (Lui, Johnston & Lee, 2013; Margari et al., 2013). Sonuga-Barke et al. (2006) consider maternal ADHD to be a strong limiting factor in successfully completing parenting programmes.

Another stream of research focused not on mental health issues as such, but rather the impact and management of personal and parental stress (Lange et al., 2005; Johnston & Mash, 2001; Harrison & Sofronoff, 2002; Kadesjo et al., 2002; Cheesman, 2011). Prithivirajh (2007) described stress in the context of parenting children with ADHD as a cocktail of frustration, conflict and pressure. However, Brannan and Heflinger (2001) argued that caregiver stress is normative given the challenges in rearing these children, and that psychological distress is a result of a combination of the child’s symptoms and other problematic life events.

Other research has looked at the impact of socio-economic status and the more subtle impact of gender and culture on parental stress levels (dosReis et al., 2003; Bussing et al., 2003a). Singh (2004) and Austin and Carpenter (2008) are interesting studies in this respect. Singh (2004) linked mothers’ self-blame to a cultural discourse of what constitutes an ‘ideal mother’. Austin and Carpenter (2008), in a continuation of this theme, described mothers in their study as ‘troubled, troublesome and troubling’ as they failed to measure up to what society expects of ‘good mothers’, given their ‘disorderly, disordered, disorganized and disruptive’ children. Austin and Carpenter (2008) concluded that these children are seen as a threat to cultural notions of ‘good’ children, hence external and internal labelling as ‘bad mothers’. Experience of mothering is diminished, and knowledge and expertise is not recognized.

Parenting and personal stress seems to increase when children have co-occurring disorders such as Oppositional Defiance and Conduct Disorders, which in turn are linked to harsher parenting practices (Cunningham & Boyle, 2002). However, Rogers et al. (2009) argue that ADHD symptoms in themselves are enough to cause parenting stress; especially as the symptoms are always embedded within relationships (Singh, 2004) and that mothers seem to
be particularly stressed by inattentive symptoms and when girls present with behavioral problems (Podolski & Nigg, 2001).

Against this backdrop of mental health problems and high levels of personal and parenting stress, the literature documents problematic parenting responses such as low parenting confidence, self-blame, isolation (Mash & Johnston, 1983; Cunningham, Benness & Siegel, 1988; Lange et al., 2005) and authoritarian, negative parenting (Margari et al., 2013; Lange et al., 2005; Cunningham & Boyle, 2002; Kaiser, McBurnett & Pfiffner, 2013). Intolerant, punitive and inconsistent parenting results in more problematic behavior (Hinshaw, 2007; Kaiser, McBurnett & Pfiffner, 2013; Lange et al., 2005), and parents can develop a ‘learned helplessness’ (Harrison & Sofronoff, 2002) in managing the behavior.

However, stress is not an objective reality: stress is in the perception of the problem, and the available resources (both internal and external) to manage the problem (McCleary, 2002). In considering how to help parents develop long term resiliency in the face of a chronic condition it is helpful to consider Mash and Johnston (1990), Harrison and Sofronoff (2002), Hoza et al. (2000), Kadesjo et al. (2002), McCleary (2002), and Bussing et al.’s (2003a) argument that it is vitally important to understand the impact of ADHD on parents: what they believe about ADHD; how they seek help; how they understand and use resources; and how they view their effectiveness as parents. Studies by Bussing et al. (2003a) and Davis et al. (2012) found that parents initially interpreted ADHD behavior as being naughty or lazy, or due to developmental delays, and thus handled their children according to this viewpoint.

A third stream of research takes this social constructivist stance and attempts to explore the lived experience of being a parent of a child with ADHD. McIntyre and Hennessy (2012) argue that the lived experience of parents should be understood, and point out that there has been little research unpacking how parents themselves understand their challenges and successes. This challenge was taken up by McIntyre and Hennessy (2012), Peters and Jackson (2009), Singh (2004), Harborne, Wolpert and Clare (2004) and Firmin and Phillips (2009).

As this study falls within this ambit, and adds a South African parenting experience, it is interesting to look more closely at the themes that have evolved from similar research.
Peters and Jackson (2009) conducted their research in Australia. They found that parents experienced their parental responsibilities as stressful, relentless, overwhelming, and with no end in sight. Parents carried a sense of guilt and self-blame, which was exacerbated by the reaction of others. This prompted Peters and Jackson (2009) to name one of their themes ‘stigmatized, scrutinized and criticized’. Frustration was a lesser theme, but was linked to the need for constant surveillance of the child, feelings of inadequacy, competing demands at home, and having to restrict their friendships because of the child’s behavior. An additional stress for mothers was assuming sole responsibility for the children. Lack of resources added to parental problems.

Harborne, Wolpert and Clare (2004) called their three themes ‘blame, battles and emotional distress’. These parents were also overwhelmed and emotionally distressed by the relentless role of caring within an environment of being criticized for their parenting. Parents felt that teachers were not managing their children correctly.

McIntyre and Hennessy’s (2012) Irish cohort described battling with a sense of parenting or relationship guilt because of the disproportionate amount of time it took to manage the child. Parents worried about not doing enough or the right thing, and struggled to manage exhaustion. Their feelings were exacerbated by a sense of being blamed for their child’s behavior, and because they constantly experienced ignorance and discrimination by family and the wider community. These mothers were dissatisfied with state support structures.

This theme of feeling judged and having their parenting criticized was also described by Neophytou and Webber (2005). However, once the children had been diagnosed the behavior was reframed and parents felt less blame, a finding reflected by Singh (2004), although Singh cautioned against medicalizing the disorder. Neophytou and Webber (2005) reported that parents felt that neither they nor teachers had been given enough information and support in learning to cope with the children.

Singh (2004) linked self-blame to a sense of inadequacy at ‘solving’ the child’s problem, despair at making it worse through a lack of personal resources, and shame attached to out of control feelings of anger, frustration and hate. Singh’s (2004) analysis was that mothers internalized a
sense of being a bad mother: they struggled to connect with their children, and battled with negative emotions such as anger, rejection, depression, and isolation. Singh’s (2004) mothers felt blamed by their partners and the wider community.

It would thus seem that there are key themes that run through these studies, which are also supported by evidence from other studies. Parents were frustrated by their perception that it was not going to get better over time, and that family life was constantly disrupted by the child’s demanding, disorganized behavior (Coghill et al., 2008) or unpredictability (Mash & Johnston, 1990). Stress was linked to single parenthood, or when mothers assumed more parenting responsibility because fathers were unable to cope, parented too coercively, or engaged less with the child (Rogers et al., 2009). Podolski and Nigg (2001) found that as the child’s behavior worsened, parents experienced less support.

A fourth stream of research, not as well developed, has considered not only challenges facing parents, but also parental coping adaptations. It is a more holistic view, based within a resiliency framework that echoes Walsh’s (2002) ‘struggling well’. Cunningham (2007) argues that in a chronic condition such as ADHD, adaptability is a more important marker of progress and management than symptom reduction.

The research by McIntyre and Hennessey (2012), Singh (2004) and Peters and Jackson (2009) included adaptive strategies employed by parents, although these tended to be overshadowed by the challenges. McIntyre and Hennessy (2012) examined two adaptive themes: understand ADHD and its developmental impact; and look for the success stories. These strategies helped parents reduce self-blame, whilst creating a space to reframe behavior more appropriately. Podolski and Nigg (2001) noted that the ability to reframe behavior positively reduced maternal distress, which in turn reduced problematic behavior. Lench, Levine and Whalen (2013) echoed this ability to reframe as parents referred to their children as “indigo children”. These parents, whilst not denying difficulties, were able to see the positives within ADHD. A South African study conducted by Brown, Howcroft and Muthen (2010) found a similar effect as families used knowledge effectively to reframe behavior. However, the ability to reframe behavior is dependent on accessing accurate information on ADHD.
Accessing support, talking to others and seeking advice was another protective adaptive theme (McIntyre & Hennessy, 2012; Brown, Howcroft & Muthen, 2010; Brannan & Heflinger, 2001). Faith could be considered a form of support, and has been noted by Bussing and Gary (2001), Bussing et al. (2006), Brown, Howcroft and Muthen (2010) and Podolski and Nigg (2001). Walsh (2003) wrote that faith can give comfort and strength in the face of chronic impairment.

Fermin and Phillips (2009)’s study sampled participants from an active support group. The themes that arose were considerably more adaptive, begging the question whether ongoing education and support helps parents become more adaptive. These parents were knowledgeable about ADHD, and could differentiate between naughtiness and developmental problems linked to ADHD. They were described as being sensitively attuned to their children, and employed proactive parenting strategies, especially in developing routine, structure, and managing the more stressful afternoon period. Bussing and Gary (2001) recorded adaptive parenting strategies such as keeping children busy, giving extra attention, and providing structure and responsibility.

Brown, Howcroft and Muthen (2010) conducted a South African study into family resiliency and concluded that families demonstrate resilient strategies that offset chronic stressors of ADHD parenting. The most significant adaptive factors were, in order of significance: social support; maintaining medication; gaining knowledge and understanding; creating family time and routine; accepting the diagnosis and understanding the child within his context; honest and open family communication; adapting disciplining techniques at home and school; and drawing strength from religious beliefs and practices. It must be noted that these parents were accessed via support groups and professionals.

Common themes in terms of successful adaptive parenting strategies can be summarized as follows:

- Routine and structure (Bussing & Gary, 2001; Brown, Howcroft & Muthen, 2010; Fermin & Phillips, 2009). This was a key strategy noted in self-help books directed at parents (Bester, 2006, 2014; Kutscher, 2008).
• Staying calm (Bussing et al., 2006; Bester, 2006, 2104; Kutscher, 2008)
• Quality time (Brown, Howcroft & Muthen, 2010)
• Being proactive and willing to adjust lifestyles (Firmin & Phillips, 2009)
• A key role for mothers was one of advocacy, especially with the school, but also around medication (Peters & Jackson, 2009; Singh, 2004)
• Family warmth and effective disciplining (Kaiser, McBurnett & Pfiffner, 2013)
• Implementing specific behavioral interventions suggested by professionals (Brown, Howcroft & Muthen, 2010; Firmin & Phillips, 2009)

However, Bussing and Gary (2001) and Bussing et al., (2006) conclude that whilst it is important to understand adaptive strategies being used by parents in order to strengthen them, few of these self-help strategies prevent the need for other intervention strategies such as counselling or medication. A number of ADHD parenting programmes specifically enhance coping strategies (Daley & Birchwood, 2010; Sonuga-Barke et al., 2006; Young & Amarasinghe, 2010).

2.5.3 **Microsystemic factors: the classroom**

The teaching environment is an important microsystem, and considerable research has been devoted to the management of ADHD at school (DuPaul, Weyandt & Janusis, 2011; Du Paul, 2007). Large classes, classroom noise and distractions, and lack of one on one teaching are risk factors for the child managing at school (Daley & Birchwood, 2010; Loe & Feldman, 2007). Although hyperactivity is the behavior most noticed, inattentive behavior, which manifests as daydreaming, poor working memory, disorganization and poor planning ability (Daley & Birchwood, 2010) is problematic academically.

According to Bester (2006:117) 33% of South African children with ADHD do not finish school, and 80% underachieve as a result of inattention, poor working memory, and learning disabilities. LeFever, Villiers and Morrow (2002:67) found that these children were between four and seven times more likely to need remedial or special education or be suspended or
expelled because of unacceptable behavior, and in their study 40% of the parents felt that the school was not providing enough services for their children.

Apart from the teacher’s role in buffering academic and peer impact of ADHD, the school also has a role in assessment referrals, and implementing treatment strategies (dosReis et al., 2003; Vereb & DiPerna, 2004). This may not always be the case as this finding contrasts with a Stellenbosch study conducted by Perold, Louw and Kleynhans (2010), who found very little involvement of teachers in the assessment and treatment of children with ADHD.

Less research has been conducted around teachers’ knowledge and attitudes towards ADHD but consensus is that teachers require specialized training (Kos, Richdale & Hay, 2006; Sherman, Rasmussen & Baydala, 2008; West et al., 2005; Bell et al., 2011). Perold, Louw & Kleynhans (2010) conducted a survey of primary school teachers working in schools in the Stellenbosch area of Cape Town and ascertained that overall knowledge of ADHD was poor, and that information was not based on scientific research but popular knowledge. West et al. (2005) commented that although parents know more about ADHD than teachers, teachers are the most important factor in the child succeeding at school. Professional development in knowledge and management of ADHD is thus critical. The Department of Basic Education (2010) has acknowledged that teachers lack training and skills to manage academically vulnerable children.

Aside from classroom management, teachers can help prevent peer isolation and stigma by helping classes reframe ADHD behavior and learn to relate to the child more empathically (Bell et al., 2011).

Homework is one of the strongest areas of overlap between home and school, and difficulties that are evident at school will be evident in managing and completing homework, often causing considerable frustration and strife at home (Power et al., 2006). In a book written mainly for South African parents, Bester (2006) notes that some of the key areas that cause concern for parents in the primary school years are around how children record homework (because without recording it, it does not get done), getting children to do and/or complete homework, erratic performance as they know the work at home but get poor results in tests, messy work,
untidy handwriting, and lost work and books. Raggi and Chronis (2006), reviewing research, note that these children present with poor comprehension and study skills, poor preparation for class, and are in conflict both with peers and teachers. This problem is compounded when parents feel less able to help their children academically, as was found by Rogers et al. (2009) although other studies have found that parents do give academic encouragement and support (Diez et al. as described in Garcia, Jara & Sanchez, 2011: 545).

Power et al. (2006) and Raggi and Chronis (2006) believe that co-operative intervention between parents and teachers around homework is as essential as medication, behavioral training for parents and teachers, and class based interventions.

2.5.4 Exosystemic factors: treatment

2.5.4.1 Medication

Carr (2006) argues for a multi-systemic treatment programme that targets the child within his contexts. Based on work done by the Collaborative Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder (MTA)² (Wells et al., 2000a) and the resulting post MTA analyses (Raggi & Chronis, 2006), there was a 12% greater success in children who were exposed to combined interventions of medication, parent training, parent-school collaboration, and classroom specific interventions than those on medication alone.

Despite medication for ADHD being so prevalent, the decision to medicate children is a complex one, given the considerable controversy around the use of stimulant medication in treating ADHD. In treatment algorithms medication is considered first line treatment with the exception of borderline or mild ADHD (Remschmidt, 2005; Corcoran & Walsh, 2006), but there are

² “The Collaborative Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder (ADHD), the MTA, is the first multisite, cooperative agreement treatment study of children, and the largest psychiatric/psychological treatment trial ever conducted by the National Institute of Mental Health. It examines the effectiveness of Medication vs. Psychosocial treatment vs. their combination for treatment of ADHD and compares these experimental arms to each other and to routine community care” (Wells et al., 2000a:483). The results were released in 1999.
concerns that it is being overprescribed as a response to challenging behavior rather than an accurate diagnosis, and that it becomes a stand-alone treatment without accompanying psychosocial interventions (Travell & Visser, 2006). Raggi and Chronis (2006) point out that medication manages the core symptoms but does not normalize behavior, nor does it result in long term development of skills and habits as it is effective only whilst the medication is active in the body. They continue to note that psycho-social interventions are thus crucial for longer term management, particularly as 25% -30% of children do not respond to medication, take it erratically, or not at all.

Parents and children are concerned about the side effects and appropriateness of medication, particularly over the long term. Bussing and Gary (2001) reported on parents who were anxious about the side effects of medication, felt pressurized by others not to medicate, yet could see its positive impact on the children. Parents thus experienced ambivalence, anxiety and stigma in their decision to medicate, which Busing and Gary (2001) concluded could be avoided if accurate information was generated by the press. This underlines the importance of parents accessing credible, scientifically generated knowledge about ADHD. dosReis et al. (2003) found 40% of children disliked medication because of side effects, embarrassment, or dislike of pills. However, Brown, Howcroft and Muthen (2010) found that medication was a protective factor when taken consistently, and this concurs with research conducted by Harpin (2005) and Danckaerts et al., (2010) who found that medication improves the quality of life of the child and the family.

2.5.4.2 Psycho-social interventions

Studies by Bussing et al. (2003b) and dosReis et al. (2003) demonstrated that parents favoured psycho-social over medical intervention, and that parents felt they were not sufficiently helped. Behavioral improvement seemed to be the most common wish (Bussing et al.,2003b; dosReis et al., 2003) together with improved school performance (dosReis et al., 2003).
Bussing et al. (2005; 2006) examined help seeking behavior, and discovered that parents did not easily initiate seeking help, which led the authors to argue that what parents understand about ADHD impacts on how they manage it. Bussing and Gary (2001) also noted that self-help strategies rarely work well enough to prevent professional intervention.

Smith et al. (2014) identified a number of problems around accessing and completing treatment strategies, such as low self-confidence and fear of being judged, inconvenient time and location, and poor motivation to change. This study also looked at what parents thought professionals should be offering which would improve their use of interventions and reported on the following: focusing on positives; sharing and modelling successful strategies; developing a buddy system; meeting parents’ needs; and acknowledging that progress could be slow and frustrating. Parents wanted flexible programmes to meet both crisis and chronic needs, and address co-occurring disorders. Parents were also clear that they wanted professionals to have good knowledge of ADHD, direct experience of challenging behavior, and be non-judgmental, caring and informal. This confirms Roger et al.’s. (2009) finding that parents want intervention covering positive parenting and learning strategies. Bussing and Gary (2001) also ascertained that parents preferred interventions to be managed by one centralized professional.

Family intervention seems to focus either on parenting training (Bester, 2006; Mash & Johnson, 1990; Thomas & Corcoran, 2003; Lange et al., 2005; Kaiser, McBurnett & Pfiffner, 2011; Prithivirajh, 2007; Cunningham, 2007; Corcoran & Dattalo, 2006; Hinshaw, 2000; Wells et al., 2000b), or interventions targeting positive adaptations to stress (McCleary, 2002; Cheesman, 2011; Kadesjo et al., 2002). Prithivirajh (2007) successfully piloted a South African parenting programme that included a stress management component. The structured New Forest Parenting Programme (Sonuga-Barke et al., 2006; Daley & O’Brien, 2013) trains parents in behavior management strategies based on understanding neurodevelopmental issues that impact on self-regulation. Bussing et al. (2006) found that parents with access to professional resources tended to use less coercive disciplining techniques.

McCleary (2002) and Thomas and Corcoran’s (2003) contention is that parent education and skills training alone is inadequate in the face of ADHD as a chronic condition. Parents have to be
supported to feel and believe competent over the long term, and a support group is an essential element in this process. Thomas and Corcoran (2003) contend that parents value support above training, whilst Christenson (2003) believes that to create an environment of shared power, support is more valuable than intention to ‘fix’. Brown, Howcroft and Muthen (2010) differentiated between emotional and informational support, and strongly recommended that families avail themselves of both in their quest to become more resilient. The role of support groups thus needs to be considered as a valuable intervention, and is noted in a number of studies such as Firmin and Phillips (2009), Peters and Jackson (2009), Brannan and Heflinger (2001), Singer (2002), Rogers et al. (2009) and Neophytou and Webber (2005).

South African support systems for parents have developed along self-help principles, and are accessible via the internet. Living ADDventure (www.ladd.co.za) offers an informative website with the byline “discover who you are, know who you can be, love who you are” and they offer individual, couple, group and school interventions which can also be accessed via Skype, as well as resource material for parents. ADHASA, the ADHD Association of South Africa (www.ADHASA.co.za), offers a similar service, whose byline is “accept-don’t reject”. There are a number of books aimed at helping parents, which explain ADHD and parental management in clear, supportive terms (Kutscher, 2008; Green & Chee, 1995; Bester, 2006, 2014; Laver-Bradbury et al., 2010).

2.5.5 Chronosystem

Children with ADHD are “those who do everything that other children do, but with greater intensity, more erratically, and more inconsistently” (Comfort, cited in Lobar and Phillips, 1995: 119).

Children in the middle childhood range (grades R – 5) have the developmental task of mastering cognitive and social skills, and the two most important contexts in which this happens is home and school (Bhana, 2012). Self-regulation improves as the frontal lobes of the brain develop during this period, and the emotional foundation in terms of self-esteem and self-efficacy is
laid as children move into the pre-adolescent phase in grades 6 and 7 (Bhana, 2012). As ADHD is a neurobiological disorder, it would be expected to impact on the child developmentally.

Children with ADHD thus struggle to master key developmental tasks. Children start to be seen as ‘different’, and family can no longer attribute social and behavioral difficulties to their age, nor can they relax parental supervision (Harpin, 2005), which may account for some research indicating that older ADHD children are more stressful to parent (Donenberg & Baker, cited in McLaughlin & Harrison, 2006: 82). Children themselves start to become aware of being different in this period (Singer, 2002) which can impact on self-esteem (Becker, Luebbe & Langberg, 2012).

Families also have developmental tasks, and during the middle childhood phase Lobar and Phillips (1995) argue that children gradually need more freedom in managing tasks and their social life. However, this is compromised in ADHD, as parents struggle to make sense of what is developmentally appropriate for their child (Rogers et al., 2009).

Sonuga-Barke et al. (2006) believe that children as young as three can be diagnosed with ADHD, and the sooner parents are trained to deal with their children in a sensitive, authoritative and positive manner, the better the outcome for the child. Sonuga-Barke et al. (2006) suggest that by middle childhood both children and parents have hardened their attitudes due to poor self-esteem and low self-efficacy, so programmes targeting behavioral management are less effective. Travell and Visser (2006) reached a similar conclusion, suggesting that when this happens medication tends to become the only option.

ADHD generally has an earlier age of onset compared to other disorders, and it also tends to precede other mental health problems (Becker, Luebbe & Langberg, 2012). However, Sonuga-Barke et al. (2006) found that proactive firm limit setting by parents and teachers at pre-school level had a significant protective function. Young and Amarasinghe (2010) argue that treatment options should take into account the developmental stage of the child, and younger children should be reached indirectly through work with parents.
2.5.6 Mesosystemic factors: school-parent partnerships

Special Needs Education legislation in the USA is titled: No Child Left Behind. Woolley (2006) suggests that perhaps we should consider an alternative 'No Parent Left Behind'?

