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Parental Stress and Marital Satisfaction in Families of Children With Attention Deficit/Hyperactivity Disorder

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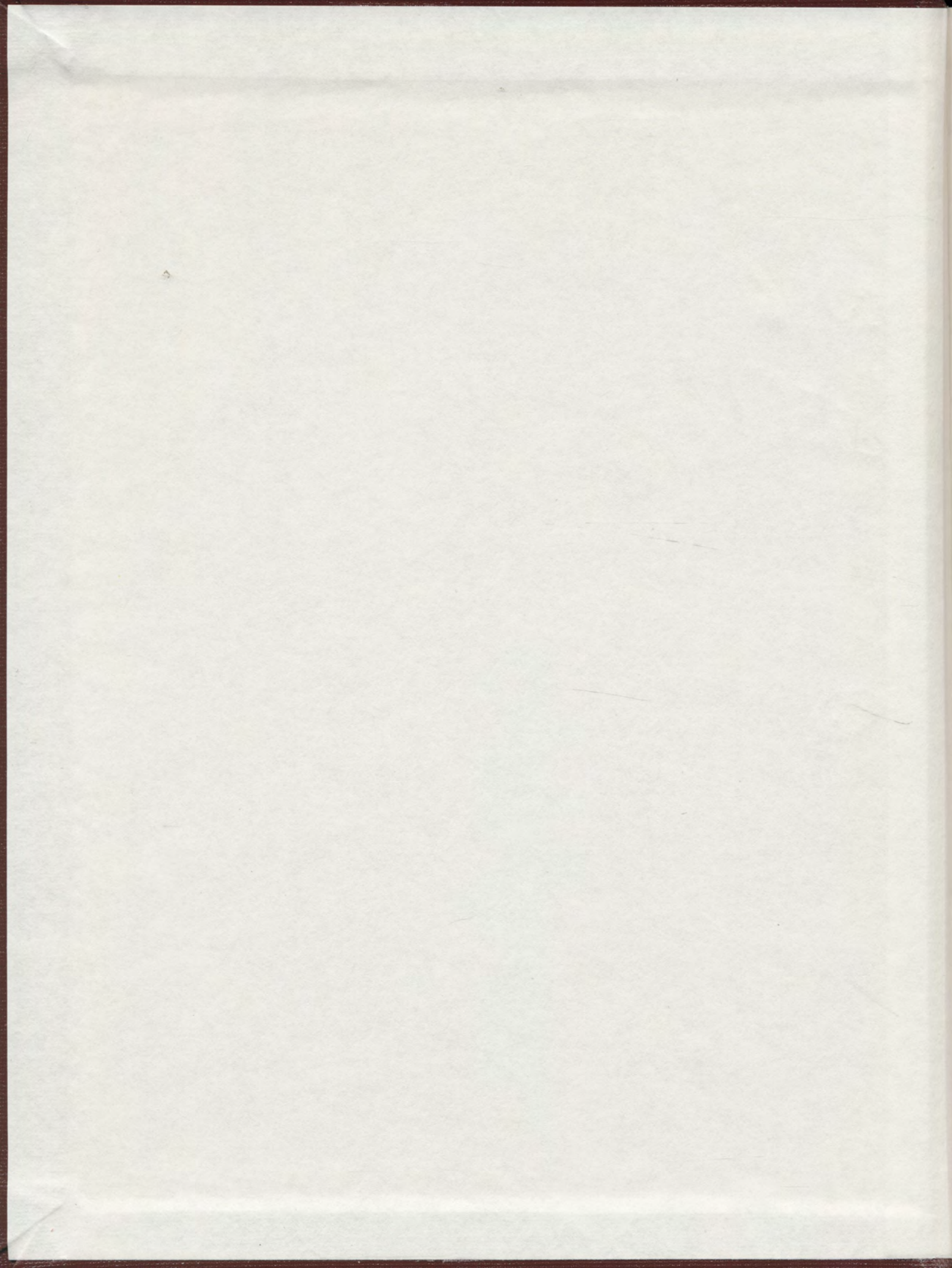
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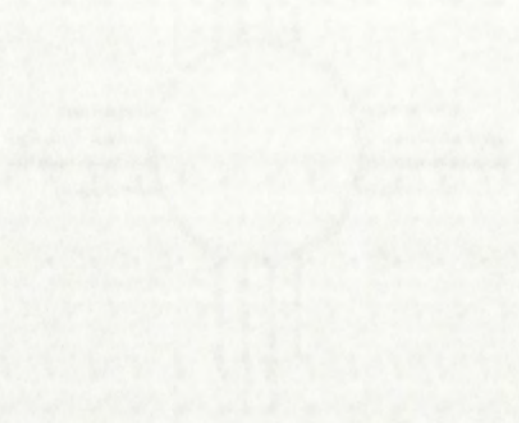
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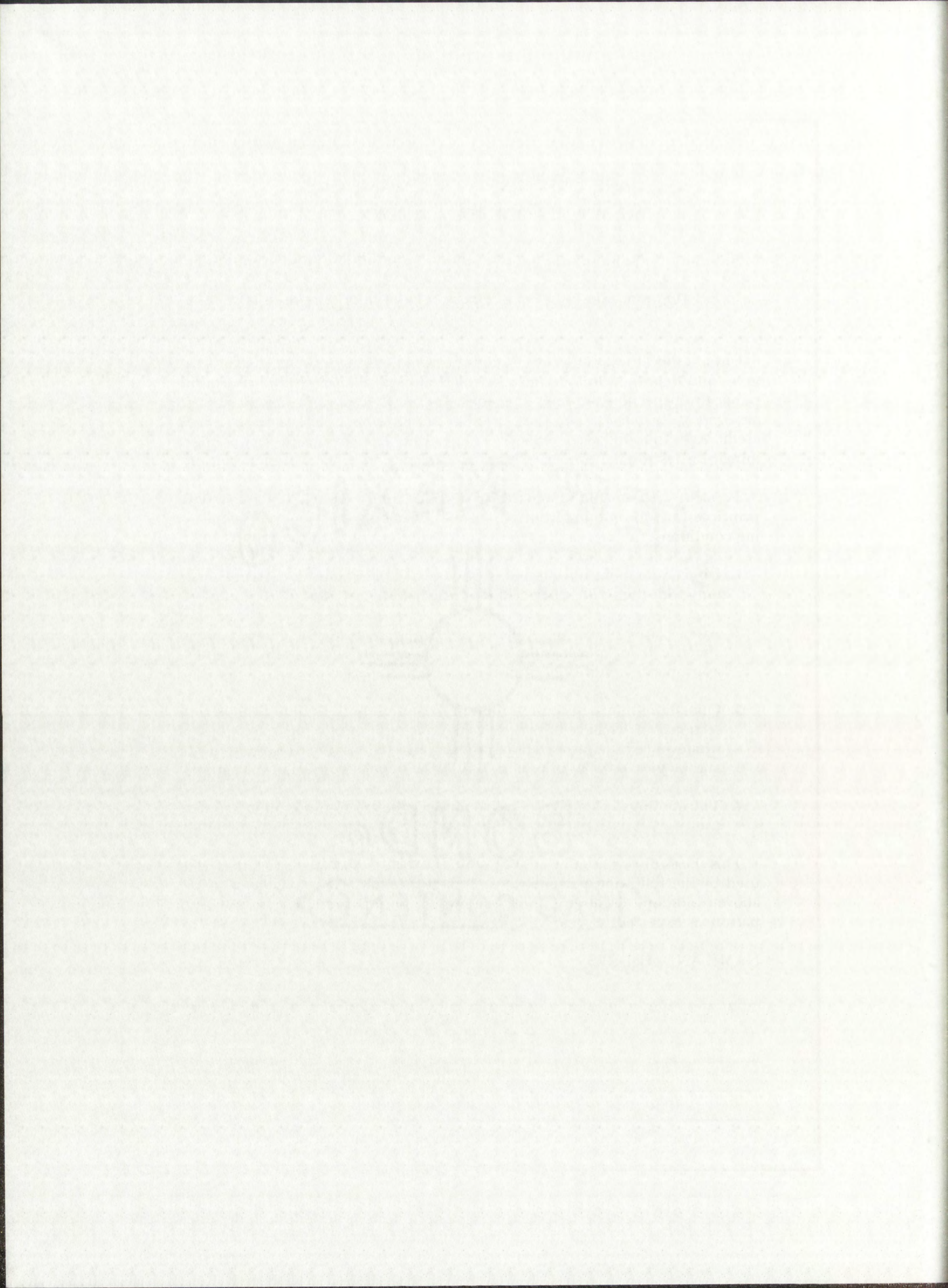
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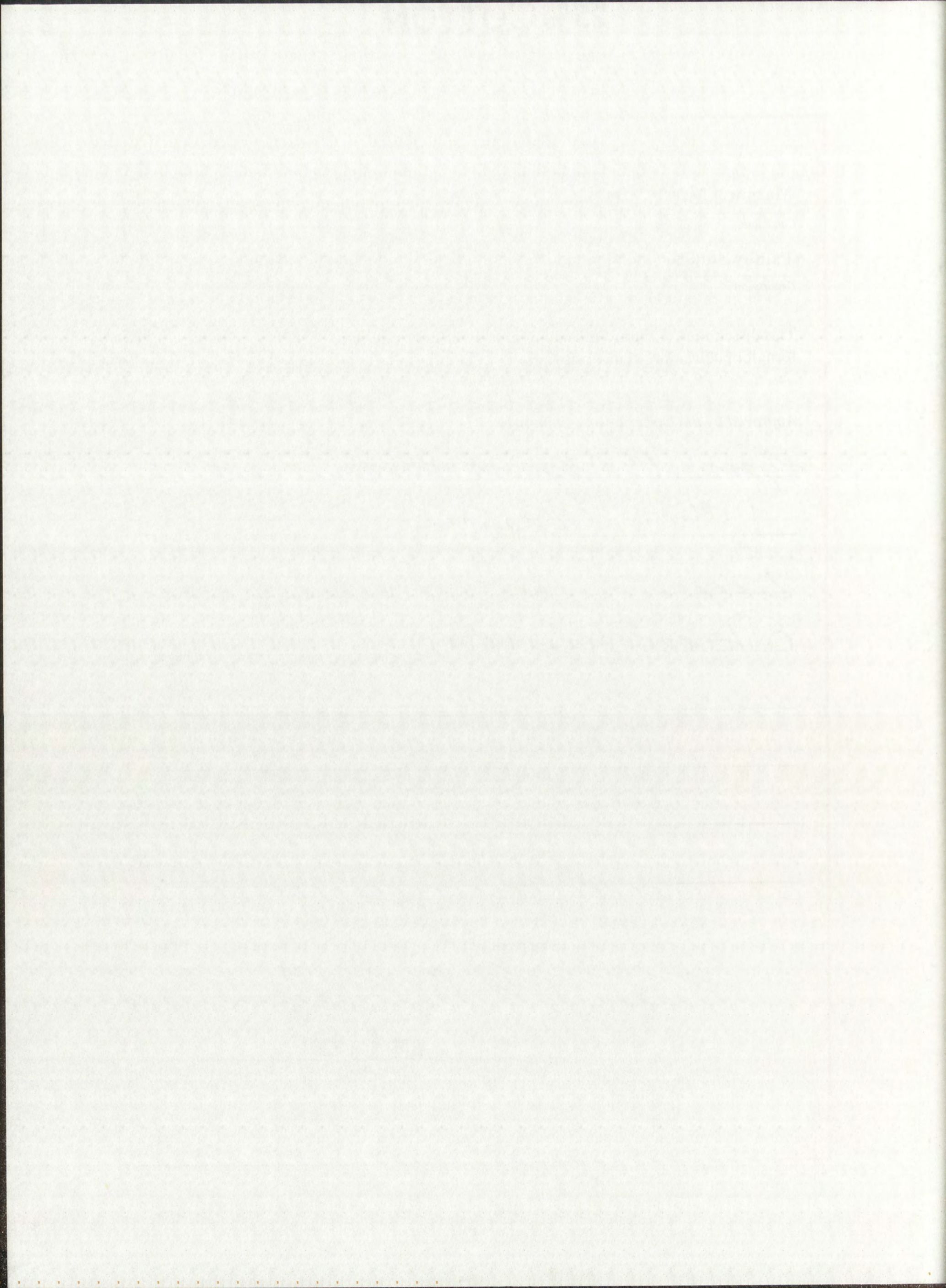
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PARENTAL STRESS AND MARITAL SATISFACTION
IN FAMILIES OF CHILDREN
WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER

BY

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B.S., Education, University of Albuquerque, 1975
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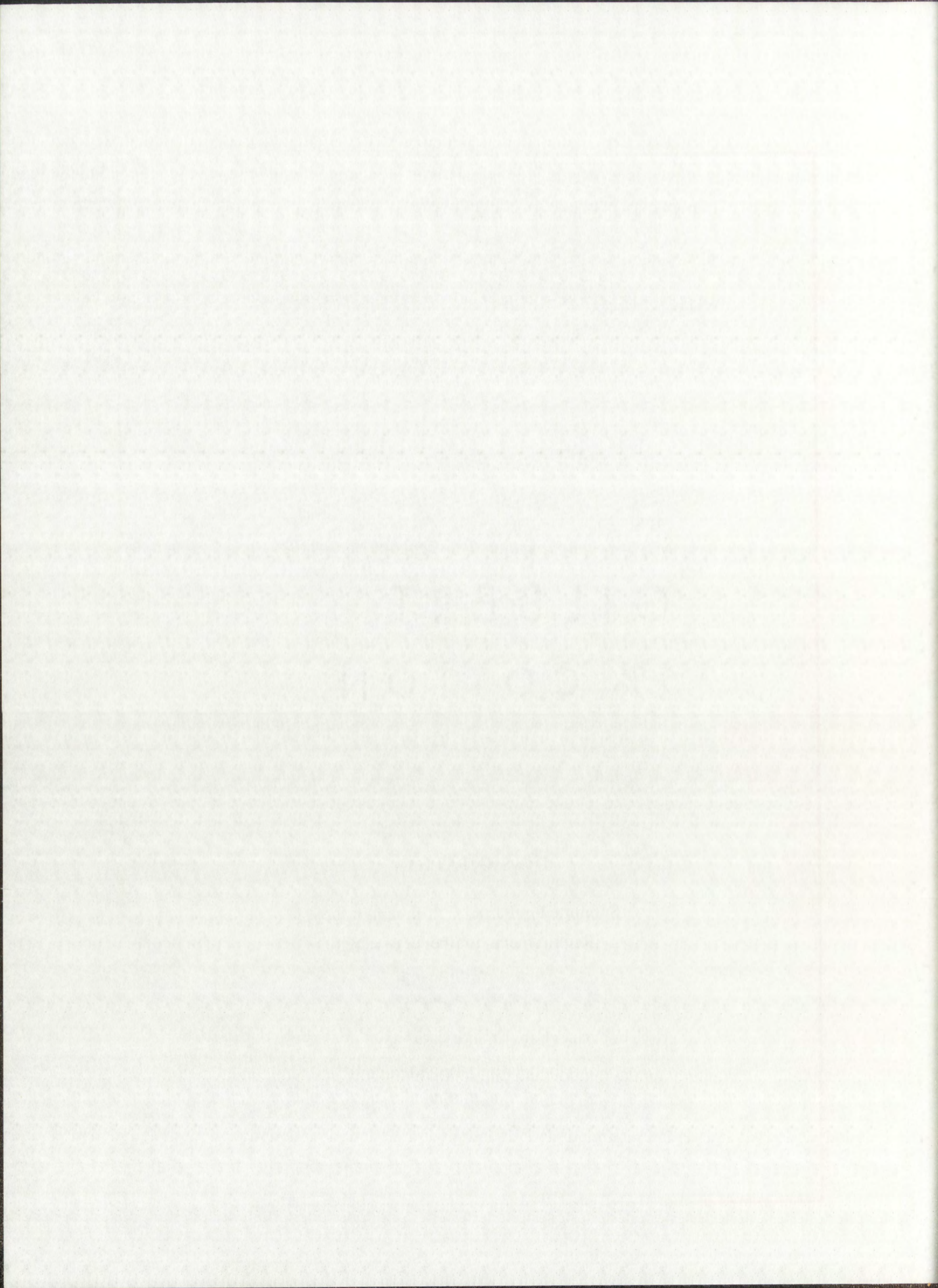
DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
Family Studies**

The University of New Mexico
Albuquerque, New Mexico

May, 2000



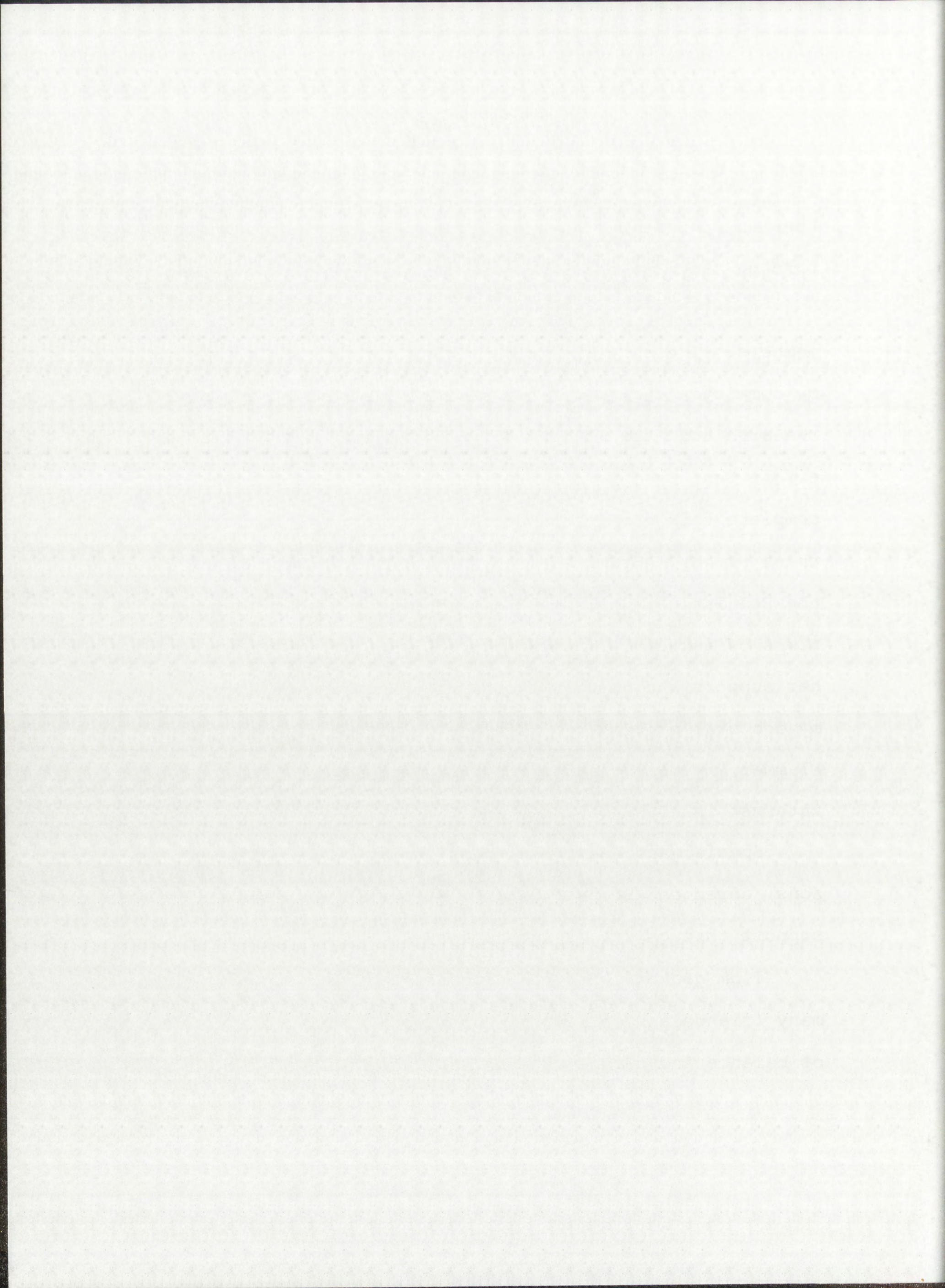
ACKNOWLEDGEMENTS

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Special and heartfelt thanks to my husband Stewart, my sons, Jared and Stephen, and my sister, Kathy, for their support through this long process.

I am grateful for the encouragement and support of my many friends and colleagues who helped me maintain a sense of balance and perspective during this process. Lastly, I



would like to acknowledge and thank each of the parents who participated in my study.



PARENTAL STRESS AND MARITAL SATISFACTION
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BY

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ABSTRACT OF DISSERTATION

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May, 2000

FACTORS AFFECTING A CHILD'S ATTENTION
IN FAMILIES OF CHILDREN
WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER

BY
MARGARET ROBERT MORRIS

A SUMMARY OF DISSERTATION

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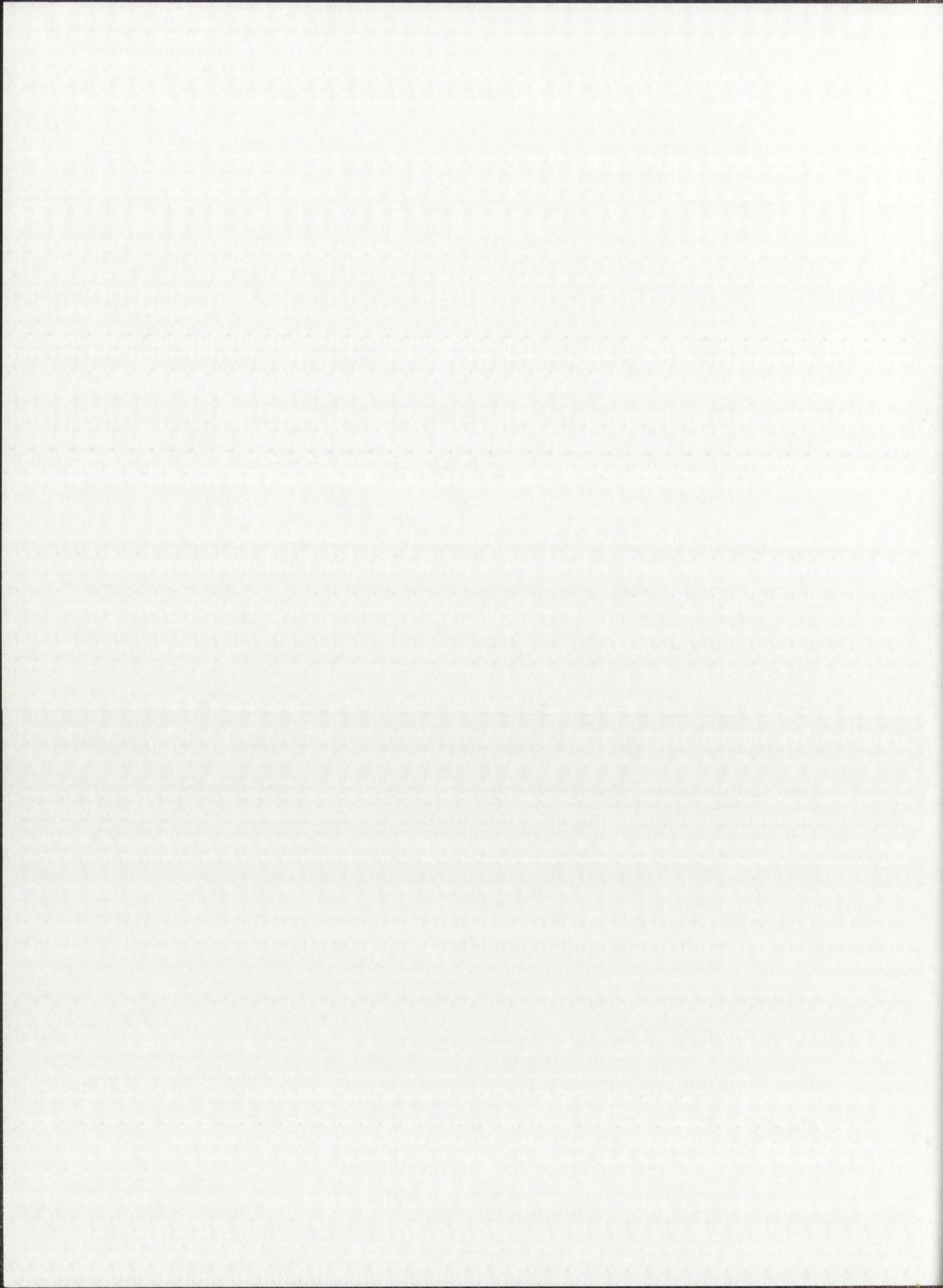
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ABSTRACT

Based on a family systems conceptual framework, this study examined perceptions of parental stress and marital satisfaction among parents of children with Attention Deficit/Hyperactivity Disorder (AD/HD). The study sought to examine levels and interrelationships between parental stress and marital satisfaction as well as to determine if the findings differed for mothers and fathers. In addition, the relationship of these findings to mothers' and fathers' perceptions of the severity of their child's behavior symptoms was investigated.

Twenty-one families ($n = 42$ parents) with a male child between the ages of 6 and 11 who had been diagnosed with AD/HD within the past six months volunteered to participate in the study. The majority of the sample were Anglo, had attended college, and their childrens' treatment included



medication and behavioral therapy. Participants completed demographic questionnaires, the Parenting Stress Index/Short Form (Abidin, 1995), the Dyadic Adjustment Scale (Spanier, 1989), and the Child Behavior Checklist (Achenbach, 1975). Data analyses included the use of descriptive statistics, correlated samples t -tests, and correlational analysis as appropriate.

The results obtained indicated high levels of parental stress scores for both mothers and fathers of children with AD/HD. In general, marital satisfaction levels for both mothers and fathers were found to be within the normal range. The severity of reported child behavior symptoms was found to be related to increased levels of parental stress and decreased levels of marital satisfaction, with the strongest relationship between parental stress and severity of reported child behavior symptoms. There were no significant gender differences found in either parental stress or marital satisfaction scores or their interrelationships.

Implications for the areas of family studies and counseling were discussed and suggestions for further research were proposed.

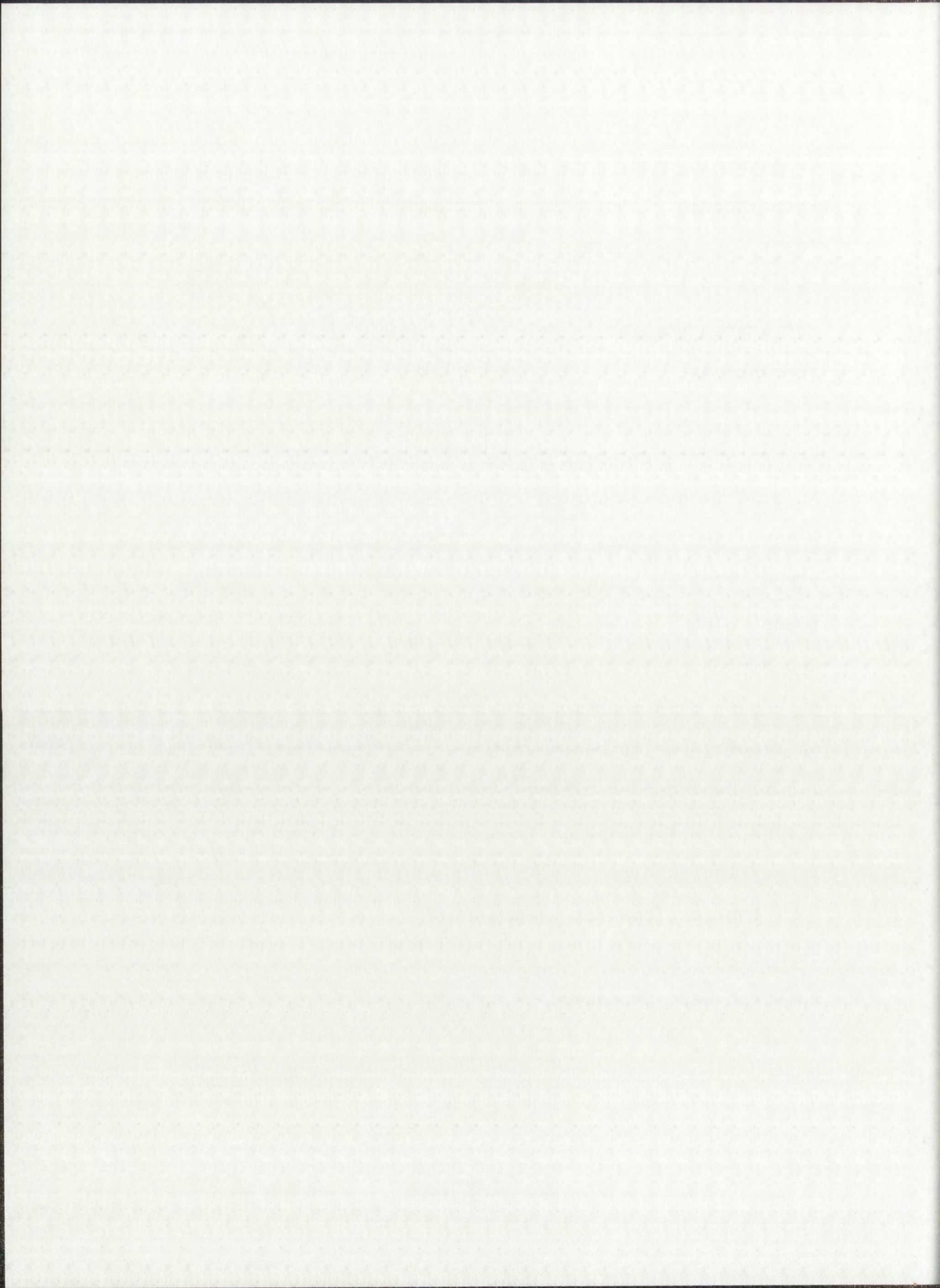
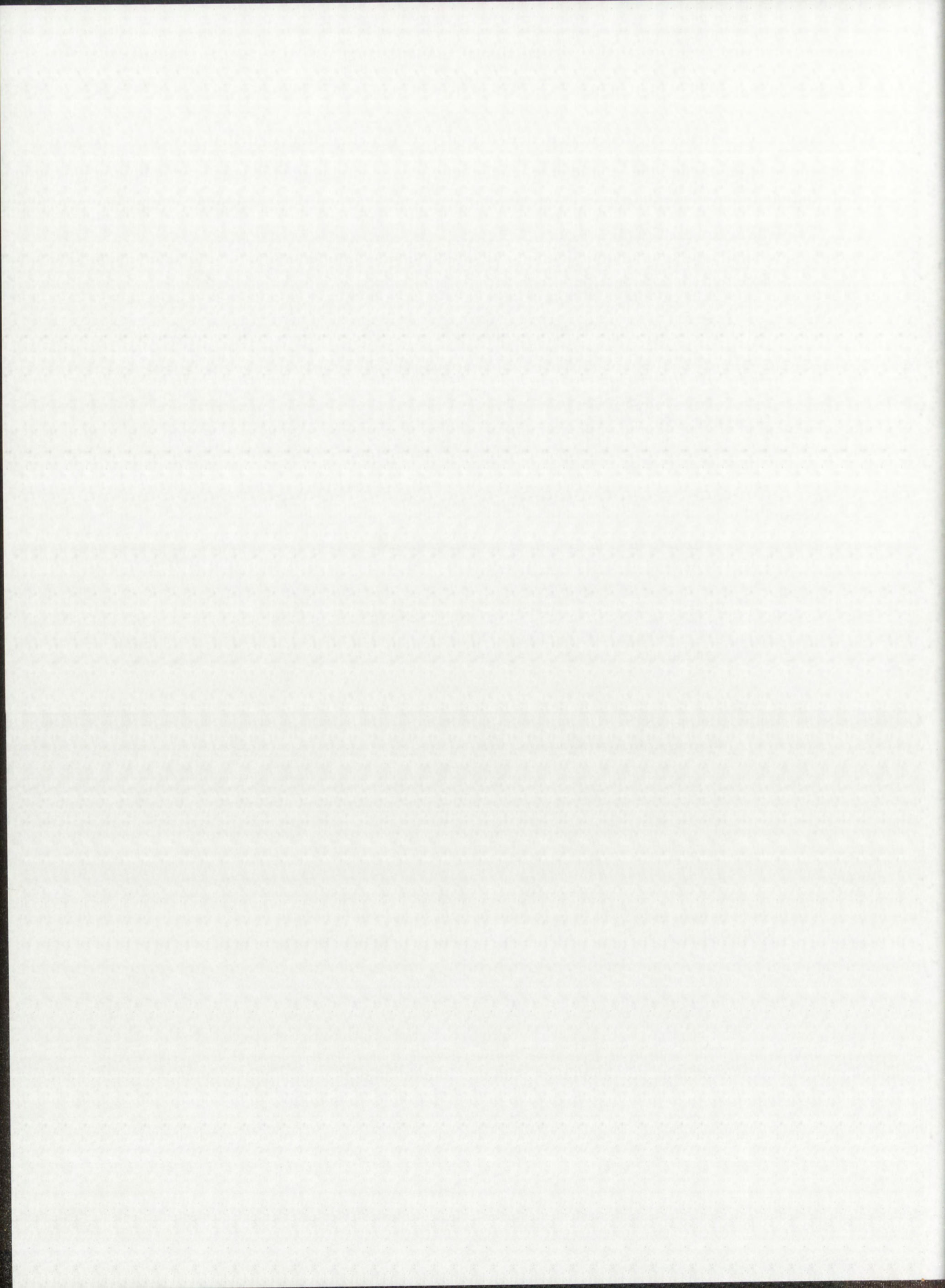
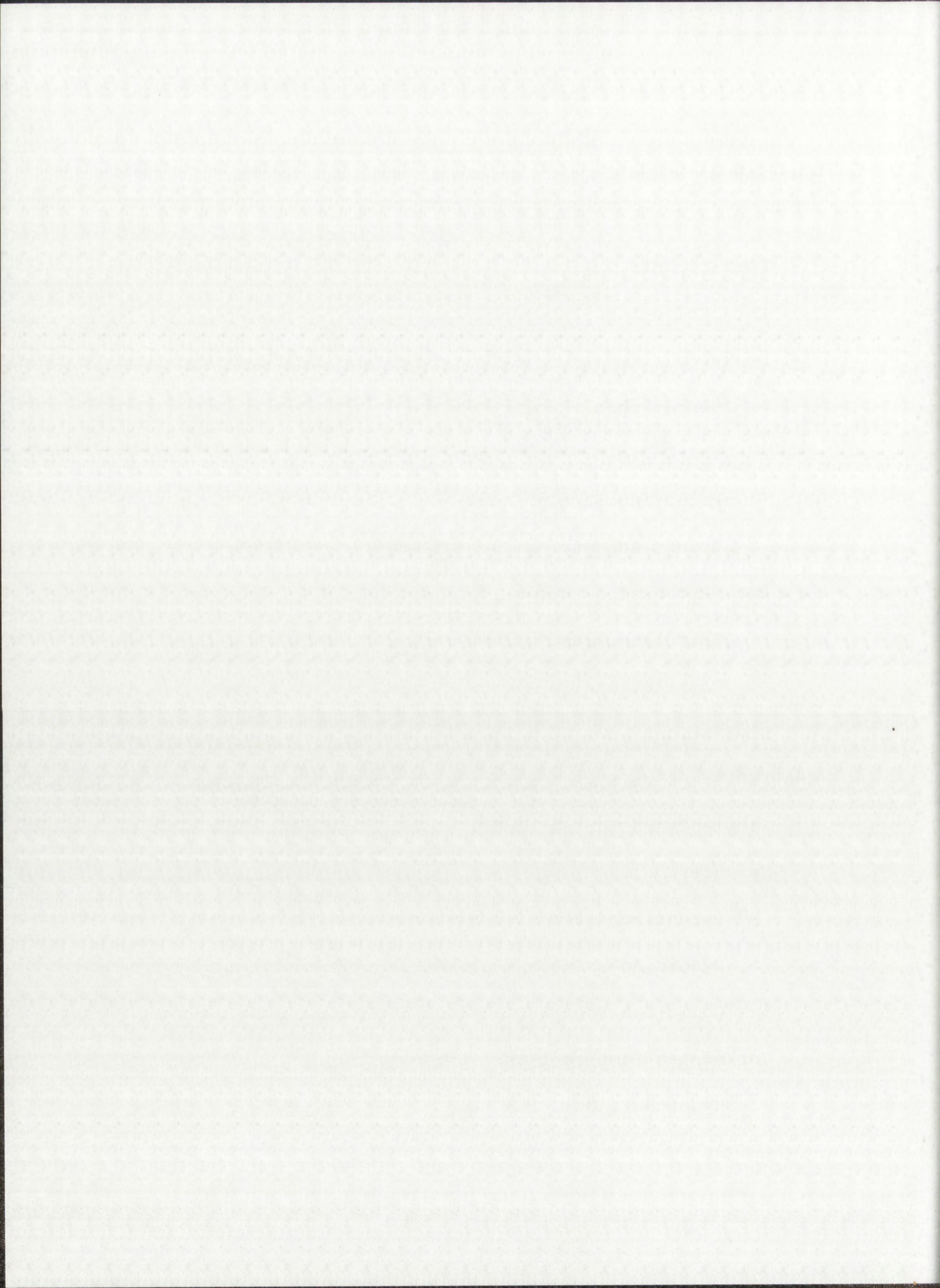


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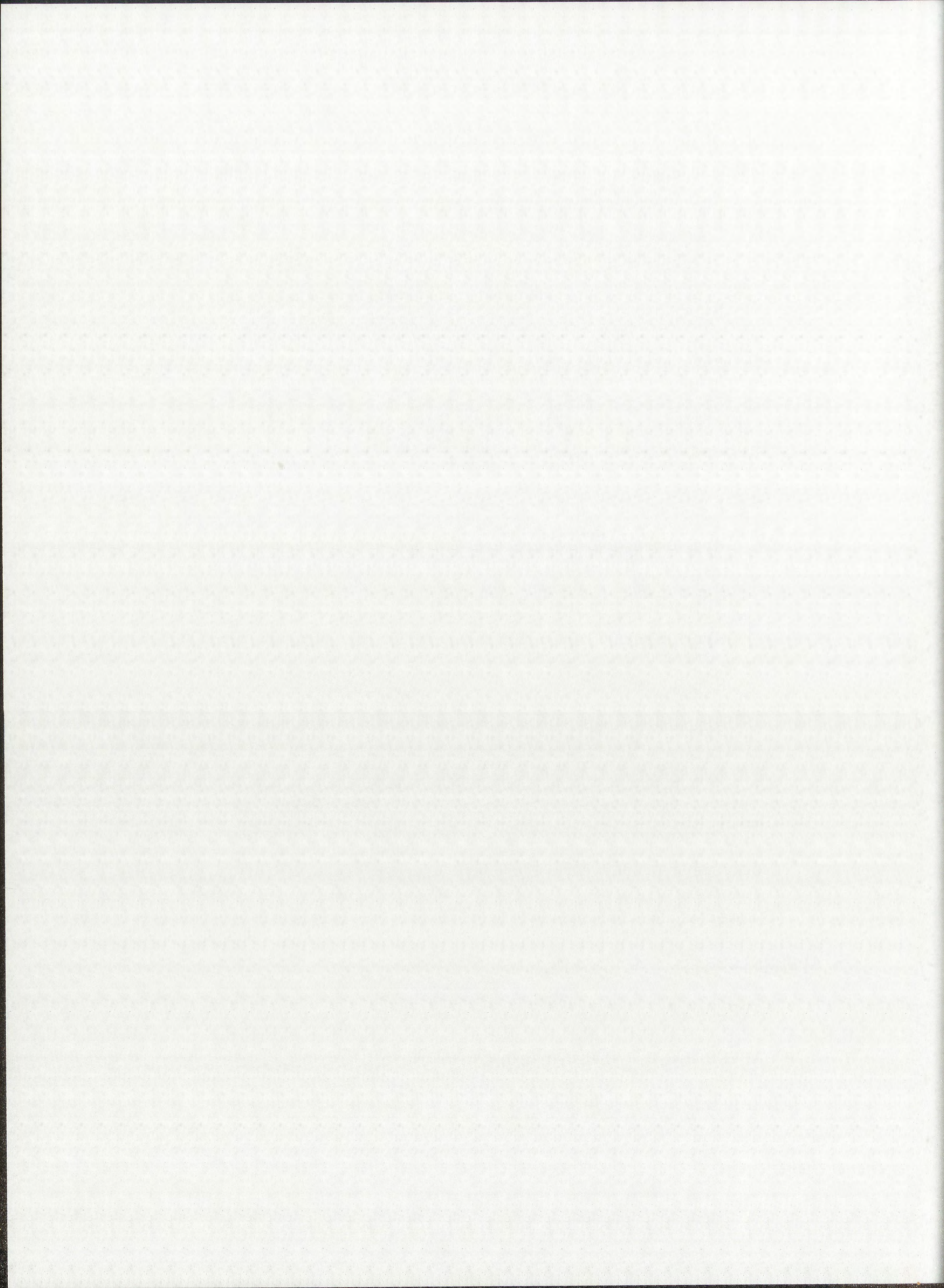
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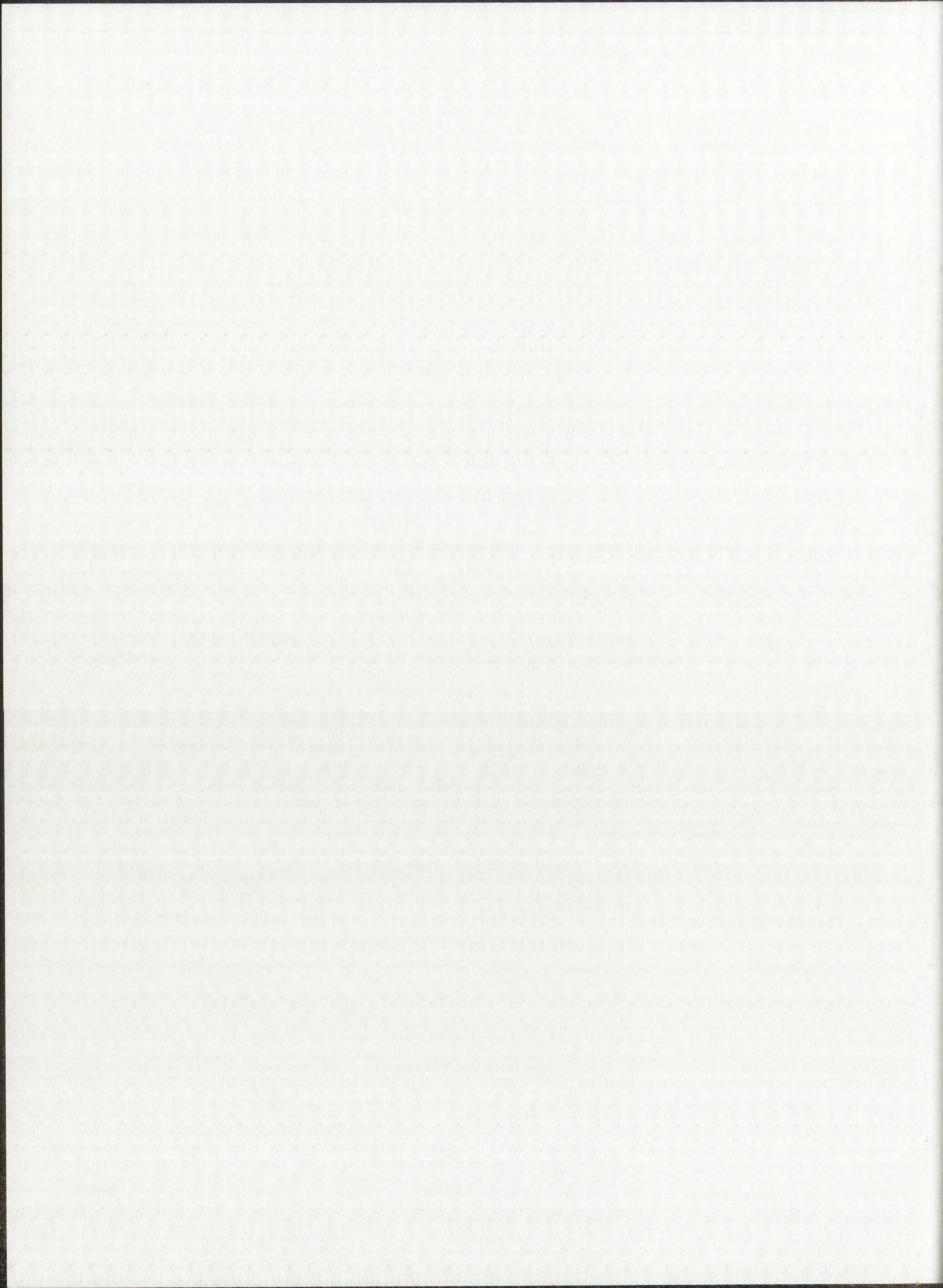
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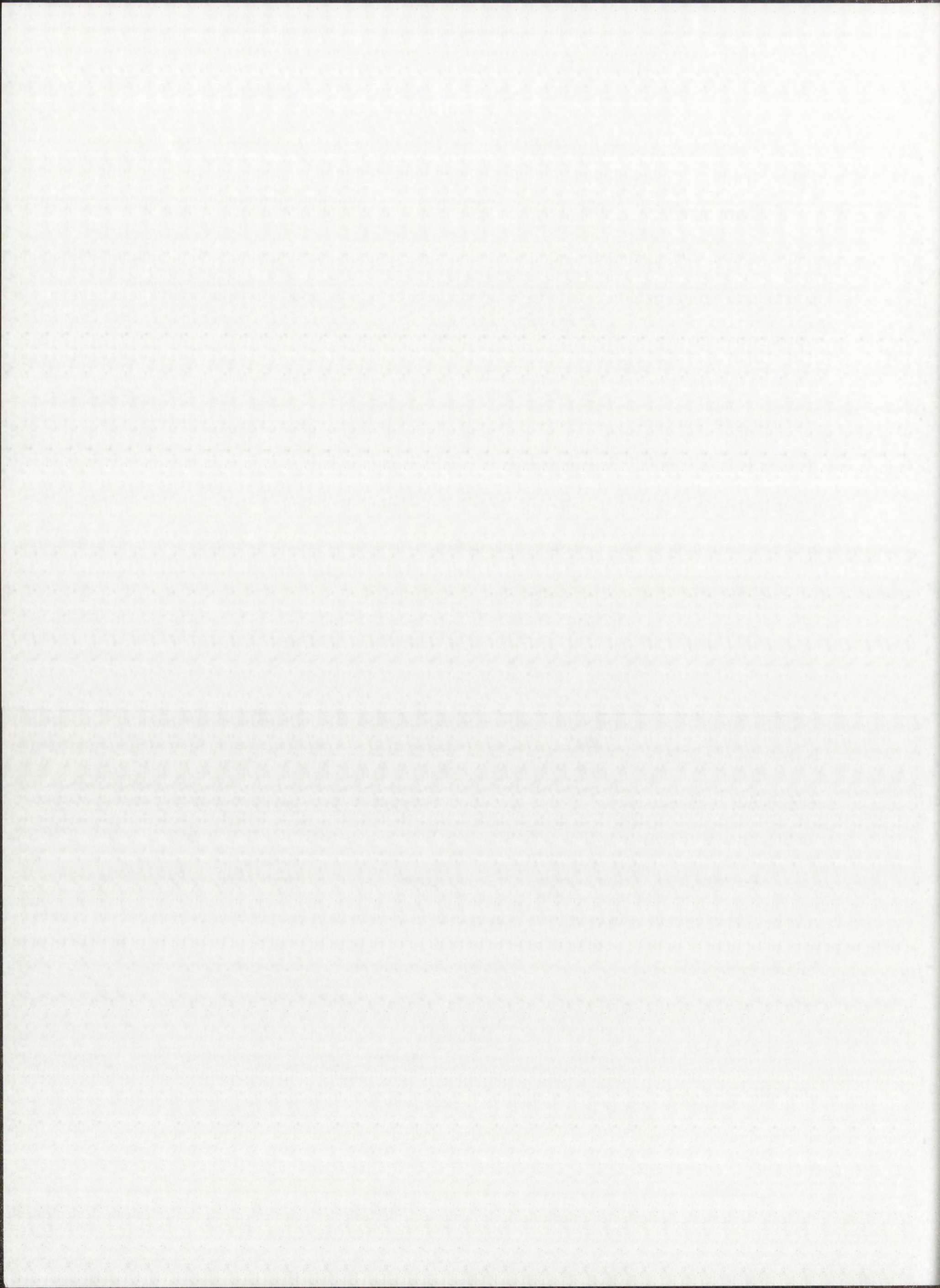
CHAPTER 1:

INTRODUCTION

The family is an important socializing institution in countries around the world. Family relationships, particularly parent-child and marital relationships, continue to be the most important relationships for a large majority of people despite the radical changes in family structure during the past 20 years (Bronfenbrenner, 1986). Because of the importance of family relationships to one's psychological functioning, these relationships have attracted interest among mental health professionals, including researchers and clinicians.

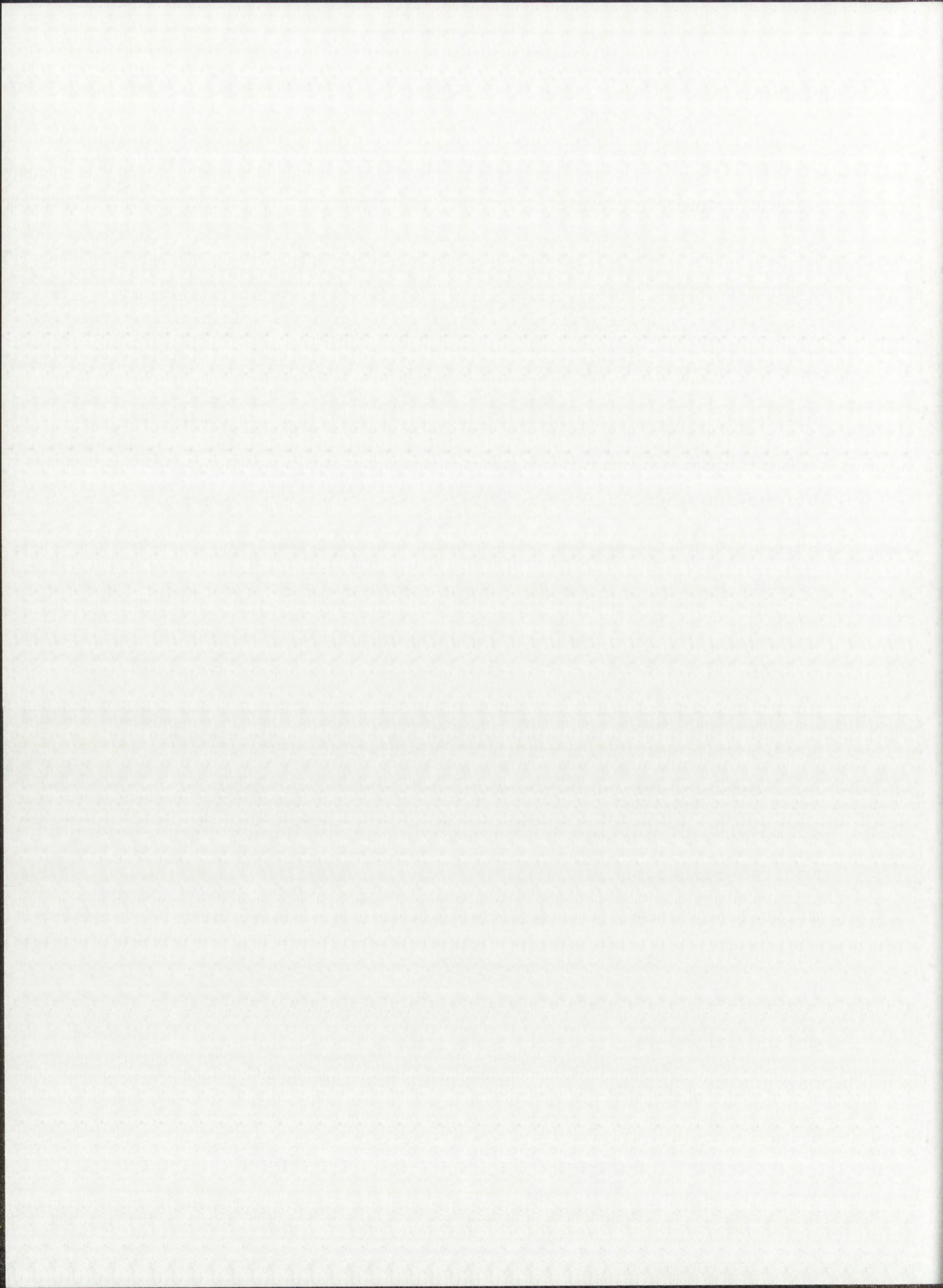
A degree of stress is inherent in the parenting role. Stress of the parent role has most often been described at times of developmental transitions such as the birth of a baby, a child's entry into school, adolescence, and a child leaving home. Additionally, there are stressors associated with the everyday parenting of children.

Recently, researchers have attended to the impact that a child with a disability has on family members. Children vary a great deal in their temperament and behavior. A child with a disability along with a difficult temperament and behavior problems may create stress in the family and impact the parents' marital relationship.



Many studies have found that child disability is related to increased parental stress. For example, Beckman (1991) found that parents of children with various disabilities reported significantly higher levels of stress than did parents of nondisabled children. Using the Parenting Stress Index (PSI) (Abidin, 1990), Innocenti, Huh, and Boyce (1992) compared mothers of children with disabilities to the PSI normative sample (N=725). Parents of children with disabilities reported significantly greater stress and these differences were more consistent for the Child Domain score (child behavior and characteristics). Parents of children with Attention Deficit/Hyperactivity Disorder (AD/HD) face more than the usual amount of stress in parenting, particularly in regard to children's behavior (Barkley, 1990; Breen & Barkley, 1988; Mash & Johnston, 1983; Mouton & Tuma, 1988; Webster-Stratton, 1990).

Given the potential for increased stress in parenting a child with disabilities, one might expect an impact on the marital relationship of the parents. Findings related to marital adjustment and satisfaction in families with children with disabilities have been mixed. There appears to be great variability in families who are coping with a child with special needs. Some studies have found that parents of children with special needs experience more marital strain and marital adjustment problems (Fisman,



Wolf, & Noh, 1989; Quittner, Jackson, & Glueckauf, 1990). Other studies have failed to find differences in marital satisfaction between families with and without a child with disabilities (Kazak, 1987; Kazak & Marvin, 1984). Research findings on marital satisfaction in families with children with AD/HD is similar to those for families with children with disabilities in general. Some studies have found increased rates of marital distress, separation, and divorce in parents of children with AD/HD (Barkley, Fischer, Edelbrock & Smallish, 1990; Befera & Barkley, 1985; Brown & Pacini, 1989). Other studies have failed to show higher rates of marital distress among parents of children with AD/HD (Barkley, DePaul, & McMurray, 1990; Mash & Johnston, 1983).

In order to better understand families and their members, research needs to be conducted that looks not only at relationships in isolation, but more importantly, at their interrelations. The study of family relationships needs to be examined from a systems perspective. For example, in order to study parental stress in the parent-child subsystem, a family systems approach suggests that one also must look at the marital subsystem as well as parenting variables and child variables.

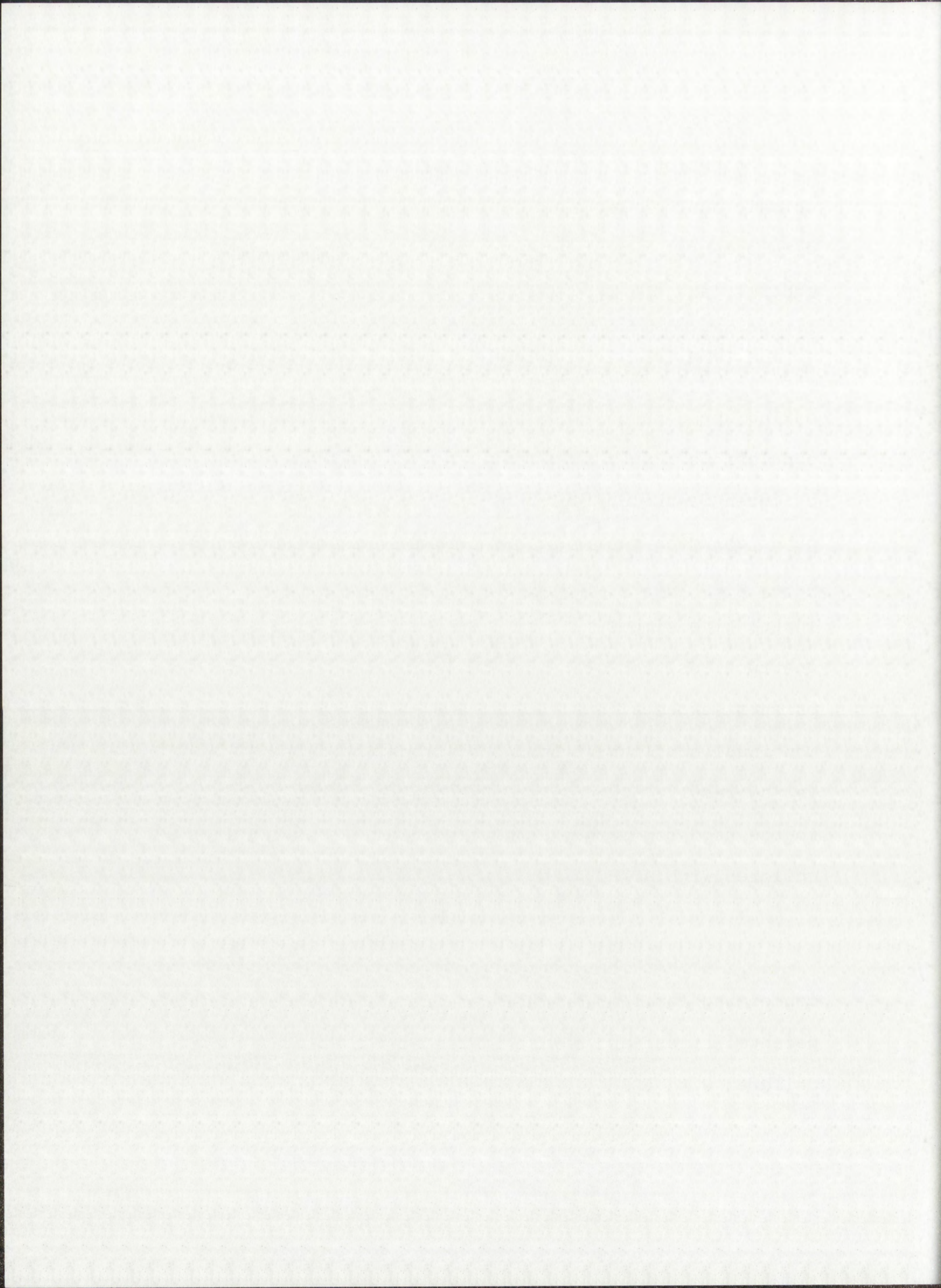


Overview of Attention Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder (AD/HD) is a chronic and pervasive condition characterized by developmental deficiencies in sustained attention, impulse control, and the regulation of motor activity in response to situational demands (American Psychiatric Association, 1987). AD/HD is a highly prevalent childhood disorder, making up as much as 50% of child psychiatric clinic populations (Cantwell, 1996). A prominent feature of AD/HD children is the deviation of their behavior from that of other children their age. These children do not conform to adult expectations regarding their behavior. They are inattentive, impulsive, have difficulty recalling instructions, and are often immature and overactive. When parental expectations and a child's behavior are in continual conflict, tremendous stress on the family system is the result. Cunningham, Benness, and Seigel (1998) point to the need for more extensive studies of the families of children with AD/HD.

Purpose of the Study

The purpose of this study was to extend the research concerning families of children with AD/HD by examining parental stress and marital satisfaction among parents of children with AD/HD. The specific focus of the study was



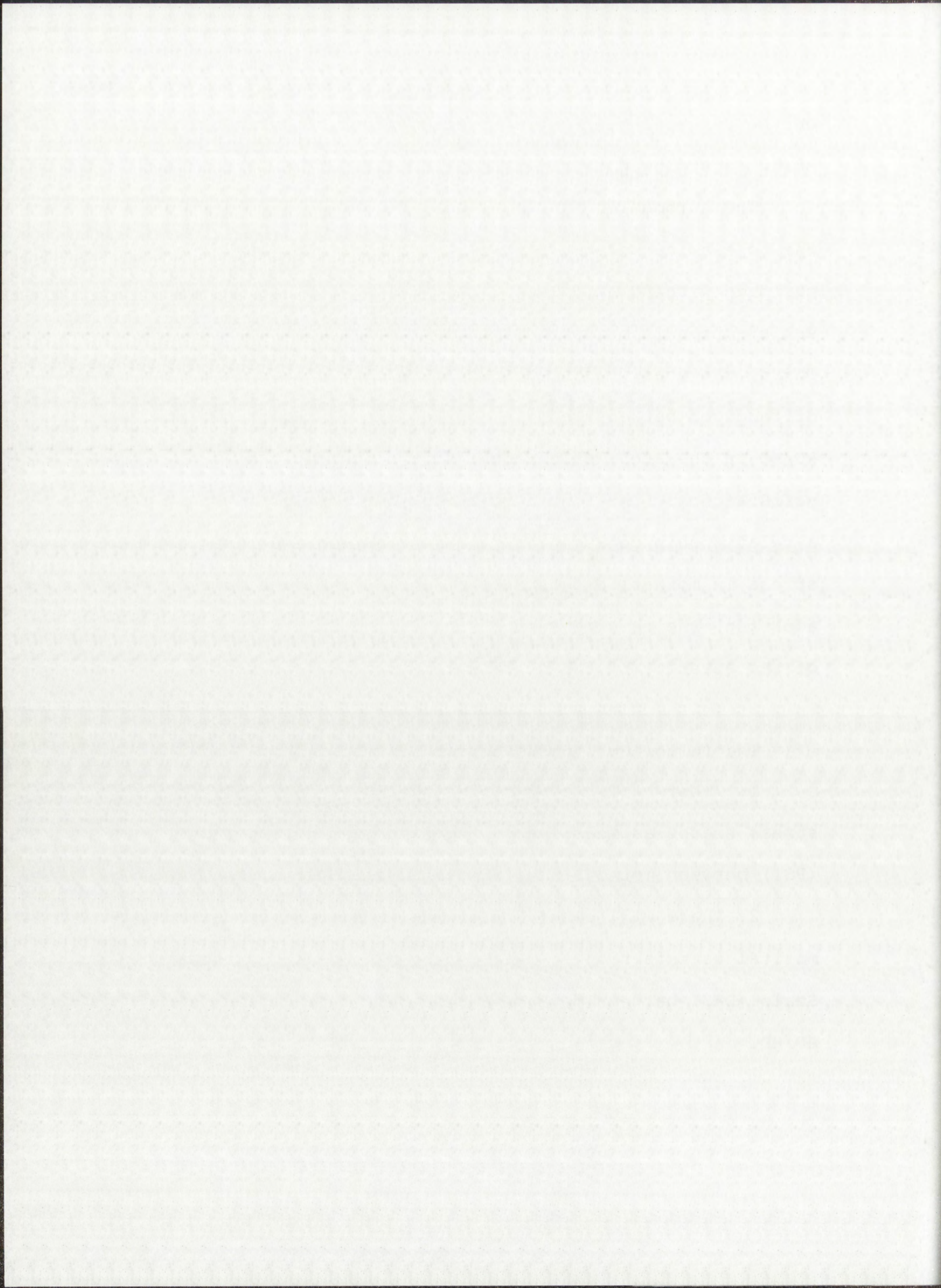
on the perceptions of mothers and fathers of children with AD/HD regarding parental stress and marital satisfaction.

The purpose of the study was fourfold. The first goal was to examine parental stress in mothers and fathers of children with AD/HD. The second goal was to examine marital satisfaction in mothers and fathers of children with AD/HD. Third, the study sought to determine if there were differences between mothers and fathers of children with AD/HD in the areas of parental stress and marital satisfaction. The fourth goal was to determine if there was a relationship between marital satisfaction and parental stress in mothers and fathers of children with AD/HD. In addition, the relationship of these findings to perceptions of the severity of the child's symptoms was assessed.

Hypotheses

The following hypotheses were investigated:

1. There will be no difference in average parental stress scores as measured by the Parenting Stress Index (PSI) between mothers and fathers of children with AD/HD.
2. There will be no difference in average scores of marital satisfaction as measured by the Dyadic Adjustment Scale (DAS) between mothers and fathers of children with AD/HD.



3. There will be no correlation between marital satisfaction and parental stress scores for parents of children with AD/HD.

3a. The degree of correlation between marital satisfaction and parental stress scores will not differ by gender.

4. There will be no correlation between severity of symptoms total scores on the Child Behavior Checklist (CBCL) and marital satisfaction scores for parents of children with AD/HD.

4a. The degree of correlation between severity of symptoms and marital satisfaction scores will not differ by gender.

5. There will be no correlation between severity of symptoms total scores on the CBCL and parental stress scores for parents of children with AD/HD.

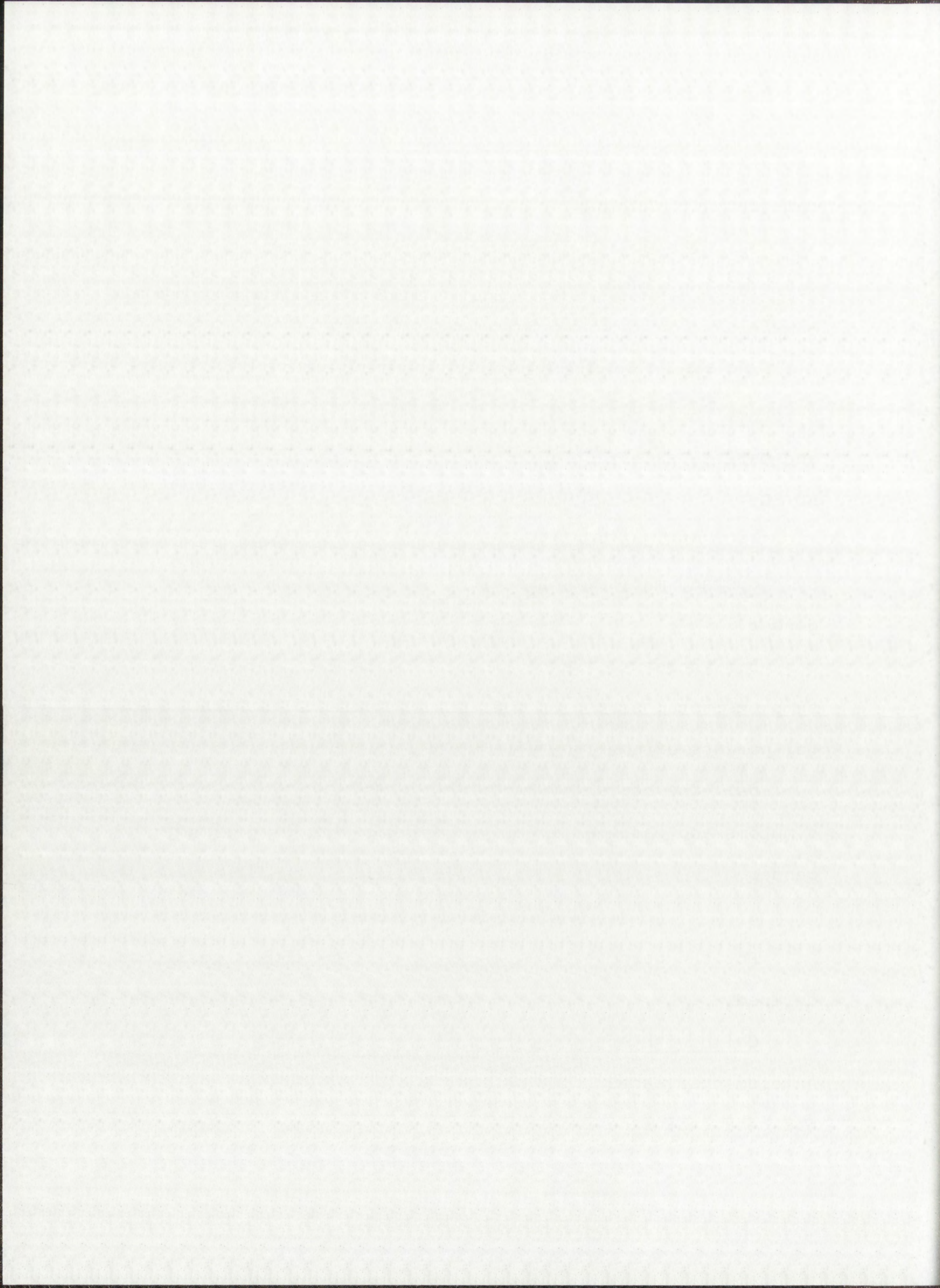
5a. The degree of correlation between severity of symptoms and parental stress scores will not differ by gender.