Epstein (1995:701) opens her seminal work on parent-school partnerships with the following quote: “The way schools care about children is reflected in the way schools care about the children’s families”. She considers families, school and community to be overlapping spheres of influence where the aim is to get family-like schools and school -like families in order to “engage, guide, energize and motivate students to produce their own successes” (Epstein,1995:701). Home and school are the primary socializing influences in a child’s life, and Christenson (2003) notes that there has been a noticeable disconnect between the two systems which needs to be redressed. Parent- school partnerships have been legislated for with the world-wide drive for inclusive education, but operationalizing it has proved more problematic (Christenson, 2003; Downer & Myers, 2010).

Beretvas, Keith and Carlson (2010: 421) consider a developmental ecological systems model as appropriate when considering family-school relationships. They describe it thus: “an ecology of schooling reflects an organized system of interactions among persons (parents, teachers, students), settings (home, school) and institutions (community, government)”.

There has been a growing awareness of the definitional difference between parent involvement and parent collaboration. Involvement implies that it is the parent who is helping the school (Anderson-Butcher, 2006) whereas collaboration is more inclusive and asks the question what the school can do to support the family, and rests on the principles of equality within the partnership, two way communication, and shared power (Cox, 2005; Mapp & Hong, 2010). Christenson (2003) notes that within this paradigm parents and school share responsibility, goals, accountability and contributions, and she pithily comments that the word ‘partnership’ needs to be a verb. The most effective form of collaboration is thus one in which a relationship develops between school and family, and interventions are designed with and not for the family (Bryan & Henry, 2012) and rest upon these relational bonds (Clarke, Sheridan & Woods, 2010).
The literature on school-family collaboration uses words such as care and support (Epstein, 1995; Christenson, 2003), trust, respect and sensitivity (Anderson-Butcher, 2006; Clarke, Sheridan & Woods, 2010), and clear communication (Clarke, Sheridan & Woods, 2010) as key foundational qualities to encourage parents into these partnerships, particularly the more vulnerable families who are already experienced by schools as hard to reach (Terrion, 2006).

Mapp and Hong (2010: 346) identify four core beliefs for teachers in order to create a culture promoting partnership: all parents want their children to succeed at school; all parents can support learning in their own unique way (when parents’ contribution is ignored, disrespected and not valued, they disconnect); power relationships are equalized between school and parent wherein they are challenging but not adversarial; and most importantly that schools must take the lead in establishing these partnerships and setting the climate. Christenson (2003:467) comments that “families do not need to be fixed but they need to be supported in their efforts to educate their children in ways they see fit”. Working mesosystemically shifts the paradigm from ‘fixing the parent’ to supporting the parent through developing relationships (Mapp & Hong, 2010).

Bryan and Henry (2012) argue that effective collaborative programmes, in addition to the above, need to have a strengths-based focus to promote resiliency and to entice participation from harder to reach families. Effective partnerships should manage conflict, have processes to solve problems, and circumvent blame, particularly for families who struggle with being labeled as ‘bad’ parents (Epstein, 1995). Smith et al.’s (2014) study on parents’ perceptions of barriers in taking part in ADHD interventions concurs with this.

Terrion (2006) argues that school programmes aimed at developing protective factors for vulnerable families should address isolation, lack of support and stress, through activities that encourage bonding, bridging and linking with the school. Families need to bond through feeling welcomed, feel a sense of belonging to the school community, and feel supported emotionally to manage difficulties. Through bridging, families connect to others experiencing similar problems, and gain hope through solidarity. Linking allows families to connect to resources and
power structures. Terrion (2006) thus links effective collaboration to the development of social capital between parents and school.

A collaborative process therefore needs to take into account parents’ beliefs, values and experiences, not only in understanding barriers to learning, but also in thinking about the development and enhancement of resiliency (Swart & Phasha, 2011).

Pianta and Walsh (1998) as well as Frey and Dupper (2005) argue that resiliency needs to be located in the system rather than individual microsystemic elements, and that the vehicle for this is the quality of the relationships that are fostered over time. Schools are in a position to focus on what Doll and Lyon (1998:357) call “hazardous niches of multiple chronic risk”. This study attempts to do that, as families with children with ADHD are at chronic risk, particularly in the presence of multiple stressors.

Developing effective collaborative relationships is thus a protective factor for vulnerable children and their families. However, the risk factors have been well documented (Epstein, 1995; Christenson, 2003; Clarke, Sheridan & Woods, 2010) from physical access to the school and its programmes, to beliefs held by the parent around how welcome he feels at the school, resentment at how his child is viewed by teachers, alienation as a result of cross cultural and/or socio-economic differences, feelings of inadequacy and low- self efficacy both in parenting and ability to help the child academically, and structural problems such as lack of staff and money to sustain programmes. Mapp and Hong (2010) believe that school culture, as expressed by teachers’ beliefs about parents, norms, values and expectations, stands in the way of developing and sustaining partnerships, especially if what a school offers is not what parents need or want. Graue and Brown (2003) recommend that teachers be trained in inclusive and collaborative strategies, to help them learn to engage with more ‘difficult’ families, and to use these insights to improve their teaching environment.

Although some research contends that parents of children with ADHD were less able to help their children academically and were frustrated at levels of support (Rogers et al., 2009), other research demonstrates that parents work harder to help their children (Diez et al., as quoted in
Garcia, Jara & Sanchez, 2011:545), or take on active advocacy roles between their child and school (Peters & Jackson, 2009; Firmin & Phillips, 2009).

Lord Nelson, Summers and Turnbull’s (2004) study found parents of special needs children valued availability and accessibility of teachers, and concluded that parent-teacher relationships were critical in enhancing quality of life for families and teachers. Bussing et al. (2003b) concluded that research was necessary to understand parents’ perception of their ability to ‘navigate’ the school on behalf of their children, although an earlier study by Bussing and Gary (2001) found that parents worked at co-operation with teachers despite ongoing stress and tension. Kayama’s (2010) research indicated that parents are often not willing to actively challenge the school for fear of making the situation worse.

Interventions that work across home and school systems involving children, parents and teachers will accord the best results for the child, as demonstrated by Pfiffner et al. (2011; 2013) and Mautone, Lefler and Power (2011). Pfiffner et al. (2011) argue that interventions be school based as intervention works best within the targeted system and as it is a real life setting, gains can be generalized across home and school, as well as within the child’s social relationships. These interventions need to be driven by the mental health practitioner based at the school (Langberg et al., 2011).

2.5.7 Exosystemic factor: the school social worker

Torres’s (2006:1123) description of school social work as improving the social and psychological functioning of children and their families as well as maximizing family well-being and academic functioning of children, clearly places school social work at the interface of families and schools. Germaine (Broussard, 2003) sees increasing the school’s responsiveness to the needs of children, parents and the community as part of the school social worker’s ethical duties. Ahlman (2006) notes that children’s mental health issues are family issues, therefore parents must be engaged and empowered at school level. In reality, however, casework services to children seems to be the dominant methodology (Kelly, 2008), not altogether unexpected.
considering that 70% of children’s mental health needs are met through school (Franklin, 2005). It must be noted however that in the literature around mental health services in school, social work is but one of the professions. Psychologists, nurses, counsellors, and teacher trained counsellors fall under the general term of school mental health professionals (Torres, 2006).

The ecological model can be adapted as a guiding framework for school social workers, as has been done by Frey and Dupper (2005). In South Africa Kasiram (1995), in one of the few published articles on school social work, encourages the use of the ecological model.

Frey and Dupper (2005) conceptualize social work functions into four quadrants and argue that a school social worker needs to be effective within all quadrants (Frey & Dupper, 2005). Quadrant A is to intervene with children/families/small groups to promote change in the school environment; quadrant B is working on a macro level with policy/ coordinating services; quadrant C is individual work and quadrant D is designing interventions for groups at risk/prevention. In thinking about the development of parent-school partnerships, it is useful to synthesize Terrion’s (2006) social capital concepts of linking, bridging and bonding, as previously discussed, within Frey and Dupper’s (2005) model. The following table demonstrates how this can be used by a school social worker in South Africa with reference to ADHD (own synthesis).
### Table 1: A synthesis of Frey and Dupper’s (2005) ecological model for social workers with Terrion’s (2006) concept of social capital, adapted for intervention in ADHD.

<table>
<thead>
<tr>
<th>Quadrant A: children/family/small groups</th>
<th>Quadrant B: Policy and co-ordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridging (Terrion 2006)</td>
<td>Linking (Terrion, 2006)</td>
</tr>
<tr>
<td>- Initiating and coordinating interventions</td>
<td>- Developing community networks and resources</td>
</tr>
<tr>
<td>- Encouraging connections between families e.g. buddy system, family days</td>
<td>- Operationalizing Inclusive Education philosophy</td>
</tr>
<tr>
<td>- Encouraging parent involvement with the Governing body through various activities</td>
<td>- Advocating for children's needs</td>
</tr>
<tr>
<td>- Facilitating support groups or Parenting Programmes</td>
<td></td>
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<tr>
<td>- Encouraging participation in research</td>
<td></td>
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<tr>
<td>- Encouraging teacher/parent support opportunities</td>
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<tr>
<td>- Developing interventions to reach out to vulnerable, harder to reach families</td>
<td></td>
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<tr>
<td>- Encouraging volunteerism</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Quadrant C: Individual Bonding (Terrion, 2006)</th>
<th>Quadrant D: Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Child and family clinical intervention</td>
<td>- Information dissemination to teachers and parents via newsletter, publications, workshops, and social media</td>
</tr>
<tr>
<td>- Assessment</td>
<td>- parental involvement in the design of interventions</td>
</tr>
<tr>
<td>- Medication management</td>
<td>- Implementing resiliency interventions</td>
</tr>
<tr>
<td>- Parenting intervention</td>
<td></td>
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<tr>
<td>- Behavior modification training</td>
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<tr>
<td>- Individual counselling</td>
<td></td>
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<tr>
<td>- Telephonic availability for crises</td>
<td></td>
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<tr>
<td>- ILST intervention</td>
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<tr>
<td>- Homework management programmes</td>
<td></td>
</tr>
<tr>
<td>- Implementing and monitoring interventions</td>
<td></td>
</tr>
<tr>
<td>- Creating a kind, caring, non-judgmental culture with staff to encourage a sense of safety and belonging in children and their families</td>
<td></td>
</tr>
</tbody>
</table>

In considering the literature relevant to school social work and ADHD, there are some key themes that fit in with the model proposed by Frey and Dupper (2005). Teasley (2006) discusses what could be considered an initiating and coordinating function as she outlines expectations that a school social worker be involved in the diagnosis, development and monitoring of the treatment plan that includes the teacher, child, parent and other external professionals; a supportive function to both the teacher and the parent, and a linking function to connect with
other networks. Rogers et al. (2009) expanded the role to training and helping teachers modify their teaching practices and improve communication with parents.

Work with parents is noted in a number of studies (DuPaul, Weyandt & Janusis, 2011; Kayama, 2010; Smith et al., 2014; Thomas & Corcoran, 2003). Both Kayama (2010) and DuPaul, Weyandt and Janusis (2011) emphasized the importance of facilitating regular meetings between the teacher and parent, the latter recommending biweekly contact of all the parties. Kayama (2010) asserted that parents felt disempowered by teachers and feared being assertive in case they jeopardized their children even further. She believes social workers have a key role in facilitating more effective and equal relationships between teachers and parents.

Two other elements deserve mention: parents need intervention guided by in depth knowledge and experience of ADHD (Smith et al., 2014), and intervention is needed over considerable periods of time given that ADHD is a chronic and fluctuating condition. Thomas and Corcoran (2003) maintain that the school social worker is in an ideal position to provide accessible services over time, and they recommend the use of group work.

The role of school social work in South Africa is under researched. A review of Social Work/Maatskaplike Werk and the Social Work Practitioner/Researcher over the past 10 years reveals no published research in this field. One of the motivations for this research was concern from school social workers around effective management of children with ADHD and the recognition that intervention cannot only target medical and classroom management.

Perhaps it is not surprising then that the National Model for Action concerning the Care and Support for Teaching and Learning (CSTL) presented by the Department of Basic Education (2010) does not acknowledge the role of social workers in schools, but refers to psychologists, psychiatrists and occupational therapists as providing psycho-social intervention. Social workers are only considered as external resources to facilitate child protection and grants. According to this document, schools should mobilise their resources in structuring care and support. Many schools have done this by employing social workers, who are uniquely trained to work mesosystemically, rather than refer to external resources that are difficult to access for the majority of children.
2.5.8 Macrosystemic factors: Education Policies

The Department of Basic Education sees its role as also responding to emotional, behavioral and mental health needs of children, possibly because the school is the most effective place to access children (Department of Basic Education, 2010). In order to support vulnerable learners a more systemic understanding of education and school functioning is required, which is presented in the Department of Basic Educations’s National Model for Action which explains the Department’s philosophy concerning their expectations of Care and Support for Teaching and Learning (Department of Basic Education, 2010). The National Model for Action (Department of Basic Education, 2010) is based on an ecological systems approach in which risk and protective factors are discussed.

The Department of Basic Education (2001) furthermore acknowledges that inclusive education is broader than formal learning, in that learning also occurs in the home and community and that partnerships between parents and schools are essential. Inclusive education has two arms: firstly to facilitate access to appropriate education for all students, secondly to provide support services to students, schools, staff, and parents through mechanisms such as a school’s ILST team with its collective problem solving, and on a wider scale district support teams and the resources of full support schools. Bester (2006:120) notes that education policy dictates that the Governing Body must co-opt a member whose responsibility it is to oversee the needs of children with learning difficulties.

Inclusive education at school level means that perceptions and needs of parents should be explored and taken into account. Parents need to gain a sense of ownership in the school.

“At the institutional education level, partnerships will be established with parents so that they can, armed with information, counselling and skills, participate more effectively in the planning and implementation of inclusion activities, and so that they can play a more active role in the learning and teaching
of their own children, despite limitations due to disabilities or chronic illnesses” (Department of Education, 2001:50)

Swart and Pasha (2011) argue that active involvement of families as equal partners is considered to be fundamental to the success of inclusive education.

ADHD can impact quite severely within the school domain, and is certainly one of the disabilities to be included within the inclusive education label (Bester, 2006). Although full resource and specialized schools are provided, only a small percentage of children who qualify are admitted. The majority of children with ADHD, even with a co-occurring learning disability, need to be accommodated within the mainstream school classroom. This fits with the vision of the Department of Basic Education that learners with special need be integrated into mainstream schools.

However, there are challenges to the care and support of children within the school environment, as noted by the Department of Basic Education (2010). Teachers lack skills, motivation and training to provide care and support; school assessments are only based on academic outcomes which can undermine investing in care and support strategies as these are not required to be included in assessments; and teachers can become overwhelmed by increasing demands to provide care and support for academically vulnerable children.

2.6 Conclusion

This chapter traced current literature concerning challenges and adaptations facing parents of children with ADHD using bio-ecological and resiliency theoretical frameworks. As this is a study located in a school, with an emphasis on exploring what the school can do to help families develop resilience, it also traced literature around school based resiliency interventions, and the role of the school social worker.
CHAPTER THREE: RESEARCH METHODOLOGY AND DESIGN

3.1 Introduction

This chapter charts the course of the research: the rationale for choosing this design; the trustworthiness of the design strategy; data collection implementation; pilot study; and data verification process. Enough details are provided to decide whether the results can be applied to other situations (Shenton, 2004), and whether the chain of evidence is clear and maintained (Yin, 2009). The chapter concludes with considering ethical issues and the researcher’s own reflexivity.

3.2 Research methodology and design

Leedy and Ormrod (2010: 141) describe a phenomenological study as “a study that attempts to understand people’s perceptions, perspectives, and understandings of a particular situation”. This research is thus located within a qualitative phenomenological framework, exploring parental experiences and perceptions embedded within a specific context. The phenomenological paradigm dovetails with social work principles of participation, partnership, self-determination and a people centered approach (Beytell & Nell, 2005), especially as the outcome is linked to future practice within this specific environment.

As the context for this research is bounded in place and time, is exploratory, and seeks to understand the experiences and perceptions of parents within the real life context of a specific school, the research design is that of an exploratory cross-sectional single case design with multiple respondents (Yin, 2009).

The case study explores complexity within a single unit in a specific environment (Gilgun 1994; Fouche & Schurink, 2011). In this research the unit of study is the parents of children with ADHD at a Primary School in the Southern suburbs of Cape Town. A case study specifically lends
itself to ‘how or why’ research questions (Yin, 2009), appropriate for the type of research questions asked in this study.

Stoecker (1991:108) comments that “the most successful case studies may be those that start with a community problem and work collaboratively with the community on that problem”. Gilgun (1994) and Strydom (1996) consider the case study a useful research technique for social work research and practice, especially as it provides detail on practice issues in contexts in which the practice is embedded, echoing Singer’s (2002) call for a goodness of fit between needs and services. The link to an ecological perspective has been recognized by Gilgun (1994).

Gilgun (1994: 355) argued that three questions should be asked of a case study:

- Does it increase understanding?
- Can it be replicated?
- Do the findings hold over place, time, context and person?

Shenton (2004: 64), in addressing this issue, suggests that Guba’s constructs of credibility, transferability, dependability and confirmability be used when assessing the trustworthiness of qualitative design and data.

3.2.1 Credibility

Case study methodology within a phenomenological framework is a credible research design within the social work profession, particularly when linked to a practice outcome. In case study design, credibility rests firstly upon unambiguous and clearly defined research questions that are embedded in the literature review, and secondly a familiarity with the research context (Yin, 2009; Stoecker, 1991). Data from supporting documents and other informants builds a contextual picture, as has been outlined in Chapter One. The researcher is familiar with the context being studied, as she works at the school, and enjoys a level of trust both with the
school and parents who have used her services. The process was aided by regular supervisory
debriefings, and peer review opportunities.

### 3.2.2 Transferability

Within a phenomenological case study, the result is a working hypothesis rather than a
conclusion (Cronbach in Gilgun 1994: 372), or as Shenton (2004: 70) stated, a piece of a puzzle
rather than transferable data. The trustworthiness depends upon the researcher identifying
and linking all the gathered data to current theory (Gilgun, 1994). Accurately describing in
depth the context of the study, as well as the design methodology, allows the reader to
consider transferability.

### 3.2.3 Dependability and Confirmability

The detail in the research design and its implementation allows the reader to assess both
dependability and replicability.

Confirmability is established through the chain of evidence that is discussed in this chapter.

### 3.3 Sampling

#### 3.3.1 Sampling design

In order to be credible, the sample should reflect the reality of parenting children with ADHD.
This entailed a balance between choosing a range of participants who would reflect the
typicality of perceptions and experience, whilst also ensuring that the selected participants
could honestly share valuable data (Shenton, 2004). Therefore a purposive and discriminant
sampling design was used (Leedy & Ormrod, 2010; Yin, 2009).
The first step was to identify operational criteria (Yin, 2009):

- Children diagnosed with ADHD from grade 1 – 7, and currently on prescribed stimulant medication (e.g. Ritalin) for ADHD, as a marker of impairment
- In the case of single parents, the custodial parent who has responsibility for the child

The second step was to select the sample, which occurred in two stages. The first stage was collecting information from teachers on the entire population of potential participants, and their contact details. A letter to teachers outlined the operational criteria (Appendix 5), and a class list was completed which identified children with ADHD from both private and public health domains.

The following table details the population of children with ADHD on medication at the school:

<table>
<thead>
<tr>
<th>grade</th>
<th>boys</th>
<th>girls</th>
<th>Total (% rounded)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>3</td>
<td>9 15%</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>2</td>
<td>8 14%</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>5</td>
<td>15 24%</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>2</td>
<td>13 22%</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>3</td>
<td>8 14%</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>1</td>
<td>5 8%</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2 3%</td>
</tr>
<tr>
<td>Totals:</td>
<td>44</td>
<td>16</td>
<td>60</td>
</tr>
<tr>
<td>Total percentage</td>
<td>72.88% (73%)</td>
<td>27.11% (27%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Population of children with ADHD

The second stage was sampling parents from this list using a purposive, discriminant sampling design. The researcher was cognizant of sampling more parents of boys and from grades that carried a higher proportion of children with ADHD, and to include parents known and unknown to the researcher. In some cases the researcher was guided by the teacher as to whether the mother or father should be the first point of contact. All grades were represented. Mothers were easier to access, and had greater flexibility in attending the research interview, thus skewing the sample in their favour. The following graph shows the sample per grade, and the breakdown into boys and girls.
Participants were contacted telephonically, and the scope of the research explained. One participant declined to take part, and one failed to attend two appointments so another participant was chosen from that grade. Prior to the data collection process each participant was given a letter outlining the research, it was discussed, and written consent was obtained (Appendix 6). The researcher encouraged honesty of response, and attempted to track her own bias through reflective commentary and supervision.

3.3.2 Sample size and composition

This study had a sample of 18\(^3\) participants from a total population of 57 families. The sample comprised of 3 fathers and 15 mothers. Three of the sampled families had more than one child diagnosed with ADHD at the school, thus the sample involved 21 children, of a population of 60 children with ADHD.

\(^3\) As determined by the criteria for a minor dissertation in the Department of Social Development, UCT.
3.4 Data collection strategy

As the research design involved exploring the perceptions and experiences of multiple participants within a specific focus, the standardized semi-structured interview was used as the means of data collection (Rubin & Babbie, 2011). This enabled the researcher to aim for consistency and thoroughness whilst minimizing subjectivity and bias (Rubin & Babbie, 2011). Greef (2011) notes that one of the strengths of this form of data collection is that it can probe for more in-depth information flexibly. The same interview schedule was used with all the participants, although the researcher allowed the interview to flow, and explored different areas in more depth depending upon the quality of information and circumstances of the participants.

Interviews lasted an average of 90 minutes. Seventeen interviews took place at school, including after hours and Saturdays, and one was conducted in the participant’s home. One was done over two interviews due to the participant’s time constraints. Interviews at school took place in the researcher’s room, which was relatively quiet and private. Times were arranged in advance according to the schedules of the researcher and the participant, and took place over a six week period. All the interviews were conducted in English, and were recorded for accuracy.