Definition of Terms

For the purposes of this study, the following terms are defined:

Child with Attention-Deficit/Hyperactivity Disorder.

An elementary-aged child between 6 and 11 years of age who has been evaluated and diagnosed by a physician or licensed



mental health professional according to the criteria in the DSM-IV (American Psychiatric Association, 1994) as having Attention Deficit/Hyperactivity Disorder (AD/HD).

Mother. The female adult caretaker, living in the home.

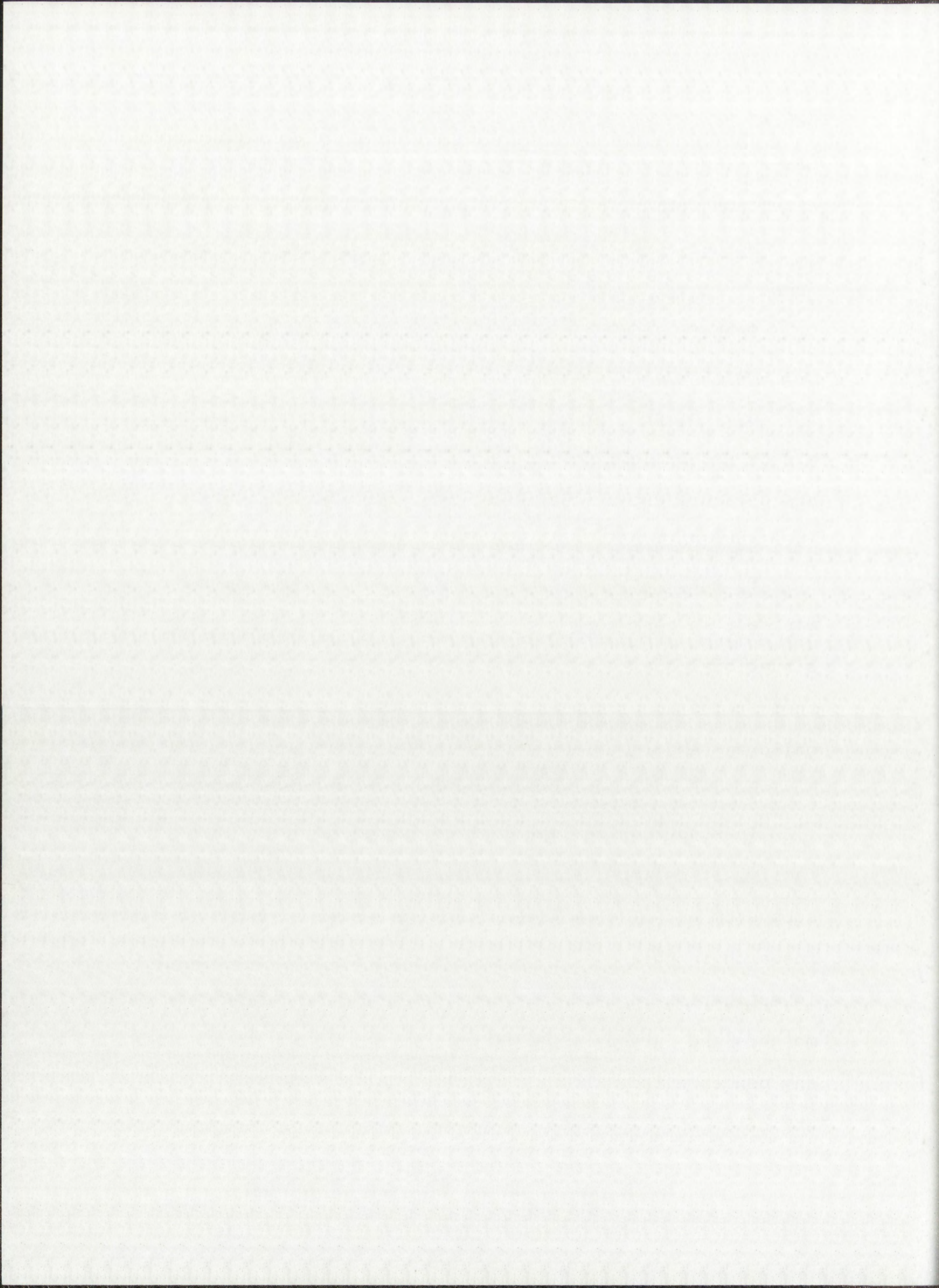
Father. The male adult caretaker, living in the home.

Marital Satisfaction. A spouse's conceptualization of the level of quality in the marital relationship based on his or her subjective feelings of happiness, satisfaction, and pleasure experienced when considering all aspects of the marriage (Rollins & Galligan, 1978).

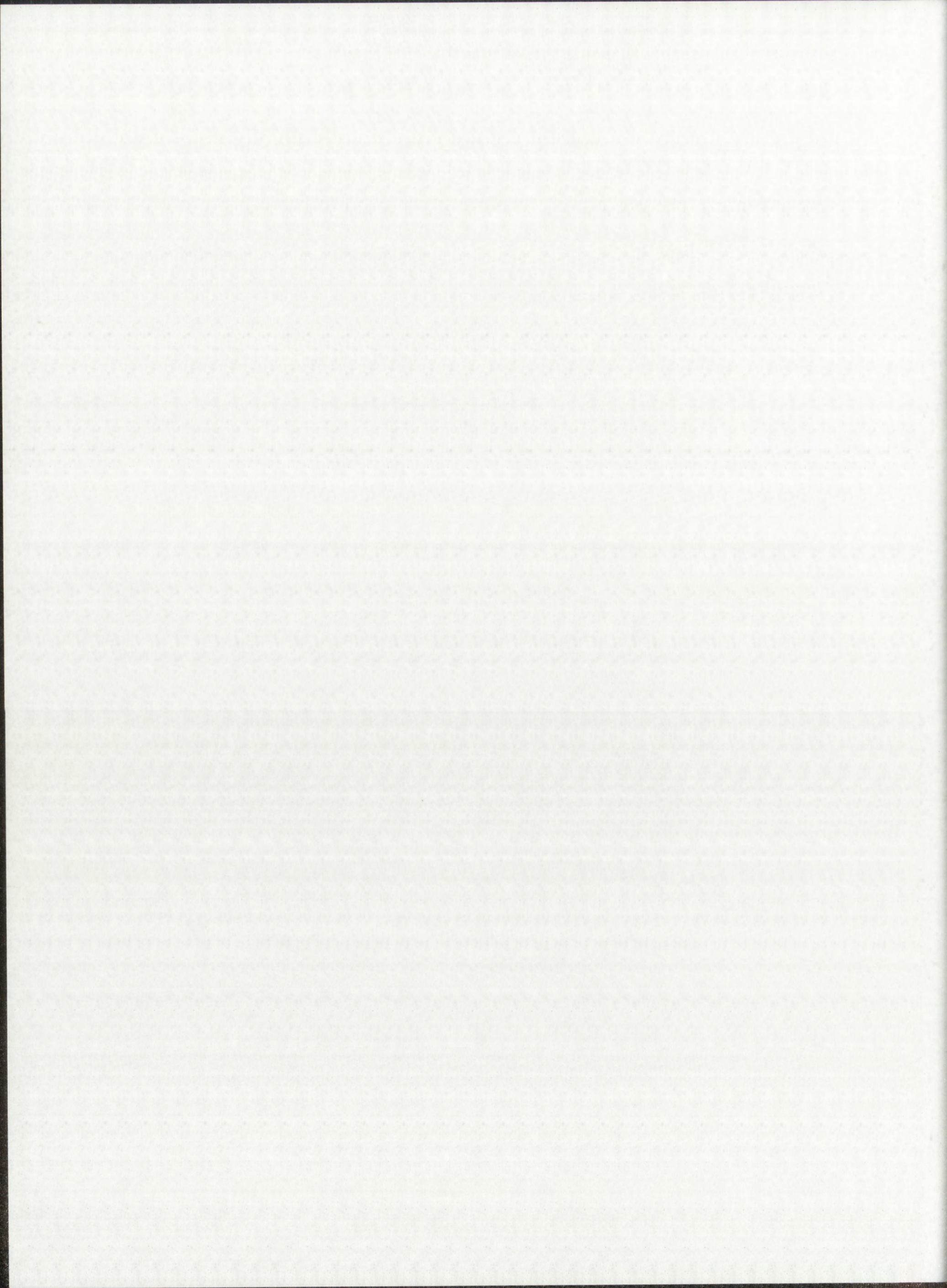
Parental Stress. The excess anxiety and tension manifest in behaviors and symptoms of parents that is situational and stimulus specific, and directly related to their roles as parents and to their interactions with their children (Abidin, 1990).

Justification

In studying the impact of having an AD/HD child on the family, it is important to look not only at the parent-child subsystem but also at the spousal subsystem. Previous research in this area has focused primarily on mothers. An investigation into the similarities and differences between mothers and fathers of AD/HD children will help to identify any gender effects related to parenting stress and marital satisfaction. In addition, there is a lack of research



examining the relationship between parental stress and marital satisfaction. Implications of this study include broadening the scope of existing research findings and contributing to the development and expansion of successful counseling interventions for families of children with ADHD.



CHAPTER 2:

REVIEW OF THE LITERATURE

This chapter begins with a brief overview of family stress theory and family systems theory as these are the theoretical frameworks underlying this study. Next, a historical overview of AD/HD and a review of the changing diagnostic criteria for AD/HD will be discussed with an emphasis on the characteristics of inattention, impulsivity and hyperactivity. Prevalance and comorbidity will be addressed. Finally, a review of findings for related research on families of children with AD/HD will be presented.

Theoretical Frameworks

Family Stress Theory

The marriage and family literature has been influential for more than three decades in guiding research into stress theory. Hill's (1949) classic ABCX model of family stress led much of the early work that investigated the processes and effects of family stressors. In Hill's model, a stressor event (A) interacts with a family's crisis-meeting resources (B) and the seriousness with which the family views the event (C) to produce the crisis (X). An important component of the model is the distinction between the stressor events and the experience of the crisis as a result of the stressor.

CHAPTER 1

THE HISTORY OF THE UNITED STATES

The history of the United States is a story of growth and change, from a small collection of colonies to a global superpower.

In the early years, the colonies were largely self-sufficient, but they began to look towards Britain for protection and trade.

The American Revolution was a turning point, as the colonies declared their independence from British rule.

The new nation faced many challenges, including the struggle to create a strong central government.

The Constitution was drafted to provide a framework for the new government, and it has since been amended to reflect the needs of the people.

The United States has played a significant role in world history, from the American Revolution to the present day.

The country has expanded its territory, fought wars, and achieved many milestones in science, technology, and culture.

Today, the United States remains a leading nation, with a rich and diverse heritage.

The story of the United States is one of resilience and progress, and it continues to unfold.

As the nation grows, it faces new challenges, but it has always found a way to overcome them.

The future of the United States is bright, and it is up to the people to shape it.

The history of the United States is a testament to the power of the American dream.

It is a story of hope and possibility, and it is one that we can all be proud of.

The United States is a land of opportunity, and it is a place where everyone can thrive.

The history of the United States is a story of triumph and adversity, and it is one that we can all learn from.

The United States is a nation of freedom, and it is a place where everyone can live their best life.

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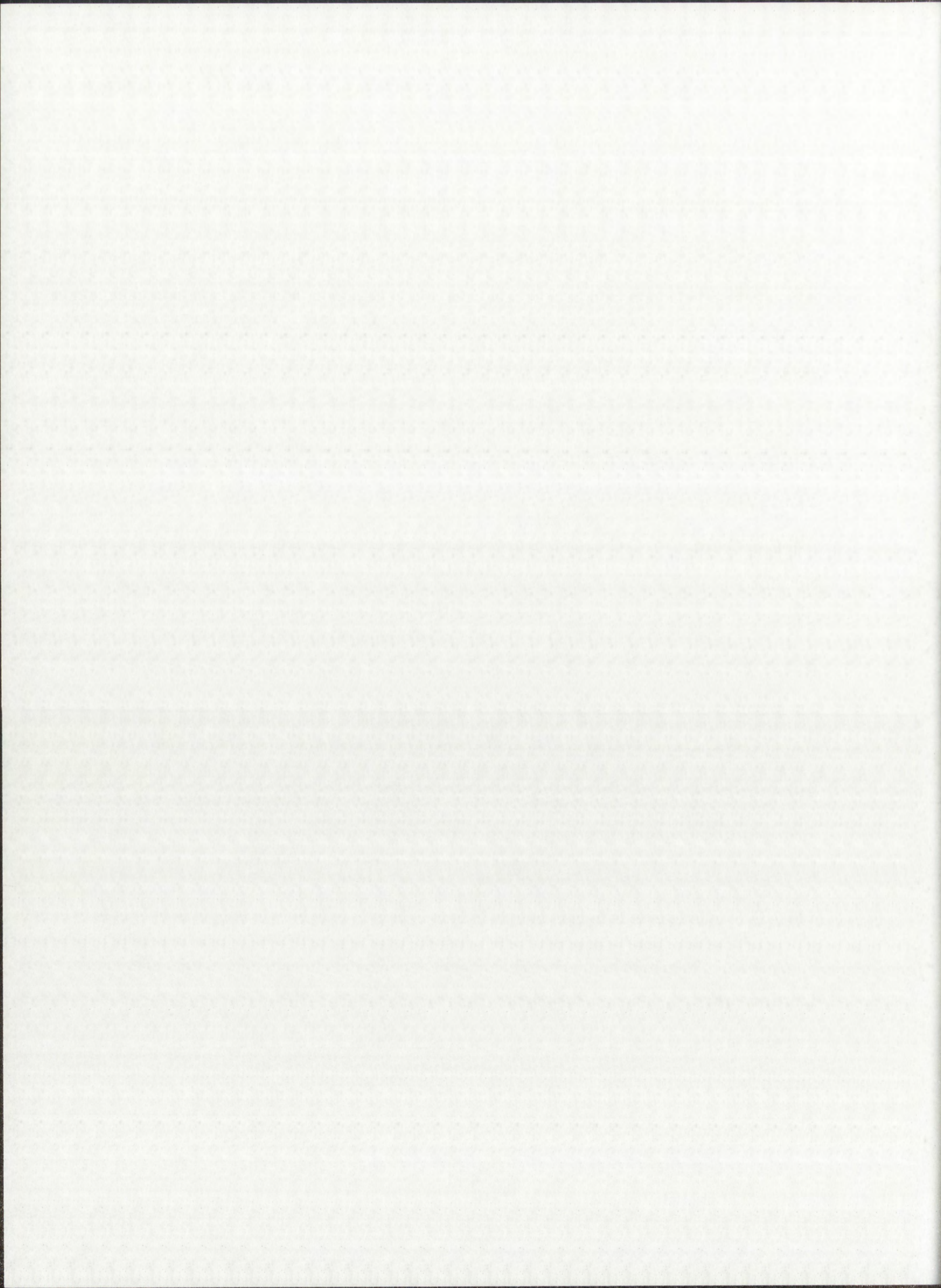
The United States is a land of opportunity, and it is a place where everyone can thrive.

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McCubbin and Patterson (1983) introduced the Double ABCX model of family stressors and strains as an extension of the Hill model. This model was an effort to better describe how families manage while experiencing stress. It includes a second set of factors conceptualized as contributors to a family's experienced stress. These additional factors are related to a family's ability to cope with stress and crisis over time. They include: the aA Factor (pile-up of stressors and strains); the bB Factor (a family's adaptive resources); and the xX Factor (a family's adaptation and balancing capabilities). In this model, McCubbin and Patterson suggest that a family's stressors and strains are typically a series of continuing events that pile up over time rather than individual events. Also, it is proposed that stress may never reach a crisis point if a family is able to utilize existing resources in handling the stressors and defines the situation as a manageable event.

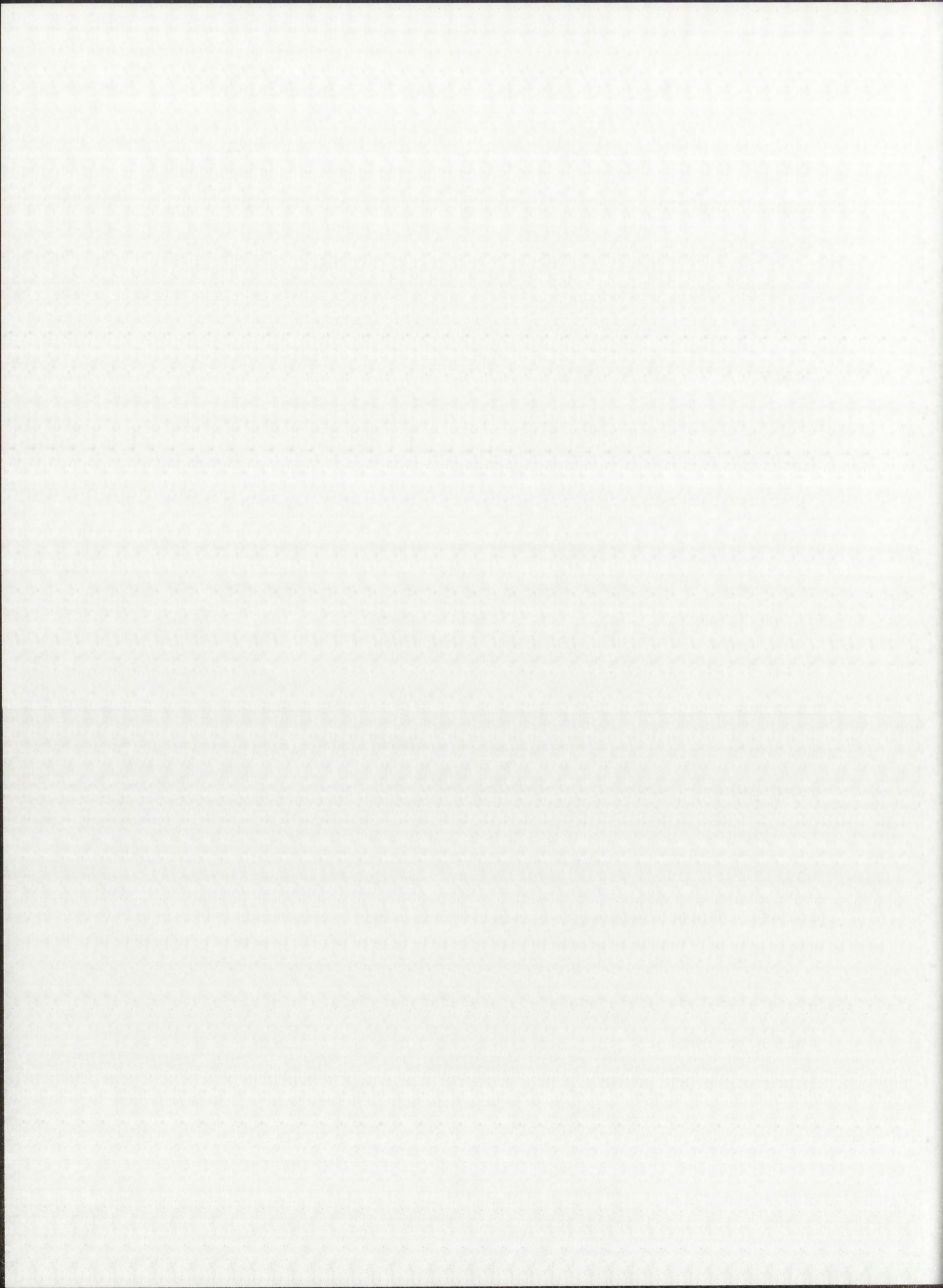
Another significant contribution found in the family stress literature is the work of Pearlin and Schooler (1978). These authors identified various coping skills that are used by families in handling stressors. Their investigation examined emotional attributes associated with stress and parental roles. In their study, Pearlin and Schooler found that one of the most frequent coping strategies was the modification of the meaning of a



stressful event. This strategy is related to the role of perception in handling stressful situations. Their findings support further investigation of parental perception as a useful coping mechanism.

An issue raised in the research literature concerns the sources of stress. Is stress to be measured only as a response to major life events or should it also include the chronic stressors and strains in daily life? Lazarus and Folkman (1984) provided the definition of stress as a "particular relationship between the person and the environment that is appraised by the person as taxing or exceeding their resources and endangering their well-being" (p.19). This is in contrast to the view taken by many that only major life events are seen as stressors. According to Lazarus and Folkman (1984), the chronic or repeated events in one's life that arise from daily living are seen as the most pervasive sources of stress.

Lazarus and Folkman (1984) identified the outcome of the stress process as adaptation and described three basic forms: functioning in social living and work, life satisfaction or morale, and physical health. Social living is defined as the manner in which one fulfills one's various roles in society and includes feelings of satisfaction with interpersonal relationships obtained from functioning in these roles. Morale has to do with how people feel about



themselves and their conditions in life. It includes the dimensions of happiness, satisfaction, and well-being. The third form of adaptation proposed by Lazarus and Folkman is that of an individual's physical health and well-being.

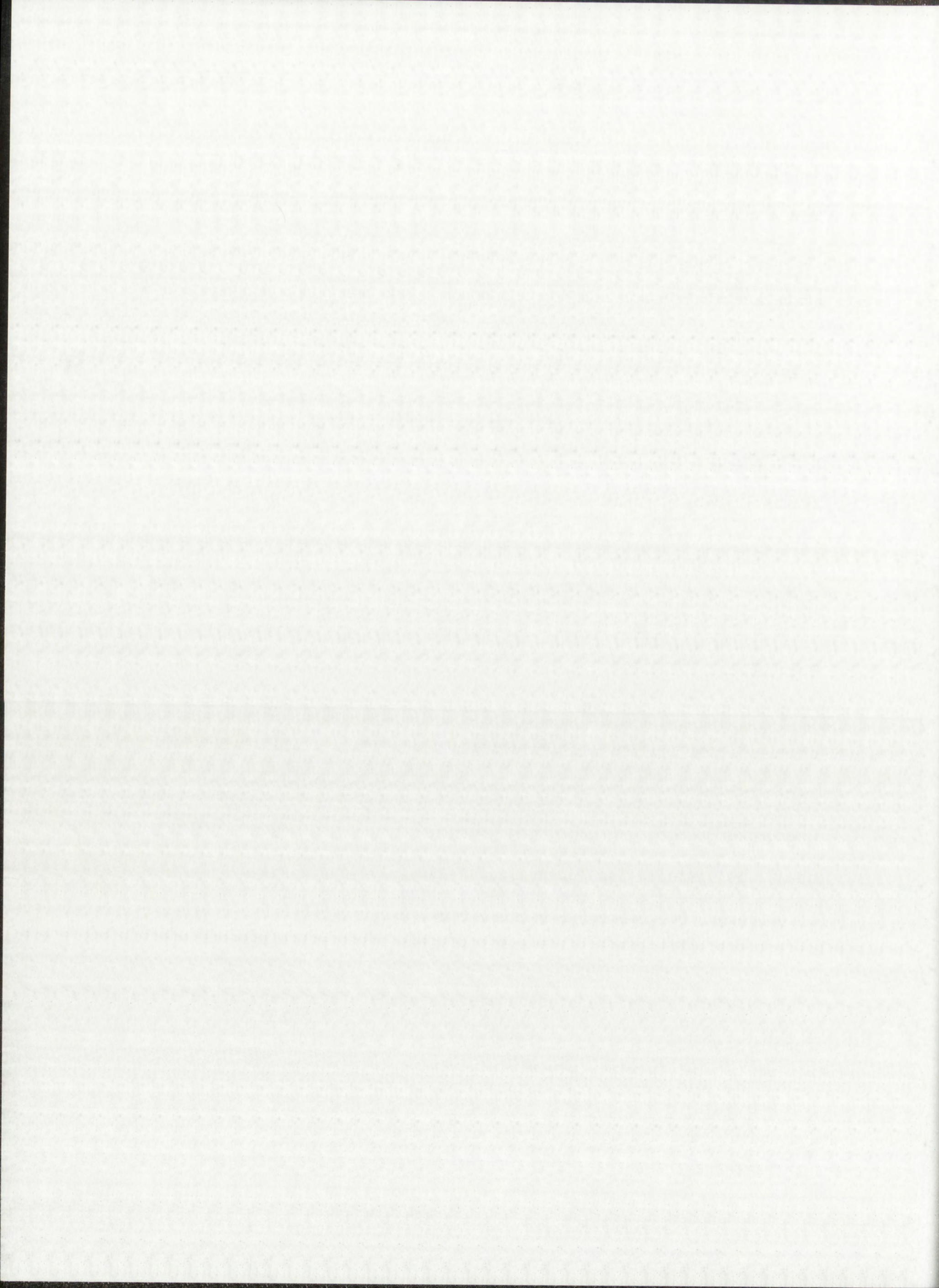
Family Systems Theory

Family systems theory is derived from general systems theory. The systems view has developed over many years. There is a well-developed perspective, a set of terms, and a vast amount of literature and research that utilizes these terms. The systems perspective has helped us to understand family life. Through this approach, we have learned about the interactive and reciprocal nature of family behavior.

A family is seen as a living system. Ludwig von Bertalanffy (1968) observed that all living systems are composed of interdependent parts and the interaction of these parts creates characteristics not contained in the separate entities. Although family systems have characteristics of physical systems, they are different in that they are social systems and have the ability to adapt or attempt to adapt to situations.

Minuchin (1974) described the interactive nature of the family system:

The individual influences his context and is influenced by it in constantly recurring sequences of interaction. The individual who lives within a family is a member of



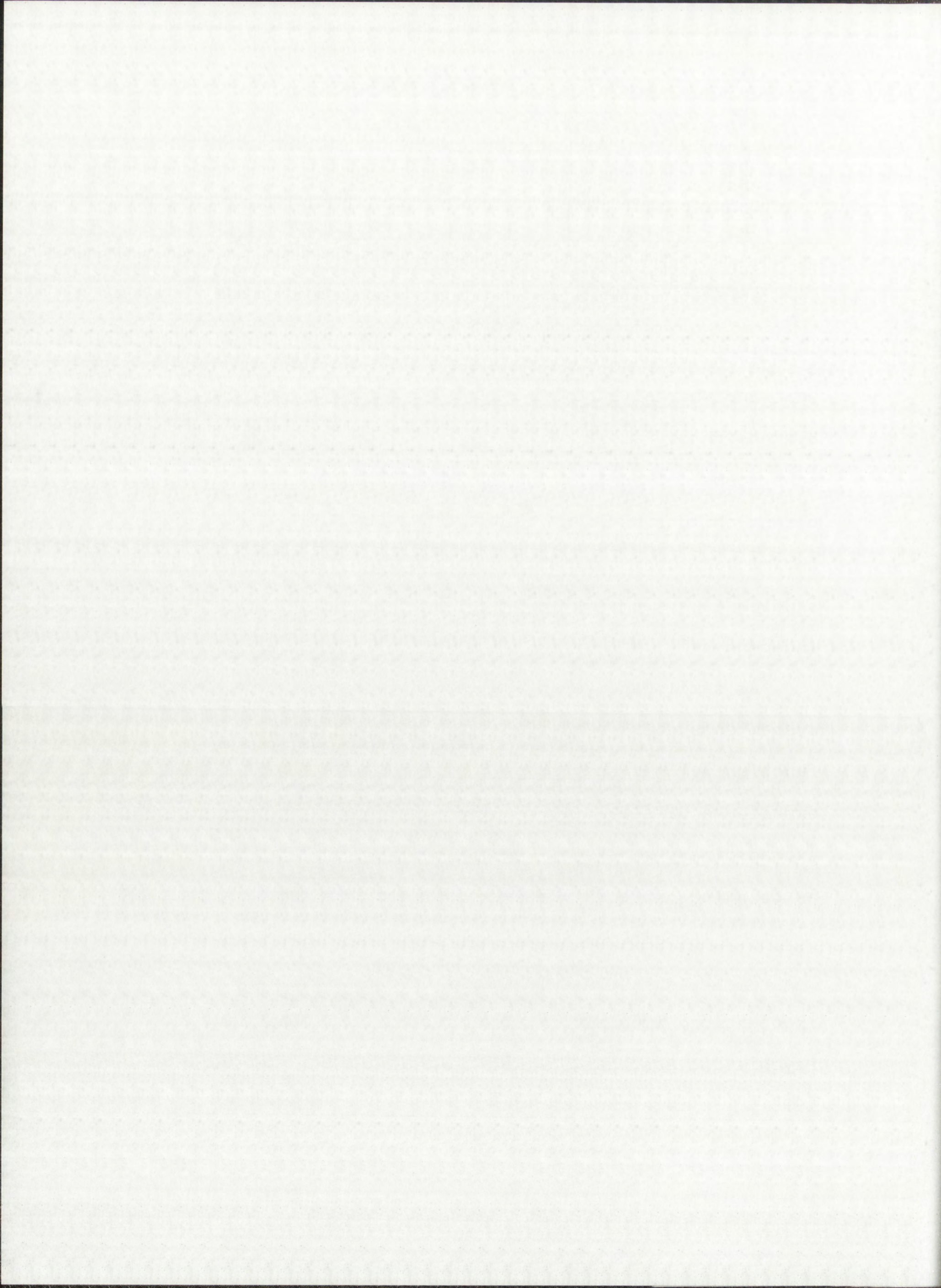
a social system to which he must adapt. His actions are governed by the characteristics of the system and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system to which he adapts; and he may contribute significantly to stressing other members of the system. The individual can be approached as a subsystem, or part of the system, but the whole must be taken into account. (p.9)

It is clear that the family operates as an interactive unit and what affects one member affects all members. Systems theory views the family as a unit of related subsystems. These include the spousal subsystem, the parent-child subsystem, the sibling subsystem, and the individual subsystem. To be understood, families must be studied as systems rather than separate subsystems operating independently.

As families develop and change over time, the family system encounters stressful situations. Families may function well as they adapt to ordinary stressors. They may experience difficulties when confronted with difficult, extraordinary stressors. A child with AD/HD may be viewed as bringing extraordinary stressors to the family system.

Attention-Deficit/Hyperactivity Disorder

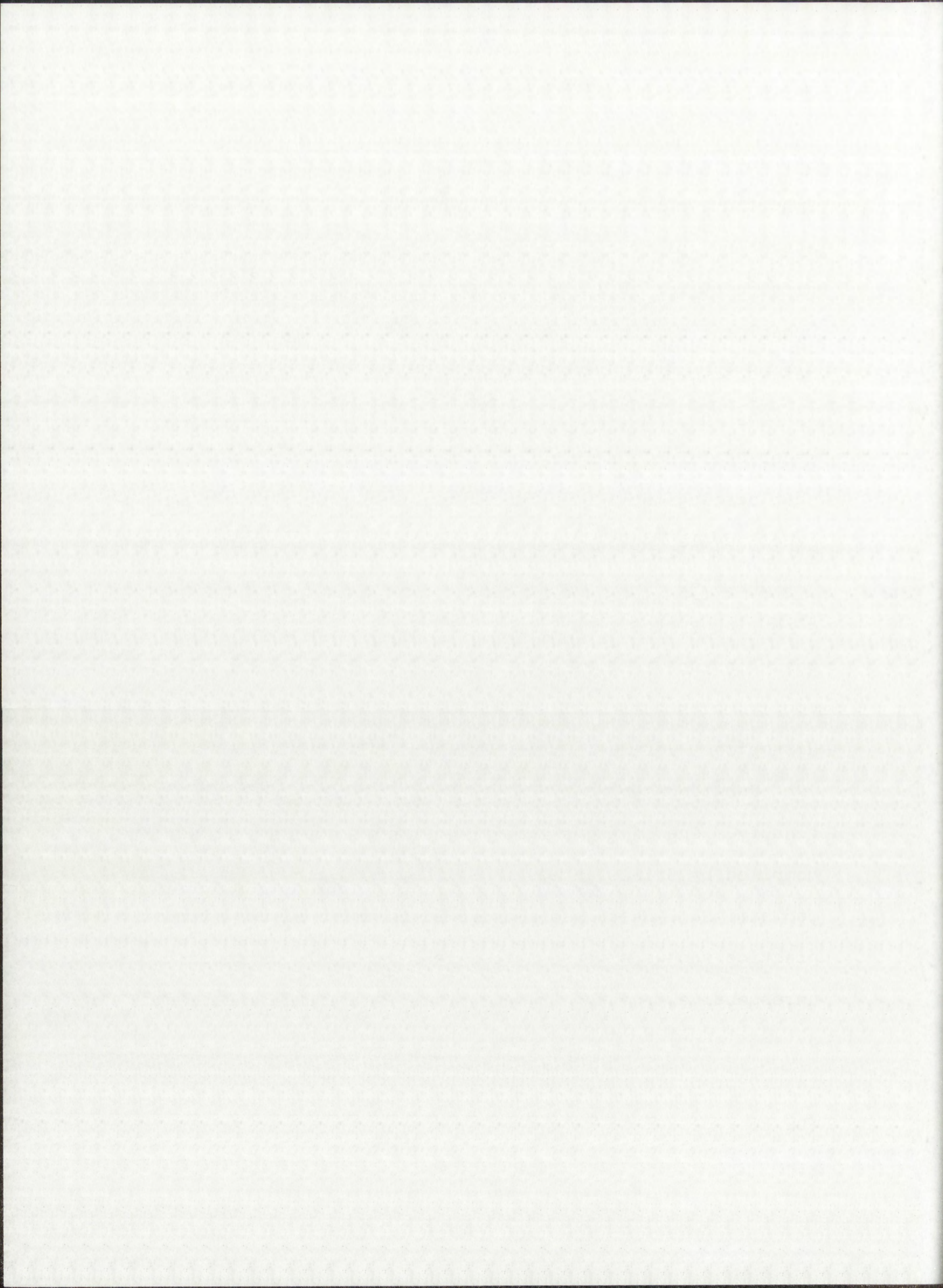
AD/HD is a developmental disorder characterized by inattention, impulsivity, and overactivity (American Psychiatric Association, 1994; Barkley, 1990; Cantwell, 1996). It is a disorder that has gone by many labels as the



understanding of the disorder has changed. According to Barkley (1990), inattention refers to a multitude of specific symptoms such as problems with arousal, sustained attention, distractability, and alertness. Another major difficulty for children with AD/HD is impulsivity, or behavioral disinhibition (Barkley, 1990). This typically refers to behavior which is rushed, hasty, and seemingly lacking in conscious control relative to the behavior of other children. Barkley contends that it is not inattention that distinguishes the child with AD/HD from children with other developmental disabilities, but rather the impulsive, disinhibited behavior. The third behavioral symptom of AD/HD is hyperactivity. This refers to a range of symptoms which include restlessness, fidgeting, and unnecessary gross bodily movements (Barkley, 1990).