3.4.1 Trustworthiness

Yin (2009) argues for three principles of data collection that speak to the trustworthiness of the captured data. The first is that there are multiple sources of evidence. However, as this study targets the perceptions of parents, multiple sources of evidence are not required, and enough interviews were conducted to ascertain themes, patterns and inconsistencies in the data.

The second principle is verification of data. Once the analysis had been completed the researcher invited participants to a Saturday morning meeting where the findings were presented, followed by a group discussion. This was attended by 12 participants, the remainder receiving an emailed copy of the presentation and an invitation to comment. All agreed on the
accuracy of the data captured, and the key themes arose spontaneously in the group discussion. This method of data verification allowed the participants to check accuracy, but it also allowed the researcher to explore reasons for emerging themes (Shenton, 2004).

The third principle is the maintenance of the chain of evidence by creating a case study database, in which the original case study documents are available to other researchers who wish to replicate or expand upon the research. The interviews in this research have been stored electronically and can be accessed via the researcher. The participants’ details will remain anonymous. Effort has been made to present the data clearly, and to be mindful of not losing information through bias or carelessness.

3.5 Data collection instrument

3.5.1 The interview schedule

Within the standardized semi-structured interview format, the instrument for data collection is the interview schedule. This is a set of predetermined questions linked to the research objectives, and developed according to prevailing research as established in the literature review. The interview schedule can be accessed in appendix 7. Although the questions were predetermined, they were used flexibly when further exploration was necessary (Rubin & Babbie, 2011), or when the interview flowed organically. At the end of the interview participants were asked whether they wished to add anything to the information obtained.

3.5.2 The pilot process

The interview schedule was piloted to test for practical problems and potential limitations in the interview schedule (Greef, 2011). The pilot was conducted exactly as the research was planned (Strydom, 2011b). The pilot participant was a grade 7 mother, who was not known to the researcher, but who had a history of concerned engagement with the school. The pilot
participant was contacted telephonically; the research was explained as well as the additional piloting role. The pilot process included asking the participant to comment on the research letter and the informed consent document. In addition to recording the content of the interview, attention was paid to the length of the interview, the clarity and flow of the questions, and whether the pilot participant felt that there were other areas that should be explored. These technical issues were explored after each of the four research questions. The pilot was also used to ensure that the recording and transcribing process had integrity, and was used to iron out problems. Minor changes were necessary, particularly in recording demographic information. The pilot interview was included in the research data.

3.5.3 Trustworthiness

The researcher followed Leedy and Ormrod’s (2010) interviewing guidelines. Written informed consent was obtained prior to collecting data (Appendix 6). Data was recorded verbatim using a dictaphone, transcribed and stored on hardcopy and electronically. The researcher was able to check accuracy of the hard copy against the recorded interview. The flexible nature of the interview allowed the researcher to rephrase, clarify, explore and encourage the use of examples to illustrate experiences.

The researcher used the interview format flexibly when she suspected compromised information. The researcher was aware that being employed by the school, and in some cases not having a prior relationship of trust, could predispose participants to biased responses. In some interviews participants needed to be reassured that information would not be reported back to the teachers. Participants were reminded that there was no right or wrong answer, information was confidential, and that their identity would be protected.
3.6 Data collection tools

Qualitative research relies on the researcher’s interviewing skills to elicit honest and focused data. Skills used in this study included developing a relationship with the participant to enable and contain the disclosure of difficult information; clarifying; and probing.

Shenton (2004) suggests that the researcher’s credentials be recorded as part of the evidence for credibility, which were included in the research letter to the participants. The researcher graduated in 1983 from the University of Cape Town, and has worked continuously in the social work profession. The researcher has considerable experience in interviewing clients.

Data was recorded verbatim to retain depth and integrity of information (Rubin & Babbie, 2011; Greef, 2011), and then transcribed. Additionally, reflective notes were taken during the course of the interview and recorded on the interview schedule.

3.7 Data analysis

Leedy and Ormrod (2010: 139) state that the aim of analyzing qualitative data is to sort, categorise and whittle down considerable information to a small set of abstract, underlying themes that lend itself to “…clear, understandable, insightful, trustworthy and even original analysis” (Gibbs, quoted in Schurink, Fouche & de Vos, 2011: 399).

This study used Tesch’s (1990) method of analyzing data to identify these underlying themes. The following process was used in the data analysis:

- Specific themes were identified from the literature review, which were used to construct the interview schedule. The literature review was reconsidered after completion of the thematic arrangement in order to consider the data relative to theory (Gilgun, 1994)
- The first transcript was carefully read, noting topics in the margins as they arose throughout the transcript. The researcher decided to focus on each research question
throughout all the data documents in order to hold continuity in her head and not be overwhelmed by the volume of data. These became themes.

- A list was made of all the topics that arose within each theme, and through mapping, similar topics were grouped. These were colour coded, and named.
- Transcripts were then carefully read, following the process noted above, but new topics also emerged and were named.
- A table was compiled with a column for each data document, and all the topics noted. Topics were compared, linked, clustered and renamed. Out of this process major topics, unique topics and less mentioned topics were identified. Useful segments of text were noted.
- Each table continued to be adapted as the researcher worked through the research questions, particularly as participants returned to particular topics.
- Upon completion of the coding, all the tables were reconsidered, where necessary the researcher returned to the original document to check accuracy, and significant categories and sub categories were identified and named, as well as unique topics.
- The framework for analysis was compiled, which allowed the researcher to manage the analysis of the significant data.

The researcher was aware of the importance of keeping an open mind, and considering all information in order to ensure the trustworthiness of the data analysis (Gilgun, 1994; Fouche & Delport, 2011). Verification was built in by presenting the analysis to participants for comment and discussion.

3.8 Limitations of the study

3.8.1 Qualitative case study research design

Qualitative research analyzes patterns and themes that arise from data that is embedded in context, unlike quantitative data that is statistically measured for comparison (Fouche &
Delport, 2011; Gilgun, 1994). This has given rise to concerns about reliability and validity of qualitative data, in particular data derived from case studies (Shenton, 2004; Gilgun, 1994) and especially that of the single case design which has been criticized as ‘unsophisticated, lacking in rigor, and a source of insight rather than contributing to theory’ (Rubin & Babbie, 2011: 449). However, the case study design is also vigorously defended (Yin, 2009; Gilgun, 1994; Stoecker, 1991).

This research design has potential weaknesses. The research is conducted and analyzed by one person who is employed by the school, using one research method and having parents as the only sources of data.

The research would have been strengthened by including multiple sources of evidence, such as teachers, and following it up by designing a multiple case study research project that replicates the study in a sample of other schools. However, this is beyond the scope of a minor dissertation.

3.8.2 Sampling methodology

Yin (2009) argues that in a small population such as this, all potential participants should be interviewed. This is not viable for a minor dissertation, and is a limitation of this study. Although effort was made to sample accurately, bias can creep in which limits the ability to generalize the results within this case study. Case study data cannot be generalized outside the research context.

3.8.3 Data collection strategy

Bias and subjectivity of the researcher can affect the quality of data, given that data is more unstructured, and subject to interpretation (Leedy & Ormrod, 2010). One of the difficulties the researcher had to overcome was to ensure that this remained a research rather than therapeutic interview. As the researcher is employed in a clinical capacity, and many of the
participants had experienced her in this capacity, at times therapeutic and research material had to be balanced. On three occasions a therapeutic interview followed the research interview.

Quality of information is dependent upon the construction of questions in the questionnaire, the willingness of the participants to be truthful, and the skill of the researcher in eliciting accurate information. Some participants were more insightful and verbal than others.

### 3.8.4 Data analysis strategy

A limitation of this study is that only the researcher coded the data, thus it remained a subjective interpretation which could be coloured by the researcher’s own biases and inexperience in research methodology.

### 3.9 Ethics

The researcher consulted Strydom (2011a) to guide research planning and ensure that ethical considerations were upheld. These are as follows:

**Avoidance of harm:** Participants could withdraw from the study if they felt threatened. This was outlined in the written consent, and discussed verbally.

**Voluntary participation:** In the first telephonic approach to participants, voluntary participation was discussed, and participants could decline. If participants failed to keep research appointments, it was deemed that they did not wish to take part, and another participant was selected. The participant could withdraw at any stage of the interview.

**Informed consent:** At the beginning of the research interview, written consent was discussed, the participant read through and asked questions of the written consent document, which set out the outline of the research (see Appendix 6). This was signed, and stored.
Deception: The purpose of the study was outlined in the consent document, and participants were invited to verify the analysis.

Violation of privacy: The identity of the participants is confidential, and care was taken to protect the identity of participants in the narrative examples. Participants were aware that they could withdraw if they felt their privacy was being violated.

Compensation: No compensation was offered.

Debriefing: The researcher was available to any family member for debriefing, and compiled a list of referral sources should it be requested.

Actions and competence of the researcher: The researcher was supervised throughout the process by a supervisor nominated by the University who helped to ensure that the researcher had the necessary competence and skills to manage the research process. The researcher was aware that cultural sensitivity was important as some participants were of a different culture.

The researcher’s qualifications and experience was stated in the written consent form. An adaptation of Leedy and Ormrod’s (2010) criteria was used to devise the written consent.

Co-operation with contributors and sponsors. All contributors were acknowledged.

Publications of the findings: If requested, the researcher will format the findings appropriately for professional publication. The dissertation will be accessible through the library of the University of Cape Town.

3.10 Reflexivity

As qualitative research has a subjective bias both in its sampling techniques and data interpretation, reflexivity is an important process in evaluating researcher bias, both as an internal journey as well as evaluating the trustworthiness of the conclusions and their contribution to practice wisdom and, ultimately, theory. Furthermore, a phenomenological study requires the researcher to suspend personal experiences to be unbiased in capturing and
interpreting all data, which can otherwise challenge the trustworthiness of the study (Leedy & Ormrod, 2010). On the other hand, it is a method that allows for an understanding of complexity and different perspectives, provided the researcher is honest and self-aware (de Vos et al., 2011).

Two tools were used in attempting to be self-aware and honest. The first was an awareness of reflexivity through the interviewing process. As the interview was recorded, the researcher could concentrate on quality of the information, and reflective notes were jotted on the interview schedule as the interview unfolded. These provided a platform for discussion with the university supervisor, and in peer review. The second tool was the process of critical supervision throughout all the research stages.

It was particularly important that the researcher be actively reflective as she is a staff member, which could compromise quality of data. The researcher had a good understanding of the context and a trusting relationship with some participants, an important aspect of case study methodology. However, being a staff member may have deterred some participants from fully disclosing concerns or suggestions. As the researcher is embedded in the context, she also had a prior knowledge of some of the participants and their struggles, and had to differentiate between therapy and research. Some participants were stressed, and required clinical support. In three cases the research interview was followed by a therapeutic interview. The researcher’s own clinical experience of ADHD, as well as her own personal experience, had to be reflectively understood so as to not encourage or expect certain data.

3.11 Conclusion

This chapter outlined the qualitative single case design methodology used in this study. Particular attention was paid to the trustworthiness of the research design to enable the reader to consider whether the analysis, as outlined in the next chapter, is trustworthy in terms of increasing understanding and replicability, and holds true over place, time, context and person (Gilgun, 1994).
CHAPTER FOUR: A PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter presents the findings of the study, divided into two sections. The first section presents key demographic information setting the context for the study. This is separated into demographic information concerning the parents who are the participants of the study, and the children. The second section outlines the findings from the study. It begins by setting out the Framework for Analysis, which serves as the structure to present the findings. The findings are grouped into four themes, namely challenges experienced by participants, their adaptive coping and resilient responses to parenting children with ADHD, perceptions around school based interventions to promote resiliency, and perceptions around school-parent partnerships. Only significant findings are presented, which are those expressed by at least nine participants. These are illustrated by quoted examples from the data, and linked to relevant literature.

SECTION ONE: DEMOGRAPHIC INFORMATION

Although parents of children with ADHD are the unit of study in this research, demographic data pertaining to their children helps set the context for this case study. This section is thus divided into demographic data pertaining to participants as the parents, and demographic data pertaining to children of the participants.
4.2 Demographic profile of participants

The sample comprised of 18 participants, 3 fathers and 15 mothers, between the ages of 32 and 50. For demographic purposes ethnicity will be mentioned, but this is not usual practice at the school: the sample comprised of 14 ‘coloured’ participants and 4 ‘white’ participants. Three (3) participants had two children diagnosed with ADHD currently at the school, and a further two had older children, not at the school, diagnosed with ADHD.

Significant contextual demographic data can be set out as follows:

- All eighteen participants lived in brick dwellings, described as houses, flats or townhouses.
- Twelve (12) participants had at least grade 12.
- Sixteen (16) participants reported a monthly income. Two (2) participants reported no monthly income due to unemployment. However, 7 participants reported struggling to pay school fees, which indicates they are not managing household expenditure relative to income. Wage bands were not asked due to sensitivity of this information, rather the question was asked whether participants could afford school fees as an indication of financial stress.

Demographic information thus suggests that this comprises a moderate level of socio-economic status. Although no baseline data had been obtained on the demographics of the whole school, this could be considered representative based on the information presented in chapter one.

Five areas are going to be presented to further contextualize participant demographics, namely marital status, self-reported psychological problems, help seeking behavior, participant understanding of ADHD, and participant perception of the role of the school thus far in helping them manage ADHD. For a full description of the demographic data in tabulated form, please refer to Appendices 3 and 4.
4.2.1 Marital status and relationship difficulties

Data related to marital status is depicted in graph 4.1.

In this sample, 10 participants were still married to, and living with, the child’s other parent. Two (2) participants had divorced and were remarried to other partners. One participant was divorced, but had recently allowed the child’s father to return to live in the home although their relationship had not resumed. A further two participants were divorced and single and 3 participants had never married.

This finding does not concur with Barkley et al. (1990) who found parents three times more likely to divorce, but it does concur with Wymbs (2008) who suggested a lower divorce rate in families with preadolescent children.

In addition to marital status, participants were also asked about relationship difficulties. Nine (9) participants described relationship problems, but were cautious about attributing relationship difficulties to the stress of ADHD. Every participant who described relationship difficulties also acknowledged a mental health problem in either themselves or their partner, as indicated in graph 4.2 below.
From this information, relationship problems and depression and anxiety were noted for mothers, and substance abuse and ADHD in fathers. Further research would be required to establish causal and perpetuating relationship between ADHD in the family (parent or child), mental health problems and relationship difficulties.

Six (6) participants considered themselves single parents, and field notes suggest that they took strain raising the child alone.

4.2.2 Self-reported mental health problems

Thirteen (13) participants disclosed mental health problems, either in themselves or the child’s other parent. Data relating to self-reported mental health problems is set out in graph 4.3.
This data suggests that depression, anxiety, substance abuse and ADHD are the most reported mental health problems in this sample. The fact that a significant number of participants reported mental health problems in themselves or the other parent, as well as the particular scatter of depression and anxiety in the mothers and ADHD and substance abuse in the fathers concurs with research discussed by Margari et al., (2013).

Of particular interest is the high rate of ADHD reported in fathers. This finding is consistent with Biederman et al’s (cited in Lui, Johnston & Lee, 2013:988) research findings that 25% to 50% of children have a parent with ADHD and that more males are affected than females (Biederman, 2005; Margari et al., 2013). No mothers in this sample were identified as having ADHD, although field notes indicate that some of the mothers impressed as having ADHD traits.

The data suggests that a significant number of this sample experienced mental health challenges, and that a smaller subset linked mental health problems to relationship difficulties. ADHD in parents impacts on emotional regulation and management of problems (Margari et al., 2013). It is thus important to consider parents’ mental health and ADHD traits when planning and maintaining interventions.

4.2.3 Help seeking behavior

Data presented in the previous section indicates that participants experience mental health challenges. This section presents participants’ help seeking behaviour, as outlined in graph 4.4.
Five (5) participants had not sought any intervention. Although 12 participants could access medical aid, only 2 participants consulted a psychologist. One (1) participant used her priest. The remaining 11 participants accessed help for themselves via the professional dealing with the child. Of these, 4 participants used the child’s pediatrician, and 2 participants used services provided by DCAP, Red Cross Hospital. Five (5) participants referred their child to the school social worker and accessed help for themselves. Field notes indicate that these services are used when stress levels become overwhelming.

However, a further 5 participants accessed school social work services after the social worker reached out to them on request from teachers (this is not indicated on the graph as it is not a self-referral). Extrapolating from this data it is a significant finding that 10 participants received help for themselves through the school social worker.

It is thus clear that the majority of participants do not readily seek help for themselves, and when they do, they access it via the services provided for their children, most significantly through the social worker based at the school. The reliance on self-care concurs with Bussing et al. (2006), but the emphasis on using school-based mental health practitioners concurs with Franklin (2005). Further research is needed to examine the reason for this pattern of behavior amongst South Africans although it is unpacked in more detail later in the chapter.
This data underscores the importance of the school as a source of intervention for both parents and children as outlined by Flisher et al. (2010) and the Department of Basic Education (2010). However, given the severity and chronicity of the problem, it should be argued that intervention be led by a mental health professional based at a school, such as a school social worker.

4.2.4 Parental understanding of ADHD

Data presented in this section details what participants understand by ADHD. This covers both symptoms and causes.

The majority of participants (16) could describe the common symptoms of ADHD, mentioning impulsivity, inability to be still, and lack of concentration. There was a varied understanding of what causes ADHD, although the majority interpreted ADHD as a biological condition, albeit caused through a chemical imbalance, hormonal imbalance or inherited genetically. Only 4 participants mentioned diet as a causative or contributory factor. Four (4) participants noted that their children were diagnosed ADD, the other 14 participants referred to their children generically as having ADHD.

Participants thus understand ADHD as a chronic biological condition. No participant explained it as due to developmental delays, naughtiness or laziness, unlike studies conducted by Bussing et al. (2003b) and Davis et al. (2012).

Bussing et al. (2003b) argue the importance of understanding what parents believe about ADHD, as this impacts on how it’s managed. However, despite understanding the genesis of ADHD as an internal rather than external problem, participants still struggled to manage the effects of ADHD on themselves and their family. This seems to indicate that parents need more than information to manage ADHD, a factor to be taken into consideration when planning intervention.
4.2.5 Role of the school

This section presents participants’ perceptions of the role of the school in helping them manage the impact of ADHD on their child. The information is summarized in graph 4.5.

![Graph 4.5: Role of the school](image)

The data suggests that the largest role the school has played thus far is in identifying and referring children for assessment. Seventeen (17) of the eighteen participants had their children identified by the school as potentially ADHD. Six (6) children had medication supplied via the school doctor, and at least 10 children had part or all of their medication dosages administered by the teacher.

This concurs with research by dosReis et al. (2003) and Vereb and DiPerna (2004) who found schools to be the most common site for referral and treatment. However, it contrasts with a Stellenbosch study conducted by Perold, Louw and Kleynhans (2010) who found very little involvement of teachers in the assessment and treatment of children. Responsiveness to ADHD in South African schools requires further investigation.

The role of the school may account for the fact that, unlike the Bussing et al. (2005; 2006) studies where the majority of parents did not easily initiate treatment, these children had medical intervention as it was prompted by the school rather than the parent.
Social work services were identified by 11 participants, making it the second largest source of intervention provided by the school. This finding needs to be understood in the context of the help seeking behaviors, and underscores the critical role that social work plays in providing services to parents.

4.3. Demographic profile of children

Although 18 participants took part in the study, 3 had two children diagnosed ADHD, thus 21 children, 15 boys and 6 girls, were reflected in the study. Appendix 1 has full tabulated information. This section presents five areas: grade at time of diagnosis, diagnosis by health care professional, degree of severity, treatment interventions, and academic progress.

4.3.1 Grade at time of diagnosis

The findings demonstrate that all the children in this sample were diagnosed up to and including grade 4, as indicated in graph 4.6. The graph indicates that there was an even spread of diagnoses through each grade.

The average age of children in grade 4 is 10. Taking into account the possibility of repeating once, children were thus still diagnosed before the age of 12, which is one of the DSMV (APA,
2013) diagnostic criteria. This constitutes a new finding as no prior research has been conducted on South African children and grade at diagnosis.

The importance of the school in the referral for assessment is underlined as only 1 child was identified prior to school. However, this is an area that requires more attention as Sonuga-Barke et al. (2006) argue that the younger the child is diagnosed and parents assisted to use targeted parenting techniques to reduce entrenched negative interactions and low parenting self-confidence, the better the outcome. This could be true of children by grade 4, especially as some of them are older due to repeating a grade in the foundation phase.

Inattentive presentation is less noticeable, but a risk factor academically (Daley & Birchwood, 2010). This study did not differentiate between presentations of ADHD or degree of severity, so it is not sensitive enough to track whether Inattentive presentation and milder impairment tends to be diagnosed later than Impulsive/Hyperactive Presentation.

4.3.2 ADHD diagnosis confirmed by mental health practitioner

Data from this section links to participants’ help seeking behaviour. Patterns of help seeking with respect to assessment and diagnosis are presented in graph 4.7.

Graph 4.7: Confirmation of diagnosis by mental health practitioner
Whereas participants did not access professional services for themselves in the private health care field, the largest proportion of children accessed assessment and diagnosis either through a pediatrician (7) or a psychologist/psychiatrist (7). The remaining 7 children received care in the public health domain with 3 children referred to Red Cross Hospital’s DCAP service, and 4 children referred to the school doctor.

This finding constitutes new evidence, as there is no South African research that describes these trends.

However, the majority of South African children cannot access private medical care. Research into diagnosis of ADHD in schools in poorer communities is important in getting a broader indication of these trends.

### 4.3.3 Degree of severity

Participants were asked to rate their children’s ADHD as mild, moderate or severe. The findings are presented in graph 4.8.

The data indicates that only 3 children are rated as severely impaired with 2 of them fluctuating between moderate and severe. Field notes indicated that these participants were more stressed, especially as all three children displayed problematic behavior that was hard to
manage. The remaining sample is divided evenly between mild and moderately impaired and two of them are currently mild after intervention from Red Cross Children’s Hospital’s DCAP service. Field notes indicate that participants who described their child as mildly impaired experienced fewer behavioral problems at home, the challenges being located within the parent–school system given the functional problems of poor concentration and disorganization.

This finding constitutes new information as no prior research has been conducted in South Africa on parents’ perceptions of degree of impairment.