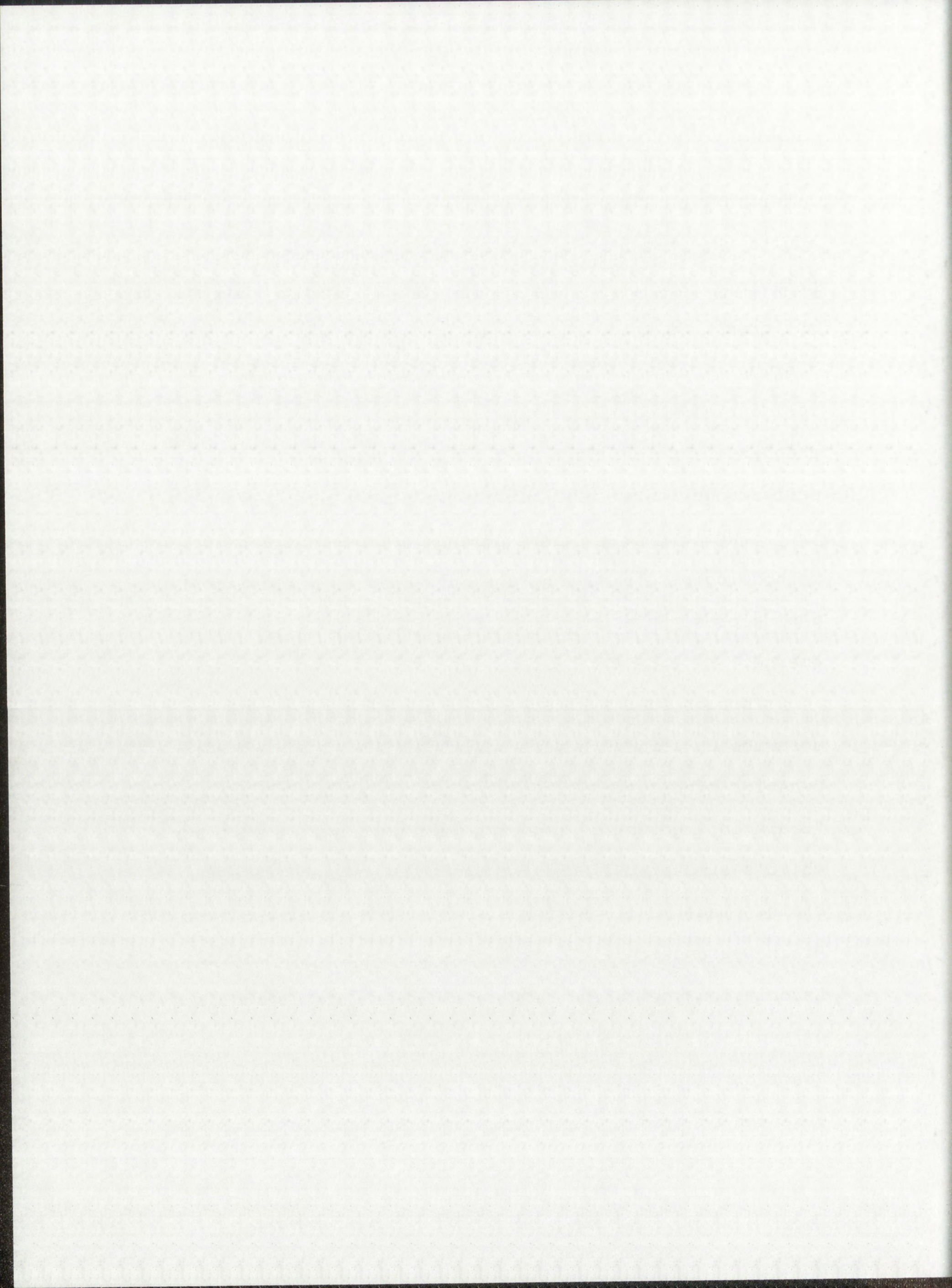
Historical Overview

Knowledge about AD/HD has been accruing over the last century. One of the earliest, most complete reports was compiled by Stills in 1902. Stills, an English pediatrician, described a group of children in his clinical practice who were often aggressive, defiant, inattentive, unresponsive, and who showed little "volitional inhibition" or self control. It was concluded that some type of head injury or brain impairment was the cause of these symptoms (Barkley, 1990; Goldstein & Goldstein, 1988).



One of the first reports of treatment for this disorder was in the 1930s by Charles Bradley. Reviewing the literature showing significant results using stimulants on adults who were having difficulties with mood and other behaviors, Bradley became interested in possible effects on children. He conducted a study prescribing amphetamines to a group of 30 emotionally disturbed children in a residential treatment center. Bradley found considerable changes in the children, with improvement in school performance and overall behavior (Goldstein & Goldstein, 1988). While this work was seminal to modern treatment methodologies, it was not until the end of World War II when a widespread interest in childhood disorders began to emerge.

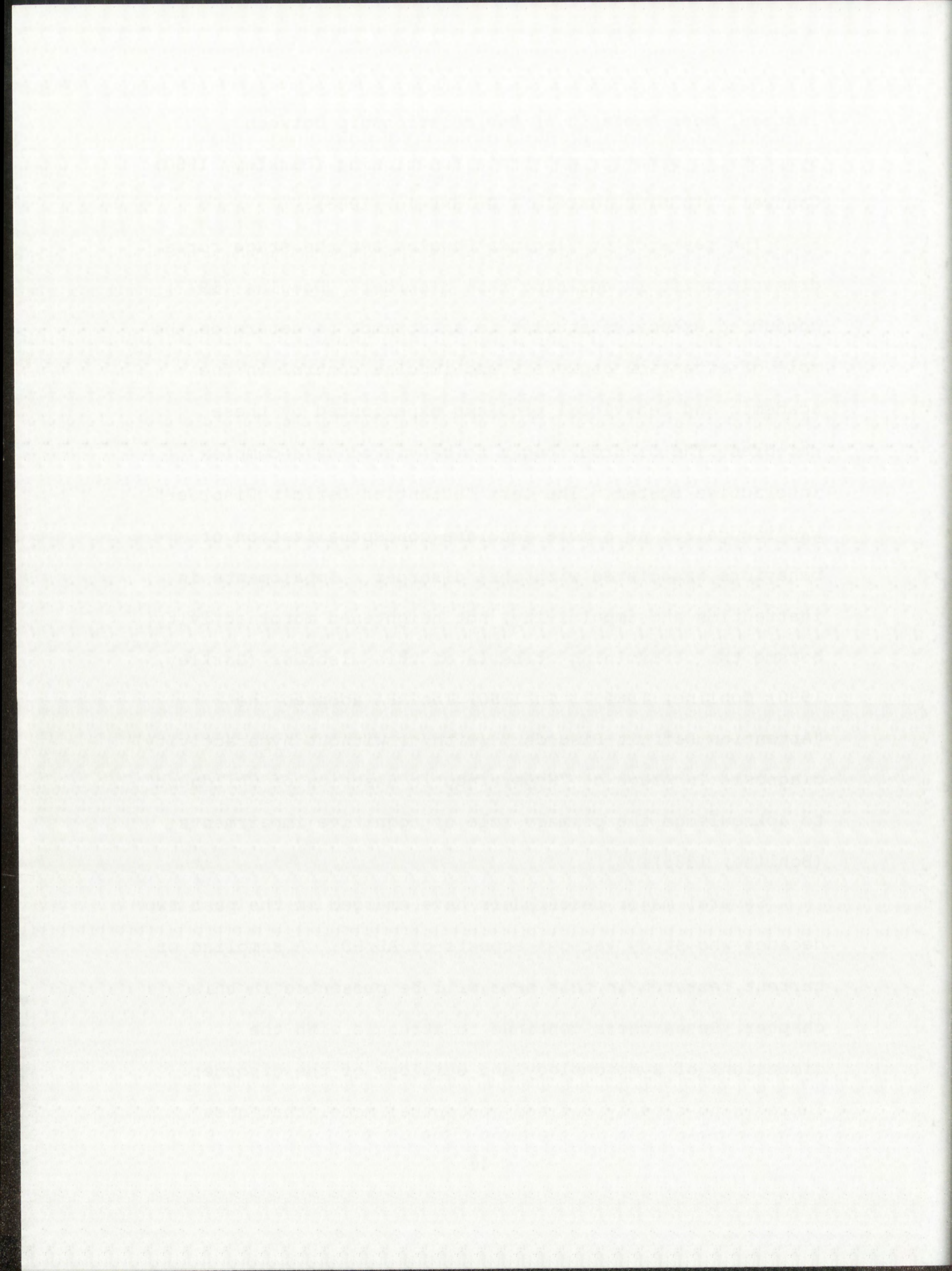
Through the next decades, various terms emerged to describe children who were observed to have excessive behavior problems. Strauss and Lehtinen used the term "Brain Injured Child" to describe the connection between a child's symptomatic behavior and functioning within the brain. Later, this term was followed by the label "Minimal Brain Dysfunction". In 1968, The American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) and the diagnosis "Hyperkinetic Reaction of Childhood Disorder" was introduced. Brain research continued with less emphasis on brain damage and



instead, more emphasis on the relationship between symptomatic behavior and brain functioning (Barkley, 1990; Cantwell, 1996; Goldstein & Goldstein, 1988).

The research of Virginia Douglas set the stage for a dramatic shift in defining this disorder. Douglas (1972) conducted extensive studies in an attempt to determine the role of attention processes and impulse control in the academic and behavioral problems experienced by these children. The disorder began to be viewed as a complex interactive system. The term "Attention Deficit Disorder" was recognized as a more accurate conceptualization of behaviors associated with this disorder. Impairments in inattention and impulsivity, not heightened motor activity, became the determining criteria of this disorder (Barkley, 1990; Bohline, 1985). In 1980, The APA adopted the "Attention Deficit Disorder" (with or without hyperactivity) diagnosis in place of "Hyperkinetic Reaction of Childhood" to acknowledge the primary role of cognitive impairments (Bohline, 1985).

Several major researchers have emerged in the past two decades who study various aspects of AD/HD. A sampling of current research in this area will be presented in this chapter. Researchers continue to struggle with the dimensions of symptomology and etiology of the disorder. There is no clearly defined conceptual model that goes



beyond descriptions of symptomology and proposals about genetic, traumatic, or environmental causes. Causes related to brain pathology have given way to studies which associate symptomology to specific brain functions. The focus has shifted from brain damage to brain functioning. What remains clear is that there is a group of children who exhibit developmentally inappropriate levels of inattention, impulsivity and hyperactivity.

Current Criteria for AD/HD

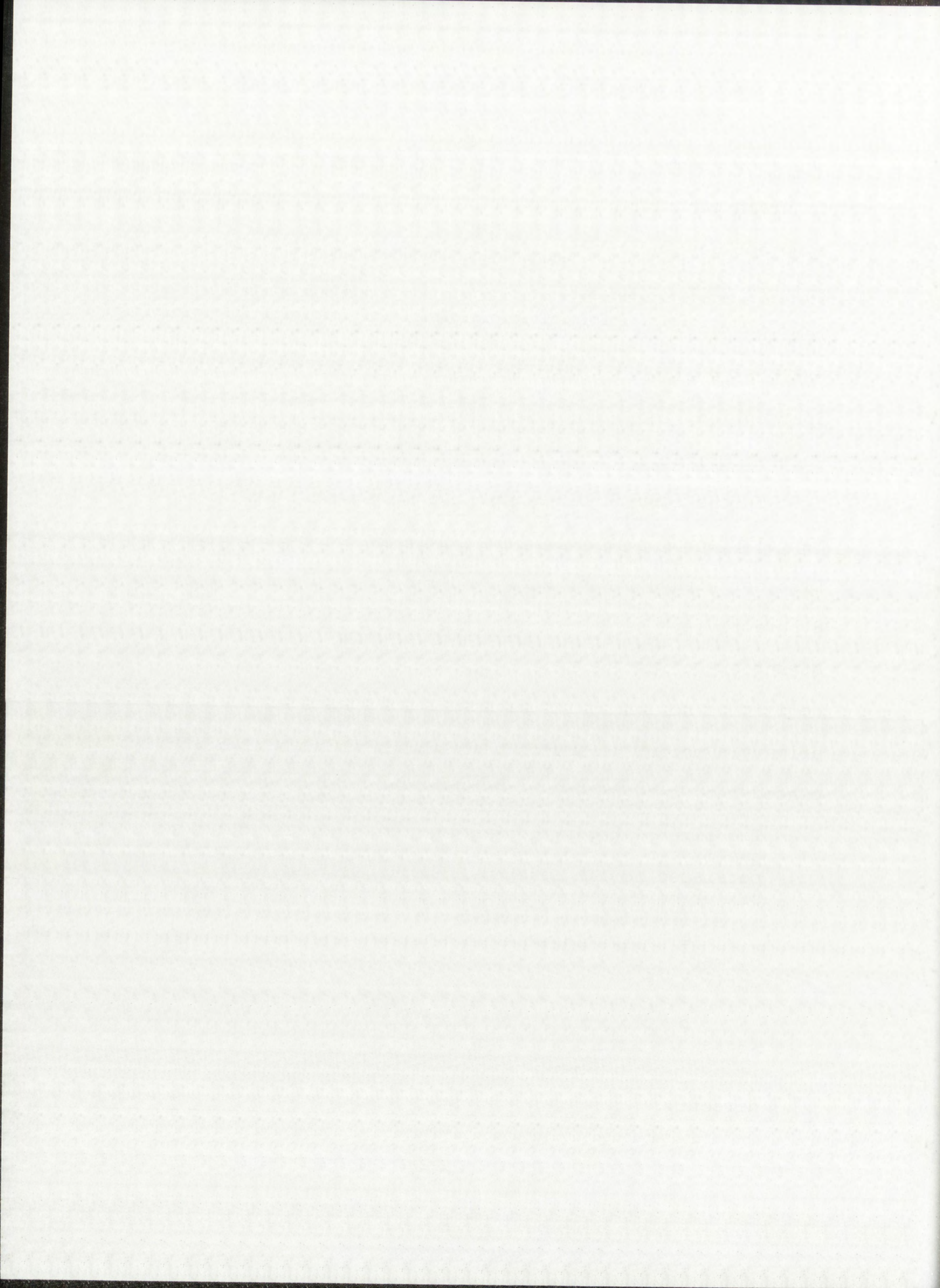
In the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA 1994), "Attention Deficit Disorder with Hyperactivity" and "Attention Deficit without Hyperactivity" have been combined into one disorder, Attention-Deficit/Hyperactivity Disorder. The current definition no longer indicates that inattention is the primary symptom. Instead, the symptoms of this disorder are placed into categories or subtypes.

The first category is Inattention. For the child to qualify in this category, his or her symptoms must have persisted for at least six months and they must have six or more of the following symptoms.

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.

(b) often has difficulty sustaining attention in tasks or play activities.

(c) often does not seem to listen when spoken to directly.



(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).

(e) often has difficulty organizing tasks and activities.

(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).

(g) often loses things necessary for tasks or activities.

(h) is often easily distracted by extraneous stimuli.

(i) is often forgetful in daily activities.

The second area is Hyperactivity-Impulsivity. These symptoms must also be present for a period of six months and six or more of the following symptoms must have been observed.

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat.

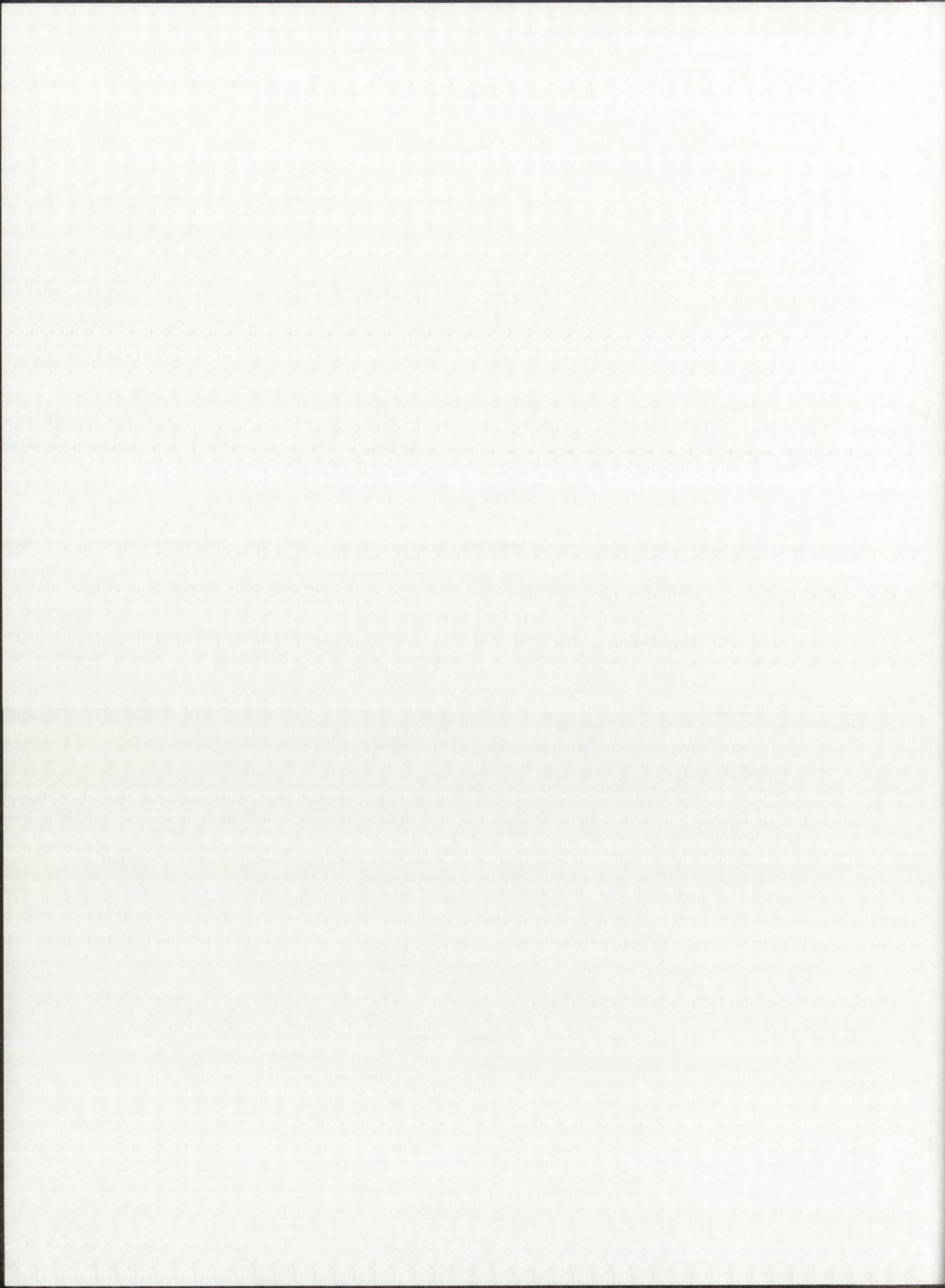
(b) often leaves seat in classroom or in other situations in which remaining seated is expected.

(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feeling of restlessness).

(d) often has difficulty playing or engaging in leisure activities quietly.

(e) is often "on the go" or often acts as if driven by a motor.

(f) often talks excessively.



Impulsivity

(g) often blurts out answers before questions have been completed.

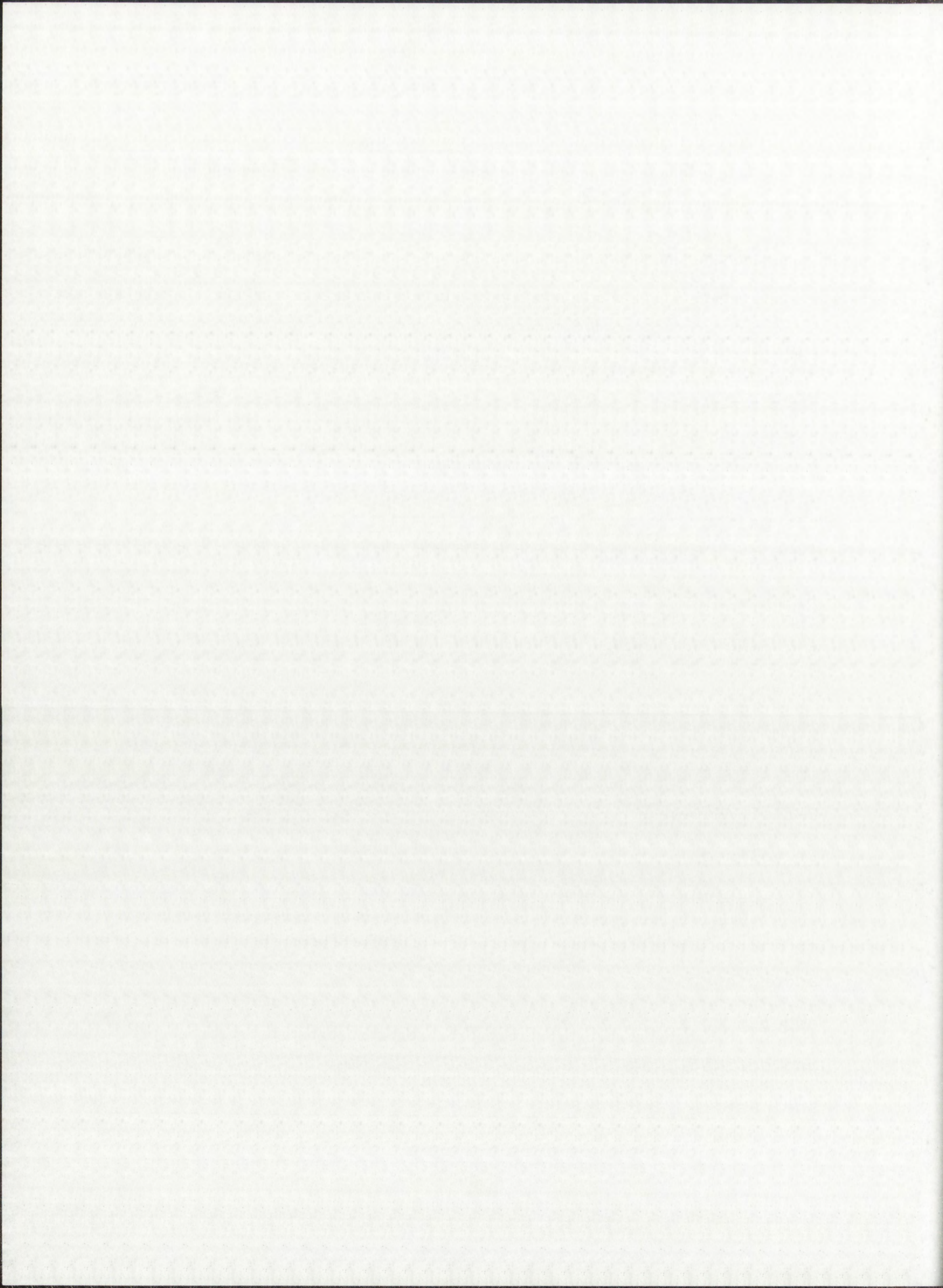
(h) often interrupts or intrudes on others (e.g., butts into conversations or games). (pp.83-86).

The subtypes are as follows: Attention

Deficit/Hyperactivity Disorder, Combined Type (if both criteria 1 and 2 are met for the past six months); Attention Deficit/Hyperactivity Disorder, Predominately Inattentive Type (if criterion 1 is met, but criterion 2 is not met for the past six months); Attention Deficit/Hyperactivity Disorder, Predominately Hyperactive-Impulsive Type (if criterion 2 is met, but criterion 1 is not met for the past six months); Attention Deficit/Hyperactivity Disorder, not otherwise specified (this category is for disorders with prominent symptoms of inattention or hyperactivity-impulsivity that do not meet criteria for Attention Deficit/Hyperactivity Disorder (DSM-IV, APA, 1994).

Prevalence

Estimates of children with AD/HD reported in the literature range from 1% to 20%. Prevalence rates vary according to the methodology, criteria, and definition adhered to at the time of diagnosis. The specific criteria and definition of AD/HD have been modified three times in the past 14 years by the APA. Although the estimates have

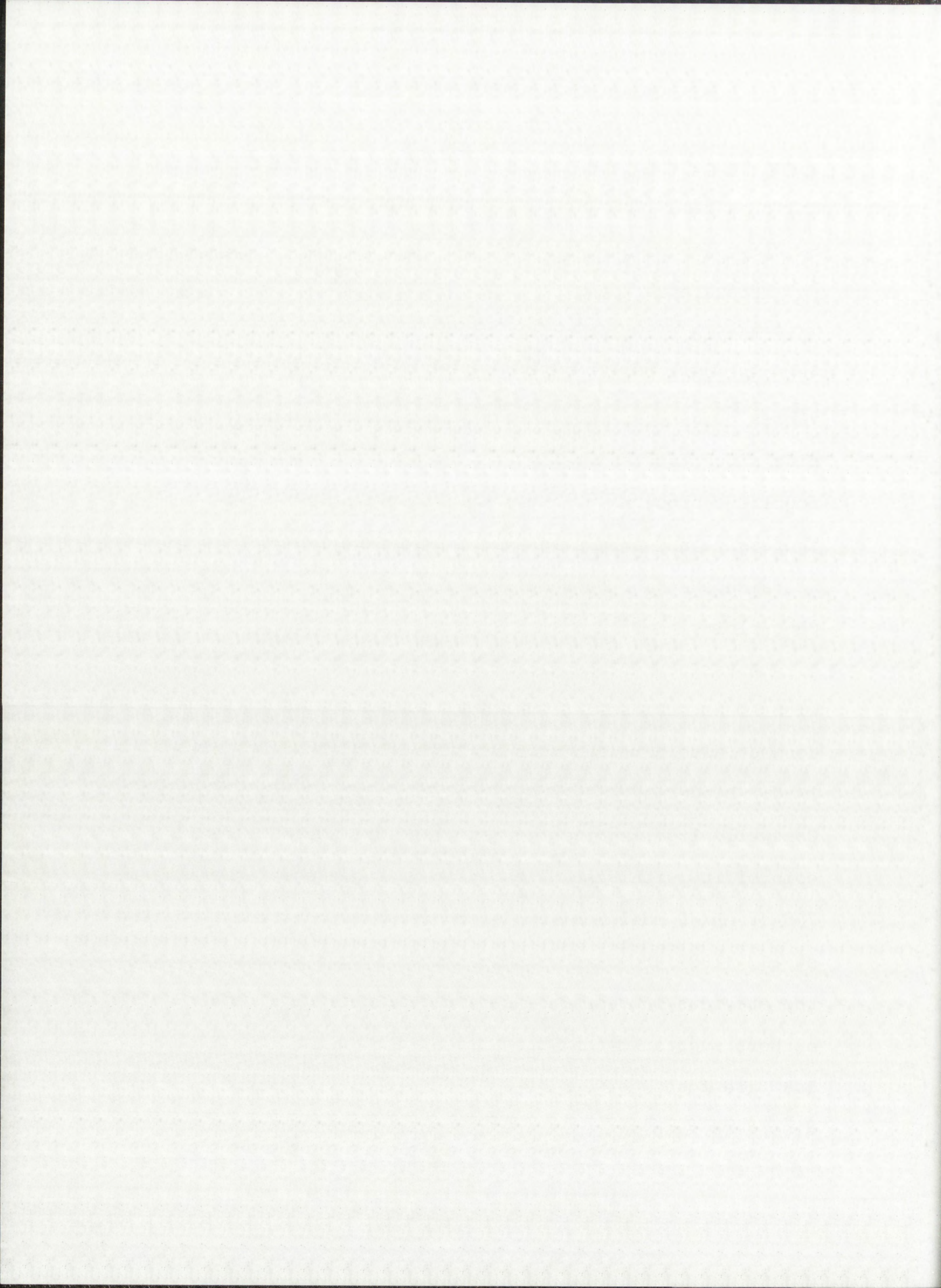


varied over the years, the consensus of expert opinion now seems to be that approximately 3% to 5% of school-age children have AD/HD (American Psychiatric Association, 1994; Barkley, 1998; Cantwell, 1996).

Prevalence rates of AD/HD are higher in males. Male/female prevalence rate estimates vary from 2:1 to 9:1. Studies suggest that the constellation of AD/HD symptoms varies by gender. It is suggested that there is a referral bias since females may experience primarily inattentive and cognitive problems, whereas males may display more aggressive and impulsive symptoms (Cantwell, 1994, 1996; Wolraich, Hannah, Pinnock, Baumgaertel, & Brown, 1996).

Comorbidity

A variety of psychiatric conditions are often comorbid with AD/HD. These include oppositional defiant disorder, conduct disorder, and mood and anxiety disorders (Barkley, 1990; Biederman, Newcorn, & Sprich, 1991; Jensen, Martin, & Cantwell, 1997). Biederman et al. (1991) have reviewed comorbidity within AD/HD extensively and suggest that 15% to 75% of AD/HD children have a comorbid mood disorder. Jensen et al. (1997) reviewed studies of AD/HD and comorbidity for the previous 15 years. Based on available data, these authors suggested that lower rates of comorbidity (13% to 50%) are found between AD/HD and internalizing mood disorders such as anxiety and depression and that



comorbidity between AD/HD and Conduct Disorder/Oppositional Defiant Disorder is between 43% and 93% (Jensen et al., 1997).

Research on Families of Children with AD/HD

Parental Stress

Stress is frequently noted in parents of children with AD/HD symptoms and related behaviors (Barkley, 1990; Breen & Barkley, 1988; Fischer, 1990; Mash & Johnston, 1983, 1990; Moulton & Tuma, 1988). Parental stress is an interactive process reflecting the behavior and emotional interactions of parent and child (Mash & Johnston, 1990).

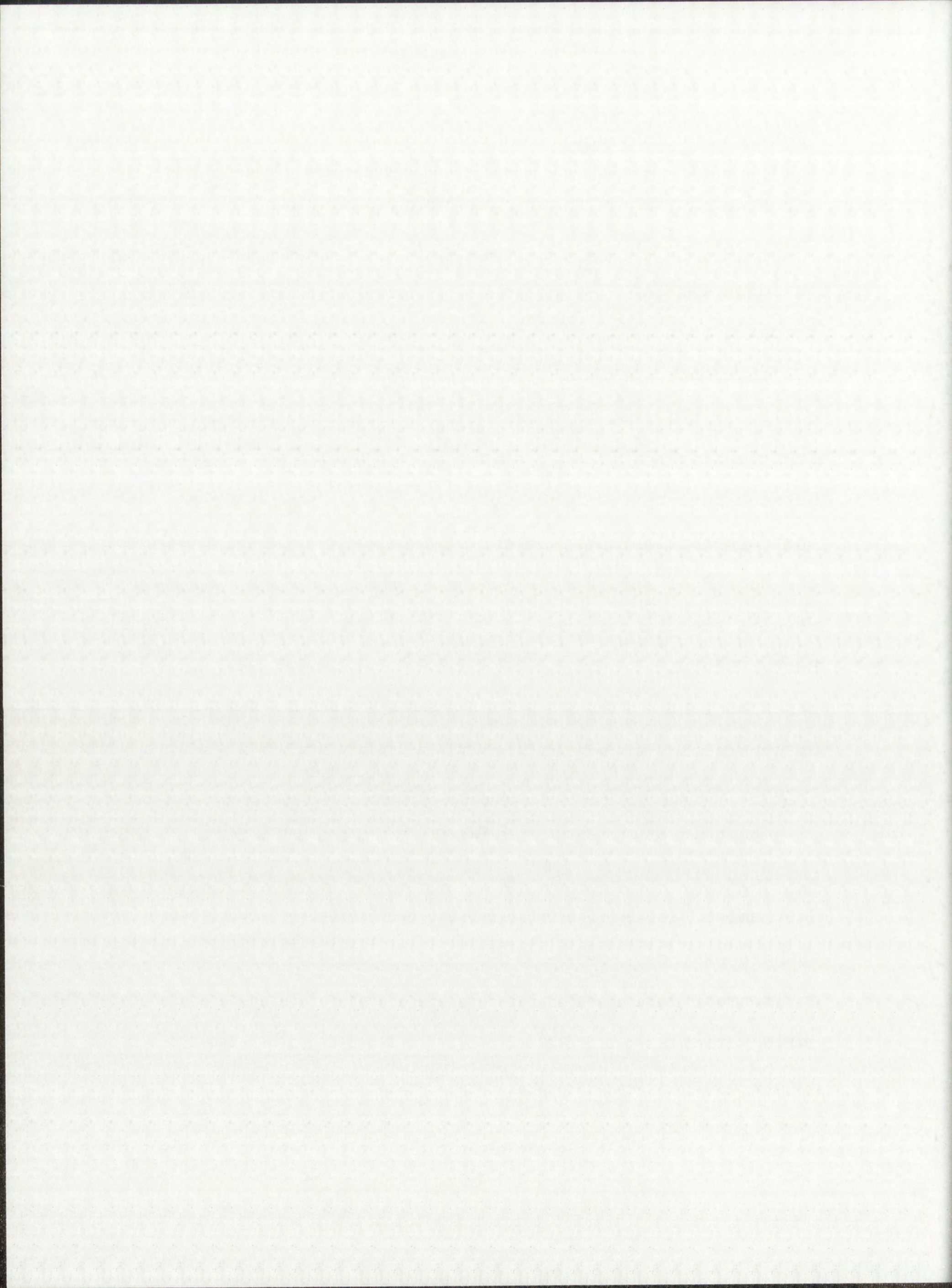
Mash and Johnston (1983) studied parental perceptions of child behavior problems, parenting self-esteem, and mother's reported stress for those with younger and older children with AD/HD and those with nondisabled children. Both parents completed three measures of their child's behavior and the Parenting Sense of Competence Scale (PSOC). Mothers only completed the Parenting Stress Index (PSI, Abidin, 1983) to examine the degree of stress in the mother-child relationship. The parents of AD/HD children reported lower levels of self esteem and perceived themselves as less competent than parents in the control group. Significantly higher levels of maternal stress were found in mothers of AD/HD children. The mothers of hyperactive children reported themselves as significantly more stressed than the



mothers of normal children on almost every dimension of stress assessed by the PSI, with child characteristics reported as the major source of their stress.

Breen and Barkley (1988) reported that parents of children with AD/HD experience greater parenting stress when compared to parents of nondisabled children. They used the PSI to compare parenting stress for parents with AD/HD girls, AD/HD boys, and non-AD/HD clinic-referred girls. The results indicated no significant differences in stress between parents of AD/HD girls and boys. They concluded that hyperactive boys and girls are similar in nature and in the degree of stress experienced by their parents. These results are contrary to the results obtained in a study by Berry, Shaywitz, and Shaywitz (1985) which indicated that parents of hyperactive girls are less stressed than parents of hyperactive boys. This appeared due in part to fewer conduct disorders reported among the girls.