Although this study did not differentiate between ADHD presentations, none of the children presented with only Hyperactive/impulsive presentation. All the children thus had an Inattentive presentation, whether combined or on its own.

A slight majority of parents thus experience their children as at least moderately impaired. However, although 9 participants perceived their child’s impairment as mild, all of them were challenged by their behaviors. This finding concurs with Podolski and Nigg (2001) who found that mothers were particularly stressed by inattentive symptoms. This fact needs to be kept in mind when exploring data derived from the next section. The implication is that even mild impairment is stressful for parents.

### 4.3.4 Treatment interventions

The data in graph 4.9 presents various forms of treatment accessed on behalf of children, in addition to prescribed medication.
The data demonstrates the largest proportion of children (8) received therapeutic intervention from the school social worker. Three (3) children received intervention from Red Cross Hospital’s DCAP service, and one received play therapy from a psychologist. Five children received no additional therapeutic intervention. The school facilitates an occupational therapy practice: 4 children accessed occupational therapy via the school, on a private contractual basis. The role of the school in providing resources thus becomes clear from this picture.

This is a new finding as there is no documented research on intervention patterns for children with ADHD in South Africa. However, although it is a lower figure than the 70% of children’s mental health problems managed in schools (Franklin, 2005), it does indicate that the school is an important site for obtaining therapeutic intervention.

No participant mentioned any formalized classroom intervention to manage behavior or academic challenges. As this is a well-documented area of intervention (DuPaul, 2007; Du Paul, Weyandt & Janusis, 2011), more attention needs to be paid to encourage parents and teachers to discuss and implement classroom interventions.

The MTA study (Wells et al., 2000a) showed that the most successful strategy is medication together with parent and classroom intervention. In this study, it would appear that medication is the most constant intervention. The data suggests that a more multi-systemic intervention programme including children, parents and teachers should be considered. The study concurs...
with Travell and Visser (2006) and Raggi and Chronis’s (2006) concerns that medication becomes a stand-alone treatment without accompanying psycho-social interventions.

In this sample, only 2 children had been formally diagnosed with co-occurring disorders, namely depression and receptive language disorder; however field notes indicated that participants discussed a multitude of problems such as suicidal behavior, substance abuse, dyslexia, severe behavioral problems and obsessive compulsive behavior. The fact that only two children had been diagnosed with co-occurring disorders does not concur with current co-occurring disorder norms (Biederman, 2005; Becker, Luebbe & Langberg, 2012). However, it is clear from the field notes that there are problems, but they are not discussed by parent or teacher, and the child is not referred for appropriate assessment. This suggests less awareness around the existence of co-occurring disorders from both parent and teacher. This is an area that requires further intervention.

4.3.5 Academic progress

The final set of data presents academic progress, as measured by repeated grades. This is summarized in graph 4.10.

Graph 4.10: Academic progress
The data shows that just under half of this sample’s children have repeated a grade, with 2 children having repeated twice. This underscores the academic impairment that is so prevalent with ADHD and confirms the literature that details academic vulnerability (Bester, 2006; LeFever, Villiers & Morrow, 2002; Carr, 2006). However, this data needs to be linked to the previous finding that co-occurring disorders, such as learning disabilities, are not diagnosed and managed and this may well confound the academic picture.

This data suggests that ADHD and its co-occurring disorders may well be a reason why South Africa struggles to improve its basic education of children, despite provided resources. Identifying and managing ADHD and co-occurring disorders are thus critical for South African children’s educational attainments.

This concludes Section One, which set the contextual framework for the data analysis. This is now followed by Section Two, which presents the analysis of research data.

SECTION TWO: ANALYSIS OF RESEARCH DATA

The structure for this section is provided by the Framework for Analysis, which is presented in Table 3. The Framework is linked to the research questions, and groups the data thematically in order to manage and present the data more effectively. Four themes are presented, namely challenges in coping with a child with ADHD, adaptations and the journey towards resiliency, the role of the school and the school social worker in promoting resiliency, and perceptions around parent-school partnerships to enhance resiliency.

4.4 Framework for analysis

The framework for the data analysis is presented in Table 3. The collected data was analyzed according to Tesch (1990), which involved methodically organizing and reducing the data into themes, categories and subcategories, as outlined in the Framework for Analysis. This chapter
specifically discusses only significant themes and categories identified by nine or more participants. The response number is indicated in brackets.

Other material did arise, which cannot be commented on in this format given the restrictions of a minor dissertation.

Table 3: Framework for Analysis

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Challenges in coping with a child</td>
<td>1.1 Parent-school challenges (18)</td>
<td>1.1.1 Classroom management (14)</td>
</tr>
<tr>
<td>with ADHD</td>
<td></td>
<td>1.1.2 Homework (12)</td>
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<tr>
<td></td>
<td></td>
<td>1.1.3 Peer relationships (11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.4 School progress (10)</td>
</tr>
<tr>
<td></td>
<td>1.2 Medication challenges (16)</td>
<td>1.2.1 Ambivalence (11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.2 Stigma (10)</td>
</tr>
<tr>
<td></td>
<td>1.3 Personal challenges (15)</td>
<td>1.3.1 Frustration (10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3.2 Inadequacy ; shame and self-blame(9)</td>
</tr>
<tr>
<td></td>
<td>1.4 Parenting challenges (15)</td>
<td>1.4.1 Discipline (11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4.2 Competing demands (9)</td>
</tr>
<tr>
<td>2. Adaptations and the journey towards</td>
<td>2.1 Personal resiliency (18)</td>
<td>2.1.1 Information (13)</td>
</tr>
<tr>
<td>resiliency</td>
<td></td>
<td>2.1.2 Support (9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1.3 Faith/spirituality (9)</td>
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<td></td>
<td>2.2 Adaptive resilient</td>
<td>2.2.1 Routine (15)</td>
</tr>
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<td>parenting (17)</td>
<td></td>
<td>2.2.2 Quality time (12)</td>
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<td></td>
<td></td>
<td>2.2.3 Calm discipline (11)</td>
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<td></td>
<td>2.3 School/parent resiliency (12)</td>
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<tr>
<td>Themes</td>
<td>Categories</td>
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<td>----------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3. Perceptions around school based interventions to strengthen resiliency</td>
<td>3.2 Social worker (18)</td>
<td>3.2.1 Initiating and coordinating (10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2.2 Direct intervention (18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2.3 Support group (16)</td>
</tr>
<tr>
<td></td>
<td>3.3 Teachers (18)</td>
<td>3.3.1 In depth and accessible contact (11)</td>
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<td></td>
<td></td>
<td>3.3.2 Proactive intervention (10)</td>
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<td></td>
<td></td>
<td>3.3.3 Trained in ADHD (10)</td>
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<tr>
<td>4. Perceptions around parent-school partnerships to promote resiliency</td>
<td>4.1 School climate (16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.2 Benefits of parent – school partnerships (13)</td>
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</table>

The data will now be presented, according to the structure provided by the Framework for Analysis.

### 4.5 Theme One: Challenges in coping with a child with ADHD

This section presents the data of theme one, the challenges in coping with a child with ADHD. Four significant categories evolved: school-parent (18); medication (16); personal (15); and parenting (15). Given the participants’ preoccupation with challenges, it is not surprising that significant subcategories were evident in each category, as outlined in the Framework for Analysis.

All 18 participants identified challenges in coping with a child with ADHD. Field notes identified this theme as absorbing the greatest proportion of interviewing time and post analysis group discussion.

“I wish there is somebody that can tell me that they will outgrow this so that we can have some normality back in life, but unfortunately it’s not like that” (mother, grade 3 girl)
This finding concurs with qualitative research conducted by McIntyre and Hennessey (2012), Peters and Jackson (2009), and Singh, (2004). The disproportionate amount of time used to discuss challenges demonstrates the chronic, overwhelming nature of ADHD, and underlines the importance of providing psycho-social services to parents as part of a multi-systemic treatment strategy.

Each category of challenges will now be discussed, in order of significance, beginning with parent-school challenges.

4.5.1 Parent-school challenges

Data suggests that this was the most significant challenge, discussed by all 18 participants in the research interview and the post analysis group discussion.

“All they (teachers) give us is negative comments. It’s negative for every report where they say your child is disruptive. But there’s very little the school puts back into saying ‘well, we can help with this, let’s try and implement this’ (mother, grade 5 boy)

I am not going to feel that feeling that ‘oh my God, do I have to go again?’ Close to tears and all that. Because sometimes a parent wants to hear good things, but for this child you go to school and it’s just the same old bad things” (mother, grade 4 boy)

Challenges involving school are expected, given the body of literature devoted to it (DuPaul, 2007; Bester, 2006; Rogers et al.,2009; Mautone, Lefler & Power, 2011). This study differs from other similar qualitative studies (McIntyre & Hennessy, 2012; Peters &Jackson, 2009) in that this study found a greater emphasis on parent-school challenges. This finding could be due to the school being the context of the research. However, school based challenges need to be understood within the context of home based challenges, especially if that parent is already stressed. Some of these challenges are microsystemic in that they are directed at what happens in the classroom, but others relate to the mesosystem of relationships between parent and school.
Five sub categories were identified as significant school based challenges for participants, namely classroom management, homework, peer relationships, school progress, and stigma. These will be discussed as follows:

4.5.1.1 Classroom management

Fourteen (14) participants voiced concern and frustration about classroom management. Participants felt that teachers were not handling their children correctly, and there was considerable variability between teachers in classroom management strategies. Participants questioned whether teachers knew enough to develop insight into their children’s behavior, and implement appropriate management strategies.

“Last year was very difficult mostly because I don’t think the teacher knew how to cope with the situation really... I just think the teacher needs a bit more help with, or more input into, how to deal with kids with this problem” (mother, grade 6 girl)

“Where is the continuity in that child’s education? Because he is going to get a different teacher. The one shouts at him because he is not done on time and gives him demerits left, right and centre. And he comes from a teacher who was very understanding because she had more knowledge about what he is going through and the disorder and what is making him so unorganized and slow in a sense” (mother, grade 5 boy)

Although these perceptions are parent based and do not take into account what the teachers think they know, participants are echoing research that concludes that teachers lack knowledge about ADHD, and require specialized training (Kos, Richdale & Hay, 2006; Sherman, Rasmussen & Baydala, 2008; West et al., 2005; Bell et al., 2011). These findings also concur with the South African study based in Stellenbosch that concluded that primary school teachers’ knowledge of ADHD was poor (Perold, Louw & Kleynhans, 2010) and the Department of Basic Education’s (2010) acknowledgement that teachers lack training and skills to manage academically vulnerable children.
Parents may have more knowledge than teachers (West et al., 2005) yet in this study participants seemed dependent on teachers to source and motivate for specialized training, and as this has not happened, remained frustrated. Participants’ unwillingness to challenge teachers directly to upskill themselves needs further investigation.

Professional development in the management of ADHD is indicated.

### 4.5.1.2 Homework

Twelve (12) participants identified homework as a challenge. Completing homework was difficult because the child’s disorganization meant that homework was not accurately recorded and correct books were not brought home. The child’s distractibility in finishing homework was particularly noticeable as medication had worn off by homework time. Homework brought participants into conflict with their children, and meant that family time became homework time if they wanted to ensure that homework requirements were met.

“If I am not physically sitting with her and monitoring her, it can take her up to 3-4 hours to complete homework, and the problem is that I don’t think teachers understand the severity of ADHD in a child and how much longer it takes them to complete a task, particularly at home once the medication has worn off” (mother, grade 5 girl).

“We are still a big failure with homework. It is one complete fighting zone...getting the homework from school to home, actually getting the correct stuff from school to home to actually do the homework. That’s the problem” (mother, grade 4 boy).

These findings concur with Bester (2006) and Power et al., (2006). Homework is one of the strongest areas of overlap between home and school, and data indicates that areas of academic difficulty due to ADHD or co-occurring disorders such as learning difficulties, play out at home, creating conflict and frustration. The findings differ from Rogers et al. (2009) who found parents felt less able to help their children academically. In this study parents put considerable effort in trying to manage homework, with frustrating results.
Given these findings, co-operative homework interventions between parents and teachers, as mooted by Raggi and Chronis (2006) and Powers et al. (2006), should be implemented.

4.5.1.3 Peer relationships

Eleven (11) participants were concerned about their children’s peer relationships, notably their ability to make or keep friends, or be attracted to friends who were perceived to be a bad influence. Nine (9) participants were concerned that their children were being stigmatized and avoided. One participant described how the children in her son’s class call Ritalin the ‘dom’ tablet (translation: dumb tablet). Participants described compensatory behavior, such as being attracted to other children with behavioral problems, or taking on the role as the class clown.

“I have seen a lot of youngsters in prison cells and I think most of them could have been ADHD as a child. And then as much as I want my child to have good friends and all of that, it’s almost like I can see a problem child. I can see that my child is more attracted to that type of friend and that is another challenge that actually scares me you know” (mother, grade 4 boy)

“And the kids had already labelled him as the child who was going to fail, or just get bad marks, and just don’t want to do a project with him” (mother, grade 5 boy)

These findings are consistent with a large body of research detailing peer problems (Kos, Richdale & Hay, 2006; Bell et al., 2011). The findings also concur with Law, Sinclair and Fraser (2007:106) who found that children with ADHD were avoided as they were perceived by other children as ‘careless, lonely, crazy and stupid’.

These findings indicate that peer directed interventions should include the child and his classmates. Bell et al. (2011) contend that teachers should help the class reframe behavior to reduce stigmatizing reactions. These findings demonstrate the importance of teachers identifying and understanding problematic behavior, and helping the class to reframe and understand ADHD more empathically.
4.5.1.4 School progress

Ten (10) participants felt that school progress was an ongoing challenge. Participants worried about their children’s academic struggles, but were also anxious about what they could do to improve school progress. Ten (10) children in this sample had already repeated a grade.

“He just makes it through every year…you can’t ask the teacher to put in the extra effort like I know I need to be his PA at home, but I can’t expect the teacher to be like that at school, I can’t expect her to double check that he has put his books in his bag, but it’s not the same as saying it to the other children…for ADHD children just saying it once more may help…” and then plaintively “I am not sure what to do with him at home to get his work onto a higher level, so I can only do so much at home, if I can sit down with the teacher” (mother, grade 4 boy)

These findings concur with literature that documents problematic school progress (Carr, 2006; Daley & Birchwood, 2010; Loé & Feldman, 2007). In South Africa, Bester (2006) estimates that 80% of children with ADHD underachieve academically, a higher figure than indicated in this study. This is surprising, as all the children in this sample have Inattentive presentation, which is considered more problematic for academic performance (Daley & Birchwood, 2010). The academic problems for children with intrinsic learning barriers are acknowledged by the Department of Basic Education (2010).

These findings suggest that parents be given guidelines by teachers on appropriate home based academic support.

This concludes the presentation of parent-school challenges. The second significant challenge, medication, will now be discussed.

4.5.2 Medication challenges

All the children in this sample are on medication for ADHD. Sixteen (16) participants discussed medication, and it arose both in Theme one as a challenge but also in Theme two as an
essential intervention. This speaks to the complexity of the decision to medicate, and the struggles participants had with ambivalence about medicating. Ambivalence is linked to the physical impact of the drug on the body and the stigma attached to ADHD medication. Both are significant sub-categories.

4.5.2.1 Ambivalence: physical impact

Eleven (11) participants expressed concerns about the impact of medication although they acknowledged they could see the benefits and would continue pharmacological intervention. Considerable time was spent in the post analysis group spontaneously discussing medication concerns. Participants were concerned it made their children too passive, the children did not like taking it, it had side effects such as weight loss, and the word ‘zombie’ was used both to describe fears about their own child as well as when recounting what others had to say about the medication.

“He just didn’t seem like my son at all...you know, he was a bit too babyish still and I sat with the idea and I thought ‘could it be because of the tablets physically on him?’ That and maybe the side effects that the teacher didn’t take note of. Because remember when the pill takes its action, well then his body is not really him” (father, grade 4 boy)

On the other hand, participants could see the benefits of medication: it allowed children to show their academic capability, improved handwriting, and children were less trouble prone. Most participants did not medicate at home, but field notes showed that participants whose children were rated on the moderate – severe scale used it on the weekends and holidays to make their lives more bearable.

“I had my doubts (about medication) but because that time when he wasn’t taking his medication there were like red dots in his book every day. Discredits. Disobedience. Disrespectful. You know” (mother, grade 4 boy)
“I always say that when he is on the Ritalin he is the child he was meant to be. It takes away all the side effects of ADHD and he is just my child…If he is having a really bad day, and I say to people ‘you can say I am a really bad parent but that little tablet, it changes my life on a bad day it really does’, I do it. Even though you hear so many bad things and everything, it has helped me” (Mother, grade 4 boy)

This data reflecting tension between the benefits for academic and behavioral stability versus negative physical impact concurs with research conducted by Bussing and Gary (2001), Travell and Visser (2006), and dosReis et al. (2003). The data also acknowledges the improvement in quality of life, particularly for families where impairment is more marked, concurring with Harpin (2005) and Danckaerts et al. (2010). The data also concurs with the South African study of Brown, Howcroft and Muthen (2010) who concluded that parents view consistent medication as a protective factor.

4.5.2.2 Ambivalence: stigma

Ten (10) participants discussed difficulties in navigating negative reactions from their spouse, families, religious elders, and general public. Participants described feeling judged and labelled as bad and incompetent parents for not coping and medicating. Parents described feeling torn between negative medication information they had read and which was repeated by others, and their own belief that medication could help their child achieve potential. This created rifts between parents and within families, resulting in feeling isolated and emotionally distressed. Participants expressed how they wished others could understand what they were going through, and why they made the decision to medicate.

“ It was everything on top of each other because my husband would not understand how they were, it was my family and medication and going to certain seminars and speaking to certain people that Ritalin was the way to go and then speaking to other people at seminars and being told it was a drug, it was speed, and it affected their brains and it affected their growth, It was difficult to decide, to make my own choices on what I felt was best for my
children because I didn’t want to upset my family, my parents. I wanted to do what was best for them school wise. It was very difficult” (mother, grade 4 boy)

“When they are diagnosed don’t believe all the negative stories about children on medication. If medication is what your child needs to accomplish their goals and to perform at their best then that is what they need to do, so it shouldn’t be a bad reflection on them as parents, something they did wrong, there shouldn’t be any guilt attached to it” (mother, grade 5 boy)

This data, summarized as ambivalence related to the stigma of medicating, concurs with Bussing and Gary (2001). Unlike Singh (2004) who suggests self-blame is reduced once children are diagnosed and medicated, this study found that medicating promoted self-blame and emotional distress. The data partly concurs with Bussing and Gary’s (2001) contention that ambivalence and anxiety is generated when parents do not have access to scientifically generated information but are exposed to lay arguments that feed controversy. This study demonstrates that stigma is perpetuated by the reaction of others.

This data suggests that parents and families need access to scientifically derived data in order to counter the emotional effects of ambivalence relating to the side effects of medication and stigma. Although medication is an exosystemic factor, Bronfenbrenner’s contention that systems are nested is clearly demonstrated in the impact that the decision to medicate has on micro- and mesosystems.

This concludes the challenges inherent in medicating children.

4.5.3 Personal challenges

The third category of challenges describes participants’ personal challenges. Two particular subcategories were noted: frustration and inadequacy linked to shame and self-blame.

Fifteen (15) participants identified ongoing personal challenges. The personal impact of a child with ADHD remained a dominant theme in the post analysis group meeting with one father
spontaneously bursting into tears as he recounted a recent incident with his child. Participants described feelings of exhaustion and stress, and the emotional impact of constant vigilance due to the relentlessness of problem behaviors.

“It’s going to sound really bad, but until recently I said that I was looking forward to raising children. I had this picture in my head, but it's not that picture, it’s scary, it’s strenuous, it’s hard, it’s tiring, it’s stressful” (mother, boys in grades 3 and 4)

“I am exhausted. I am exhausted…it’s exhausting, just holding it all together” (mother, grade 6 boy)

This finding concurs with similar qualitative research conducted by McIntyre and Hennessy (2012), Peters and Jackson (2009) and Harborne, Wolpert and Clare (2004). Despite the fact that 15 participants felt that ADHD had impacted on them personally, data described elsewhere in this study showed that participants did not readily seek help for themselves, which concurs with Bussing et al., (2006). Nine (9) participants indicated that they rated the ADHD as mild, yet most of them felt stressed and exhausted. This concurs with Rogers et al. (2009) who noted that core symptoms in themselves cause stress, and underscores Brannan and Heflinger’s (2001) contention that stress is normative given the challenges in raising these children, whilst also taking into account Podolski and Nigg’s (2001) finding that mothers are particularly stressed by Inattentive symptoms irrespective of the presence of more disruptive behavior.

4.5.3.1 Frustration

Personal frustration was described by 10 participants. Participants recounted how frustrating it was constantly repeating instructions, and dealing with their child’s disorganization and forgetfulness, especially in the mornings and doing homework. What complicated frustration was participants’ uncertainty around developmental implications of ADHD, and how to balance normal developmental expectations with limitations caused by ADHD. Participants reflected their frustration at partners unable to cope and who often made the situation worse; field
notes indicate more relational conflict in these families. This was a common experience when the partner had ADHD traits, and was reflected on in the post analysis group.

“I don’t want to tell my children early in the morning: you know you work on my nerves…I just hate myself. I understand that they are so disorganized. But what I am thinking is this: that after I have repeatedly told you, or asked you, or requested, that don’t do this, or do this for daddy, it’s kind of not sinking in. It’s frustrating” (father, grades 4 and 5)

“…I run out of patience sometimes with the child so much it has affected my relationship with her because I am constantly screaming at her to ‘get out and do your homework, sit still, get dressed, don’t take 20 years’, so it has affected my relationship with her where it is seen as if I am constantly shouting rather than offering support, which is what I should really be doing.” (mother, grade 5 girl)

“…he doesn’t have total control and I get very, very, very frustrated. And I think that also contributes to me actually shouting a lot” (mother, grade 3 girl)

These findings concur with Peters and Jackson (2009) but differ from similar studies conducted by Neophytou and Webber (2005) and McIntye and Hennessy (2012) where frustration was a less common finding. However, the data does support Coghill et al. (2008) who described problems for parents in coping with demanding, disorganized behavior particularly as these behaviors do not get better over time. The data concurs with Rogers et al. (2009) that parents need to developmentally understand ADHD so that expectations of developmental tasks are appropriate.