Another study exploring parenting stress in families of children with AD/HD was conducted by Anastopoulos, Guevremont, Shelton, and DuPaul (1992). In this study, the authors examined several parent, child, and family environment variables related to parenting stress. The child variables included in the study were severity of AD/HD, aggressive behavior, peer relationships, health status, medication status, special education status, and

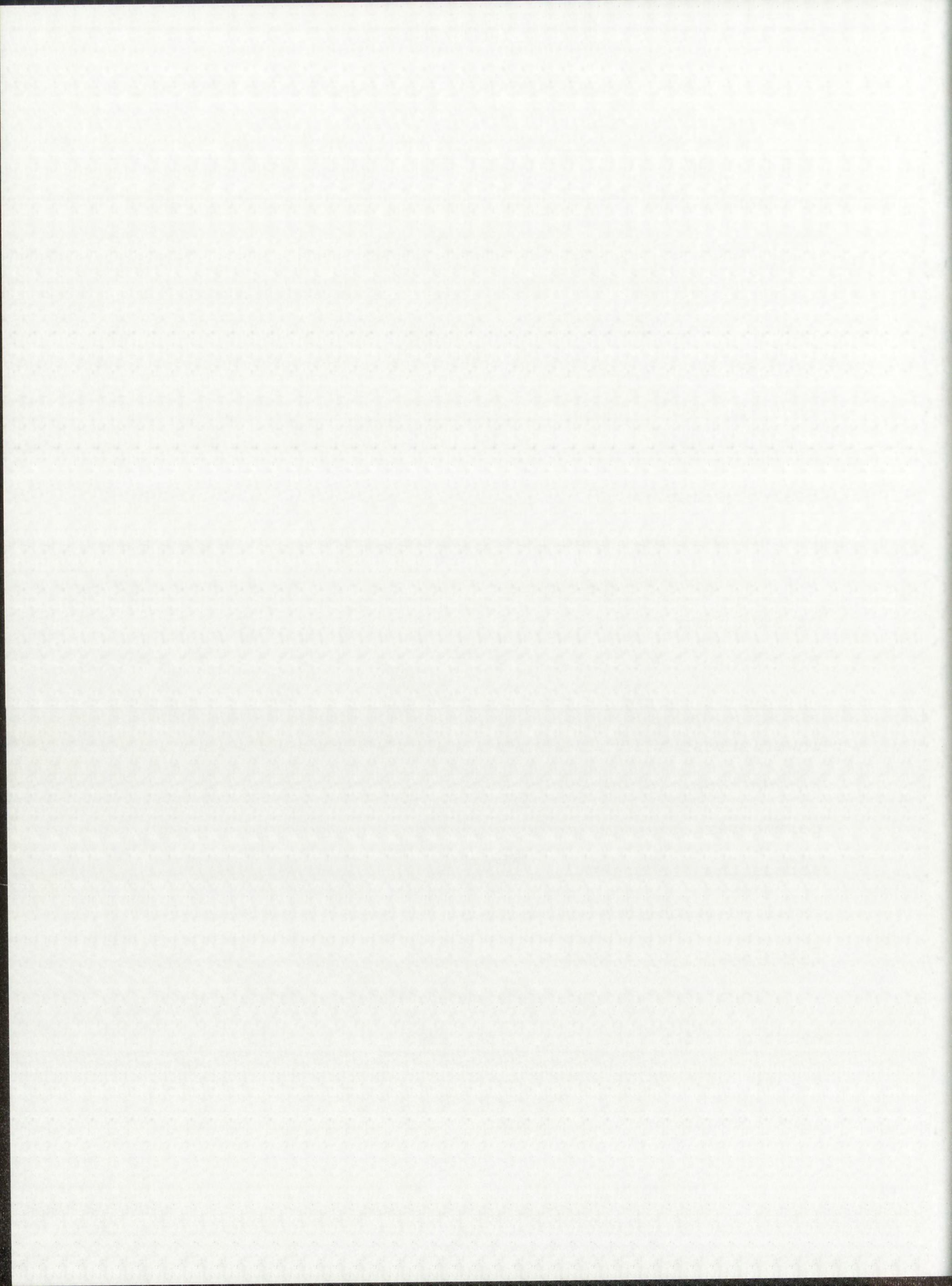


demographic information. Parent variables included maternal health, depression, overall psychopathology, and demographic characteristics. Family environment variables included were socioeconomic status and psychosocial stress.

The findings indicated significantly high parenting stress levels within the family. The three child variables of aggression, severity of AD/HD symptoms, and health status contributed 43% of the variance in parenting stress scores. Parent variables of overall psychopathology and maternal health (somatization) accounted for 13% of the variance in parenting stress. Family environment variables accounted for 4% of the variance. In this study, the overall severity of AD/HD symptoms seemed to be one of the most significant predictors of parenting stress. Additionally, mothers of children with AD/HD as the only diagnosis had significantly lower stress scores than did mothers of AD/HD children with an additional diagnosis. It was concluded that child and parent variables are more related to perceived parenting stress than to other family environment variables in families of children with ADHD.

Parental Psychopathology

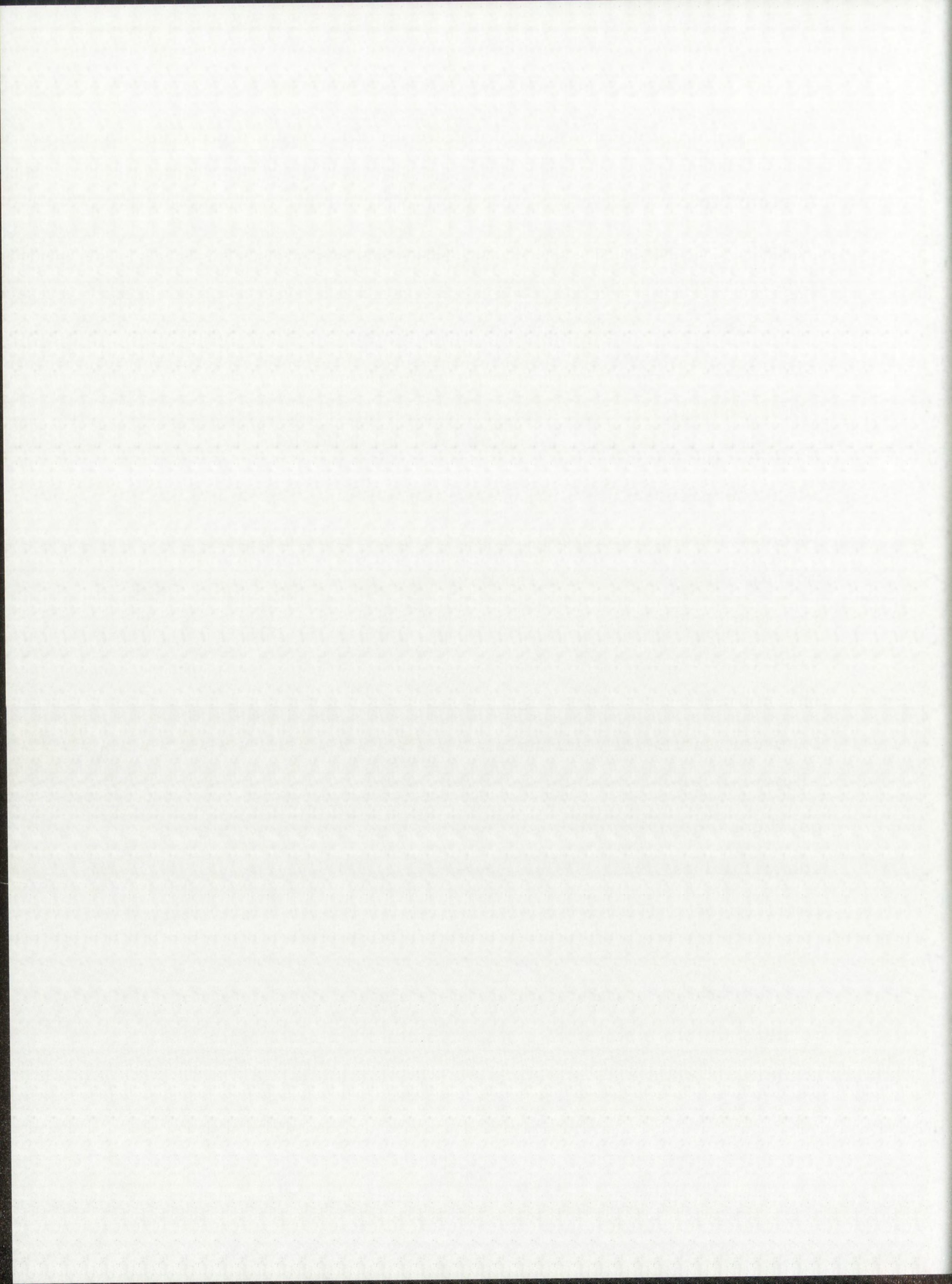
In a review of the literature, Fischer (1990) found evidence which indicated a relationship between presence of a child with AD/HD and parental psychopathology. Hechtman (1981) conducted a longitudinal study examining families of



65 hyperactive children. She used a comparison group and assessed differences between the two groups after 10 years. A significantly higher prevalence of emotional and mental health concerns were found among the family members of hyperactive children.

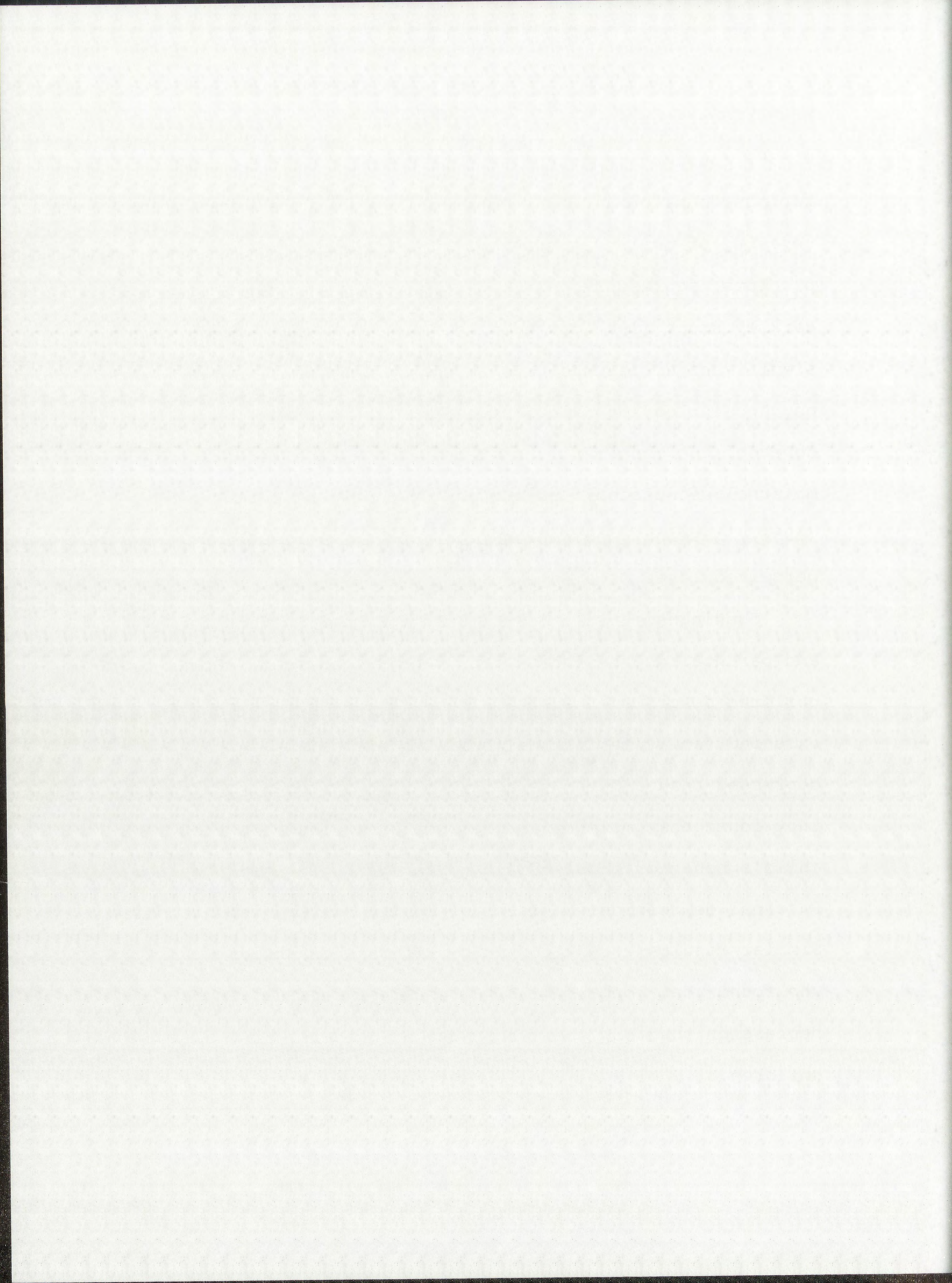
Biederman (1986) conducted a study of families of 22 clinically diagnosed boys with Attention Deficit Disorder (ADD) and a matched control group that was screened for medical and psychiatric problems. Interviews were conducted with the parents and siblings in each group. Raters were unaware of the family's group identification. Although both mothers and fathers were interviewed, mothers represented the majority of the sample. The results demonstrated a significant prevalence of psychopathology among families in the ADD group, including higher rates of ADD, Oppositional Disorder and Major Depressive Disorder. Biederman et al. (1991) in a later study reviewed family prevalence of psychopathology studies and found several studies that identified paternal alcoholism and antisocial behavior among families of children with conduct disorders, but not among families of children with AD/HD.

Several studies reported higher rates of depression in mothers of children with AD/HD compared to rates observed in mothers of nondisabled children (Befera & Barkley, 1985; Breen & Barkley, 1988; Cunningham, Benness, & Siegel, 1988;



Mash & Johnston , 1983). In their study, Breen and Barkley (1988) found that ratings of stress were associated with ratings of maternal depression and also with ratings of the severity of child psychopathology, especially conduct problems, aggression, and hyperactivity. In the Befera and Barkley study (1985), the authors reported that there was no significant difference between the ratings of psychopathology of hyperactive girls and hyperactive boys; however, the mothers of hyperactive boys reported greater maternal depression. In a study by Brody and Forehand (1986), maternal depression was found to be related to perceived level of distress posed by the child.

Cunningham et al. (1988) examined family functioning and parental depression and found that mothers of AD/HD children described their children as more difficult, their extended family as less helpful, and themselves as more depressed than did the fathers of AD/HD children. Further, they found that maternal depression was related to the child's behavior problems and to family dysfunction. Paternal depression was related only to family dysfunction. Similar results were reported by Befera and Barkley (1985) who found that mothers of AD/HD children reported higher depression than did their husbands or mothers of nondisabled children.



There is also evidence that AD/HD is present in the biological parents of children with AD/HD. Barkley (1990) reported a prevalence rate between 20% to 30% in fathers and 15% to 20% in mothers of children with AD/HD.

Data from studies investigating other areas of parental psychopathology are conflicting and inconclusive (Fischer, 1990). Methodological problems with these studies are based on the wide variety of criteria used to assess psychopathology as well as AD/HD and on the inclusion of children with conduct disorders and other comorbid conditions in the samples evaluated.

Marital Satisfaction

From a family systems perspective, the impact of a child's disability affects the spousal subsystem. Behavior problems in children with AD/HD have been associated with the presence of marital discord (Fischer, 1990). There were no studies found in the literature that examined the relationship between marital satisfaction and parenting stress in families of children with AD/HD. However, there is evidence which suggests the emergence of marital problems in families of children with AD/HD after the diagnosis has been made (Befera & Barkley, 1985). Befera & Barkley (1985) found that mothers of hyperactive children reported significantly more marital discord than mothers of



nondisordered children on the Locke-Thomas Marital Adjustment Scale.

In an eight-year longitudinal study, Barkley et al. (1990) found that the family status of hyperactive children changed significantly over time as compared to a matched control group. The divorce rate was three times higher in families of children with hyperactivity. Other studies have failed to show a relationship between marital satisfaction and presence of a child with AD/HD, with higher rates of marital discord among parents of children with behavioral disturbances (Barkley, DuPaul, & McMurray, 1990; Mash & Johnston, 1983). The direction of causality related to children with AD/HD and parental marital satisfaction is unclear (Fischer, 1990).

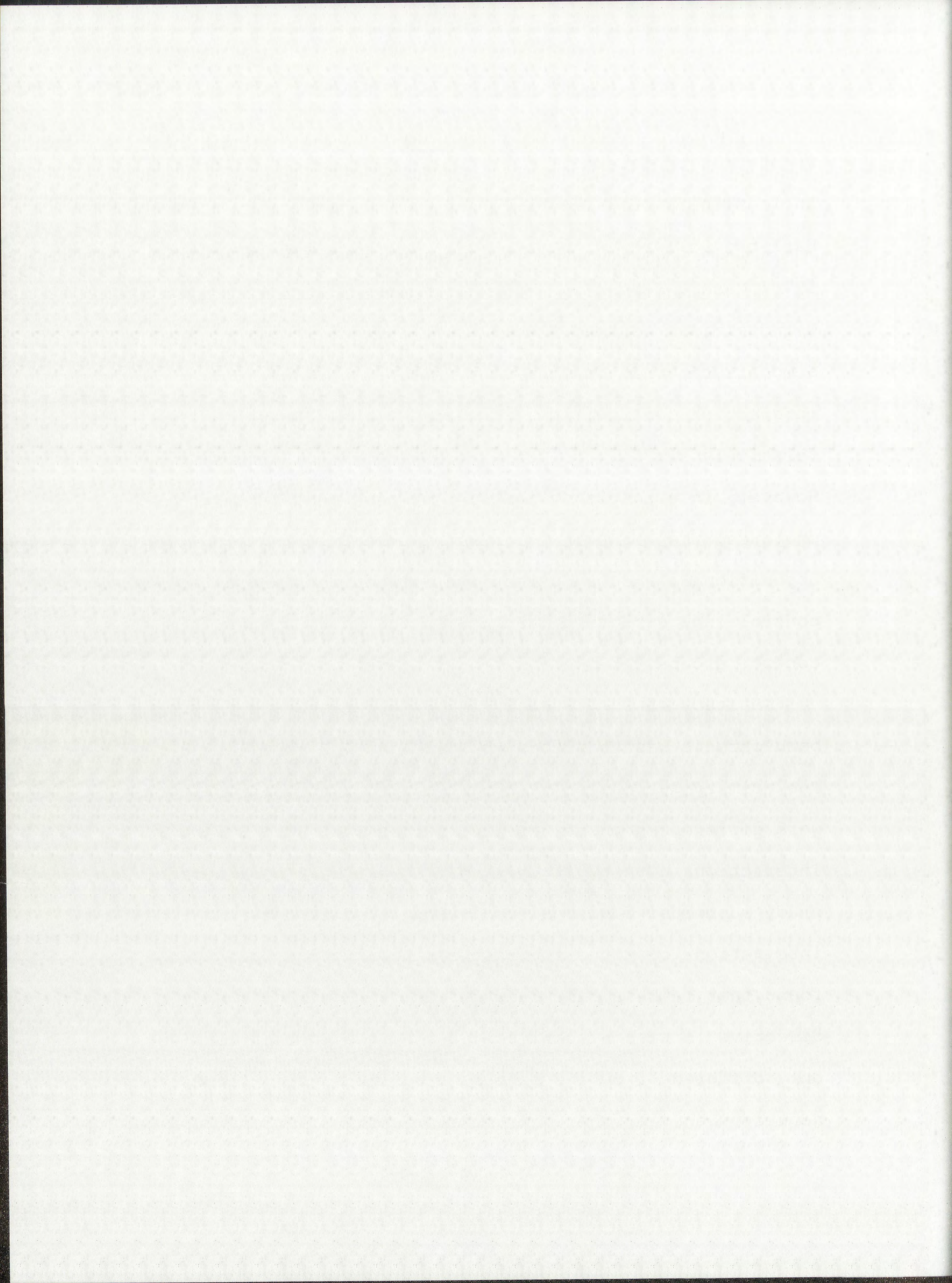
Parent-Child Interactions

The symptoms of inattentiveness, impulsivity, and hyperactivity affect the interactions engaged in by the child with AD/HD (Fischer, 1990). Parent-child interactions, usually involving mothers and sons, have been extensively examined in studies of families with children with AD/HD. These studies have generally shown that children with AD/HD are more non-compliant to parental requests, off-task frequently, and are more demanding of attention than other children.



Conflictual interactions have been a recurring pattern in studies of interactions between hyperactive children and their mothers (Barkley, Karlsson, & Pollard, 1985; Barkley, Karlson, Pollard, & Murphy, 1985; Cunningham & Barkley, 1979; Mash & Johnston, 1983; Tallmudge & Barkley, 1983). Using similar methodology in these studies it was demonstrated that in free-play settings parent-child interactions in families of children with ADHD were relatively similar to interactions in control groups. However, in situations where parents assigned tasks to the children, the AD/HD children were less compliant and more oppositional; and the parents were found to be more controlling, directive, and commanding than parents in the control groups.

A study of the interactions of hyperactive boys with both parents was conducted by Tallmudge & Barkley (1983). The primary purpose of the study was to ascertain if there were differences in mothers and fathers in their interactions with their children. The findings of this study supported findings from other research regarding the interactions of mothers with their hyperactive child and found that fathers also tend to be more commanding and directive in task situations. Boys with hyperactivity were only different from the control group in noncompliance and negative behavior when with their mothers. Mothers were not



found to be different from fathers of hyperactive children in their interactions. Rather, the difference was in the child's response, with the child being more compliant and less negative with the father (Tallmadge & Barkley, 1983).

Summary

General information regarding the child with AD/HD has been discussed. Although there is no conclusive theory of etiology of this disorder, there is agreement regarding symptomology. Children with AD/HD exhibit developmentally inappropriate levels of inattention, impulsiveness, and hyperactivity.

A review of studies of families with a child with AD/HD revealed a population that is vulnerable to further psychopathology at the individual and dyad level.

Interactions between children with AD/HD and their mothers have been the focus of research for more than two decades. This research has found that mothers of children with AD/HD were more directive and negative with their children than mothers of control group children. These findings were supported in further studies looking at interactions between mothers and their AD/HD and non-AD/HD children.

Several studies have examined stress in mothers of children with AD/HD using the same instrument as in the present study. Mothers of children with AD/HD were



repeatedly found to have higher levels of parental stress than mothers of non-AD/HD children. There were no studies found in the literature that examined differences in parental stress between mothers and fathers of children with AD/HD.

Research in the area of marital satisfaction in families with a child with AD/HD is limited and conflictual. One study (Befera & Barkley, 1985) found that mothers of hyperactive children reported significantly more marital discord than mothers of nondisordered children. Another study failed to show increased rates of marital discord among parents of children with AD/HD (Barkley, DuPaul, & McMurray, 1990).

In summary, parental stress in mothers has been found to be a problem area for families of children with AD/HD. There is a lack of research in the area of marital satisfaction in families with a child diagnosed as AD/HD. Most studies of families with AD/HD used mothers as the primary informant. The present study will attempt to expand the research on families with an AD/HD child by looking at both mothers and fathers' levels of parental stress and marital satisfaction as well as the relationship between these variables.



CHAPTER 3:

METHODOLOGY

This chapter reviews the purpose of the study. A description of the methodology includes a description of the participants, data collection procedures, and an explanation of the test instrumentation. Finally, a description of data processing and analysis procedures is presented.

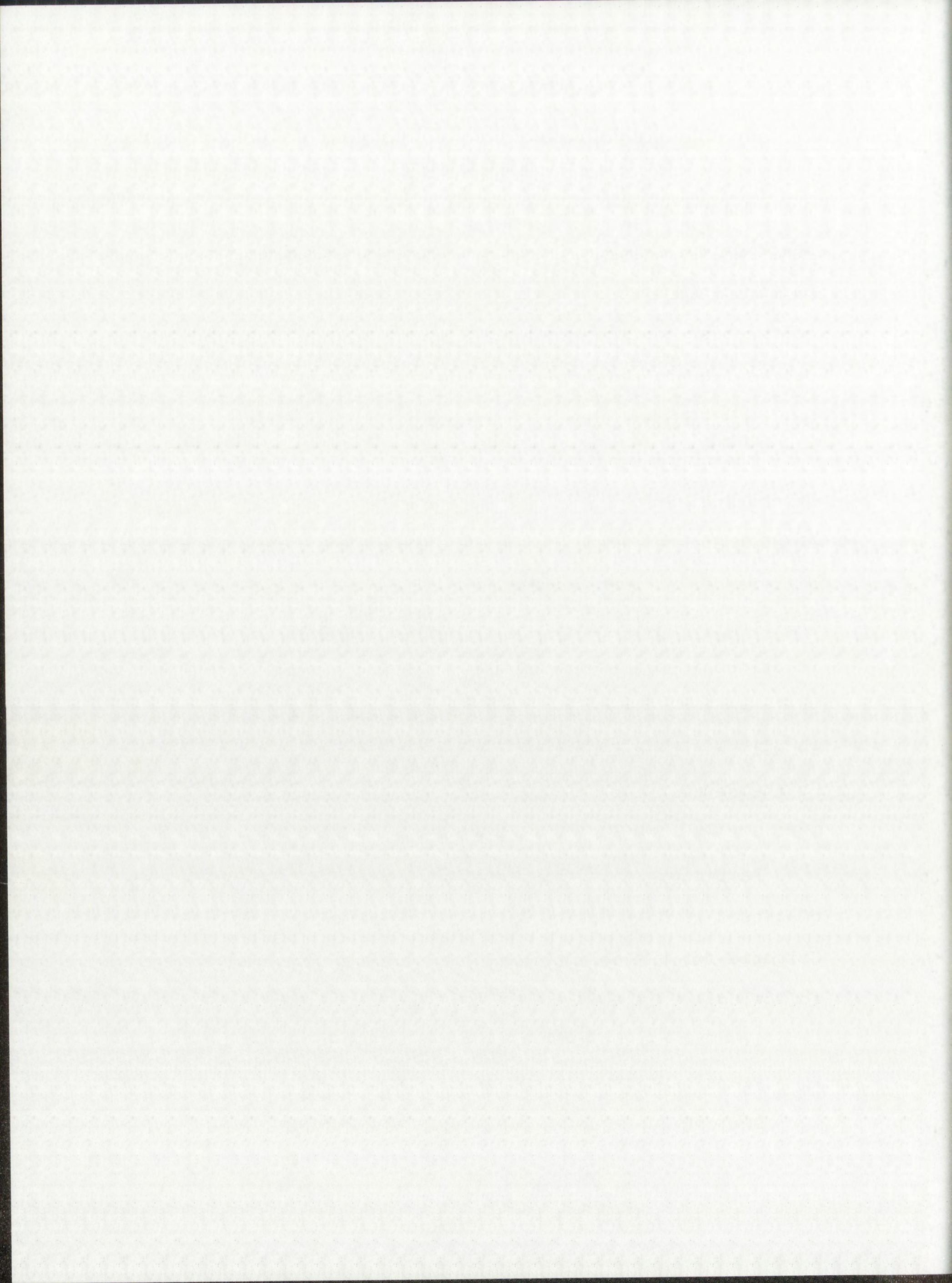
Purpose

The purpose of this research was to examine parental stress and marital satisfaction in parents of children with AD/HD. Specifically, the study examined similarities and differences between mothers and fathers in these two areas. The study also sought to determine if there was a relationship between parental stress and marital satisfaction in mothers and fathers of children with AD/HD as well as the extent to which the findings are influenced by the severity of the child's behavioral symptoms.

Participants

Participants in this study were parents of a child diagnosed with Attention Deficit/Hyperactivity Disorder. Criteria for the selection of participants included the following:

1. The target child must be a male between 6 and 11 years of age who has been diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD) by a clinician



at Lovelace Health Systems on the basis of DSM-IV criteria within six months of participation in the study.

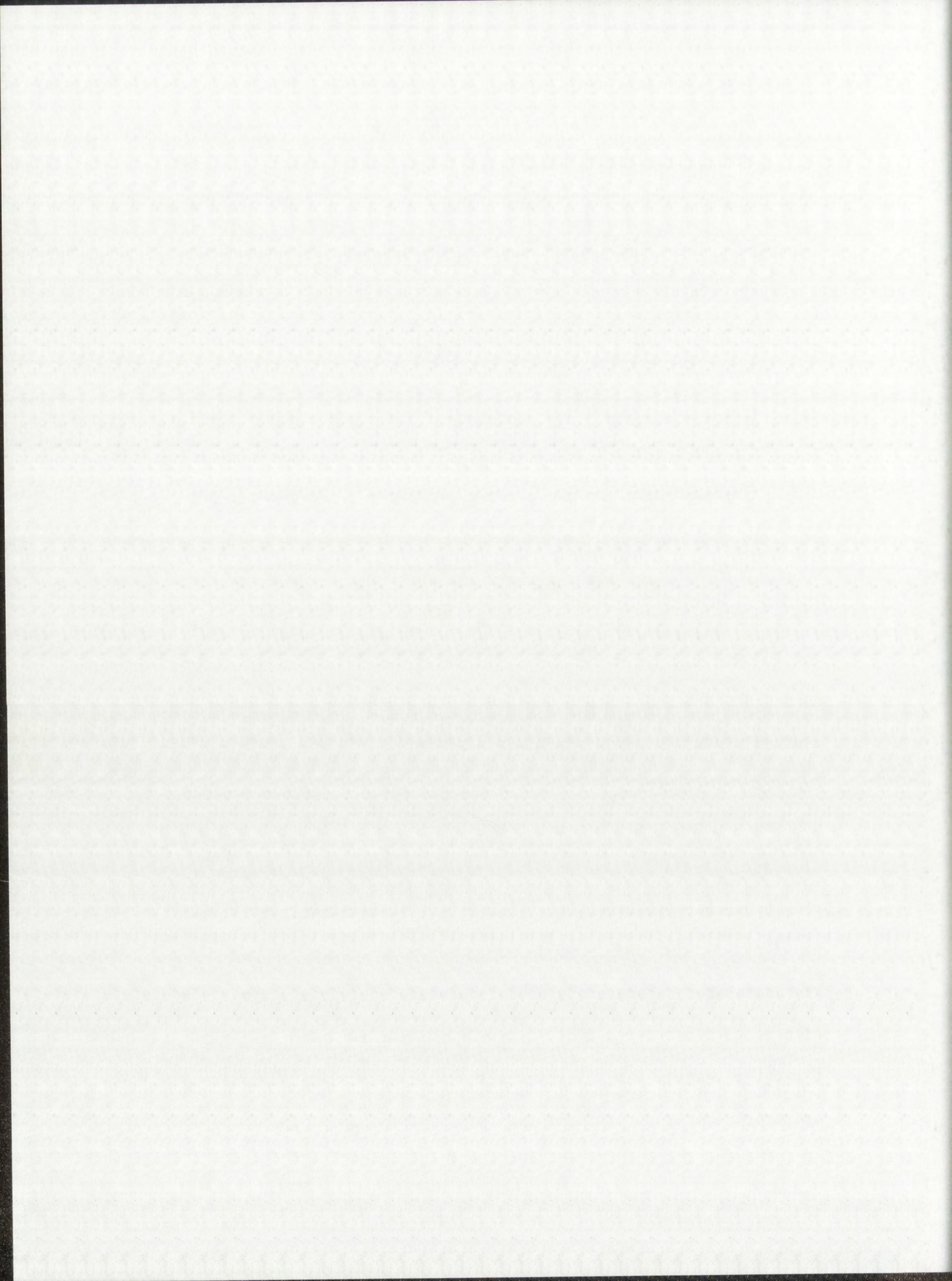
2. Each of the families must include both a resident mother and father figure who have lived together for at least one year.

3. Both parent figures must agree to participate in the study.

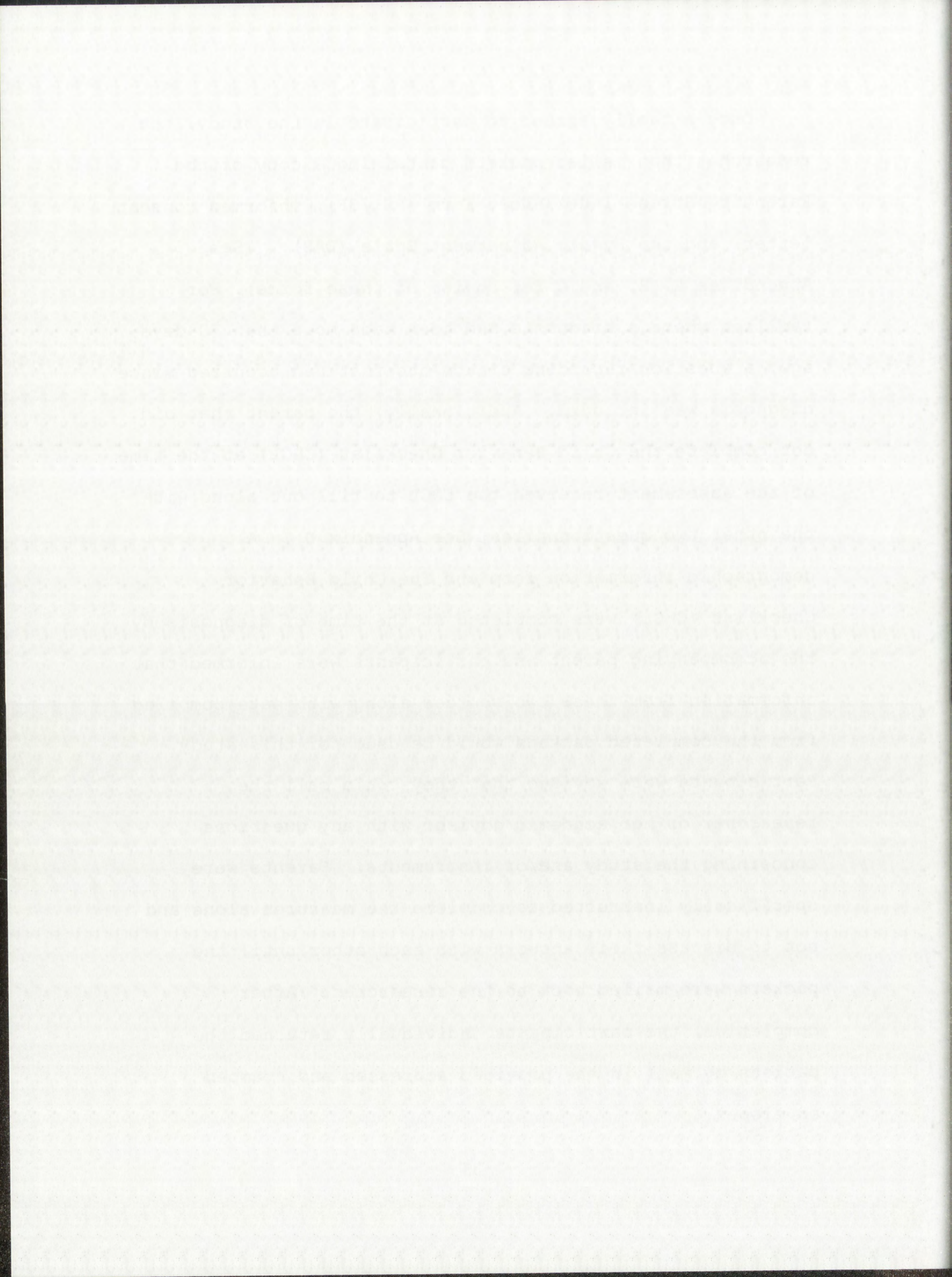
4. The target child must be living in the home with the parents who participate in the study at least 50% of the time.