This data points to how much more difficult it is when the participant does not feel supported, either because of single parenthood or because the partner is unable to cope. That the responsibility tends to rest with mothers concurs with Singh (2004) and Peters and Jackson (2012). This finding is consistent with Rogers et al. (2009) who found fathers to be less engaged, or discipline more coercively.
Frustration is linked to areas of parenting or family life that are most disrupted by the child (Coghill et al., 2008). Understanding these patterns can be used to target the most effective family interventions.

4.5.3.2 Inadequacy, shame and self-blame

Nine (9) participants commented on feelings of inadequacy as parents. There was a sense of guilt that they often disliked their children, that nothing they did as parents really worked, and they compared themselves with better functioning families. However, not only did participants reflect how the children made them feel inadequate and useless as parents, but they also felt guilty about what they were doing to their children because of inadequate parenting. Participants despaired that they were harming their children, that they let them down, that they had failed them, that they had “crushed their souls”. These findings suggest guilt, shame and self-blame in their role as parents.

“When my child was first diagnosed I sat with the psychiatrist and I said to him ‘I love her because she is my child but at the best of times I don’t like her’ and I felt the worst kind of parent ever saying this about my child and he said ‘90% of parents with ADHD children feel this way, they just never voice it’. Because I felt like all I did was shout and scream and fight with her from the time she woke up in the morning to the time she went to bed. I would lie in bed at night and I would think for today there wasn’t one thing nice I said about her, there wasn’t one thing positive that I found because it’s almost like you wallow in your own self-pity and ‘Oh my child is just a disaster’ and nothing you are doing is right and you go somewhere and your child is acting out and here sits these parents with perfect children that do everything right and I don’t know, you get down on yourself and you get down on your child and you beat yourself up” (mother, grade 4 boy)

“You know if there is one thing I don’t like, it’s this feeling I have, that I am incompetent as a parent. It’s like they bring out the incompetency in me. It kind of makes me feel
very, very bad. You know, they make a person feel as if you have no clue of what you are doing” (father, 2 children)

“...yes as a parent I felt completely worthless because I couldn’t do right by this little boy” (mother, grade 5 boy)

This finding of parental sense of inadequacy, guilt and self-blame is consistent with a number of studies (Johnston & Mash, 2001; Harborne, Wolpert & Clare, 2004; McIntyre & Hennessy, 2012; Peters & Jackson, 2009). The data also confirms Singh’s (2004) research linking self-blame to a sense of inadequacy at ‘solving’ the child’s problem, despair at possibly making it worse through lack of personal resources, and shame attached to out of control feelings of anger, frustration and hate.

These findings suggest that interventions normalizing parental feelings, and providing support and education, will help reduce parental emotional distress.

This concludes the data on personal challenges. The final category in Theme one is Parenting Challenges.

4.5.4 Parenting Challenges

Fifteen (15) participants identified parenting challenges, bearing in mind 6 participants had more than one child diagnosed ADHD. Two significant sub categories emerged, discipline and competing demands.

4.5.4.1 Discipline

Eleven (11) participants discussed discipline challenges. Participants discussed their struggle to find disciplining techniques that consistently worked. However, the data shows that disciplining
is more complex than just finding the right technique. Participants felt ineffectual in managing inexplicable mood swings and erratic behavior which often felt unstable, and in some circumstances, uncontrollable. Many children also displayed a single minded perseverance in a given course of behavior that was very difficult to redirect. Children who were rated as on the moderate-severe range by the participants had aggressive, defiant behavior that almost traumatized the participants.

“I have had to try so many things and so many different methods, it’s just trial and error all the time because I don’t know, this is completely new and things will work for a while and then she will be bored and she is so clever, she will find her way around it, and then you try something else, something else. It is exhausting” (mother, grade 4 girl)

“One day he will be fine. I will get him dressed, he will listen to me and he will be fine the whole day. And then tomorrow will come and he will be the exact opposite and I will sit back and think: ‘You know, why or what has changed between yesterday and today for him to react the way he is today?’ It’s that erratic thing you know, there’s no consistency, it just depends on how they wake up that morning, every day is not the same” (mother, grade 1 boy)

“He kind of in a way runs my house because I am fearful of him because he hits me really bad if he is having a bad day and he gets into anger issues, he attacks me, he physically attacks me and he will do things to hurt me...“ (mother, grade 4 boy)

This finding concurs with Mash and Johnston (1990) who note that unpredictability and uncertainty of ADHD behavior increases parental challenges. This would explain why this study’s participants, even though they know it’s a neurobiological impairment, still struggle to cope, contrary to the thinking that understanding reduces stress (Bussing et al., 2003b). This study’s findings thus do not concur with similar research in which parents felt largely blamed by others (Neophytou & Webber, 2005; Harborne, Wolpert & Clare, 2004; McIntyre & Hennessy, 2012). These participants largely blamed themselves for their struggles to discipline.
This finding reinforces participants’ need for information and support in parenting strategies. Consideration should be given to examining the efficacy of long term and continuous support that reinforces parental training, but this needs further examination within the South African context.

4.5.4.2 Competing demands

Nine (9) participants identified challenges around managing their family and personal responsibilities because of the disproportionate amount of time the child absorbed. Competing demands ranged from sacrificing their own needs to the impact on siblings.

“For his sisters, it’s been the hardest. We tend to give him more attention because we constantly say to him to adjust his mood, or adjust his temper. We’re constantly calling him back and constantly reminding him. We tend to spend more time with him explaining things whereas the girls will catch onto a concept like that. With him we have to remind him of the consequences all the time and have to put up big notices everywhere. So the girls feel that he has the ADHD yet they are the ones suffering”

(mother, grade 5 boy)

These findings concur with McIntyre and Hennessy (2012) and Peters and Jackson (2009) who found similar problems around competing demands, to the extent that McIntyre and Hennessy (2012) felt it constituted a theme in its own right, entitled ‘The child takes over’. As with discipline, this finding suggests that parents need to be supported in thinking about how to manage and structure family time. This is possibly made more difficult when the parent struggles with organization and time management as a result of ADHD traits in herself or partner.
4.5.5 Summary and consolidation of Theme 1

This concludes the presentation of findings organized around the first theme of ‘challenges’. As this study is located within a framework of resiliency, the following section looks at what participants are doing to strengthen their ability to cope and make their parenting role more bearable. This theme is entitled ‘Adaptation and the journey towards resiliency’.

4.6 Theme 2: Adaptation and the journey towards resiliency

This section presents the data from Theme two, which focuses on resiliency and the development of coping skills in the face of adversity. Three categories were significant: personal resiliency (18), adaptive parenting (17), and school-parent strategies (12). Significant subcategories were identified for both personal and parenting categories. This section begins with a general discussion, before discussing significant adaptations.

All 18 participants were able to identify adaptations or strategies that helped them become more resilient in coping with their child. These adaptations shadowed the challenges, calling to mind Walsh’s (2002) contention that resiliency is a process that develops over time. However, more time was spent by participants on challenges, highlighting that adaptation is present, but overshadowed by challenges. Resiliency is in the balance between stressors and protective factors, and this study suggests that more work needs to be done to strengthen the protective factors to enhance the development and stabilization of resiliency.

“Find out as much as you can about this. What it is, the effects it has on your child, what are the challenges a child faces, exactly to the T, with this disorder. Because if you don’t know that you can’t help your child. And it doesn’t matter, you can parent and parent and parent as much as you want, it’s all going to go wrong if you are not adapting to what your child has to deal with” (mother, grade 7 girl)

Although there has been considerably less research on how families adapt to ADHD, studies by McIntyre and Hennessy (2012) in Ireland, Firmin and Phillips (2009) in the USA and Brown,
Howcroft and Muthen, (2010) in South Africa concur with the findings of this study, although this study’s findings seem to suggest that families are not yet as resilient as those described by Fermin and Phillips (2009). Families can be resilient, but resiliency is hard won. This study found similar adaptive themes as Brown, Howcroft and Muthen (2010), but with less significant emphasis on family communication, and more emphasis on adaptability within the school environment, discussed in a separate sub category.

4.6.1 Personal resiliency

All 18 participants made reference to aspects of personal resiliency in themselves and their children that helped them keep going despite daily challenges. All participants could identify positive qualities in their children that they enjoyed, and which lent strength to themselves and the child. Participants described how they try to remain positive, and work at thinking positively, for example by learning to reframe behavior. Participants identified how they had to learn to be strong, and took pride in this aspect of resiliency.

“Everything about my life has changed, and yet I think it has changed in a good way... because maybe if I didn’t have children who were ADHD, difficult and a challenge and something to work on, I wouldn’t be the person that I am. I have to wake up every morning and be positive about something.” (mother, grade 4 boy)

“On the positive side I always say OK tomorrow, he can’t get any worse, this is my saying, at the moment it’s bad but it can’t get any worse than it is...take one day at a time, tomorrow will help itself, we will sort something out. I try to be positive most of the time because if you are negative you will never get anywhere” (mother, grade 4 boy)

This data, suggesting that parents try and see the positives in ADHD both for themselves and their children, concurs with McIntyre and Hennessy (2012); and the ability to reframe behavior is similar to findings discussed in Lench, Levine and Whalen (2013).
Participants identified three significant strategies promoting personal resiliency: knowledge, faith, and support. These protective factors form part of the coping/ resource networks as described in Hill’s ABCX formulation of family stress as described in section 2.4 of the literature review.

4.6.1.1 Information

The importance of obtaining information about ADHD was cited by 13 participants, impacting positively on personal and parenting resiliency. Eleven (11) participants identified how knowledge about ADHD helped reframe and contextualize behavior more appropriately whilst 10 participants described how knowledge of ADHD helped them think about the impact of ADHD from the child’s point of view, which deepened understanding around why the child behaved in particular ways. These insights helped improve support and handling of the child.

“I think knowing more about ADHD, that definitely helped, knowing that some of the symptoms he was displaying wasn’t just him acting out or being naughty, it was just certain things he couldn’t control. I think I am more lenient knowing he has ADHD”
(mother, grade 6 boy)

“She has to deal with it every day, so if I understand it more, I can be more supportive”
(mother, grade 7 girl)

This finding concurs with research conducted by Lench, Levine and Whalen (2013) whilst Brown, Howcroft and Muthen (2010) found a similar effect in South African families who used knowledge effectively to reframe behavior. Podolski and Nigg (2001) suggested that the ability to understand and reframe behavior reduced parental stress, although this study presented a more generalized sense of usefulness in accessing information.

This finding suggests that enabling parents to access information about ADHD will facilitate resilient personal adaptations. Knowledge about ADHD is thus critical in terms of reframing behavior and developing empathetic responses to their children.
4.6.1.2 Faith

Nine (9) participants identified faith/spirituality as helping them cope.

“I am not religious or special. I tell you, if I didn’t have the Lord I know – honestly, it’s been hectic” (mother, grade 6 boy)

The use of religion as a coping strategy was a finding in the two studies headed by Bussing (Bussing & Gary, 2001; Bussing et al., 2006) and to a lesser degree in Podolski and Nigg (2001). It was a significant finding in Brown, Howcroft and Muthen’s (2010) South African study. The findings of this study thus concur with Walsh (2003) who highlighted how religious beliefs can give comfort and strength in the face of chronic impairment. In this study, it was the personal sense of faith rather than support from being part of a religious community that seemed emphasized. Although faith was a significant finding, it was expressed by fewer participants than the need for knowledge as a source of resiliency.

4.6.1.3 Support

Nine (9) participants mentioned support as being necessary for coping. The most common form of support was from families, a minority mentioning professional support. However, although support was cited as a coping strategy, a closer look suggests that participants want support rather than actually receiving the quality of support that would be more helpful. Only three participants avoided social contexts and isolated themselves from their families, and all three identified their children as on the moderate-severe range.

“Yes, I think you have to have support otherwise I think you will go crazy. I think having an ADHD child you question yourself every day because you don’t know if you are doing the right thing, you don’t know if an anger outburst is because of something you have done. Every day you question yourself so I think you have to have a support system or somebody you can go to and say ‘I am having a really bad day’ because I think keeping it in will make you go crazy” (mother, grade 3 girl)
“Just support all around. Just support. I need people to understand the severity of the situation first of all. I need them to understand the weight that I have on my shoulders as the child’s mother and then just support in the discipline, in the handling and management of the child. I don’t know, it’s not too much to ask” (mother, grade 3 girl)

This study’s finding that support is seen as significant in helping parents cope concurs with Brown, Howcroft and Muthen (2010), and Firmin and Philips (2009). Podolski and Nigg’s (2001) finding that as child behavior worsens parents’ experience less support, seems borne out by this study.

These findings reinforce the importance of setting up support structures for parents, especially as support has a protective role in the face of parental strain (Brannan & Heflinger, 2001).

4.6.2 Adaptive resilient parenting

Seventeen (17) participants described adaptive parenting strategies to cope. Three strategies, providing routine, staying calm, and ensuring quality time with their children, were described by the majority of participants. Adaptation was apparent in thinking how to parent creatively and differently on an ongoing basis, as well as trying to adapt family routines and rules to the strengths and difficulties of the child.

“We are constantly assessing...so with them you are going to be experimenting with things you’ve never thought. You are going to have to be creative all the time” (mother, grade 5 boy)

“You’ve got to find out what are their interests, their passions and then on bad days try and steer them into those areas whilst also recognizing that the ADHD kid is not going to have a clean room and that kind of thing. Walk away and accept it, know what fight is worth fighting and which ones are worth leaving” (parents, grade 1 boy)
This finding concurs with Firmin and Phillips (2009), who found proactive parents willing to adjust their lifestyles, resulting in more successful parenting. Participants did not specifically talk about disciplining strategies, unlike the majority of participants in Bussing and Gary’s (2001) study, and what were significant trends in this study, such as keeping children busy, providing extra attention, structure and predictability were lesser trends in Bussing and Gary (2001). The findings also concur with Bussing and Gary’s (2001) conclusion that few of these adaptive self-help strategies are enough to prevent further intervention such as medication and counselling, as is evident when considering other data presented in this study.

Bussing et al. (2006) believe it is important to understand adaptive strategies used by parents, to plan interventions that strengthen and expand them. In this study, the most common coping strategies were developing a routine, staying calm, and spending quality time with the child.

### 4.6.2.1 Routine

Routine was discussed by 15 participants, making it the most common adaptive parenting strategy. Some participants elaborated on how they used routine: combining it with visual charts, or reinforcing at bedtime what is going to happen the next day.

“I have long ago learnt that routine works best for him. Routine is our strength at home” (mother, grade 4 boy)

“...we have laminated a timetable and she will tick, tick, tick, tick and then she will go ‘oh I still need to brush my teeth’. And she hates it when we don’t follow it or forget about it when we are running late ‘I want to check Mommy, you don’t have to tell me’, she wants that responsibility of keeping herself in check” (mother, grade 3 girl)

The importance of routine concurs with a number of studies such as Bussing and Gary (2001), Brown, Howcroft and Muthen (2010) and Firmin and Phillips (2009); it is also a key parenting component in self-help books that address parenting ADHD children (Bester 2006; Kutscher, 2008).
This finding suggests that an exploration of routine is important when helping families develop protective strategies, and should be part of the clinical work done with the family by the social worker.

4.6.2.2 Quality time

The second most significant coping strategy identified by 12 participants was spending quality time with their children. Participants described how this helped offset difficult times, or helped calm the child down, improving the family’s quality of life.

“It’s important that the family pull together. That we spend more joyful times together than stressful times when it comes to homework and assignments and tasks and studies” (father, grade 4 boy)

“I put the lights off and the candles on and we lie on the couches and I would talk or there is music playing or we watch a movie. It seems to calm him, he likes it, he feels more comfortable and relaxed” (mother, grade 4 boy)

This finding of the importance of balancing family life with quality time concurs with Brown, Howcroft and Muthen’s (2010) South African study. Both routine and quality time can be impacted when parents become overwhelmed, as described under challenges. The finding suggests that the social worker helps families think about how to develop and sustain activities that enhance quality time and routine.

4.6.2.3 Staying calm

The third adaptive strategy, identified by 11 participants, was trying to stay calm, as becoming angry or emotional worsened behavior. Mothers identified how they preferred to do most of the parenting as they felt they were better at remaining calm than fathers. However, participants also acknowledged how difficult this was to do.
“In all honesty the first thing that comes to mind is to remain calm because at any time that you get highly strung or stressed out they pick up on it and you are setting them off. They look for an anger outburst or a tearful moment, so I think remaining calm is definitely one of the factors” (mother, grade 4 boy)

“I need to remind myself I have to stay calm in order to get her to stay calm, and I have seen it, but it is difficult for me to stay calm when I am scolding her for something I have told her a hundred times not to do” (mother, grade 5 girl)

“If I pressurize my son I get nothing out of him. He gets confused right there and then. He gets so frantic that he can’t think straight. He starts smacking his head saying something like ‘Oh I am so stupid, I am useless, I am this, I am that’. So for parents to not have that effect on their children suffering from this disorder, have patience and give them the space and time to complete their work” (father, grade 4 boy)

The importance of staying calm concurs with Bussing et al., (2006) as well as self-help books (Bester, 2006; Kutscher, 2008). This finding suggests that the social worker considers helping parents find strategies that help them to remain calm in the face of feeling overwhelmed.

This concludes the category pertaining to adaptive parenting. The third category in the theme of adaptations and resiliency is parent-school resiliency.

**4.6.3 Parent - school resiliency**

Data suggests that navigating school and school work on behalf of the child is complex. Participants discussed school as a considerable challenge, but they also found ways of trying to deal with it, albeit not always as successfully as they would like. It is notable that all 18 participants described challenges in this area, yet only 12 reflected on finding proactive and adaptive ways to help their child navigate school and its tasks. No specific areas of parent
school resiliency stood out as significant, hence this is the only category in this theme that does not have sub categories.

The most common proactive strategy was initiating contact with the teacher. Participants described various ways of ensuring contact, although this was variable. Some parents stayed in email contact, whilst others initiated contact early in the first term to discuss their child. One participant described trying to explain to the teacher that on good days they would accomplish homework tasks, but on bad days they had to go with the flow. Participants commonly tried to access teaching material so that they could work with the child on weekends and holidays to fill gaps caused by fluctuating concentration, and had various strategies to try and get children to manage their homework.

“I think the fact that I have at least been able to make email contact with the teacher at times when it has got tough. Just to get things clarified. I don’t always get an answer, and I don’t always get the answer I want, but that’s life. And the fact that I know I can make that contact has made a huge difference” (mother, grade 4 boy)

“Do you know what we normally do on a Sunday? We revise mathematics. I see where the child has got it wrong and go over it. We go onto the website for question papers for English and Maths. And I think that is helping him” (father, grade 3 boy)

“I said to his teacher that it’s pointless for me to try and drum into him or try and finish this page when I know the ability to finish that page on that specific day is just not there you know. His teacher was very accommodating in that” (mother, grade 1 boy)

School-parent resiliency was more a factor in this study, as it was not mentioned by Brown, Howcroft and Muthen (2010), and only in the context of advocacy by Peters and Jackson (2009). However, Firmin and Phillips (2009) describe how their participants were proactive in sorting out problems at school, and Bussing and Gary (2001) mention how parents worked at a relationship with teachers, despite difficulties, because they believed in its importance. The finding concurs with Diez et al., (as described in Garcia, Jara & Sanchez,
2011: 545) that parents of children with ADHD give extra academic encouragement and support.

Although participants worked at finding solutions to school based challenges, it is the weakest of the resiliency areas. This suggests that attention should be paid to developing interventions that help strengthen school- parent resiliency, particularly as resiliency is now better understood to reside in the mesosystemic relationships generated by home and school, as discussed by Pianta and Walsh (1998).

This concludes the presentation of findings concerning the second theme, that of adaptation and the journey towards resiliency.

The third theme presents data that reflects what participants think the school can do to promote resiliency.

4.7 Theme 3: Perceptions around school based support to strengthen resiliency

This theme explored how participants, given their challenges and adaptations, thought the school could help them cope better. The emphasis therefore is on what the school can provide to support resiliency. On analyzing the data, two significant categories emerged, the role of the school social worker, and the role of teachers. Each of these had significant sub-categories. This section will begin by looking at the role of the social worker, followed by the role of the teacher.

4.7.1 The social worker

All 18 participants felt the social worker should be involved in developing resiliency. Participants expressed that knowledge and experience made the social worker’s role pivotal in providing services to support resiliency. Significant categories emerging from the data suggest
that participants expect the social worker to initiate and co-ordinate interventions, provide
direct intervention for themselves and their child, and facilitate a support group for parents.
These will be discussed in more detail. However, participants also expressed a need for the
social worker to provide a linking/mediating service between themselves and teachers, to
understand the issues of each system and then integrate them holistically. One participant saw
the role of the social worker as being the child’s voice at the school.

“I think that your knowledge and your years of experience with people, that is
invaluable. Because you are the one person in that room who has been dealing with
problems like this, or similar, and you’ve seen resolutions. So I think you are an
important part in this whole equation simply because you’ve been taught how to deal
with people. Even teachers don’t get taught that. You’ve got qualifications when it
comes to people, and not text books. You can only study so much in a book and you can
only do so much research. Talking to people gives you insight as to the things they are
struggling with. None of us have that, and I don’t think teachers have that. So your job is
especially unique in situations like this” (mother, grade 5 boy)

“…actively monitoring her, having regular sessions with her, being in constant contact
with her teacher, with her parents. Making sure home is as it should be to help her
thrive; that the school environment is as it should be for her to be successful. And I know
it’s hard, shame. It’s asking a lot. I don’t know how possible this is, having one social
worker, because it is a hell of a lot for one person in a school of how many students?”
(mother, grade 3 girl)

From a South African perspective, the data that is presented here is a new finding as there
is no research into school social work and ADHD. However, the findings do concur with
Teasley’s (2006) work around the role of a school social worker in the USA., although his
guidelines were more all-encompassing, written from a professional perspective rather than
the less informed perspective of parents. The data also suggests that parents expect more
of the social worker than providing traditional ‘casework’ services for children as their
expectations fall along the full continuum of services expected of social workers following a more ecological framework as outlined by Frey and Dupper (2005).