Data Collection Procedures

Following approval by the UNM Institutional Review Board for the Protection of Human Subjects and the Lovelace Institutional Review Board, an invitation to participate in the study was issued to families who met the above criteria. Initial contact letters from the researcher were mailed to 114 eligible families describing the purpose and scope of the study as well as confidentiality issues. Included with the informed consent letter was a stamped and addressed envelope which families were asked to return to the researcher indicating their interest in participating in the study. After three weeks, reminder cards were sent to those families who had not responded. There were 34 families that returned consent letters signed by both parents.



Once a family agreed to participate in the study, the researcher then mailed packets containing a copy of the Parenting Stress Index/Short Form (PSI/SF), informed consent letter, and the Dyadic Adjustment Scale (DAS). (See Appendices A, B, and C for copies of these forms). For families where a diagnosis had been made more than 30 days ago, a question regarding treatments that had occurred since diagnosis was included. Additionally, the parent that did not complete the Child Behavior Checklist (CBCL) at the time of the assessment received the CBCL to fill out along with the other two questionnaires (See Appendix D). A demographic information form and The Child Behavior Checklist (CBCL) were completed at the time of diagnosis by the accompanying parent and participants were informed that information from these two sources along with data compiled from the completed packets would be used for this study. Participants were advised that they could call the researcher or her academic advisor with any questions concerning the study and/or instruments. Parents were specifically instructed to complete the measures alone and not to discuss their answers with each other until the packets were mailed back to the researcher. After completion, the participants individually returned the packets by mail in the provided addressed and stamped envelopes.



Twenty-one families returned completed questionnaires by both parents. Return time for the questionnaires was from one to six weeks. Follow-up notes were required for the return of one-half of the completed questionnaires.

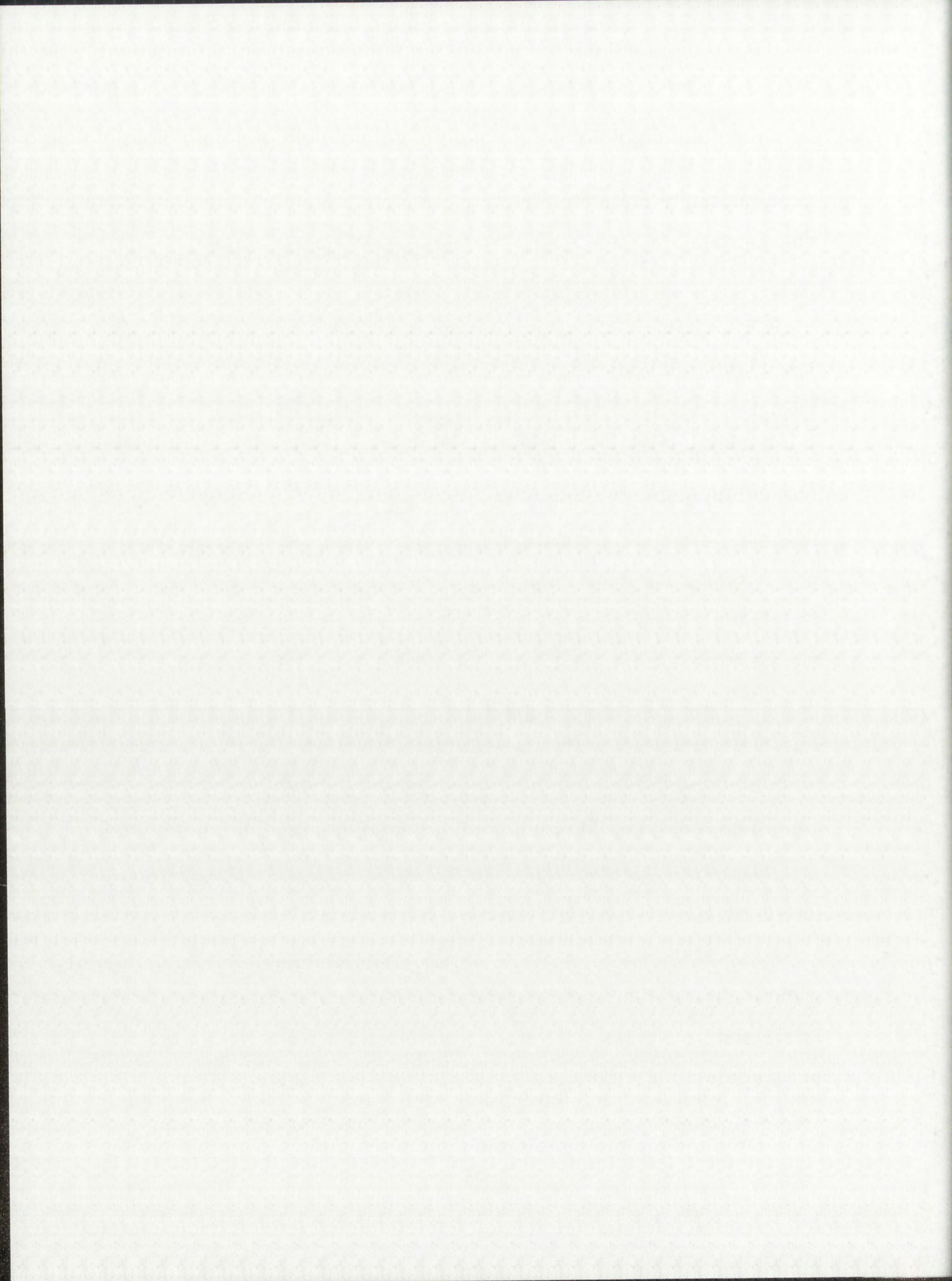
Measures

Four data-gathering measures were used in this study. The first two measures were completed at the time the targeted child was diagnosed as having Attention Deficit/Hyperactivity Disorder by the parent accompanying the child. The remaining two measures were completed after parents agreed to participate in this study. Additionally, the parent that did not complete the Child Behavior Checklist at the time of assessment completed it as one of the measures included in his or her packet. The measures are as follows:

1. Demographic Information
2. The Child Behavior Checklist (CBCL)
3. Parenting Stress Index-Short Form (PSI/SF)
4. Dyadic Adjustment Scale (DAS)

Demographic Information

Demographic information was obtained through a questionnaire (Child and Adolescent Patient Information Form) and interview with the parent or parents at the time of diagnosis of the target child. Information obtained included parental ages, educational level, ethnicity/race,



current marital status, past separation and divorce of parental figures (natural, adoptive, stepparent), family size, ages of other children, visitation/custody arrangements, and diagnosed psychopathology in the family. This information was used to describe the sample.

(See Appendix E for a copy of the Child and Adolescent Information Form.)

The Child Behavior Checklist (CBCL)

The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) has been used extensively in clinical and research settings as a parental report measure of problem child behavior. The instrument provides a comprehensive list of behavior problems across a wide span of ages. Cutoff points and subscales are provided for three age groups (4-5 years, 6-11 years, and 12-18 years).

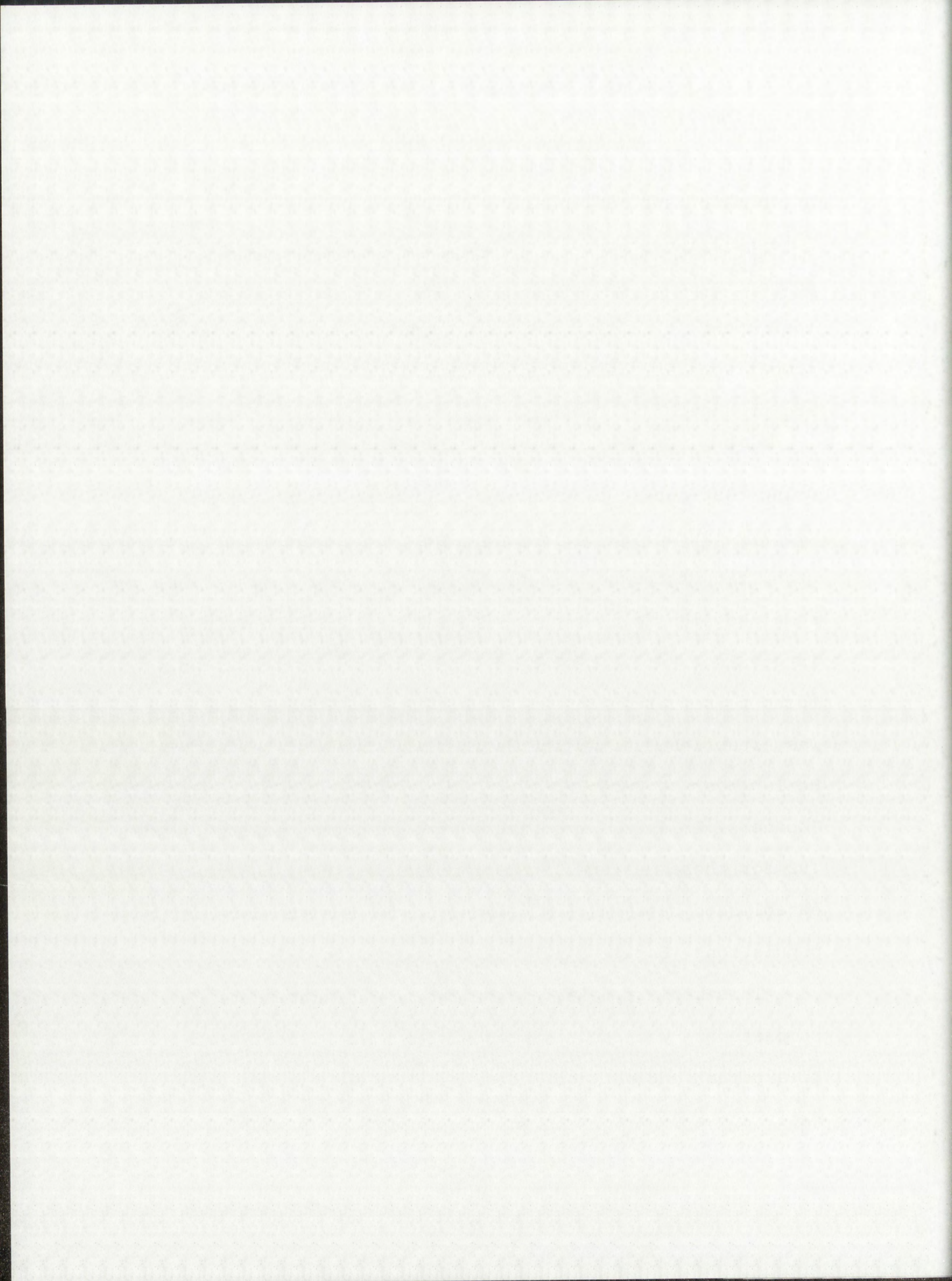
The CBCL is a 138-item checklist made up of two sections. The first section, comprised of 25 items, is designed to obtain parent ratings of their child's competencies and problem behaviors and thereby evaluates a parent's perception of a child's "social competence" in several areas. The second section focuses on specific behavior problems and is made up of 113 items. Eight subscales for types of behavior and specific behavior problems are provided: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems,



Attention Problems, Delinquent Behavior, and Aggressive Behavior. Second-order factor analysis has identified two broad-band factors representing Externalizing and Internalizing scores. The Total Problem score is a composite score of the 113 behavior items presented in the instrument. The CBCL has been standardized and normative comparisons are available. Clinically significant scores are presented as T scores.

The reliability of the instrument has been examined using test-retest procedures. According to Achenbach (1981), intraclass correlations were used to examine the stability of the measure across time. These correlations remained high following one-week (.98) and three-month intervals (.84). Inter-parent agreement scores also were found to be very high (.98). Evidence of concurrent validity was established using the Werry-Weiss-Quay-Peters Activity Scale (Weery & Sprague, 1970) and the Connors Rating Scale (Connors, 1973). Correlations were reported between .71 to .92 for these measures. Discriminant validity has been established between clinical and controls among hyperactive populations (Barkley, 1981; Mash & Johnston, 1983).

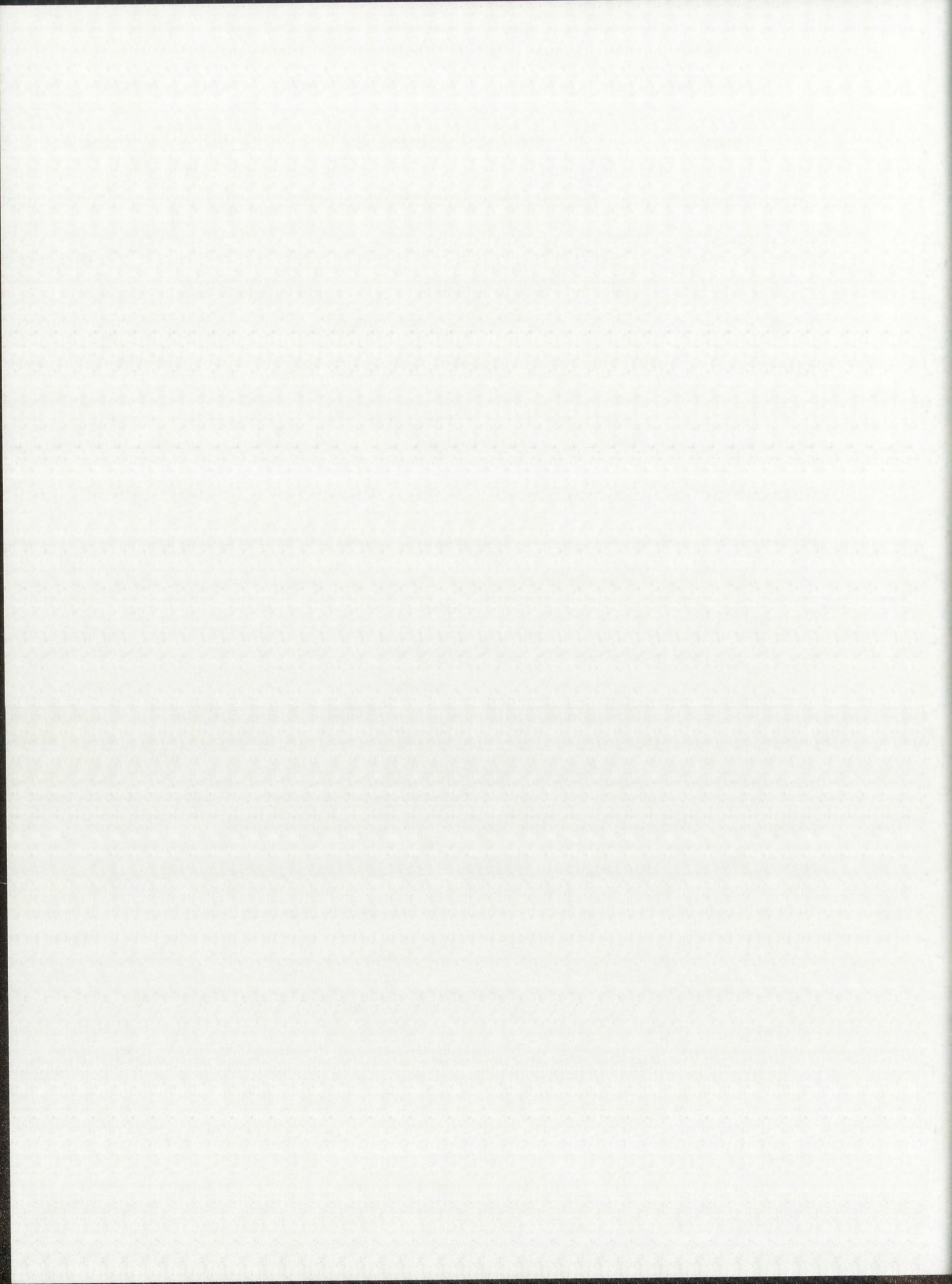
This measure takes approximately 20 minutes to complete and was administered during the diagnostic visit. If a parent had not completed the CBCL, it was included in their subsequent test packet.



Parenting Stress Index/Short Form (PSI/SF)

The PSI/SF (Abidin, 1995) is designed to assess stress in the parent-child system. It served as the measure of overall stress within the parent-child system. The PSI/SF is a 36-item questionnaire with items that are rated on a five-point Likert-type scale (strongly agree to strongly disagree). The Short Form is comprised of items from the long form of the PSI found to have the highest factor loadings on each of the three domains. It measures three domains of stressors that can impact the quality of the parent-child system: Difficult Child (DC), Parental Distress (PD), and Parental-Child Dysfunctional Interaction (P-CDI). A subscale score is obtained for each of these domains. A Total Stress score is obtained from the subscale scores.

The Difficult Child (DC) domain assesses the parent's perception of behavioral characteristics (e.g. temperament, demanding or noncompliant behavior) of the child. The Parental Distress (PD) domain score assesses parent perceptions of parenting competence, role restriction, social isolation, conflict with spouse, and presence of depression. The Parental-Child Dysfunctional Interaction (P-CDI) domain assesses the child's acceptability to the parent, attitudes about parent-child interactions, and the reinforcement the parent receives from the child. A Total

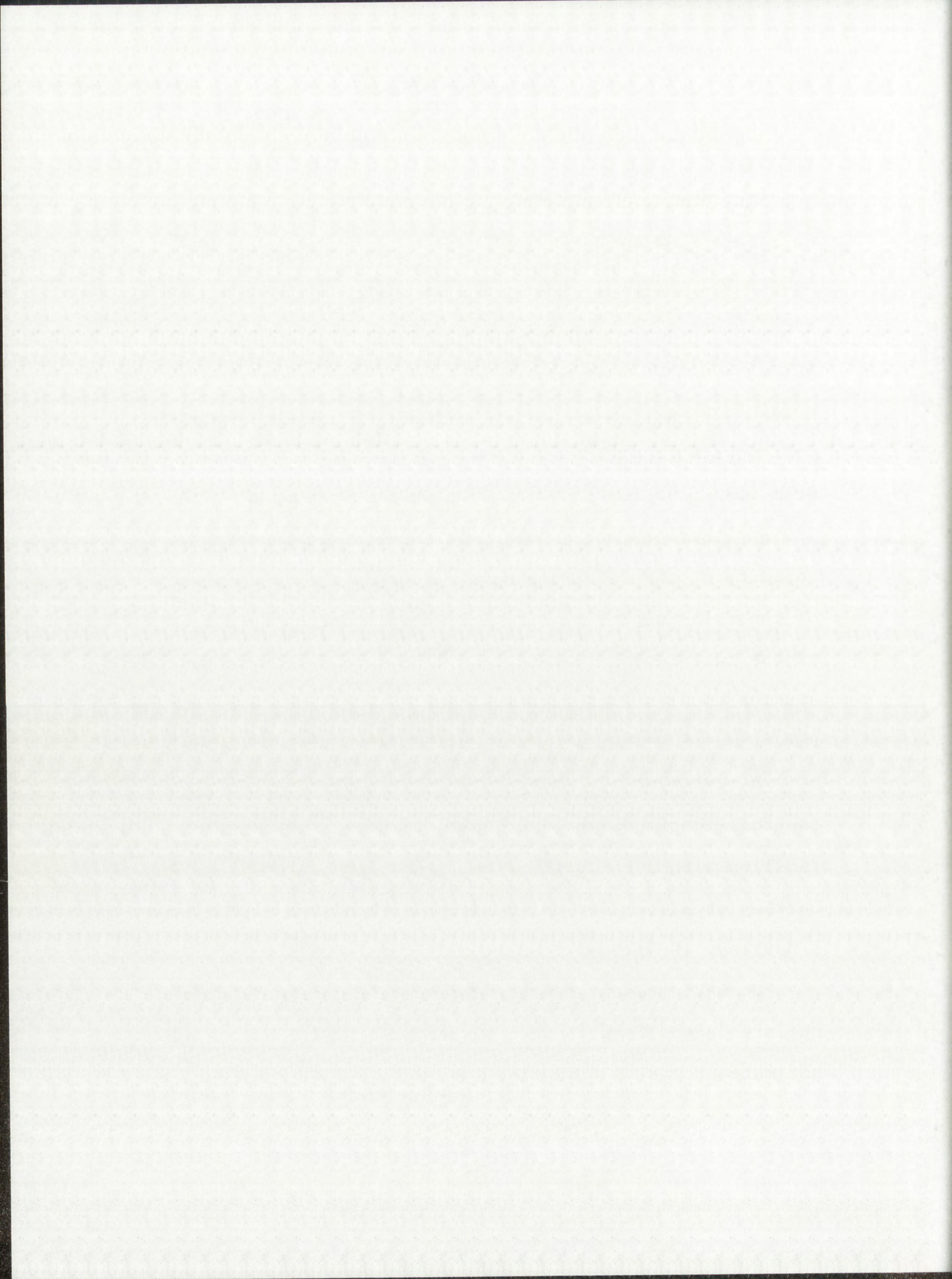


Stress score is calculated by summing the three domain scores.

The Total Stress score of the PSI/SF was found to correlate .94 with the Total Stress score on the full-length PSI (Abidin, 1995). Abidin (1995) reported coefficient alphas of .91 for the Total Score on the short form, with alphas ranging from .80 - .87 for the individual domain scores. Test-retest reliabilities over a six-month period were reported as .84 for the Total Score and ranged from .68 - .85 for the domain scores. As reported by Abidin (1995), there is not a body of literature to support the validity of the PSI/SF; however, because it is a derivative of the full-length PSI, it is likely to share the validity of the full-length PSI. Abidin (1995) has reviewed numerous studies documenting concurrent validity of the full-length PSI.

A review of the literature in this area reveals that the full-length PSI has been used in several studies of families with a child with ADHD (Anastopoulos et al., 1992; Barkley et al., 1988; Beck, Young, & Tarnowski, 1990; Breen & Barkley, 1988).

Normative data have been provided for parents of children aged 12 years and younger. The PSI/SF has been estimated to take 10 minutes to complete. For this study,



both parents were asked to individually complete the measure and return it to the researcher.

Dyadic Adjustment Scale (DAS)

The DAS (Spanier, 1989) is designed to assess the quality and satisfaction of married couples and other similar dyads. It served as the measure of overall marital satisfaction of parents in the study. The Dyadic Adjustment Scale (DAS) is a 32-item self-report measure that measures major areas of marital satisfaction or dissatisfaction. Responses to the items are coded on Likert-type scales ranging from 0-6 points. The instrument provides an assessment of four dimensions as they relate to marital satisfaction or adjustment: Dyadic Consensus, Dyadic Satisfaction, Affectional Expression, and Dyadic Cohesion.

The Dyadic Consensus subscale measures the extent of agreement on potentially important matters such as money, religion, recreation, household tasks, and time spent together. The Dyadic Satisfaction subscale assesses the amount of tension in the relationship. The Affectional Expression subscale assesses satisfaction with the expression of affection and sex in the relationship. The Dyadic Cohesion subscale measures common interests and activities. A Total Adjustment score is obtained by summing the scores on the subscales. Spanier (1976) reported a



Total Adjustment score with internal consistency reliability of .96.

This instrument is used in both research and clinical settings. It takes about 10 minutes to complete. According to Spanier (1989), the DAS is the most widely used measure of relationship satisfaction and quality in the world. It has been translated into French, German, Spanish, and Polish. A review of the literature did not reveal any studies in which the DAS had been used with parents of children with Attention Deficit/ Hyperactivity Disorder.

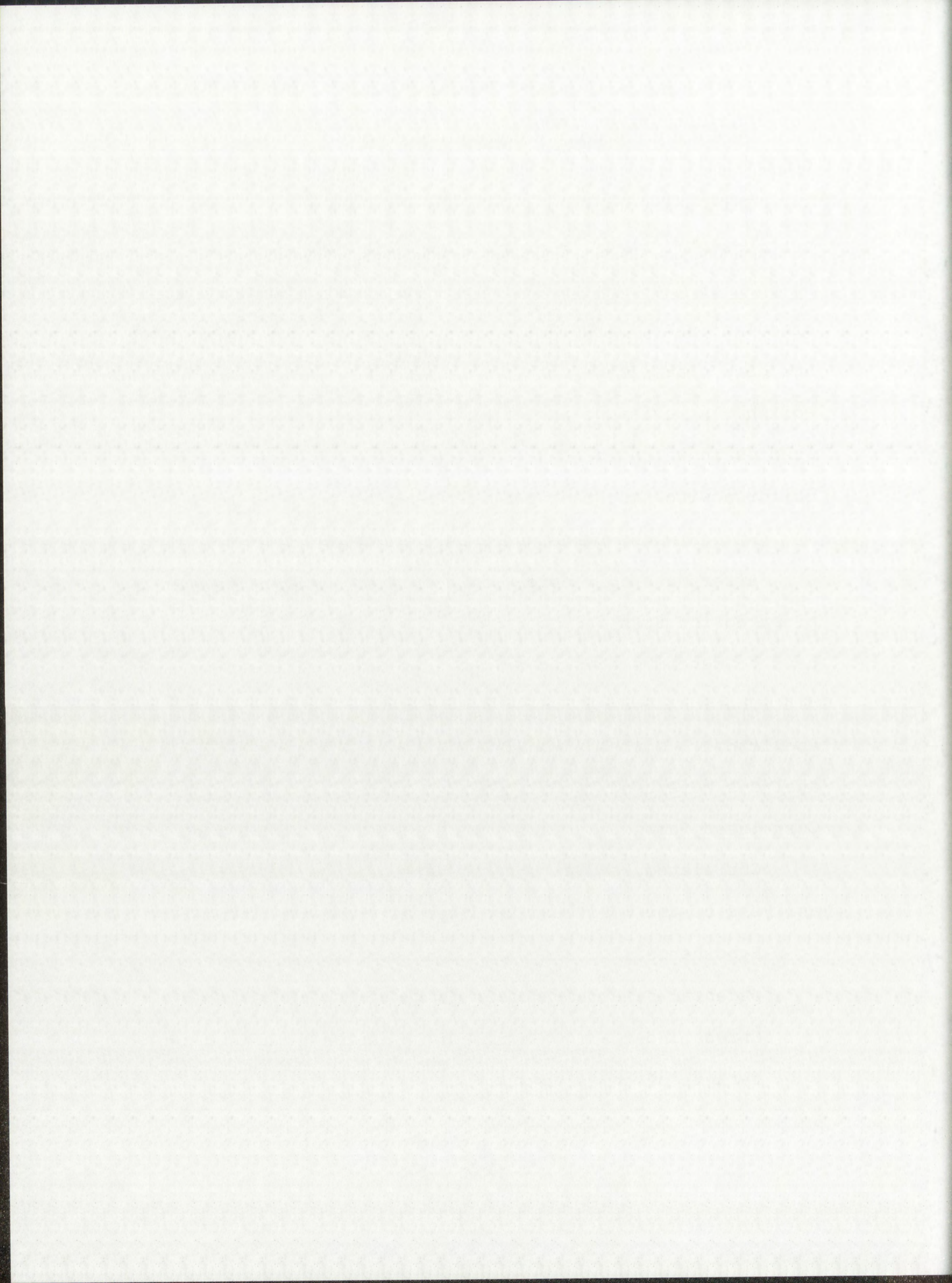
Data Processing and Analysis Procedures

After data collection was complete, information was prepared for statistical analysis. Demographic data were used to describe the participants by means of frequency distributions, means, and standard deviations where applicable. Correlated samples t-tests and correlational analyses were used to test the hypotheses.

Correlated Samples t-tests

Correlated samples t-tests were utilized in the analysis of the first two hypotheses:

Hypothesis 1. There will be no difference in average parental stress scores as measured by the Parenting Stress Index/Short Form (PSI/SF) between mothers and fathers of children with ADHD.



Hypothesis 2. There will be no difference in average scores of marital satisfaction as measured by the Dyadic Adjustment Scale (DAS) between mothers and fathers of children with ADHD.

Correlated samples t -tests were obtained to determine if two nonindependent groups are significantly different when the data being analyzed are interval measures. The .05 level of significance was chosen for this study (two-tailed).

Correlational Analyses

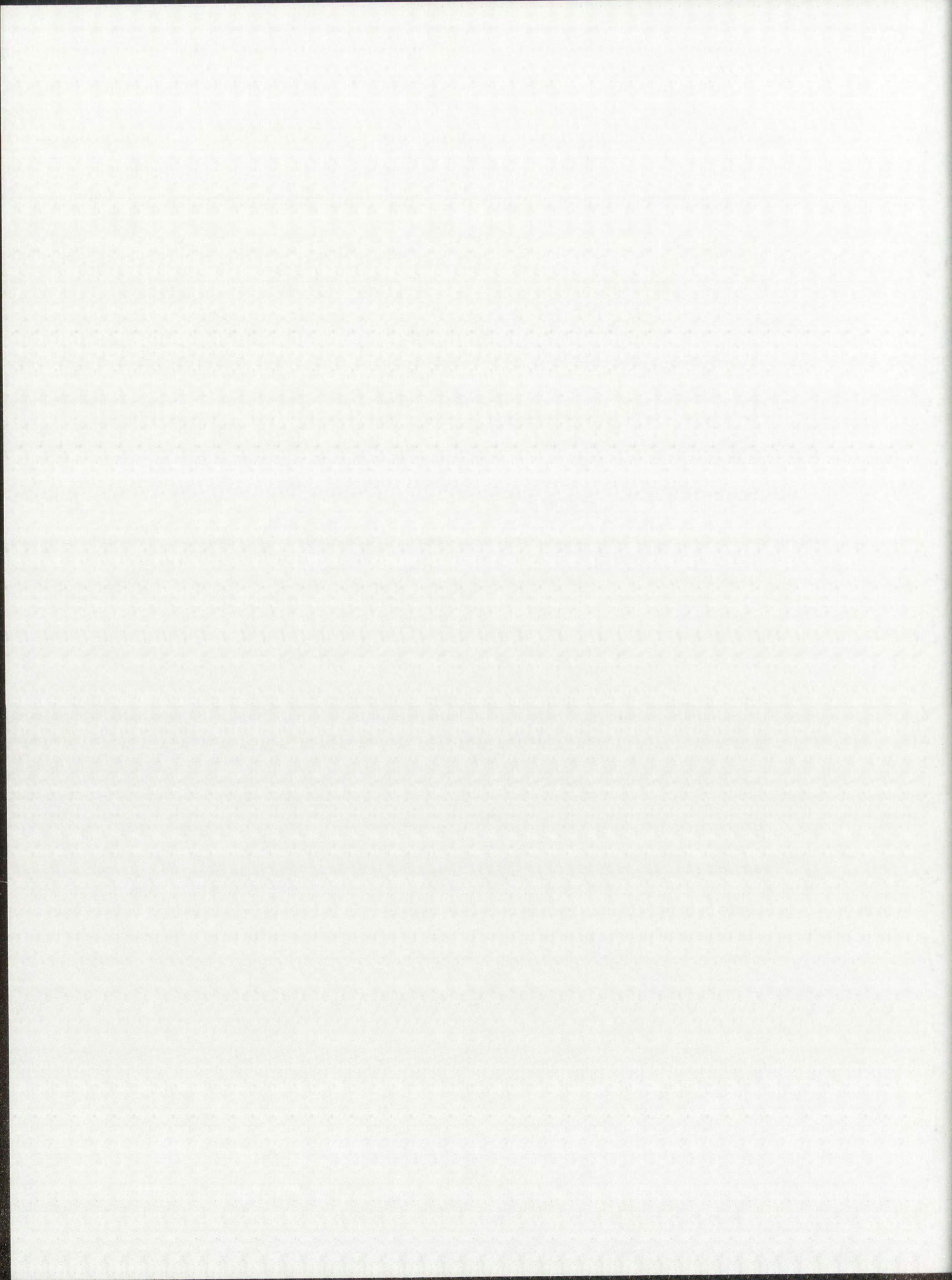
Correlational analysis was used to test the remaining hypotheses. These hypotheses were as follows:

Hypothesis 3. There will be no correlation between marital satisfaction and parental stress scores for parents of children with AD/HD.

Hypothesis 3a. The degree of correlation between marital satisfaction and parental stress scores will not differ by gender.

Hypothesis 4. There will be no correlation between the severity of symptoms total score on the Child Behavior Checklist (CBCL) and marital satisfaction scores for parents of children with AD/HD.

Hypothesis 4a. The degree of correlation between severity of symptoms and marital satisfaction scores will not differ by gender.