The data supports Smith et al.’s (2014) study that parents require intervention that is guided by in-depth knowledge and experience of ADHD. The data also supports DuPaul (2007) and Kayama (2010) in considering the role of the school social worker as one of linking and mediating. Kayama (2010) considers this role essential in developing resilient partnerships between school and home, which will be discussed in more detail within the next theme.

Three significant suggestions from participants concerning their expectations of the social worker’s role are outlined in the next three sub sections, namely direct counselling for participants and their children, facilitating a support group, and initiating and coordinating interventions.

4.7.1.1 Direct intervention

All 18 participants requested direct intervention services for themselves, and 17 participants for their child. Sixteen (16) participants wanted direct intervention in the form of a support group. The fact that all participants wanted direct services for themselves is contrasted with the demographic information that participants seek help through the service provider for their children; the majority (8) had sourced help from the school social worker. However, 2 participants had not been aware that there was a social worker at the school prior to being contacted for this research, and a further two had been confused about the difference between a social worker and a psychologist.

The data suggests trends. Participants acknowledged that it was easier to access the social worker because she was at the school in a familiar environment. The social worker was available telephonically and for interviews. Important aspects of direct intervention included help with coping strategies, access to information, and support.
“As much as the child needs it the family needs it. Sometimes more – because if I don’t know how to deal with the child, what will happen to her?” (mother, grade 3 girl)

“I think sometimes the families need direction. It’s like teenage myths. You believe what someone else says because they are in the same situation as you. But that isn’t necessarily true. So I think it’s important that the social worker works with the family of the ADHD child because then not only does the family benefit from that, but I think the child benefits as well because the social worker gets to understand the extenuating circumstances and she’s able to say to the parents ‘well, you need help as well’” (mother, grade 4 boy)

“This has been helping me to meet with you as well. It’s helped me a great deal. It’s nice to know that I can also pick up the phone and say: this is a challenge for me, or I need some guidance on this. That you know you have got that contact. It’s nice to have the contact at one place, and you know, that is where your child is” (mother, grade 5 girl)

Seventeen (17) participants wanted the social worker available for the child, but in a variety of formats: helping the child manage difficulties, being accessible on an ad hoc basis when the child needs help, or merely keeping the child under observation.

“We all need a confidant. My child has problems and I ask ‘why don’t you put your hands up in class and talk to the teacher about what is bothering you?’ but he says ‘no, she never listens to me or she says I should keep quiet’. And then I always tell him ‘why don’t you go to Sian?’ because I feel your door should always be open to them. All of them. All the children. And I know if the child comes to see you, you will see the weight of whatever the problem is and decide whether to sort it out here or take it further” (mother, grade 4 boy)

“And it’s nice to know there’s a social worker so if there’s a problem you are on hand with skills and to maybe defuse a situation” (mother, grade 4 boy)

This finding that parents want intervention for themselves and their children concurs with Davis et al., (2012). Although not explicitly stated, direct intervention is in addition to medication,
which is the finding in Davis et al. (2012) if not Bussing and Gary (2001), who found that their sample preferred direct intervention to medication. The help seeking pattern also concurs with Davis et al. (2012) who concluded that although parents want intervention, few sought it because of costs. The findings also concur with Bussing and Gary (2001) in that interventions should reside in one professional rather than spread out between professionals, and confirms Rogers et al. (2009) that the role of mental health professional in schools includes direct intervention, particularly around positive parenting and learning strategies.

This study was not specific enough to explore the complexities behind help seeking patterns, but research into South African patterns would be helpful in terms of targeting the most effective source of intervention, which is widely believed to be the school (Department of Basic Education, 2010; Franklin, 2005; Flisher et al., 2010).

### 4.7.1.2 Support group

Sixteen (16) participants expressed the need for a support group, facilitated by the social worker. Participants described wanting to feel normal, be reassured that they are not the only ones struggling, and to learn about different ways of coping.

“...like a parents’ support group, even if none of them can offer a solution to any of my problems, just being able to speak to a parent whose child has the same problems, who has gone through the same thing, who is experiencing the same problem...because you feel like your child is the worst child, she just does the worst things. I think that type of support would help tremendously in me going home again and feeling and getting that renewed energy. I can handle this, we can overcome this thing you know” (mother, grade 3 girl)

“I think that identifying that there is another child in my child’s class with a normal set of parents who have this problem means that we are actually normal, there is nothing wrong with us. Give the opportunity to parents to form support groups if they want to” (mother, grade 7 girl)
Firmin and Phillips’ (2009) and Brown, Howcroft and Muthen (2010) drew from support groups. These two studies present a stronger adaptation theme, which highlights the importance of support groups. This study’s data concurs with these studies as participants value the importance of support groups and would welcome the facilitation of one through the school. Neophytou and Webber (2005), Singer (2002), and Rogers et al. (2009) also identified support groups as an effective intervention.

The request for group support is interesting as its bears out McCleary’s (2002) contention that parent education and skills training are inadequate in the face of ADHD as a chronic condition. The findings thus indicate that parents have to be supported to feel and believe competent over the long term, and a support group can be an essential element in this process.

4.7.1.3 Initiating and coordinating interventions

The data suggests that 10 participants valued initiating and coordinating interventions as a social worker’s role, based on skill set, knowledge and experience.

“Somebody is going to have to take the lead right? And me as a parent, I would feel more comfortable if the person taking the lead is somebody who actually knows what they are talking about...it needs to be somebody who can offer assistance, not just coordinating but actually offering more than just coordinating. Share some knowledge and so you can counsel people” (mother, grade 7 girl)

This data concurs with Teasley (2006) in that one of the roles of a school social worker should be the initiating and coordination of interventions. Although this was not explicitly stated by participants, it also concurs with Rogers et al. (2009) who believe that school mental health practitioners should be training and helping teachers modify their teaching practices and improve communication with parents.

Resiliency is about enhancing that which works, and has a protective function. It therefore behooves the social work profession to consider the needs of recipients of services in order
to design and implement interventions that are relevant and useful, as outlined by Bryan and Henry (2012) in their discussion on parent-school partnerships.

The following section explores participants’ perceptions on what teachers can do to promote protective factors supporting resiliency in themselves and their children.

4.7.2 Teachers

Data presented in Theme one indicated that participants have concerns about classroom support, as well as concerns about their role bridging classroom problems. Data from analyzing Theme three provides recommendations from parents to teachers around what can be done to manage these challenges and provide a more supportive and caring environment for both children and parents.

“Last year it was very difficult to speak to the teacher and get things, work together. The only messages we ever got was that the child’s medication needed to be upped, he is not coping, but they didn’t call me in and sit with me and say to me you know what he is not doing so well, let’s see what areas he is struggling with and let’s see how we can work together. Let’s see if we can find old papers that you can do with him at home, or even not that, say to me if you go to this bookshop you can buy this and this book and it will help him. Things like that. I have a better relationship with this year’s teacher. She explained to me where he wasn’t coping and what I could do to make it better. Last term I didn’t even have to go in and see the teacher. I was so happy. I was always waiting for the letter and it didn’t come. ‘Mommy my teacher said I was too good and you don’t need to come in’. So of course I cried. I was so impressed that it was the first term I didn’t have to see the teachers in ages. So” (mother, grade 4 boy)

Three sub categories were identified, which although stated separately, are interlinked as the above quote indicates. Participants want teachers better educated about ADHD, proactive, and providing more in-depth and accessible contact. The recommendations give voice to the need
for a more collaborative relationship with the teacher, and for the teacher to become more empowered to deal with their children.

4.7.2.1 In-depth and accessible contact

Eleven (11) participants wanted more in-depth contact with teachers. There was dissatisfaction with parent-teacher meetings at the end of term, with sentiments such as its too late by then, too public, and too short to have a meaningful discussion. Participants also wanted to not only hear bad news, but also when the child performed well, so that this could be reinforced at home. Many participants struggled to access teachers, whilst others were relieved at their availability. This suggests variability in accessing teachers and their response to managing ADHD behavior in class. Participants also voiced the importance of developing a relationship with the teacher where there was an exchange of information that helped both parent and teacher to contextualize the child’s behavior and challenges.

“I think that for a child with ADHD or a learning disorder it is very important for the parent and teacher to have a good relationship so the teacher knows what this child is like at home and what the challenges are. But also so that the parent understands that school is a different place, your child is surrounded by different people so therefore reactions are different. It’s not the same child you have at home“ (mother, grade 4 boy)

This finding resonates with Lord Nelson, Summers and Turnbull (2004) who found that parents of special needs children valued availability and accessibility of teachers, and concluded that parent-teacher relationships were critical in enhancing quality of life for families and teachers. It also confirms DuPaul’s (2007) recommendation of biweekly meetings between parents, teachers and child. As participants expect the social worker to provide a bridging role between themselves and the teacher, it could be considered that the social worker enable more in-depth and accessible contact.
4.7.2.2 Proactive intervention

Ten (10) participants wanted proactive intervention from teachers. They wanted to be advised immediately of problems, and they wanted an idea of what work is being done so that they can help the child catch up. Participants want to help their children, but are clearly struggling to effect joint interventions with teachers: they know what they want, but struggle to implement it.

“I think there’s a lack of consistent interaction between parent and teacher. And once a term – it doesn’t help- the term is over. It should be at the beginning of the term. Let’s have a plan of action for parent and teacher, so the parent can assist the child at home and the teacher helps in the class and the two of them are on the same structure. If parents were given term planning, you would be surprised how parents will sit with their kids” (mother, grade 5 boy)

This finding concurs with Kayama (2010) and Lord Nelson, Summers and Turnbull (2004) concerning the importance of collaborative and proactive relationships between teachers and parents. The social worker could consider creating a proactive and collaborative environment as one of her bridging tasks, as suggested by the researcher in her synthesis of the work of Terrion (2006) and Frey and Duper(2005) in Table 2.1 (p 24 of this dissertation).

4.7.2.3 Teachers trained in ADHD

Ten (10) participants wanted teachers better educated in managing ADHD. Participants described wanting teachers to be more emotionally equipped to deal with how frustrating these children can be to teach. Participants discussed the importance of teachers developing effective teaching interventions, and transferring information about the child for continuity.

“...for a teacher to say she felt like slapping my child in the face because she was so frustrated, I found that was quite harsh. Sometimes I think that some of the teachers need to remember what child they are dealing with, to understand their difference. They
need to understand, be a bit more patient because ADHD children try your patience a lot. There has obviously got to be a different angle to tackle these kids to other kids, you know” (mother, grade 2 girl)

“Not all teachers know exactly how to deal with children who are ADD and ADHD. They need to get a better understanding of who this child is. Also for teachers to speak to one another about the child’s abilities and weaknesses so that you can already in your planning be able to assist...there is an even greater need for teachers to be able to cope with this type of learner, to allow this learner to also have a valuable learning experience in their class. They might be a bit more challenging but you can’t just leave them behind” (father, 2 children)

This finding concurs with an increasing body of literature that calls for teachers to receive specific input on managing ADHD in the classroom, notably Kos, Richdale and Hay (2006); Sherman, Rasmussen and Baydala (2008); West et al., (2005) and Bell et al., (2011). This study did not include teachers’ knowledge, attitudes and skills in managing ADHD, but it is recommended that this be explored to develop a holistic picture prior to designing and implementing a strategy to up-skill teachers, as is recommended by the Department of Basic Education (2010).

Although the social worker is not a teacher, part of her recommended role is the initiating and coordinating of services, and providing a link between teacher and parent where necessary. Understanding the challenges and solutions provided by parents is thus a vital component of developing protective strategies and creating a supportive and caring environment for parents and children.

The fourth and final theme explores perceptions of parent-school partnerships to promote resiliency.
4.8 Theme 4: Parental perceptions of parent-school partnerships to promote resiliency

This theme explores perceptions of parent-school partnerships as well as the possibilities inherent in partnerships. The significant data has been grouped into two categories, namely school climate, and the benefits of partnerships. No sub categories were evident, unlike the other themes. The rationale behind this line of enquiry was to explore what can be achieved together with the school rather than what the school can do for you, which was Theme three. Field notes indicate that participants struggled to explore this theme, as participants returned to discussing what they needed from the school.

School climate is discussed first as it sets the tone for interactional relationships between parents and teachers (Epstein, 1995).

4.8.1 School climate

This section presents the findings grouped under the category ‘school climate’. Two areas in the data analysis will be discussed in more depth, that of school support and sense of involvement.

Participants’ perception of school climate reflects their sense of being welcomed, sense of belonging to the school community and sense of support (Terrion, 2006). Despite the challenges noted thus far, data suggests that the school climate is healthy as 17 participants felt welcome at the school, 16 had a sense of belonging, and all 18 felt that they would approach the teacher if they needed to.

Responses relating to support however, indicate that relationships between parents and teachers are more complex. Although 12 participants felt supported, on further inspection this support was often qualified, and sense of support varied according to the teacher. Participants
described concrete examples of help, or supportive words; another described it as present but ‘latent’. Other parents were more critical about support.

“You can see where the heart is, it’s for the learners. It’s not just ‘right, OK, we’ve got a school we must put 20000 kids through school from A-B and kla if the one falls off the bus then ja he can go somewhere else or go to a special school or go to Vista Nova or somewhere because we haven’t got time to deal with his problems’. The whole holistic approach feels comforting” (father, grade 1 boy)

“You can read some of the emails I have sent her teacher where I have said I feel so bad, so embarrassed and she will say ‘you know what, these kids do these things, you are not to blame, don’t worry, get over that feeling it’s not you, this is what they do’. She has never made me feel like I am to blame (mother, grade 3 girl)

“Because of all the negativity surrounding ADHD and all the backlash, parents need all the support. I felt thrown in the water and left to sink or swim. I think support should have been more forthcoming from the educational department more than anything else” (mother, grade 5 boy)

Complex attitudes towards the school were evident when participants discussed their feelings about level of school involvement. Participants say they have something to offer, but there was no sense of partnership, rather a sense of yearning to get involved. Participants described feelings of frustration, yet they seemed to rely on the school to diagnose and rectify problems. Although parents seem to be waiting for the school to reach out, they want the chance to educate the teachers themselves: “they must hear from us rather than reading books”.

“Don’t make us feel like we just don’t matter. It’s like these kids are here, but they are not doing anything to make anyone know these kids are here” (mother, grade 7 girl)

“We come, we learn, we go home – that’s it. I think the school has to get back to a point that it’s a village that raises a child and that we need to pull our resources together” (mother, 2 boys)
The finding that participants felt disempowered by the school concurs with Rogers et al., (2009). However, unlike Rogers et al. (2009) there was still a sense of connection and belonging at the school despite feelings of ambivalence and frustration, which concurs with Lord Nelson, Summers and Turnbull (2004). Participants say they feel supported, but their actions indicate otherwise, demonstrating Kayama’s (2010) sense that parents are not willing to actively challenge the school for fear of making the situation worse. Data suggests that participants are not confident in becoming advocates within the school system as was evident in other studies (Peters & Jackson, 2009). Data suggests that participants were articulating the need to work together, have good communication and be treated as equals, which concurs with Cox (2005).

These findings concur with Graue and Brown (2003) who felt that teachers were not trained in inclusive and collaborative strategies. This study concurs with their recommendation that teachers learn how to engage with more ‘difficult’ families, learn from families, and use these insights to improve their teaching environment.

Participants seem to be waiting for the school to reach out, demonstrating a lack of efficacy and power sharing. These are factors that need to be addressed to develop collaborative interventions, and this finding concurs with Mapp and Hong’s suggestion (2010) that schools needs to take the lead. Further research is needed to understand what is hindering parents from actively pursuing more effective relationships with teachers and partnerships with the school.

4.8.2 Benefits of school-parent partnerships

Thirteen (13) participants linked benefits of parent-school partnerships to support, and 10 to improving quality of life in families. One participant summed it up to say partnerships between
home and school would help empower parents, which in turn would empower their children. Partnerships were thus seen to have a protective function.

Although one participant hoped that partnerships between school and parent would result in a greater sense of belonging at the school, an analysis of the data with respect to support points to parents seeing benefits between peers rather than parent-school, although this is in context of the school facilitating peer support. Participants also reflected on wanting to be given the opportunity to provide support to others. Field notes indicated that parents who did not want to reach out to others felt too needy themselves, and doubted they had anything to offer.

Participants had a number of practical intervention suggestions: articles in the newsletter, setting up a blog, holding workshops for staff and all parents, and family days. None of these suggestions were cited by a majority.

“...less vulnerable pupils and children. That’s what it’s ultimately about. When we are empowered, we can empower our children, which makes them less vulnerable you know” (mother, grade 5 boy)

“...a place to feel, to be OK in society, to feel normal, to feel part of the family at school” (mother, grade 4 boy)

“...I can encourage them, talk about what I have gone through and I can give them advice and feedback and just that there is light at the end of the tunnel” (mother, grade 7 girl)

“And get people involved and say ‘You have been through this, your grade is in grade 7 now, what other challenges can we be expected to face?’ Because sometimes if we know what we can expect to face, we can start planning how we are going to deal with it when the time gets there” (mother, grade 7 girl)

These findings concur with Christenson’s (2003) beliefs that families need to be supported rather than ‘fixed’, and concur with Epstein (1995), Christenson (2003) and Clarke, Sheridan and
Woods (2010) around what constitutes protective factors in parent-school partnerships. The findings also concur with Mautone, Lefler and Power (2011): interventions that encompass both home and school, such as those that develop through partnerships, are potentially the most effective.

The findings are new in that they relate to South African experiences of parent-school partnerships with respect to South African schools and ADHD.

This finding suggests that more work needs to be done by the school to encourage a climate of collaboration, equality and shared decision making. Participants did not explore how this was to happen, although Rogers et al. (2009) see the fostering of positive relationships within the school the role of the school mental health professional.

4.9 Conclusion

This chapter was divided into two sections. Section one presented the demographic data that provided a context for the data findings. Section two presented the data derived from the four research questions outlined in chapter one. The data was organized into four themes. The first two themes related to participants’ experiences of challenges and coping strategies (resilience) and the last two themes explored resiliency from the perspective of the school: what the school can offer and how parents perceive parent-school partnerships.

The next chapter discusses conclusions and recommendations stemming from this chapter.
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Four research questions were asked in this case study: what are the challenges perceived by parents in coping with a child with ADHD; how have parents successfully coped with and adapted to the impact of ADHD; how do parents perceive the role of the school and the school social worker in strengthening resiliency; and how do parents perceive parent-school partnerships to promote resiliency. Section One of this chapter considers the conclusions that can be derived from addressing these four research questions, whilst Section Two presents the recommendations that follow from the conclusions.

5.2 SECTION ONE: CONCLUSIONS

This section begins by considering conclusions derived from the demographic data before addressing conclusions derived from the research questions.

5.2.1 Contextual demographic information

Some aspects of the demographic information deserve mention in the conclusion, as they provide a context to understand the experiences of the participants, therefore generating recommendations in their own right.

5.2.1.1 Parents are emotionally vulnerable and need support

Although the divorce rate in this sample is lower than expected, a significant number of participants described relationship problems, and all of these participants also described
mental health problems in either themselves or their partner, notably depression and anxiety in mothers, and substance abuse and ADHD in fathers. This needs to be taken into account when developing effective interventions.

5.2.1.2 Parents best access support through their children

Despite mental health stressors, help seeking behavior is muted, and mostly accessed via the professional dealing with their children with an increasing and significant use of the school social worker. The school social worker is ideally placed to offer this support, particularly as ADHD is a chronic condition with fluctuating levels of severity and stress.

5.2.1.3 Support needs to be both informational and emotional

This study’s participants understood that ADHD is a neurobiological condition. Despite this knowledge, participants still struggled to manage the effects of ADHD. The conclusion that can be drawn is that parents need both informational and emotional support to become resilient in managing ADHD.

5.2.1.4 The social worker plays a key role in supporting parents

The social worker can play a key role supporting, educating and counselling parents and children. Given that many parents cannot access private professional care, it behooves the social worker to ensure that s/he has the necessary clinical skills to fill this role.
5.2.1.5 The school is an important intervention site for families with children with ADHD

The importance of the school as a referral and intervention site was reinforced when examining data relating to how children access intervention.

In this study, the school played a key role in the identification and referral for assessment. In all but one family, the teacher initiated assessment, which indicates that it is the school rather than parents driving the identification process. As was noted in chapter 2, school response is variable. As the majority of South African children do not have access to the private medical sector, the role of the school in identifying children who need to be assessed and correctly managed assumes critical importance. Three issues become evident: the importance of research into the practice of teachers in the referral for assessment of ADHD; research into how competent teachers feel in recognizing ADHD and co-occurring disorders; and the capacity of the state system to absorb referrals for diagnosis and management.

In this study there are a constant number of diagnoses each year up to grade 4, but only one was diagnosed prior to school. Given that the earlier the diagnosis and intervention the better the outcome (Sonuga-Barke et al., 2006), it must be concluded that diagnosis and intervention be targeted as early as possible in the foundation phase, with a greater awareness of the symptoms of Inattentive Presentation.

In terms of intervention the largest proportion of children were receiving support from the school social worker, and furthermore the school was promoting access to a private Occupational Therapy Practice as well as being involved in managing medication. Of concern is that medication remained the most constant strategy. In line with the recommendations of the MTA study (Wells et al., 2000a) it could be concluded that a more multi-systemic intervention programme be designed that addresses and involves children, parents and teachers. I would argue that the school, and the school social worker, is ideally placed to develop such a programme.
5.2.1.6  **Co-occurring diagnoses need to be diagnosed and managed**

What is alarming, and needs further investigation, is the lack of identification of co-occurring disorders in this study, especially considering the high rate of children repeating grades. It suggests that teachers be trained not only in recognizing and managing ADHD, but also recognizing co-occurring disorders and referring appropriately for management.

5.2.1.7  **Address the gap between what is being provided by the school and what parents feel they need**

Although the school seems to assume importance in the absence of concerted help seeking strategies by participants for themselves and their children, participants noted teachers’ roles as identifying problems and medication management. No participant commented on the role of teachers in providing classroom interventions to help their child, although this was discussed in depth in the themes relating to challenges and partnerships. This underscores the gap between what is being provided and what parents need.