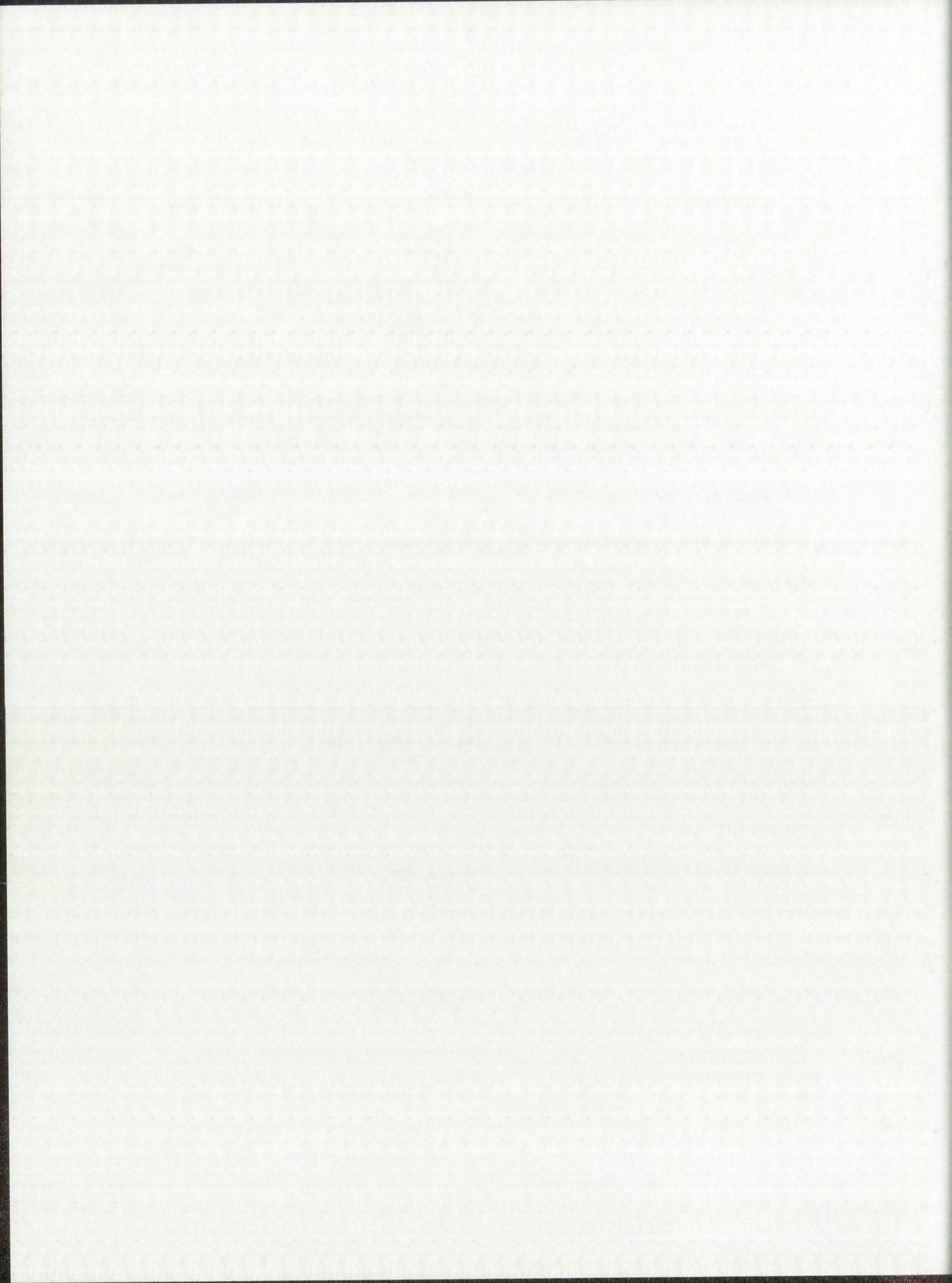
Hypothesis 5. There will be no correlation between severity of symptoms total scores on the CBCL and parental stress scores for parents of children with AD/HD.

Hypothesis 5a. The degree of correlation between severity of symptoms and parental stress scores will not differ by gender.

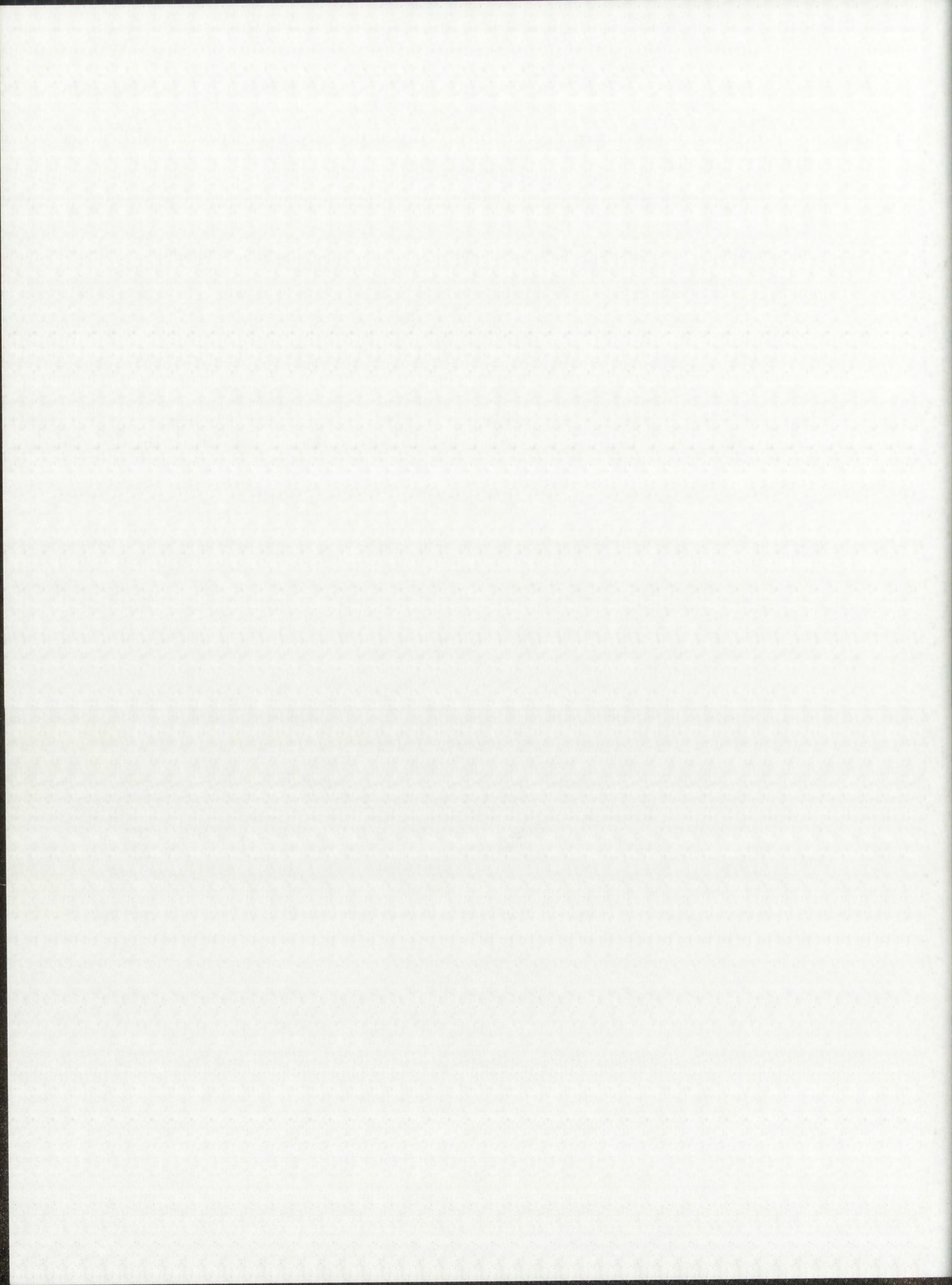
Correlations are obtained to determine whether values on one variable are associated with values on another variable. The Pearson Product-Moment correlation coefficient, a commonly used measure of linear relationship, was used for this study.

Limitations

While this study was able to gather rich data concerning both mothers and fathers of children with AD/HD, it is important that the reader is mindful of the limitations of this study. The most obvious limitation of the study is the small sample size and the volunteer nature of the participants which limits power and generalizability. The fact that families were selected from a clinic population may indicate that there are more serious concerns than in the general population of families with children with ADHD. In addition, the questionnaires were completed away from the clinic site. Although participants were encouraged to answer questions individually, it is not known



to what extent items were discussed, and if so, how such discussion influenced their responses.



CHAPTER 4:

RESULTS

Results of the study are presented in this chapter. The chapter is organized into five sections. The first section presents demographic characteristics of the participants in the study. The second section provides descriptive statistics for the three measures used in the study. The third section presents the t-test results for correlated samples that were used to test hypotheses one and two. In the fourth section, results of the correlation analyses used to test the remaining hypotheses are reported. The chapter ends with a summary.

Sample Characteristics

Twenty-one families participated in the study (21 mothers and 21 fathers) for a total of 42 participants. The majority (73.8%, n=31) identified themselves as Anglo, 21.4% (n=9) as Hispanic, and 4.8% (n=2) as African American.

As can be seen in Table 1, parents' ages ranged from 27 to 52 years, with a mean age of 38.17. The identified AD/HD male child ranged in age from 7 to 11 years, with a mean age of 9.10. In a majority of the families (57.1%, n=12), there was one other child in the home. In 14.3% (n=3) of the families, there were no other children in the home.

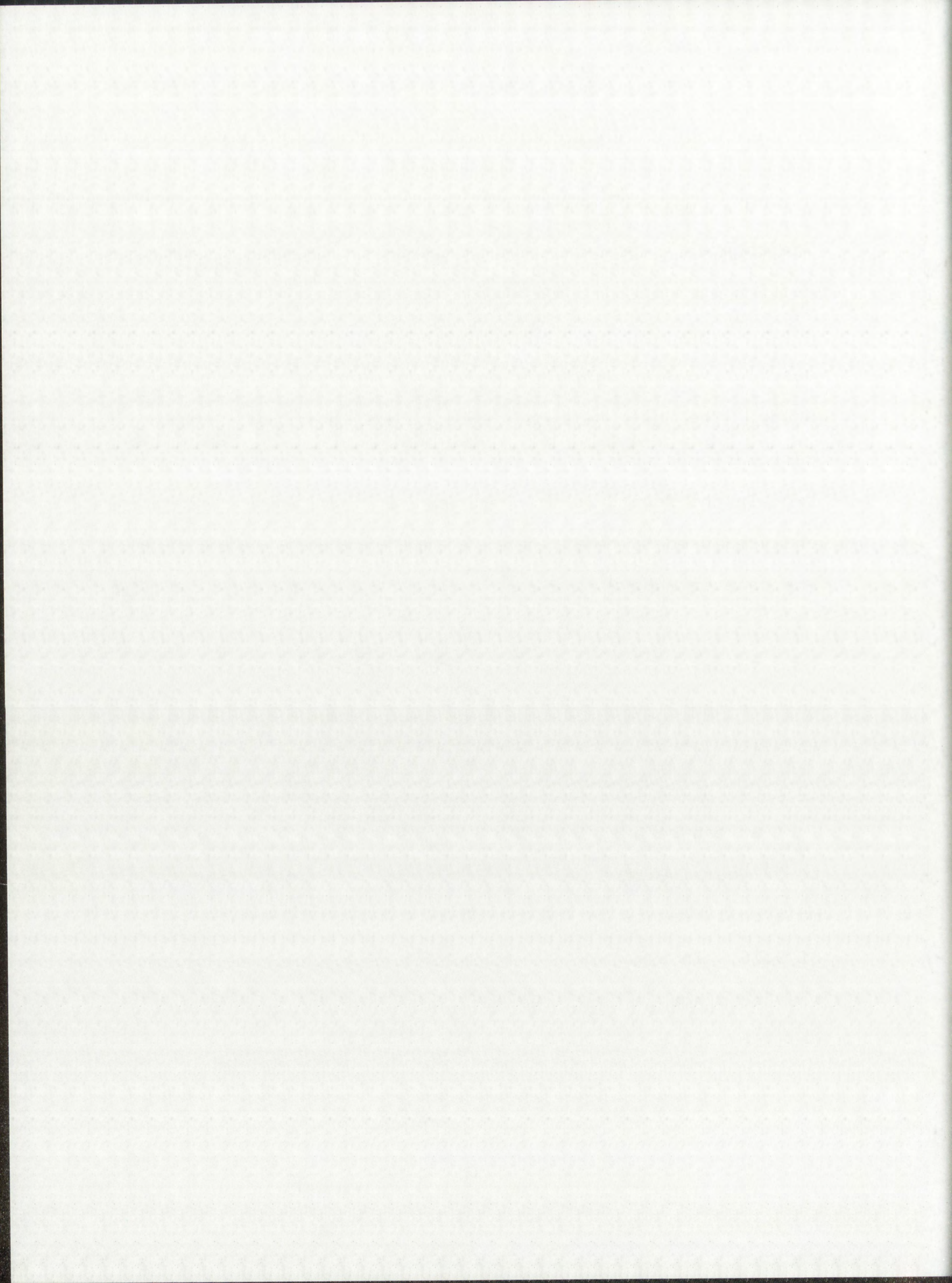


Table 1. Parent and Child Ages

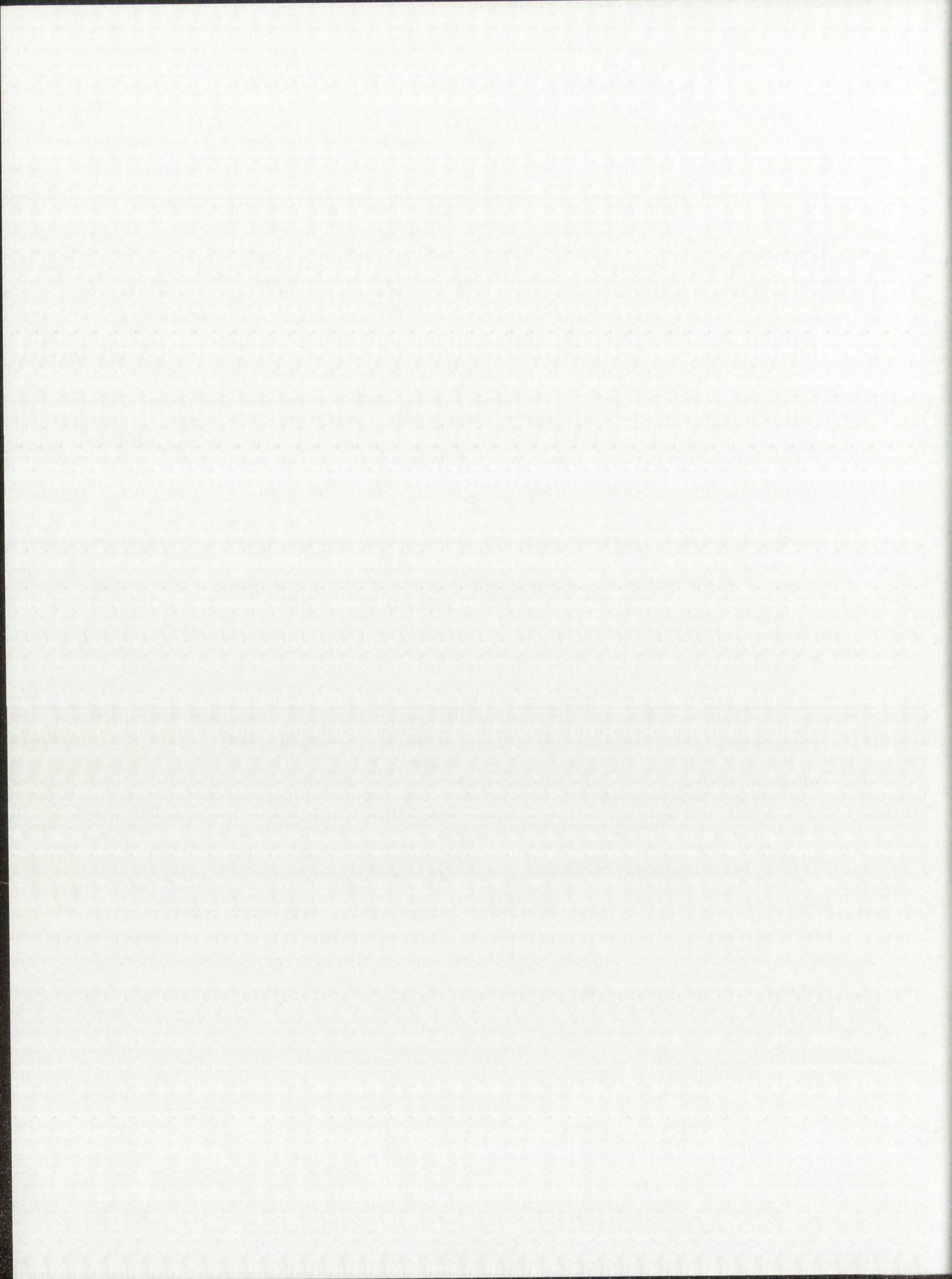
	N	Minimum	Maximum	Mean	<u>SD</u>
Mother	21	27	47	37.04	6.22
Father	21	29	52	39.28	5.72
Child	21	7	11	9.10	1.39

In examining the relationship of the parent to the child, 81% ($n=34$) of the participants reported they were biological parents, 14% ($n=6$) said they were stepparents, 2.4% ($n=1$) each indicated they were an adoptive parent, or a live-in parental figure.

The educational level of the parents is provided in Table 2. The majority of the participants, 23 or 54.8%, reported they had at least a Bachelor's degree, with another 11 (21.4%) indicating they had attended college. The remainder (19%, $n=8$) had obtained a high school diploma or GED equivalent certificate.

Table 2. Parents' Educational Level ($N = 42$)

	Mother Freq.	Mother Percent	Father Freq.	Father Percent	Total percent
HS/GED	6	28.6	2	9.5	19.0
HS +	1	4.8	1	4.8	4.8
AA/AS	4	19.0	5	23.8	21.4
BA/BS	9	42.9	9	42.9	42.9
MA/MS	1	4.8	4	19.0	11.9
Total	21	100.0	21	100.0	100.0



In response to questions concerning family psychiatric history and family medical problems, a psychiatric diagnosis in a family member was reported in 42.9% ($n=9$) of the families. A chronic medical condition in a family member was reported in 28.6% ($n=6$) of the families.

In describing the current treatment for the child with AD/HD, combined use of medication and behavioral therapy was the treatment reported by the parents in 66.7% ($n=14$) of the cases. Medication alone was the treatment reported in 23.8% ($n=5$) of the cases, with behavioral therapy alone reported in 9.5% ($n=2$) of the families.

Measures

Parenting Stress Index/Short Form

On the Parenting Stress Index/Short Form (PSI/SF), raw scores between 15 and 80 are considered to be in the normal range, a score above 80 is considered to be high stress, and a score above 90 is considered to be clinically significant. In the study sample, parents scored between 43 and 146, with mothers having an average score of 91.57 ($SD = 26.45$), and fathers an average score of 83.14 ($SD = 19.33$). Thus, although mothers and fathers in this study showed considerable variability in scores, in general, both mothers and fathers reported high parenting stress scores.



Dyadic Adjustment Scale

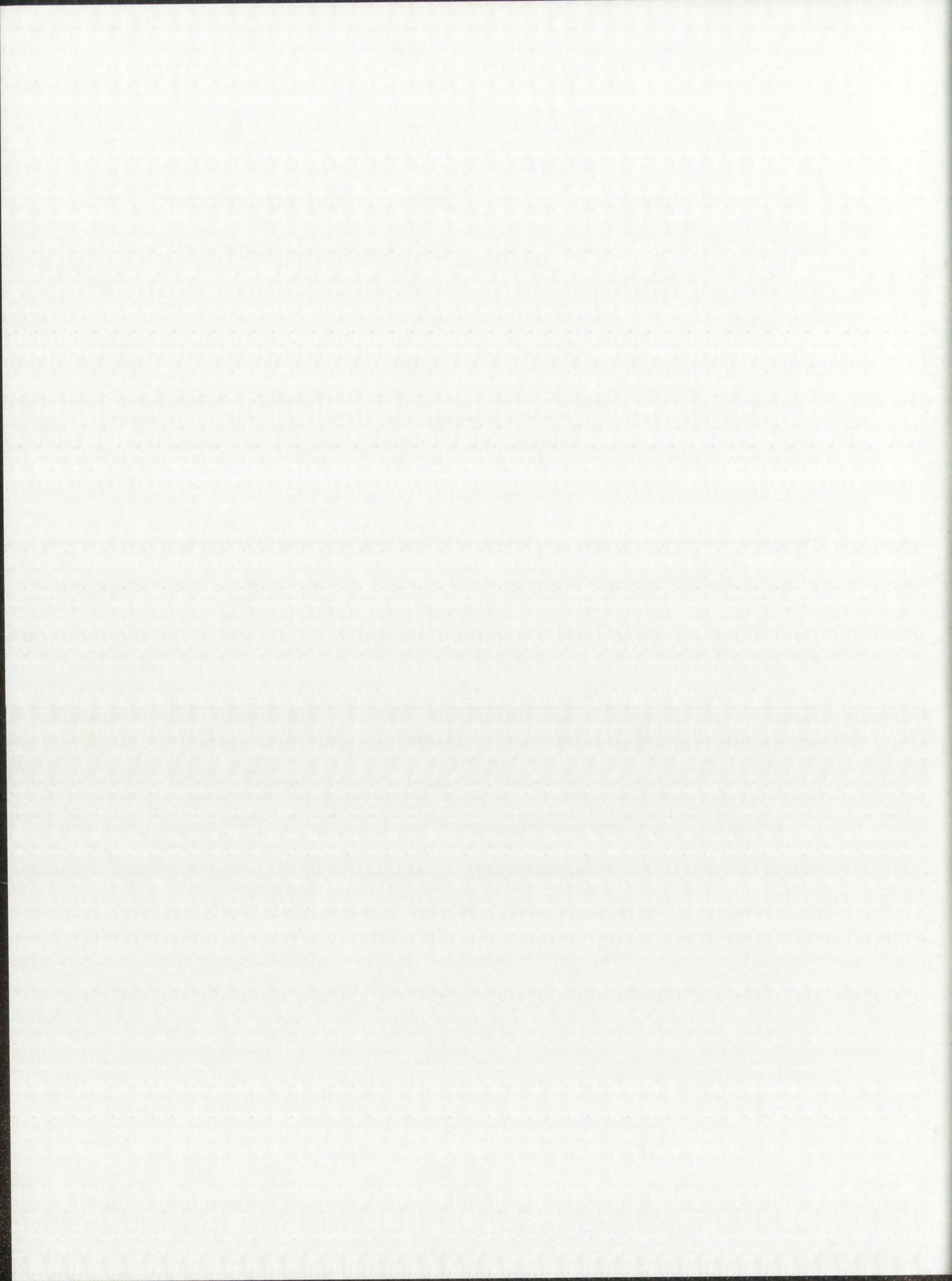
The manual for the Dyadic Adjustment Scale (DAS) reports average raw scores to be between 105 and 115, with scores below 105 indicating marital dissatisfaction and scores below 80 considered clinically significant. In the present study, scores ranged between 73 and 140. The mean score for mothers and fathers was 111.42 (SD = 18.51) and 107.14 (SD = 17.21), respectively. Although both groups, in general, were in the average range for overall marital satisfaction, a few parents (n = 5) expressed strong marital dissatisfaction.

Child Behavior Checklist

On the Child Behavior Checklist (CBCL), a raw score of 22 is considered to be an average score, whereas a score above 60 is considered to be clinically significant. In the study sample, the raw scores for the CBCL ranged from 21 to 118, with the mean reported score for mothers 58.19 (SD = 28.83) and for fathers, 57.24 (SD = 21.99). Although these are high scores for severity of symptoms, the average scores are just under the clinically significant range. Forty-five percent (n = 19) of the parents, however, reported their child to be in the clinically significant range.

Correlated Samples t-test Findings

Prior to testing hypotheses, the data were checked for meeting assumptions of the statistical procedures used.



Correlated samples t-tests were used to test hypotheses one and two. Tables 3 and 4 present the results of the correlated samples t-tests and include means and standard deviations for the relevant variables, t values, degrees of freedom, and two-tailed probabilities for the differences obtained between mothers' and fathers' scores.

Hypothesis One

Hypothesis one stated that there would be no difference in average parental stress scores as measured by the Parenting Stress Index/Short Form (PSI/SF) between mothers and fathers of children with ADHD. Although mothers, on the average, reported higher levels of stress (M=91.57, SD=26.45) than fathers (M=83.14, SD=19.33), the results revealed that there was no significant difference between mothers' and fathers' mean parental stress scores. Thus, this hypothesis was not rejected.

Table 3. Correlated Samples t-test Statistics for the Parental Stress Scores

Parent	N	Mean	<u>SD</u>	<u>t</u>-value	<u>df</u>	<u>p</u>
Mother	21	91.57	26.45	-1.856	20	.078
Father	21	83.14	19.33			

Hypothesis Two

Hypothesis two stated that there would be no difference in average scores of marital satisfaction as measured by the



Dyadic Adjustment Scale (DAS) between mothers and fathers of children with ADHD. The results revealed that there was no significant difference in the level of marital satisfaction between mothers' and fathers' scores (\underline{M} =111.42, \underline{SD} =18.51 and \underline{M} =107.14, \underline{SD} =17.21, respectively). This hypothesis, too, was not rejected.

Table 4. Correlated Samples t-test Statistics for Marital Satisfaction Scores

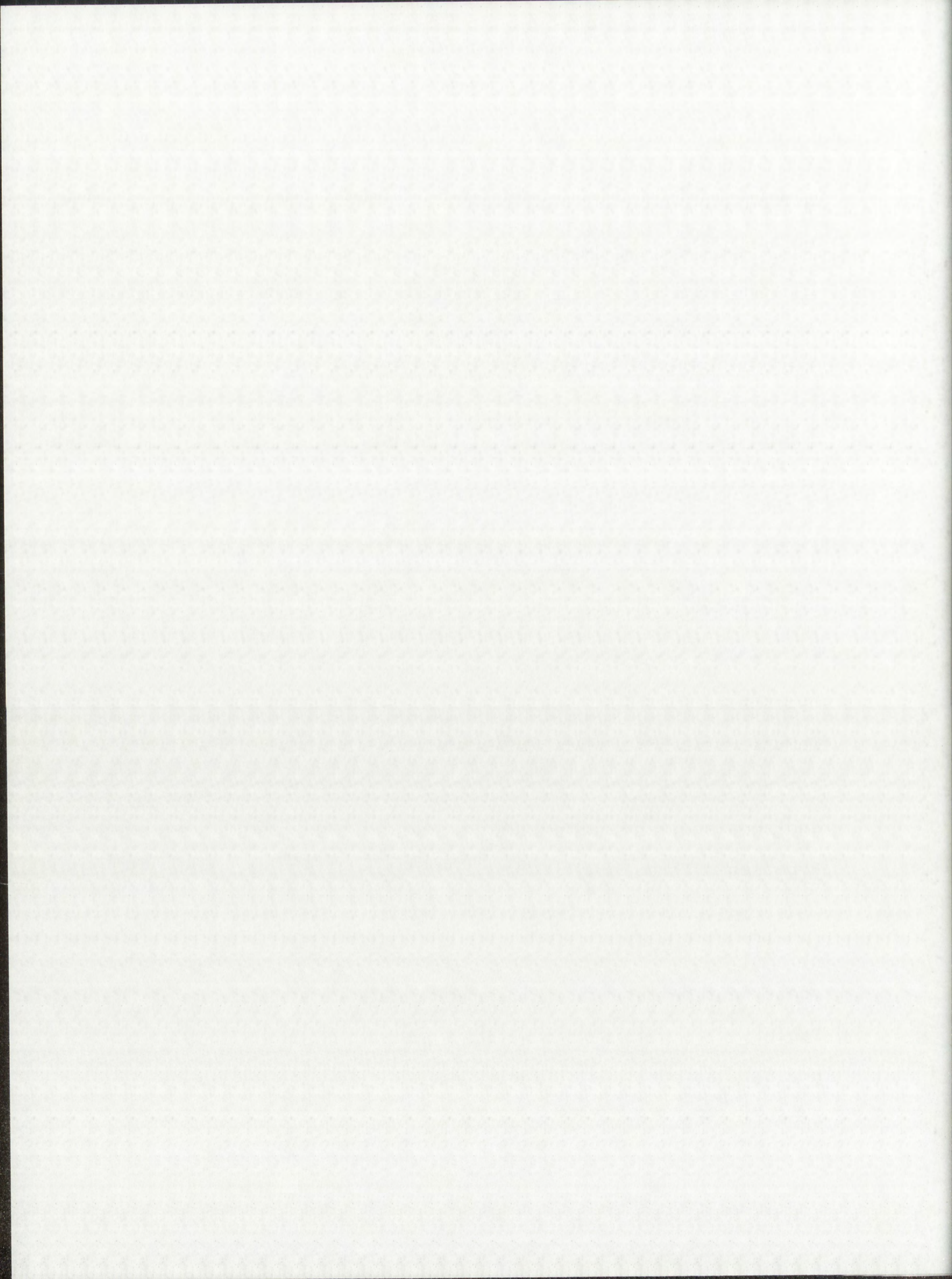
Parent	N	Mean	<u>SD</u>	<u>t-value</u>	<u>df</u>	<u>p</u>
Mother	21	111.42	18.51	-1.907	20	.071
Father	21	107.14	17.21			

Correlational Findings

Correlational analysis was used to test the remaining hypotheses. Tables 5 and 6 report the Pearson Product-Moment correlation coefficients for the relevant variables for hypotheses three, four, and five for the total sample and separately by gender.

Hypothesis Three

Hypothesis three stated that there would be no correlation between marital satisfaction and parental stress scores for parents of children with AD/HD. As shown in Table 5, a significant negative correlation (\underline{r} = - .359, \underline{p} <0.01) was obtained. Higher levels of parental stress were significantly correlated with lower levels of marital



satisfaction. Thus, hypothesis 3 was rejected. Sub-hypothesis 3a stated that the degree of correlation between marital satisfaction and parental stress scores would not differ by gender. As reported in Table 6, although negative correlations were obtained for both mothers and fathers ($r = -.332$ and $-.484$, respectively), there was not a significant difference in the degree of correlation by gender at the 0.05 level. Therefore, sub-hypothesis 3a was not rejected.

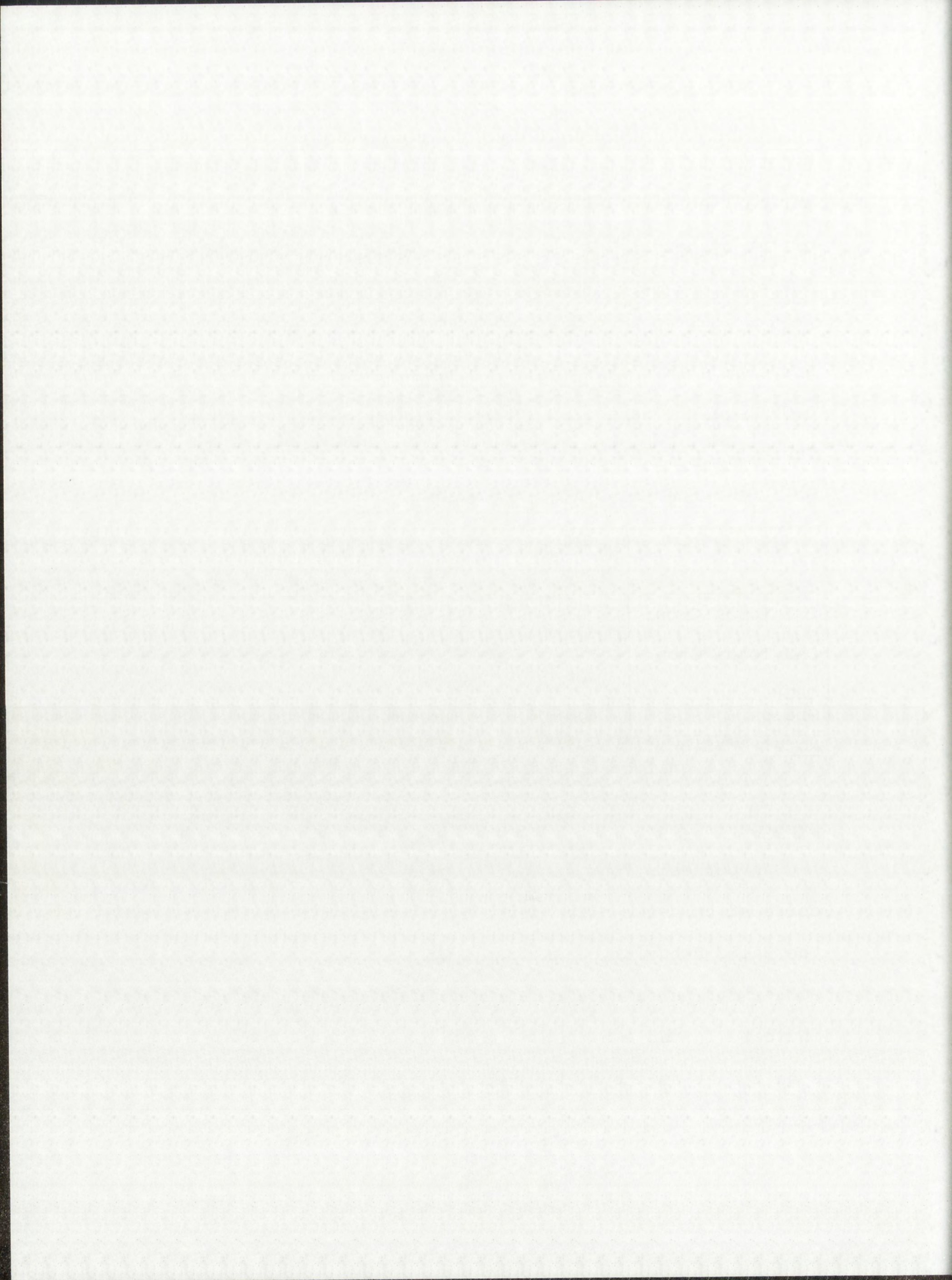
Table 5. Correlations between PSI, DAS, and CBCL Scores For the Total Group (N = 42)

	PSI Total Group	DAS Total Group	CBCL Total Group
PSI Total Group	1.000	-.359**	.617**
DAS Total Group	.359**	1.000	-.297*
CBCL Total Group	.617**	-.297*	1.000

Note: **Significant at the 0.01 level (2-tailed).
*Significant at the 0.05 level (2-tailed).