5.2.2  **Conclusions to Research Question 1: What are the challenges in coping with a child with ADHD?**

This question absorbed the most time in interviews and the post analysis group discussion. The challenges cluster around personal impact; the impact on parenting; medication; and challenges in the parent-school domain. This section also presents further conclusions generated by these challenges.
5.2.2.1 Participants were challenged by the personal cost of parenting a child with ADHD: exhaustion, stress, frustration, inadequacy and guilt

In looking back at the transcripts, it became clear that there was no sense of this getting better, participants in fact worried it would get worse when children reached adolescence. The chronic nature of ADHD and its challenges has to be understood within the personal resources available to participants. Participants described their exhaustion, stress and relentless sense of inadequacy in parenting and doing their best for these children, and their guilt at failing them as well as their other children.

The findings of this study suggest that interventions normalizing parental feelings, and providing support and education, will help reduce emotional distress of parents. Understanding patterns of frustration will also help target effective intervention strategies. These conclusions can assist the social worker to offer interventions that address these challenges.

5.2.2.2 Participants struggled to manage parenting tasks such as discipline and finding time for other family or personal responsibilities

The data suggests that participants struggled to discipline effectively. Disciplining is more complex with children with ADHD given their inexplicable mood swings, and the unpredictability and uncertainty of their behavior. Participants blamed themselves for their struggles to discipline. Even though participants understood that ADHD is a neurobiological condition, their struggle to discipline suggests that parents need both information and support to manage their parenting tasks. It could be concluded that consideration should be given for implementing long term and continuous support to reinforce parental training, a role the social worker at the school is equipped to manage.

These children absorbed a disproportionate amount of time in the family resulting in feelings of guilt around neglecting other children and the impact on siblings.
5.2.2.3 The school social worker has a role in helping parents manage their personal and parenting challenges

The stress levels of participants is concerning in the light of their help seeking patterns. The role of the school social worker in helping families manage their personal and parenting challenges thus becomes very relevant when one considers that parents are starting to use the school social worker more than any other professional avenue. It can be concluded that schools are in an ideal position to provide this level of input as they are community based and easier to access.

This study’s participants were not critical about lack of resources or professional intervention, possibly because of muted help seeking behaviors.

5.2.2.4 Attention needs to be paid to the stress caused by Inattentive-presentation

Parental level of stress is interesting in the context that 9 of the 21 children were identified as mildly impaired, and I would suggest that this is because of Inattentive type-presentation. It bears out Podolski and Nigg’s (2001) finding that Inattentive symptoms are as stressful to parents as externalizing behavioral problems. As inattentive symptoms have a marked impact on academic function, this may be why school – parent challenges were more pronounced in this study than other studies that were not school based.

5.2.2.5 Should my child be medicated or not? Challenges related to ambivalence and stigma

Medication was a double edged sword as it demonstrably improved quality of life, yet it was this intervention that set up participants for considerable stigmatizing reactions from family and community, causing further ambivalence and guilt at choices they were making on their child’s behalf. Self-blame was not reduced once the child was diagnosed and on medication,
suggesting that parents, and in particular their families, need access to scientifically derived data in order to counter the emotional effects of ambivalence relating to the side effects of medication, and stigma. The school social worker is in a position to offer informational support.

5.2.2.6 Parents had challenges in the parent-school domain

It is relevant to take cognizance of the challenges experienced in the parent-school domain, particularly as data revealed that participants struggled to challenge teachers directly around classroom based practices and their concern that teachers are not adequately equipped with knowledge and skills to manage children correctly. Participants remained frustrated at the variable response to their children, yet seemed dependent on teachers recognizing and sourcing specialized training in managing their children.

Participants identified other areas of school–linked challenges such as exhausting homework battles and worrying school progress. Disorganization in bringing homework home and distractibility in doing it meant that family time became homework time, and caused considerable frustration both with the child and the teacher who did not recognize their battles. Participants put considerable effort into helping their children with homework, probably as a result of their concern around school progress. Participants were anxious about what they could do to help their children manage better at school, but were not sure how. Although participants talked about trying to make contact with the teacher to improve school progress, the fact that the majority remained concerned about homework and progress indicates that school–parent communication needs to become more effective.

The third area of challenge that was school-home based was participants’ concern around their children’s peer relationships. Participants worried that their children struggled to make and keep friends, or were attracted to friends who were perceived to be a bad influence. Participants also felt that their children were being stigmatized and/or avoided.
5.2.3 Conclusions to Research Question 2: How have families successfully coped with and adapted to ADHD challenges?

Walsh (2002) describes resiliency as ‘struggling well’ and it was this sense of bravely struggling that shone through the vignettes. The resiliency adaptations both shadowed and were over-shadowed by the challenges as participants described adaptations in the areas of personal resiliency, parenting adaptations, and parent-school strategies.

5.2.3.1 Parents struggled more than they felt they succeeded

It was clear that parents struggled more than they felt they succeeded, which is consistent with the sense that challenges were overwhelming. This study’s findings that participants had not readily accessed help, and were not sourced from support groups or mental health professionals, could account for the fact that adaptations were overshadowed by challenges, and that participants were muted advocates for their children. This finding is important in the context of parental recommendations, and demonstrates the effectiveness of parents accessing knowledge, alternative parenting strategies and support as key aspects of developing resilience.

Nevertheless, there were adaptations and successes that were shared by the participants.

5.2.3.2 Personal resiliency: recognition of the positives in their child, themselves, and in ADHD

All participants were able to describe positive qualities in their children which helped them tolerate and manage chronic challenges inherent in having children with ADHD. The ability to reframe behavior more positively and to actively work at positive thinking were useful strategies employed by the participants.
5.2.3.3 Personal and parenting resiliency: access information about ADHD

Participants identified that increasing knowledge about ADHD helped on two levels. Knowledge helped participants reframe and contextualize behavior more appropriately whilst it also helped participants understand and empathize with their children. The ability to reframe reduced stress and assisted in thinking more adaptively about parenting. This finding thus suggests that enabling parents to access information about ADHD will facilitate more resilient personal and parenting adaptations.

5.2.3.4 Personal resiliency: the importance of faith and support

On a personal level, having support from family and the community was seen as important, and many identified faith having a protective function. In this study, support was largely accessed through family networks rather than professional outlets, which is not surprising given the muted help-seeking behavior. However, there was a sense of longing for support rather than satisfaction with support received; leading to the conclusion that support is an area that needs to be more strongly developed for resiliency. Only those participants whose children rated on the severe scale avoided social contact.

5.2.3.5 Adaptive parenting strategies: be proactive and adjust your lifestyle to accommodate the challenges of the child

It is important to understand what parenting strategies are being used successfully, and plan interventions to strengthen and expand them. In this study, participants identified the importance of trying to parent creatively, not only with the child but other siblings as well, in order to work with the child’s strengths and difficulties. Participants understood that they had to experiment with different strategies, and what worked today is not necessarily going to work tomorrow.
5.2.3.6 Adaptive parenting strategies that worked: routine, quality time, and staying calm

Three areas in parenting were seen as significant in improving the family’s quality of life, namely the importance of routine, staying calm despite provocation, and trying to find quality time to offset stress. Routine was described as the most successful adaptive strategy, with some creative uses of routine such as reinforcing routine with visual or mental charts. Although staying calm was an important strategy, difficulties in managing this were acknowledged, and mothers felt that they preferred to do most of the disciplining as they stayed calmer than fathers.

5.2.3.7 Resilient strategies used by participants for school: initiate contact, be proactive, access teaching materials to fill in the gaps, persevere with homework

School-parent resiliency was more a factor in this study, possibly because other studies were not located within a school setting. Despite the fact that this is an area that participants seemed to struggle with most, they still attempted to make it work. Participants described going the extra mile with catch up and homework strategies, and keeping lines of communication open with teachers. There was a strong sense of longing for teachers to reciprocate, recognize and enhance their strategies. The data thus seems to suggest that attention should be paid to developing interventions that strengthen parent-school interaction.

The third research question explores participants’ perceptions around how the school can support families and promote resiliency, thus operationalizing how schools can help strengthen resiliency in children and parents.
5.2.4 Conclusions to Research Question 3: How do parents perceive the role of the school and the school social worker in supporting resiliency?

Participants focused on what they saw as the potential roles of the social worker and the teacher.

5.2.4.1 The role of the social worker

There is an increasing trend in using the services of the school social worker

As can be seen in this study, parents do not readily seek help, yet there is an increasing trend to use the services of the school social worker. The social worker is seen as accessible and available, and the environment familiar.

The school social worker is in a position to maintain support over longer periods of time

As ADHD is chronic, the school social worker is in a position to maintain support over longer periods of time, which is important given that ongoing support needs to underlie parent education and skills training in order for resiliency to be maintained. Bhana’s (2010) contention that school based interventions are more effective in countries like South Africa with limited resources is confirmed in the pattern of help seeking behavior noted in this study, especially given that ADHD is under presented at mental health clinics.

This trend is not acknowledged by the Department of Basic Education

It is of some concern that social workers play an indirect role in the care and support of children, as understood by the Department of Basic Education (2010). Social workers are mentioned in the context of external referrals for abuse and neglect, and therapy is considered with external referrals to psychologists. Teachers are expected to carry the burden of care of care and support. This begs the question why the role of school social worker is so overlooked.
given the potential for making meaningful contributions to the care and support of both children and their families. It could be argued that the Department of Basic Education considers the viability of placing more social workers into schools, given the results of this study. Currently one learning support teacher is shared between two schools, and it is suggested that this model be considered for mental health professionals based at schools; alternatively for the capacity of mental health professionals to be expanded at District level.

The school social worker is valued for her knowledge and experience

Participants expressed their belief that it was in-depth knowledge and experience of ADHD that made the social worker’s role pivotal in providing services to support resiliency. This can be contrasted with their belief that teachers did not know enough to manage their children appropriately. The social worker was seen as a more accessible staff member whose specialized knowledge and experience was experienced as containing and supportive.

Participants expect more from the school social worker than providing traditional case work services to their children

This underscores the contention that interventions only targeting the child have limited value. Expectations of the school social worker fall along the continuum of services Frey and Dupper (2005) discuss in their adaptation of the ecological model for school social workers, as outlined in Chapter Two. Apart from direct intervention in terms of counselling or group work, participants expect the social worker to initiate and co-ordinate interventions as well as provide a linking and mediating service between themselves and teachers. There was an expectation that the social worker could understand the needs and issues of the three domains of child, parent and teacher and deal with them holistically.

It is interesting that in the discussion around the role of the social worker, no mention was made of her role in liaising with the school doctor to assess, manage and monitor the
medication for children who use the public health system, suggesting that participants want more than medication as an intervention.

**Participant expectations of the social worker**

All the participants acknowledged the importance of counselling availability for themselves, either telephonically or in the more structured interview. Important aspects of direct intervention included help with coping strategies, whether personal or parenting; access to knowledge; and support. It must be noted that not all participants had accessed this service; therefore the potential availability of it seems important.

Participants expressed the need for the social worker to facilitate a support group to enable them to feel ‘normal’, to not feel so isolated, and to hear about different coping and parenting strategies. Support groups are an effective intervention, particularly as a theme running through the data has been the importance of support, whether to underpin information and knowledge; fill the gap left by inadequate support offered by friends, family and teachers; or help parents feel and believe competent over the long term.

Participants indicated that it was comforting to know that a social worker was at school to immediately deal with issues concerning the child. They saw the role of the social worker with respect to the child as providing counselling sessions, availability on an ad hoc basis when needed, or keeping the child under observation.

In the parent-school mesosystemic niche the social worker’s role is not only to enable more effective relationships between parents and teachers, based on research around effective home – school practices, but also to provide a voice for the parents until they feel more confident in their own advocacy.
The social worker’s role is a complex one

It is clear that the expected role of the school social worker is complex as it encompasses intervention systemically within various micro and mesosystems. Clinical social work training is an advantage in preparing for managing all the complex roles required to support parents, child and school.

5.2.4.2 The role of the teacher

Superficially, participants felt a sense of belonging at the school, but on deeper inspection relationships with the teachers were complex, coloured by ambivalence and frustration. There was an overall sense that participants were not effectively reaching out to advocate for their children in the classroom.

However, participants know what they want: teachers who can understand and support their children in the classroom and who can understand and support their endeavors at home. Participants had the following suggestions for teachers.

Participants would like more in-depth and accessible contact with teachers

Participants were dissatisfied with the quality of their interactions with teachers. They were disconcerted at variability of insight and management between teachers, disliked the emphasis on problem related contact, and found the current end of term report back format as being too short and too public. Participants voiced the importance of developing a relationship with the teacher where there was an exchange of information that helped both parent and teacher contextualize the child’s behavior and challenges. The data supports the conclusion that regular meetings between parent and teacher are indicated, with teachers who are accessible and open to their suggestions and who take parents seriously.
Participants would like proactive intervention from teachers

Participants wanted to be advised as soon as possible of problems, and furthermore that they wanted to help their child progress by consolidating work done at school at home. However, although they were eager to help their child, they were struggling to put in place joint interventions with the teachers.

Teachers need training in classroom management of ADHD

Participants suggested that teachers receive specific input on how to manage the child more effectively in classroom. However, concern was also raised about how teachers cope emotionally, thus expecting that this be included in on-going training.

Although the social worker is not a teacher, part of her recommended role is the initiating and coordinating of services, and to provide a link between teacher and parent where necessary. Understanding the challenges and solutions provided by parents concerning teachers is thus a vital component of providing protective strategies whilst creating a supportive and caring environment for parents and children.

The fourth research question explores parental perceptions of parent-school partnerships that promote resiliency.

5.2.5 Conclusions for Research Question 4: How do parents perceive parent-school partnerships to promote resiliency?

5.2.5.1 Participants perceived the school as welcoming and felt a sense of belonging, but did not feel sufficiently supported

Two elements for developing effective parent-school partnerships are present, as participants felt a sense of welcome and belonging at the school. However, the third element of a positive
school climate is support, which participants felt was problematic. Superficially participants felt they belonged at the school, but a deeper inspection uncovered parental frustration and helplessness in navigating the system for their children. Participants wanted to be involved, yet waited for the school to reach out to them. There was a poor sense of partnership, despite the fact that parents felt they had valuable insights to offer.

5.2.5.2 Participants struggled to engage with this section

This sense of inequality between parent and teacher may also explain why participants seemed to remain “stuck” in their understanding of this section, as they interpreted the benefits of partnership as helping them personally rather than collectively. However, there was a strong desire to reach out and help others in a similar position. This suggests how overwhelmed participants currently feel in managing the school context where the narrative is more problem sodden than solution driven.

The data thus suggests that the school needs to facilitate and encourage a climate of collaboration, equality and shared decision making. Conclusions thus far have suggested that the social worker play a role in developing a more collaborative climate.

5.2.5.3 The role of the school social worker is important in fostering resilient parent-school partnerships

The school social worker can play an important role in fostering positive and resilient relationships between parents and school. It is important that parents’ positive contributions to the child and the school be acknowledged for the development of resilient partnerships, as currently there is a sense that parents feel defined by their problems, whilst their strengths and contributions are not being sought.

The social worker has been asked to give them this ‘voice’. The school social worker can play a key role in the development and maintenance of skills and relationships between child, parent
and teacher based upon the particular set of skills that are core to the profession of social work. A school social worker is thus ideally placed to intervene both across and within domains to promote resiliency. Clinical training in social work will be advantageous in developing resiliency micro- and mesosystemically.

5.2.6  General conclusions

This research has explored parents’ perceptions of challenges, successful adaptations, and the role of staff at the school in helping build resilience. The following section makes recommendations based on the conclusions generated by the analysis. Some of these recommendations have been put into practice whilst this research was being written up, such as workshops for the teachers, and the implementation of a parent support group which is now meeting monthly on a Saturday morning.

5.3  SECTION TWO: RECOMMENDATIONS

Recommendations are based on an integrated assessment of the conclusions, and are ordered for ease of reference for the following: the school; parents of children with ADHD; the Department of Basic Education; the Social Work profession; and School Social Workers.

5.3.1  The School

5.3.1.1  Recommendations for the school

It is recommended that the school takes into account that parents of children with ADHD are emotionally vulnerable, in need of support, and struggling to connect meaningfully with teachers and the school.
It is recommended that the school consider the expressed needs of parents of children with ADHD in order to develop a multi-systemic intervention programme aimed at improving resiliency across home – school - peer domains.

It is recommended that any programme that is developed should be rigorously thought through, applied and continuously evaluated, particularly for its long term efficacy in helping families and the school develop resilience in managing ADHD.

It is recommended that the school provide knowledge and support for both teachers and parents around evidence -based practices that are effective in managing peer based stigma, homework, and classroom management. It is furthermore recommended that the school utilize the knowledge and experience of the school social worker to disseminate information to parents and staff concerning evidence based interventions that promote resiliency both within and between domains.

It is recommended that the school consider the role of the social worker in terms of providing direct intervention to families in the form of individual and group sessions; providing a linking and mediation role between parents and teachers when necessary; and planning and implementing interventions that promote parent-school partnerships aimed at improving resiliency across all domains.

It is recommended that the school provide in-service training for staff on how to develop and maintain collaborative strategies that will promote resiliency and resilient parent-school partnerships. This will encourage a climate of collaboration and equality in decision making.

This research specifically addressed the parents. It is recommended that perceptions and experiences of teachers and children be researched for a more in depth case study analysis.

Further research is needed to have a deeper understanding of what is hindering parents from actively pursuing more effective relationships with teachers and the school.
5.3.1.2 Recommendations for Teachers

It is recommended that teachers in the foundation phase become skilled in recognizing the symptoms of ADHD, particularly Inattentive Presentation.

It is recommended that all teachers become skilled in recognizing symptoms of co-occurring disorders and after discussions with the parents and social worker, referring children for further assessment and management.

It is recommended that regular meetings be held between teachers, parents and children, and that special attention be paid to holding these within a spirit of partnership in order to promote more resilient relationships between the parent, teacher and child.

It is recommended that teachers be proactive in contacting parents when problems arise; but also that they be proactive in providing positive feedback.

It is recommended that teachers help parents manage homework more effectively and advise parents on what they can do to improve school progress that is consistent with the child’s ability and level of impairment.

It is recommended that teachers be offered on-going support in the management of children with ADHD.

5.3.2 Parents

Based on significant resilient adaptations, parents have the following to offer:

- The importance of routine, staying calm despite provocation, and trying to find quality time to offset the stress of daily life.
- The importance of accessing information, alternative parenting strategies and support as key aspects of developing resilience.
- The importance of being pro-active in reaching out to teachers
5.3.3 **Department of Basic Education**

Recommendations are made in respect of school based management of ADHD, the role of the school social worker (or mental health professional) and possible areas of further research.

Currently there are no specific strategies other than medication management being implemented for children with ADHD in South Africa, unlike legislated strategies in Britain and the USA. It is recommended that the Department of Basic Education consider a more holistic strategy in managing ADHD in line with best practices used elsewhere in the world.

5.3.3.1 **Recommendations re school based management of ADHD**

It is recommended that teachers receive pre-service and in-service training in the following areas:

- Identification of ADHD, particularly Inattentive Presentation, and specifically in the foundation phase.
- Management of ADHD in the classroom, where best practices can be adapted to conditions in the South African classroom.
- Training in establishing and maintaining parent-school partnerships around challenges such as ADHD and co-occurring disorders.
- This study shows that parents and schools need to develop interventions that take into account strengths and insights of parents to offset the problems these children generate across both domains. It is recommended that parents and teachers be supported in developing knowledge and skills in managing these children and developing more effective and resilient partnerships.

5.3.3.2 **Recommendations concerning the role of a school social worker**

This research has demonstrated that parents best access support via their children. It is therefore recommended that the Department of Basic Education consider the role of an in-
school mental health professional such as a school social worker to develop and implement interventions aimed at promoting resiliency within families and across domains such as home, school and peers with respect to ADHD.

Furthermore, it is recommended that the Department of Basic Education consider the role of a school social worker with respect to operationalizing the care and support for children and their families that is encapsulated in various documents (Department of Basic Education, 2010; 2001), rather than relying on teachers to carry this burden of care and support. It is suggested that various models be explored to better utilize the social work profession within schools.

Given that children are under-represented at mental health clinics, and that the majority of children in this study accessed mental health intervention through the school social worker, it is recommended that the Department of Basic Education consider the role of a school social worker in providing first line intervention for children with mental health needs.

ADHD is very apparent in the school environment as it impacts across classroom management, academic performance and peer relationships, whilst being the most common mental health disorder in children. It becomes more complicated given co-occurring disorders, notably learning difficulties, anxiety and conduct disorders. It is thus incumbent upon the Department of Basic Education to consider management strategies, especially as traumatized and poorly attached children will also present with ADHD-like symptoms. Using social workers based in schools is an under-explored strategy. Given the scope of problems this study describes, it needs to be examined whether the current model of one social worker per district, placed at the district office, is adequate.

5.3.3.3  Recommendations concerning possible future research

This study had specific boundaries. However, areas of possible research became apparent during the course of this research that would be useful to undertake in order to understand the impact of ADHD on a wider scale. These are as follows:
• Research into experiences of parents in other schools to compare findings of this study
• Research into parental help seeking patterns of behavior, for themselves and their children, in schools with and without social workers
• The role of schools in the referral for assessment of ADHD
• Research into teacher knowledge, skills and attitude towards ADHD, as well as how this knowledge is being implemented and maintained on an ongoing basis
• Research into the capacity of the State to absorb referrals for diagnosis and management of ADHD and co-occurring disorders
• Research into best practices in schools to develop resiliency in families with children with ADHD, with particular reference to the development of multi-systemic intervention programmes that highlight parent-school partnerships
• Research into school help-seeking patterns of behavior in the use of district based social workers with respect to ADHD
• Given the lack of research in South Africa around meso-systemic school based interventions, it would be recommended that interventions be carefully and rigorously implemented and evaluated in order to examine whether children and their families become more resilient across both home and school contexts.
• Research into the efficacy of long term and continuous support provided by school based mental health practitioners that reinforces parenting training

5.3.4 Recommendations for the Social Work Profession

Recommendations are offered for the social work profession, followed by specific recommendations for school social workers.

5.3.4.1 Social Work profession

It is recommended that the profession advocate for the role of school social workers to related departments such as the Department of Health, the Department of Basic Education and the Department of Social Development.
It is recommended that social work training institutions provide specific training on school social work as part of the practical curriculum, with emphasis on an ecological perspective.

It is furthermore recommended that social workers in schools receive specific training on the management of ADHD as it is the most common disorder to be referred.

### 5.3.4.2 School Social Workers

It is recommended that school social workers receive on-going training into the management of ADHD and evidence based interventions across domains of home, school and peers.

It is also recommended that the social work profession conduct research into why school social work is an attractive option for parents in accessing services for themselves and their children.

### 5.3.4.3 Clinical Social Work

The role of the school social worker is complex as it encompasses intervention systemically within various micro and mesosystems. The ability to assess and clinically manage children and their parents would be an advantage given the problems accessing professional assistance outside of the school. It is therefore recommended that school social workers undertake clinical training in order to equip themselves for this complex role.

### 5.4 Conclusion

The Department of Education (2001), in its policy on Inclusive Education, makes it clear the needs and perceptions of parents should be taken into account in order to create and sustain meaningful collaboration between parent and school. This links with Singer’s (2002) concept of the ‘goodness of fit’ between what is needed, and what is provided, for special needs children. This study set out to explore the needs and perceptions of parents of children with ADHD at a
primary school in the Southern suburbs of Cape Town, with an ultimate practice outcome aim of developing collaborative interventions that support the promotion of resiliency in these families. However, whilst this is a case study and conclusions should be considered hypotheses and only very cautiously generalized, data lends itself to contributing to clinical knowledge for social workers in schools, and provides impetus for further research and recommendations for the school, parents, the Department of Basic Education, and the Social Work profession. This study differed from others in that it is school based, and participants were not drawn from support groups or other mental health professionals. Detailed and useful data was obtained on the reality of parenting these children, with challenges and adaptations described along personal, parenting and parent-school dimensions.

The goal of this study has thus been met taking into account the limitations imposed by a minor dissertation, the case study methodology, and the researcher’s own limitations.
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Appendix 1: DSM V

DSM V

To be listed under neurodevelopmental disorders, along with learning disorders

A. Subtypes reclassified as presentations:
   1. Hyperactive–impulsive presentation
      6 or more hyperactive–impulsive but 5 or fewer inattentive symptoms have been present for the past 6 months
   2. Inattentive presentation
      6 or more inattentive but 3 to 5 hyperactive–impulsive symptoms have been present for the past 6 months
   3. Restrictive inattention presentation
      6 or more inattentive but 2 or fewer hyperactive–impulsive symptoms have been present for the past 6 months
   4. Combined presentation
      6 or more inattentive and 6 or more hyperactive–impulsive symptoms have been present for the past 6 months.

It is now understood to be a disorder across the lifespan, so criteria has been broadened to include examples of symptoms in adolescence and adulthood but without changing the core symptoms. Recognition is given to partial remission and sub-threshold symptoms

B. Age of onset. Symptoms need to be present by the age of 12

C. Pervasiveness of symptoms is still required in two or more settings, but these can include home, school, work, with friends or relatives or other activities. Information should be obtained from two different informants.

D. There needs to be clear evidence of impairment

E. Pervasive developmental disorder is no longer an exclusion criteria.

Information on the DSM V sourced from Tannock (2013); Dalsgaard (2013); APA (2013: 59 – 66)
ADHD Presentations (APA, 2013: 59 – 66)

<table>
<thead>
<tr>
<th><strong>Inattention presentation:</strong></th>
<th><strong>Examples</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities</td>
<td>Overlooks or misses details, work is inaccurate</td>
</tr>
<tr>
<td>b. Often has difficulty sustaining attention in tasks or play activities</td>
<td>Has difficulty remaining focused during lectures, conversations or reading lengthy writings</td>
</tr>
<tr>
<td>c. Often does not seem to listen when spoken to directly</td>
<td>Mind seems elsewhere, even in the absence of any obvious distraction</td>
</tr>
<tr>
<td>d. Often does not follow through on instructions and fails to finish schoolwork, chores or work duties</td>
<td>Starts tasks but quickly loses focus and is easily sidetracked</td>
</tr>
<tr>
<td>e. Often has difficulty organizing tasks and activities</td>
<td>Difficulty in managing sequential tasks; difficulty in keeping the materials and belongings in order; work messy and disorganized; poor time management; tends to fail to meet deadlines</td>
</tr>
<tr>
<td>f. Often avoids and dislikes tasks that require sustained mental effort</td>
<td>Homework or schoolwork: preparing reports, completing forms or reviewing lengthy papers</td>
</tr>
<tr>
<td>g. Often loses things necessary for tasks or activities</td>
<td>School materials, pencils, books, tools, wallets, paperwork, glasses, phones</td>
</tr>
<tr>
<td>h. Is often easily distracted by extraneous stimuli</td>
<td>Could include unrelated thoughts in adolescents and adults</td>
</tr>
<tr>
<td>i. Is often forgetful in daily activities</td>
<td>Chores, errands, returning calls, paying bills, keeping appointments</td>
</tr>
</tbody>
</table>

**Hyperactivity-impulsivity presentation**

**Hyperactivity**

| a. Often fidgets with hands or feet or squirms in seat | |
| b. Often leaves seat in classroom or in other situations in which remaining seated is expected | |
| c. Often runs about or climbs excessively in inappropriate situations | Adults: feeling restless |
| d. Often has difficulty in playing or engaging in leisure activities quietly | |
| e. Is often on the go or acts as if driven by a motor | Unable or uncomfortable keeping still for an extended time as in restaurants or meetings, may be experienced by others as restless and being difficult to keep up with |
| f. Often talks excessively | |

**Impulsivity**

| g. Often blurts out answer before question has been completed | completes people’s sentences, cannot wait for next turn in conversation |
| h. Often has difficulty awaiting turn | |
| i. Often interrupts or intrudes on others | butts into conversation, games or activities, using other people’s things without asking for permission; take over what others are doing |
APPENDIX 2: A Summary of the Clinical Features of ADHD, as adapted from Carr (2006: 427)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition</td>
<td>Short attention span, (often complains of being bored)</td>
</tr>
<tr>
<td></td>
<td>Distractibility difficulties in filtering incoming information, dealing with background noise or hyperfocussing on aspects of what is being told so miss the rest</td>
</tr>
<tr>
<td></td>
<td>Unable to foresee consequences of behavior (often the children in detention for the same problems; labeled as deliberately naughty)</td>
</tr>
<tr>
<td></td>
<td>Poor time estimation (don’t finish tasks on time, get home on time)</td>
</tr>
<tr>
<td></td>
<td>Poor planning skills (work left to the last minute and then overwhelmed)</td>
</tr>
<tr>
<td></td>
<td>Language delay, delayed internalization of speech and language impairment (some children stutter)</td>
</tr>
<tr>
<td></td>
<td>Learning difficulties, memory deficits and poor school performance (impaired working memory means many of these children are distressed by their forgetfulness; they hate having to read aloud or perform orals due to a buildup of anxiety linked to shame as a result of learning difficulties.</td>
</tr>
<tr>
<td></td>
<td>Low self-esteem (they are aware they are ‘different’, cannot do what they know they should be able to do, feel as if they are constantly in trouble despite their best efforts not to be; scapegoated)</td>
</tr>
<tr>
<td></td>
<td>Lack of conscience (it’s hard to think about someone else when your own problems take up most of your space.)</td>
</tr>
<tr>
<td>Affect</td>
<td>Poor self-regulation and lack of impulse control (dislikes change; accident prone; loses belongings constantly which causes trouble on home and school front)</td>
</tr>
<tr>
<td></td>
<td>Excitability (more marked when in company of other ADHD children or peers than in a one on one)</td>
</tr>
<tr>
<td></td>
<td>Low frustration tolerance and anger (often in detention for fighting)</td>
</tr>
<tr>
<td>Behavior</td>
<td>High rate of activity</td>
</tr>
<tr>
<td></td>
<td>Delay in motor development and poor co-ordination (a very high proportion of children are also referred to occupational therapy for co-ordination, handwriting, muscle tone problems)</td>
</tr>
<tr>
<td></td>
<td>Low conditionability</td>
</tr>
<tr>
<td></td>
<td>High level of risk taking behavior</td>
</tr>
<tr>
<td></td>
<td>Underdeveloped adaptive behavior</td>
</tr>
<tr>
<td>Physical condition</td>
<td>Immature physical size and bone growth</td>
</tr>
<tr>
<td></td>
<td>Minor physical abnormalities</td>
</tr>
<tr>
<td></td>
<td>Neurological soft signs</td>
</tr>
<tr>
<td></td>
<td>Allergies</td>
</tr>
<tr>
<td></td>
<td>Increased respiratory infections and otitis media</td>
</tr>
<tr>
<td></td>
<td>Accident prone and high rate of injury</td>
</tr>
<tr>
<td>Interpersonal adjustment</td>
<td>Problematic relationships with peers, parents and teachers</td>
</tr>
</tbody>
</table>
## APPENDIX 3: Table of Child Demographic Information

<table>
<thead>
<tr>
<th>Family</th>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>Repeated</th>
<th>Grade diagnosed</th>
<th>By whom</th>
<th>Severity, rated by parent</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>m</td>
<td>11</td>
<td>4</td>
<td>yes</td>
<td>R</td>
<td>psychologist</td>
<td>moderate</td>
<td>OT</td>
</tr>
<tr>
<td>1</td>
<td>f</td>
<td>11</td>
<td>5</td>
<td>no</td>
<td>4</td>
<td>psychologist</td>
<td>mild</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>m</td>
<td>11</td>
<td>4</td>
<td>yes</td>
<td>1</td>
<td>school doctor</td>
<td>moderate</td>
<td>-</td>
</tr>
<tr>
<td>2</td>
<td>m</td>
<td>8</td>
<td>3</td>
<td>no</td>
<td>2</td>
<td>school doctor</td>
<td>mild</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>m</td>
<td>11</td>
<td>4</td>
<td>2,3</td>
<td>R</td>
<td>Red Cross Hospital</td>
<td>severe</td>
<td>Red X</td>
</tr>
<tr>
<td>4</td>
<td>m</td>
<td>11</td>
<td>5</td>
<td>no</td>
<td>4</td>
<td>pediatrician</td>
<td>mild home moderate school</td>
<td>-</td>
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<tr>
<td>5</td>
<td>m</td>
<td>14</td>
<td>7</td>
<td>yes</td>
<td>2</td>
<td>Red Cross Hospital</td>
<td>mild</td>
<td>Red X</td>
</tr>
<tr>
<td>5</td>
<td>m</td>
<td>11</td>
<td>5</td>
<td>no</td>
<td>1</td>
<td>school doctor</td>
<td>moderate</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>m</td>
<td>10</td>
<td>4</td>
<td>no</td>
<td>1</td>
<td>psychologist</td>
<td>moderate</td>
<td>Speech OT</td>
</tr>
<tr>
<td>7</td>
<td>f</td>
<td>13</td>
<td>7</td>
<td>no</td>
<td>4</td>
<td>Red Cross Hospital</td>
<td>mild</td>
<td>Red X</td>
</tr>
<tr>
<td>8</td>
<td>f</td>
<td>13</td>
<td>7</td>
<td>1</td>
<td>4</td>
<td>school doctor</td>
<td>moderate</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>m</td>
<td>14</td>
<td>7</td>
<td>1,3</td>
<td>Aged 5</td>
<td>psychologist</td>
<td>Mom mild but actually moderate to severe</td>
<td>Play therapy Drug counselling</td>
</tr>
<tr>
<td>10</td>
<td>f</td>
<td>9</td>
<td>2</td>
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<td>moderate to severe</td>
<td>-</td>
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<td>m</td>
<td>12</td>
<td>6</td>
<td>R</td>
<td>3</td>
<td>psychologist</td>
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<tr>
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### Appendix 4: Table of Parent Demographic Information

<table>
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<tr>
<th>Family</th>
<th>Marital status</th>
<th>ADHD in family</th>
<th>Psychological history (self reported)</th>
<th>Relationship problems</th>
<th>Help seeking behavior</th>
<th>Role of the school</th>
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<td>Father</td>
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</tr>
<tr>
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<td></td>
<td>Father substance abuse</td>
<td></td>
<td></td>
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<td></td>
<td>Pediatrician</td>
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</tr>
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<td></td>
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</tr>
<tr>
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<td></td>
<td>Priest</td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td>6</td>
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<td>Mother anxious</td>
<td></td>
<td></td>
<td>assessment</td>
</tr>
<tr>
<td>7</td>
<td>single</td>
<td></td>
<td>Mother clinically depressed and anxious; cancer</td>
<td></td>
<td>Red Cross</td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>Medication administered</td>
</tr>
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<td>Step-f</td>
<td>Mother substance abuse</td>
<td>yes, divorced</td>
<td>Assessment</td>
<td></td>
</tr>
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<td>Social work</td>
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<td></td>
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<td>Self reported psychological history</td>
<td>Relations-hip problems</td>
<td>Help-seeking behavior</td>
<td>Role of the school</td>
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<td>------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------</td>
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<td>Step-f</td>
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<td>assessment</td>
</tr>
<tr>
<td>18</td>
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<td>Father</td>
<td>Mother depressed</td>
<td>yes, not current</td>
<td>Pediatrician; talks</td>
<td>assessment</td>
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</table>
APPENDIX 5: Explanatory letter to teachers

11 September 2013

Dear Teachers

I am currently studying towards a Master’s degree in Clinical Social Work through the University of Cape Town. One of the requirements is to complete a research dissertation.

My research topic is “An exploratory case study of the perceptions of parents of children with ADHD concerning the role of the school in promoting family resiliency”. There is very little South African research that is focussed on the role of the school and the school social worker with respect to parents of children with ADHD, hence my interest in pursuing this particular aspect of ADHD.

I need to obtain a sample of parents, and am aiming to interview at least 17 parents in order to make the research findings viable. Their participation will be voluntary, anonymity guaranteed, and any identifying information will remain confidential and not part of the study. They will also be entitled to withdraw from the study at any stage.

I need your help to identify parents of children with ADHD in your class. Attached to this letter is a class list. Could I please ask that you indicate on the list the children who are receiving medication for ADHD, irrespective of whether the medication is arranged by Dr .... or through their own doctors, and irrespective of whether or not you are administering it. This way I will ensure that I include in the sample parents who obtain medication via their own doctors, which I possibly am not aware of. I am only interviewing parents whose children are on medication as this implies that a diagnosis has been made that is based upon impairment in the functioning of these children. It would obviously only include parents who have notified the school, at some stage during the child’s attendance at this school, that the child is receiving medication for ADHD.

Could I please get this back as soon as possible? I am hoping to start the interviews during the holidays.

If there are any queries or concerns in compiling this list, please don’t hesitate to ask me.

Thank you in advance for your assistance!

Warm Regards

Sian Hasewinkel
30 September 2013

Dear

Request to participate in research conducted at .................Primary School

I am really hoping that you will be able to help me with the research I am doing as part of my qualification for a Masters in Clinical Social Work from the University of Cape Town. Children with ADHD can present considerable challenges at home, at school, and between home and school, and I wanted to explore what the school can do to help support families who have children with ADHD. The title of my dissertation is: “An exploratory case study at ..... Primary School of the Perceptions of Parents of Children with ADHD concerning the Role of the School in Promoting Family Resiliency”. There has been very little research conducted in South Africa, particularly around the potential role of the school social worker, yet ADHD can affect as many as three out of a class of thirty children.

This research explores your perceptions of challenges, strengths and resources in coping with a child with ADHD, and then builds on that by exploring your ideas on how the school can help support you, and your thoughts around possible parent-school initiatives.

Research format:

I am interviewing approximately 17 parents, chosen as a representative sample of parents of children with ADHD at the school. The data will be collected through in-depth interviews that will be recorded, transcribed and then analysed. These interviews will last approximately an hour, and will take place at a time and place of your choosing, during the months of October and November 2013. On completion of the analysis, you will be offered an opportunity to
examine the findings and comment on them, either by email, an individual discussion, or as a group.

**Ethical considerations:**

As a student at the University of Cape Town, I am guided by ethical considerations, which are as follows:

**Participation:** Participation in this research is voluntarily, and informed written consent is required, based on the contents of this letter. You may withdraw at any stage of the study.

**Anonymity and confidentiality:** Demographic data will be asked, but identifying details will not be recorded and your identity will not be disclosed in the research. Teachers will not be informed who is taking part, nor will family specific information be directed back to teachers or the school as a whole. The school will have access to the completed research document, which contains the analyses and not the individual interviews. The individual interviews will be stored confidentially.

**Counselling:** I am available for counselling should issues arise as a consequence of this research, or I will provide a list of referral sources should it be requested.

**Compensation:** No compensation will be offered.

**Publication:** The research may be published, if requested by the University of Cape Town, and accepted by a journal identified as appropriate by the University of Cape Town.

**Supervision:** I am supervised by Mr. Ron Addinall, a staff member of the Department of Social Development at the University of Cape Town. He is responsible for ensuring that the research complies with academic integrity and ethical standards, and appraises work at each critical stage of the research. He can be contacted at ron.addinall@uct.ac.za or 021 6503475 should you have any concerns.

**Researcher’s credentials:** I am a qualified social worker, accredited with the South African Council for Social Service Professionals (10-08044), with 29 years of social work experience. I
have a B.Soc.Sc (Hons) in Social Work and a B.Soc. Sc (Hons) in Psychology. This research is in part requirement for an M.Soc.Sc in Clinical Social Work from the University of Cape Town. I am bound by both the ethical standards of my profession, as well as the University.

I can be contacted during working hours at the school at ........ should you have any queries.

Many thanks for reading this, and for considering whether or not to participate. I am sure that the results are going to be valuable for the school to consider.

Warm Regards

Sian Hasewinkel

School Social Worker
Informed written consent

I understand the contents of the explanatory letter, and I have had opportunity to clarify any points of concern.

I agree to willingly participate in the research, entitled “An exploratory case study at ............Primary School of the perceptions of parents of children with ADHD concerning the role of the school in promoting family resiliency”.

I understand that:

- my anonymity will be protected
- any personal and identifying information will be kept confidential according to the professional ethics as determined by the SACSSP
- I can withdraw at any stage
- I or my family have access to counselling should it become necessary as a consequence of this research
- I will have access to comment on the analysis and be availed of the completed research
- the research may be published at some stage
- I have not been offered any compensation for taking part in this research
- I have the details of the supervising academic at the University of Cape Town should I have any concerns around the research.

Name:

Signed:

Date

Researcher signed:

Date
### Demographic Information

#### Child:

<table>
<thead>
<tr>
<th>Age</th>
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<tbody>
<tr>
<td>Sex</td>
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<tr>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Grade repeated</td>
<td></td>
</tr>
<tr>
<td>Diagnosis and date diagnosed</td>
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</tr>
<tr>
<td>Co-occurring disorders</td>
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</tr>
<tr>
<td>Interventions to date</td>
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#### Parent/s:

<table>
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<th>Parent/s interviewed</th>
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<td>Marital status/ reconstituted family</td>
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<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Employment</td>
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<tr>
<td>Highest educational standard</td>
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</tr>
<tr>
<td>Able to pay school fees</td>
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</tr>
<tr>
<td>Able to access private medical services?</td>
<td></td>
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<tr>
<td>Siblings? Order of child in family</td>
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<tr>
<td>No. of people in the family home</td>
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<tr>
<td>Suburb and type of house</td>
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#### Family/ parental history:

<table>
<thead>
<tr>
<th>ADHD</th>
<th></th>
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<tbody>
<tr>
<td>Depression</td>
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<tr>
<td>Anxiety</td>
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<td>Substance abuse</td>
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<td>Marital/ relationship problems</td>
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</tr>
<tr>
<td>Problems with the law</td>
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</table>
Question one: What are the challenges facing you in coping with a child with ADHD?

Understanding about ADHD

How would you describe ADHD?

What do you think causes ADHD?

How severe would you rate your child’s ADHD? Mild – moderate- severe

Do you feel you know enough about ADHD?

Impact of ADHD on:

Child
Self
Immediate family
Extended family

Challenges

Describe some of the challenges that you and your family have faced in coping with the impact of ADHD?

What has made it difficult at times to cope?

What challenges has your child faced at school?

Beliefs about parenting

How effective do you feel as a parent generally?

What has contributed to this?

Needs

What are your greatest needs in coping with your child both now and in the future?

Help seeking behavior:

Have you ever sought help in coping with your child?

How was this for you?

Have you ever sought help for your child?
**Question two:** How have you successfully coped with and adapted to the impact of ADHD?

**Identification of strengths**

What do you think has helped you successfully cope?

What has helped you to parent effectively?

What do you think has helped you cope under times of stress?

What do you think you need in order to continue to cope in the future?

What do you think are the most important things you can do to help your child cope?

What are your child’s strengths that help her/him to cope?

**Adaptation (linked to resiliency)**

How have you adapted to your child’s ADHD?

**Advice**

What is the most important piece of advice you can pass on to other families who have children with ADHD?

---

**Question three:** How do you perceive the role of the school and the school social worker in strengthening resiliency?

**Beliefs and experiences**

Do you feel welcomed at the school?

Do you feel a sense of belonging?

Do you feel your efforts are appreciated by the school?

Do you feel that the school supports your efforts?

Do you feel you can approach the school about problems?

Do you feel able to help your child manage difficulties at school?

How can you support your child’s school tasks at home?
Role of the school

What role has the school played so far in managing ADHD?
How can the school support your efforts in coping with your child?

Role of the school social worker

How can a school social worker help support your child?
How can a school social worker help support you and your family?

Question four: How do you perceive parent-school partnerships to promote resiliency?

Interventions

What parent/school initiatives would you like to see developed at the school to support families of children with ADHD?
What could be some of the problems in developing these initiatives?
What can the school do to encourage parent/school initiatives?
What can the school do to reach out to more resistant vulnerable families?
How do you see the role of a school social worker in these parent/school initiatives?
What would you like to achieve in a school-parent initiative aimed at supporting families of children with ADHD?

Parent outreach/Support

Do you see a role for yourself in supporting other families?
If so, how you like to support other families?