Hypothesis Four

Hypothesis four stated that there would be no correlation between the severity of symptoms total score on the Child Behavior Checklist (CBCL) and marital satisfaction scores for parents of children with ADHD. The findings indicate in Table 5 that a negative correlation ($r = -.297$), significant at the 0.05 level, was obtained. As the parents' perception of their child's severity of behavior symptoms

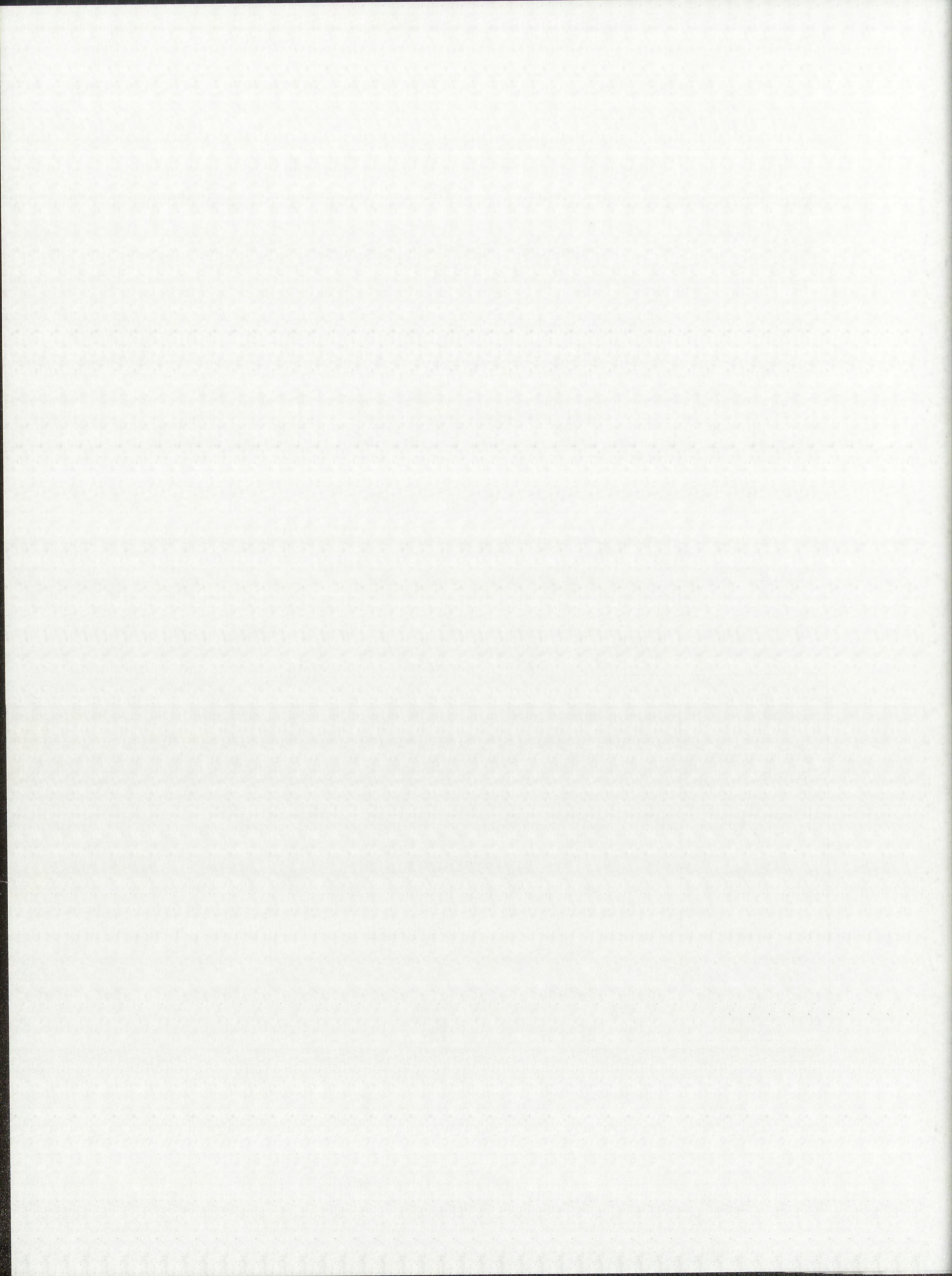


increased, marital satisfaction levels decreased. Thus hypothesis four was rejected. Sub-hypothesis 4a stated that the degree of correlation between the child's severity of symptoms and marital satisfaction would not differ by gender. As shown in Table 6, negative correlations were obtained for both mothers and fathers ($r = -.175$ and $-.485$, respectively). Although the correlation was larger and significant at the 0.05 level for fathers, the difference in magnitude was not significant at the 0.05 level. This hypothesis was not rejected.

Table 6. Correlations between PSI, DAS, and CBCL Scores by Gender (N = 21 each)

	PSI Father	DAS Father	CBCL Father	PSI Mother	DAS Mother	CBCL Mother
PSI - Father	1.00	-.484*	.634**	.626**	-.336	.042
DAS - Father	-.484*	1.00	-.485*	-.531*	.836**	-.382
CBCL - Father	.634**	-.485*	1.00	.534*	-.319	.464*
PSI - Mother	.626**	-.531*	.534*	1.00	-.332	.619**
DAS - Mother	-.336	.836**	-.319	-.332	1.00	-.175
CBCL - Mother	.042	-.382	.464*	.619**	-.175	1.00

Note: **Significant at the 0.01 level (2-tailed).
*Significant at the 0.05 level (2-tailed).

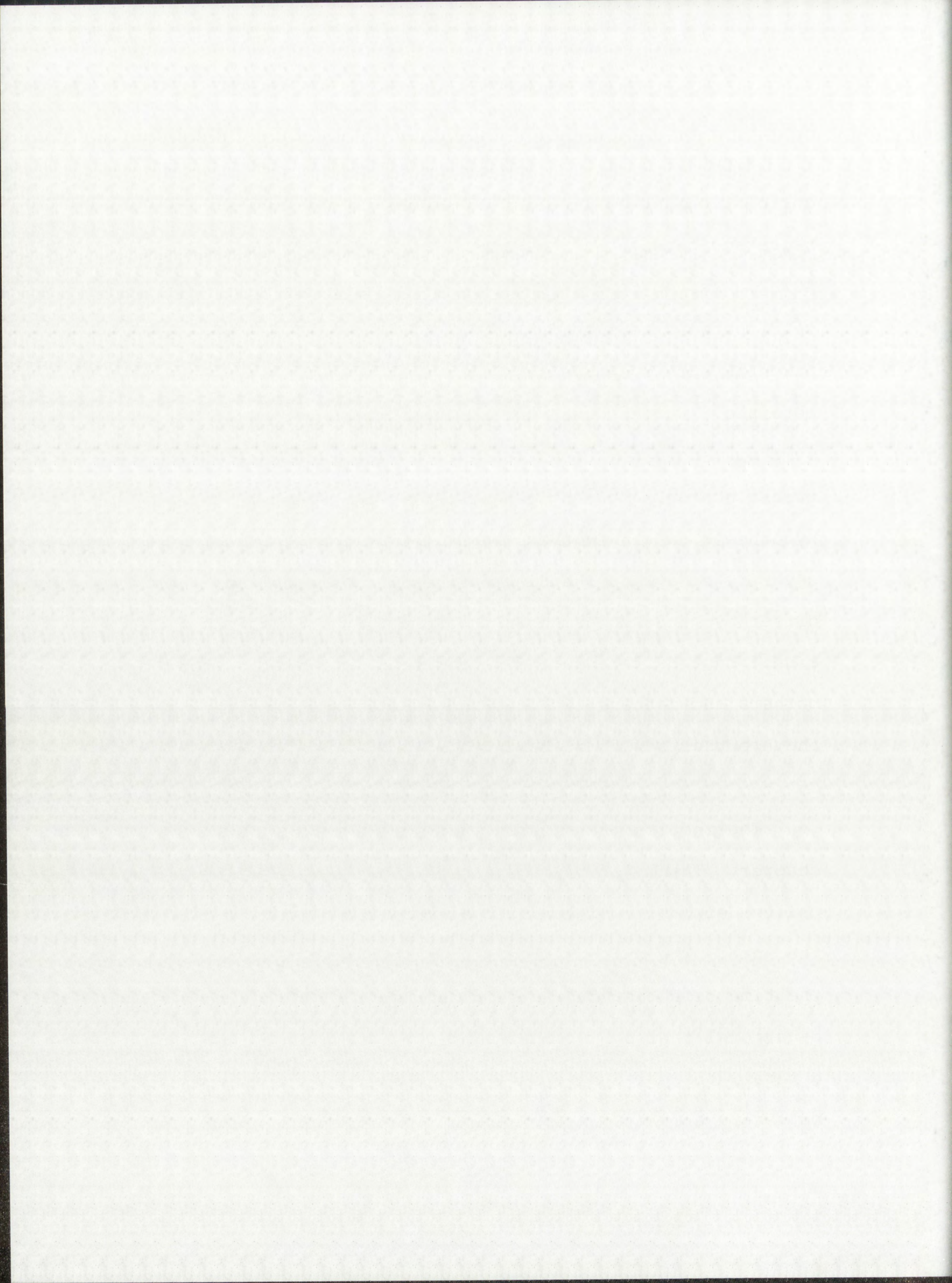


Hypothesis Five

Hypothesis five stated that there would be no correlation between the child's severity of symptoms total score and parental stress scores in parents of children with AD/HD. As reported in Table 5, a positive correlation ($\underline{r} = .617$) between reported severity of behavioral symptoms and parental stress scores significant at the 0.01 level was obtained. Parents who reported a higher severity of symptoms score for their child also reported higher parental stress scores. Thus hypothesis five was rejected. Sub-hypothesis 5a stated that the degree of correlation between severity of symptoms and parental stress scores would not differ by gender. As shown in Table 6, there was not a significant difference in the degree of correlation for mothers and fathers ($\underline{r} = .619$ and $.634$, respectively). Thus the hypothesis was not rejected.

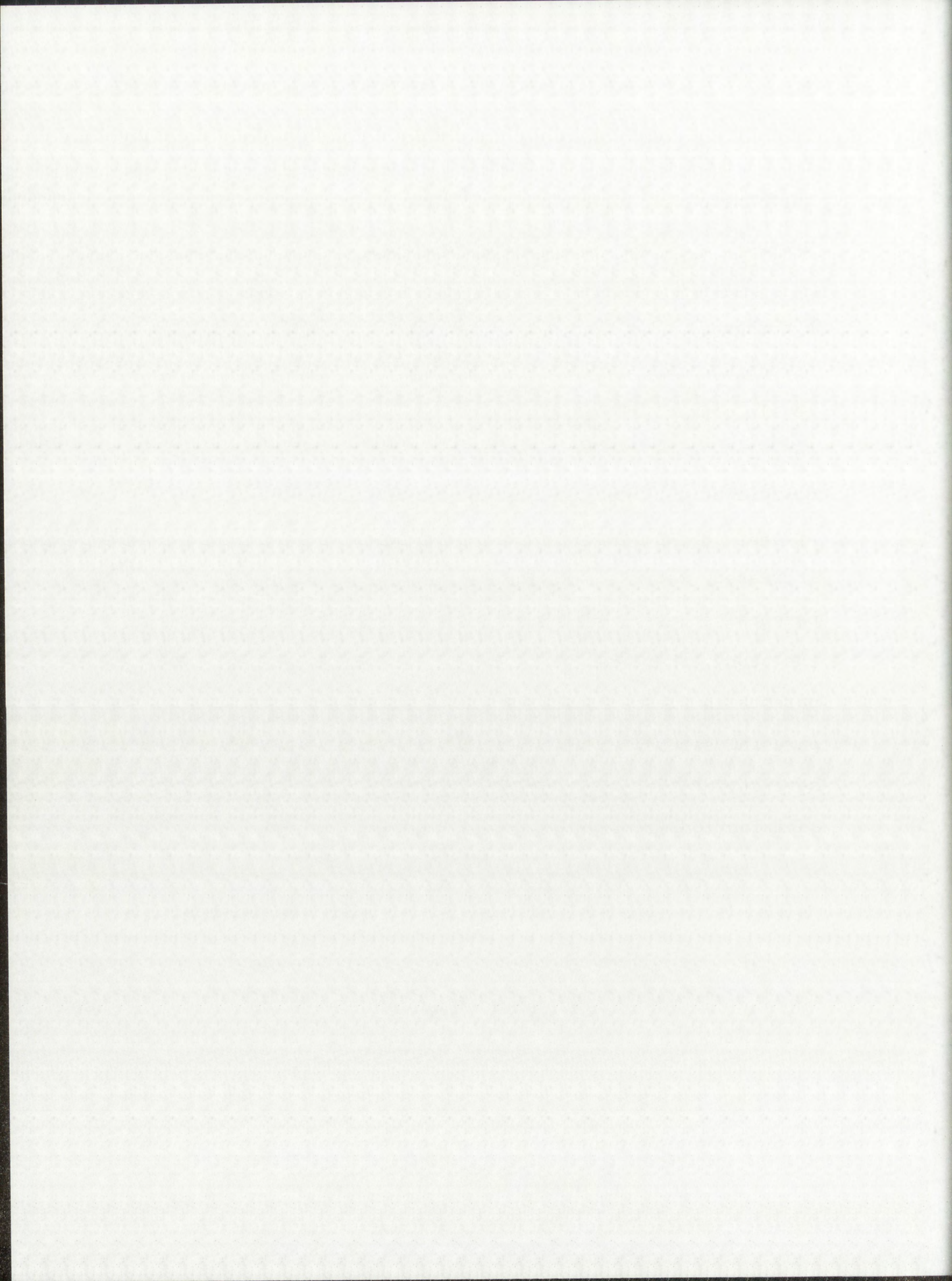
Summary

The results of the study were presented in this chapter. The majority of the participants were Anglo, college educated, biological parents with one other child in the home. The current treatment for their AD/HD child at the time of the study was a combination of medication and behavioral therapy for the majority of families. In general, the parents reported high parental stress scores, but average marital satisfaction. Correlated samples \underline{t} -



tests to test for differences in marital satisfaction and parenting stress scores between mothers and fathers found that there were no significant differences between the two groups.

Correlations were obtained to test the remaining hypotheses. The findings indicated that higher levels of parenting stress were significantly correlated with lower levels of marital satisfaction for both mothers and fathers. Perceived severity of child symptoms was significantly correlated with both marital satisfaction and parental stress. As the perceived severity of child symptoms increased, marital satisfaction levels decreased and parental stress levels increased. For the participants in the study, there was not a significant difference between parents in the correlation between marital satisfaction and parental stress, or in the relationship of perceived severity of their ADHD child's symptoms with marital satisfaction or parental stress.



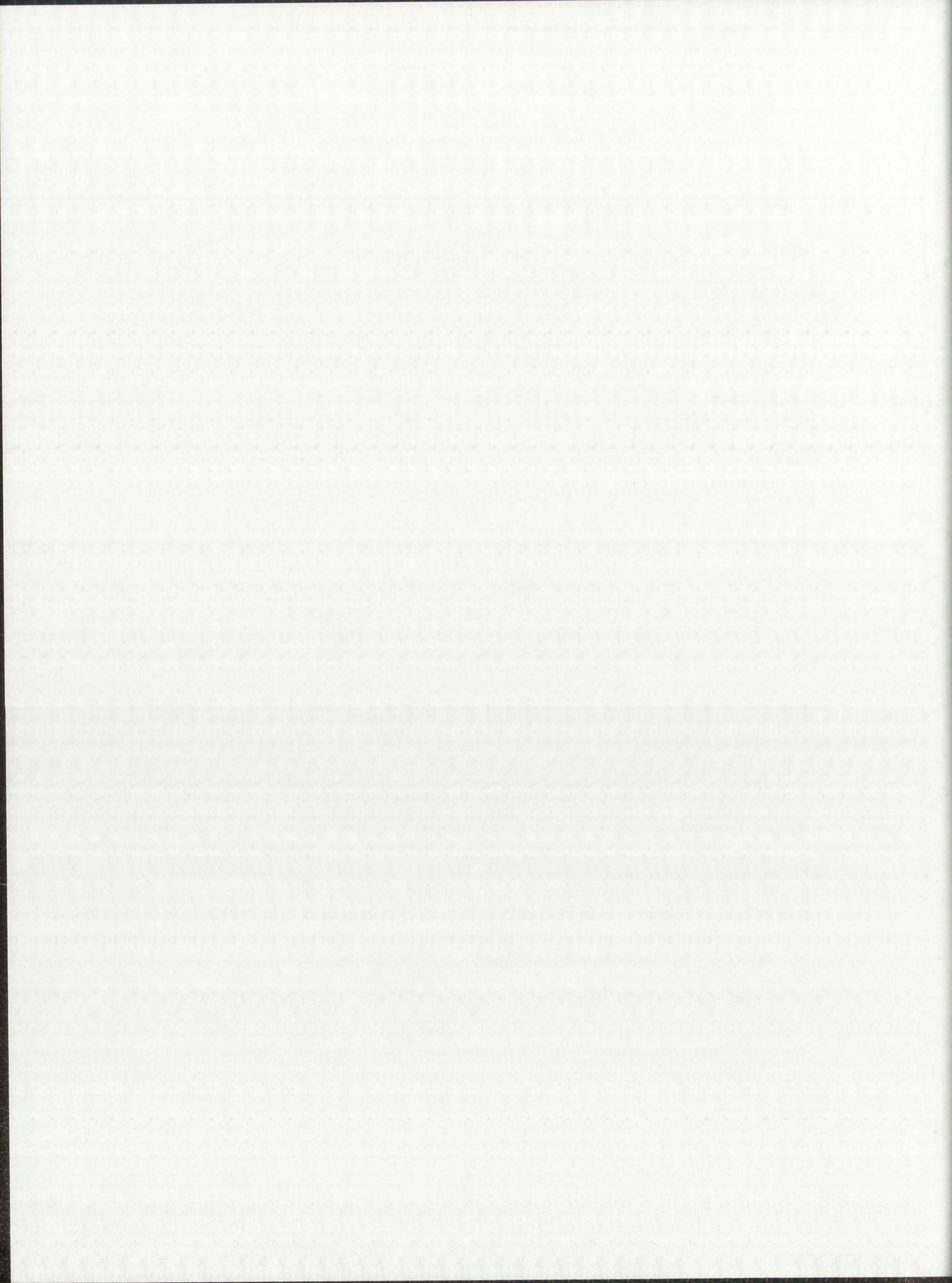
CHAPTER 5:

DISCUSSION

The final chapter of this study is divided into five sections. In the first section, the purpose of the study is restated. The second section reviews the results obtained as they relate to the hypotheses and other related research findings. In the third section, implications of the findings for the fields of family studies and counseling are discussed. The fourth section provides recommendations for future research. Finally, the chapter concludes with a summary.

Purpose of the Study

The purpose of the study was to extend the research on families with children with AD/HD by examining parental stress and marital satisfaction among parents of children with AD/HD. The focus of the study was on the perceptions of mothers and fathers of children with AD/HD regarding parental stress and marital satisfaction and the extent to which these perceptions were related to the reported severity of their child's symptoms. In addition, the study examined whether these perceptions and relationships differed for mothers and fathers.



Review of Study Findings

Five hypotheses were formulated and examined. A summary of the hypotheses and findings, as well as a discussion of related research findings are presented.

Hypothesis One

Hypothesis one stated that there would be no difference in average parental stress scores between mothers and fathers of children with AD/HD. Both groups, in general, reported high levels of parental stress, and although mothers, on the average, reported higher levels of stress, the variability was such that there was not a significant difference between mothers' and fathers' mean parental stress scores. These results are consistent with previous research that indicated higher levels of parental stress in mothers of children with AD/HD than mothers of nondisabled children (Breen & Barkley, 1988; Mash & Johnson, 1983). The present findings indicate that fathers also experience the stress of parenting an AD/HD child.

Hypothesis Two

Hypothesis two stated that there would be no difference in average scores of marital satisfaction between mothers and fathers of children with AD/HD. For both groups, the mean scores fell within the normal limits established for this instrument. Research in the area of marital satisfaction in families with AD/HD children is limited and



the findings somewhat contradictory. This study obtained the same results as a study by Barkley, DePaul & McMurray (1990) that failed to show higher rates of marital discord among parents of children with AD/HD.

Hypothesis Three

Hypothesis three stated that there would be no correlation between marital satisfaction and parental stress scores overall and that the degree of correlation would not differ by gender. A significant negative correlation was obtained overall that indicated higher levels of parental stress were significantly correlated with lower levels of marital satisfaction. The degree of correlation did not significantly differ by gender. There were no studies found in the literature that examined the relationship between marital satisfaction and parental stress. These findings, however, are consistent with a systems framework.

Hypothesis Four

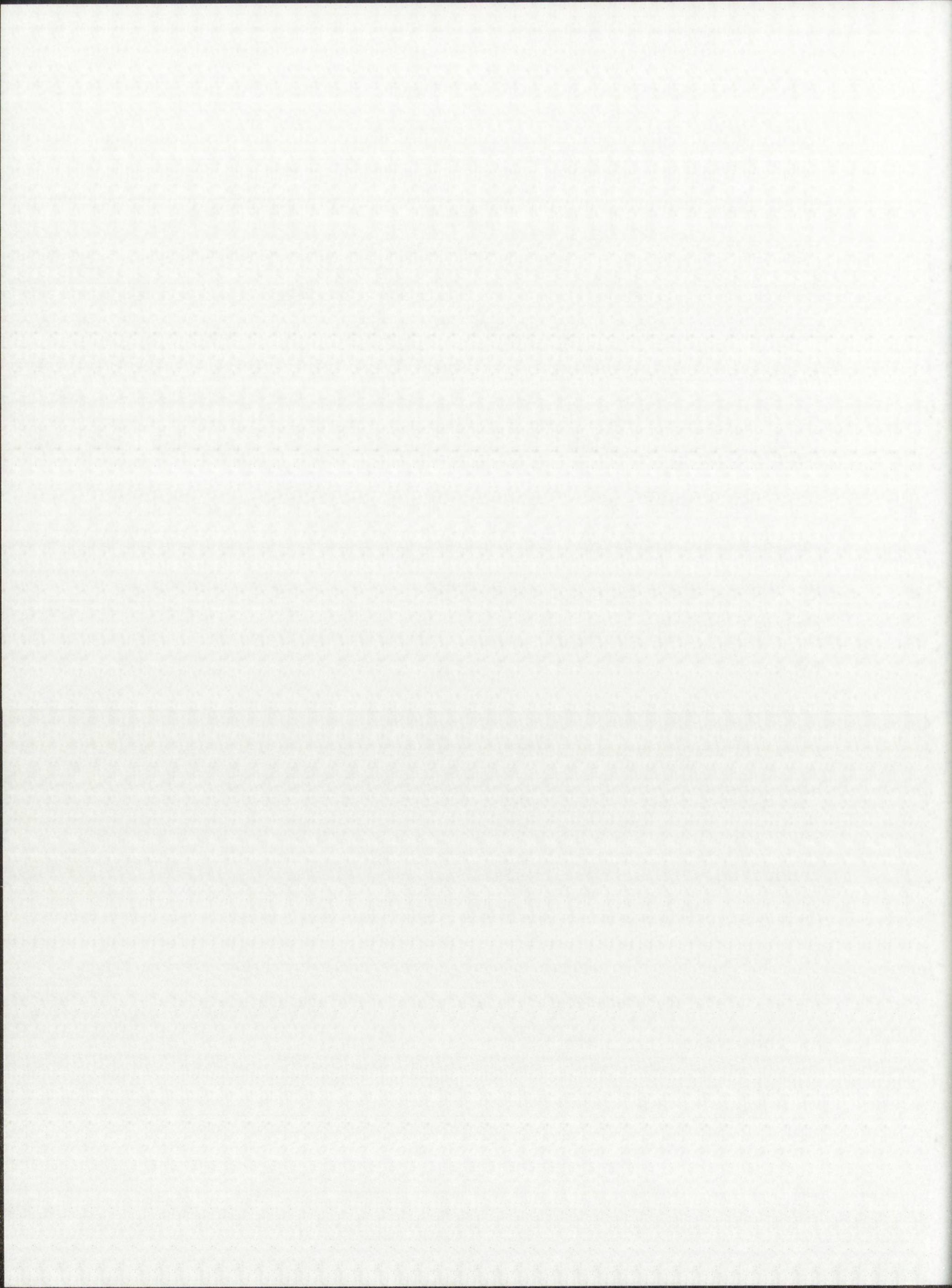
Hypothesis four stated that there would be no correlation between reported severity of the child's symptoms and marital satisfaction scores overall and that the degree of correlation would not differ by gender. Overall, a significant negative moderate correlation was obtained. As the parents' perceived severity of child symptoms increased, marital satisfaction levels decreased. The difference in correlations between severity of symptoms



and marital satisfaction scores did not differ by gender. There was only one study found in the research literature that examined marital satisfaction and child behavior problems in families with children with AD/HD (Fischer, 1990). In her study, Fischer (1990) found that child behavior problems were associated with marital discord. The present findings support her results and are consistent with a systems framework.

Hypothesis Five

Hypothesis five stated that there would be no correlation between reported severity of child symptoms and parental stress scores for parents of children with AD/HD overall and that the degree of correlation would not differ by gender. A significant positive correlation was obtained. Parents who reported a higher severity of symptoms score also reported higher parental stress scores. There was not a significant difference in the degree of correlation by gender. These findings are consistent with other research conducted with mothers of children with AD/HD that found behavior problems in children with AD/HD were related to increased levels of maternal stress (Anastopoulos et al., 1992; Breen & Barkley, 1988; Mash & Johnston, 1983, 1990). As these data indicate, the relationship also is found for fathers.

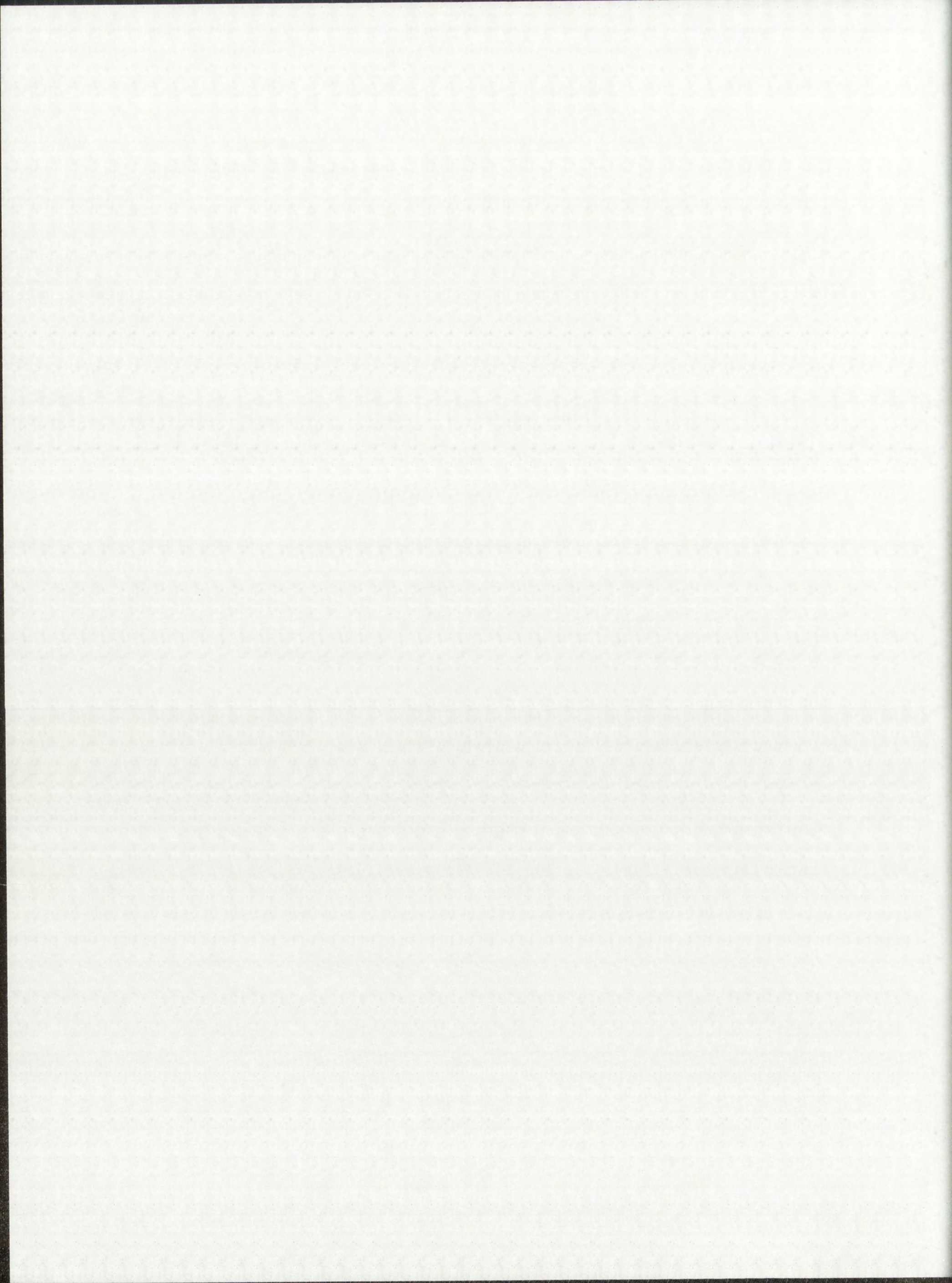


Discussion of Findings

The sample size in this study was small and consisted of volunteers, thereby creating a convenience sample. This seriously limits the generalizability of the results. Initially, 114 families were invited to participate in the study. Thirty-four families returned the consent letter agreeing to participate. However, there were only 21 families that completed and returned the questionnaires. A possible reason may be that there was not an incentive attached to participation in the study and families did not perceive sufficient benefit to responding.

A high level of parental stress was reported by both mothers and fathers. One might expect this finding in parenting a child with a disability. Moreover, the severity of reported child behavior symptoms was found to be related to increased levels of parental stress and marital dissatisfaction. This, too, was an expected finding. There were no gender differences found in either marital satisfaction scores or parental stress scores.

For both parents, marital satisfaction generally was reported to be in the normal range. The fact that the study required both spouses to participate may have led to a sample made up of parents who tended to get along, were in a stable marriage, and possibly both of whom were very involved in the day-to-day parenting of the child.



Additionally, in these families, the child was recently diagnosed with AD/HD and was being treated. The results may be different for families where the child is not being treated and symptoms are consequently more severe. Also, a longitudinal study might reveal that findings change over time as the family does or does not adapt adequately to the situation and/or other events affect the interactions being studied.

Implications

This study may contribute to increased knowledge in the areas of family studies and counseling in several ways. It serves to broaden the scope of the limited existing research findings on parental stress and marital satisfaction. Also, the study assists in efforts to better understand how family systems function in families with a child with AD/HD. Hopefully, this study will serve to influence further investigation in these areas. An additional implication of the study is that it may contribute to the development and expansion of successful counseling interventions for families with children with AD/HD. The development of a combination parenting class/support group would be beneficial. The group could provide parents with information and education about parenting a child with AD/HD as well as offer a supportive environment where parents could share



their feelings, provide support for one another, and develop a better understanding of family functioning.

Recommendations for Further Research

The findings of the current study suggest the need for further research. It is important to continue examining parental stress in both mothers and fathers as previous research has focused on mothers. Both parents reported high levels of stress but there was not a significant difference in response reported; further research is needed to confirm these findings. Moreover, a more socioeconomically diverse sample, especially including impoverished families, would provide a clearer picture of the cumulative effects on parental stress and marital satisfaction in both mothers and fathers.

Continued examination into the area of marital satisfaction is necessary as research in this area is extremely limited. This study found marital satisfaction to be within the normal limits for both mothers and fathers. However, as noted, this was a small convenience sample and this limits generalizability. Future studies using larger sample sizes, greater ethnic diversity, and incentives for participation should be designed to expand this study and may be helpful in detecting differences between mothers and fathers. In addition, given the variability found in the present study in responses of perceived parental and marital

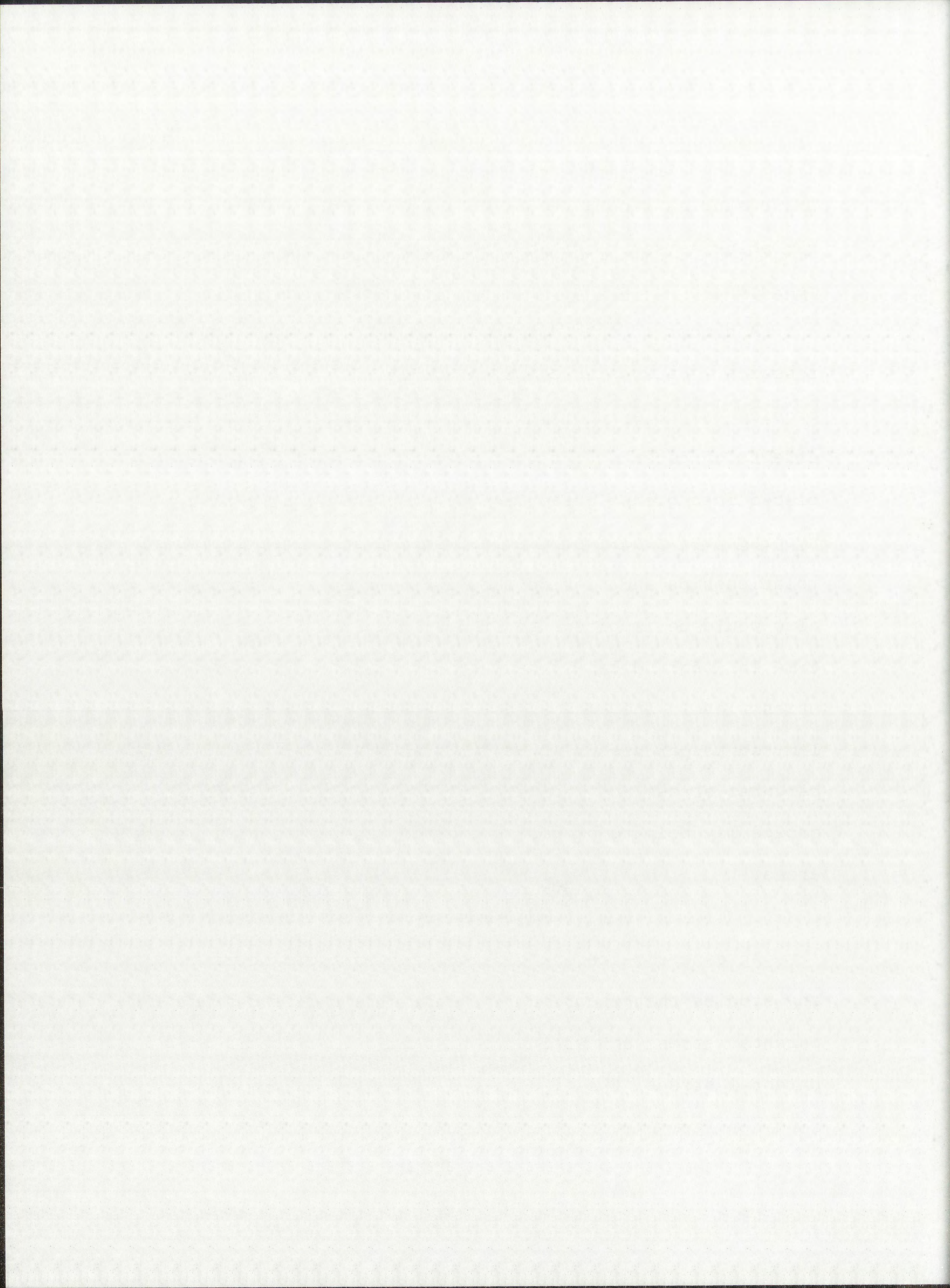


stress in both mothers and fathers, larger studies would be better able to discern variables affecting the differences. These studies should include the same instruments and variables as set forth in the present study as well as measures not as dependent on self-report.

A number of other areas should be considered in future research. Studies that include girls with AD/HD would provide valuable information in understanding child gender effects on parents. Further research in which families are placed into groups based on type of AD/HD (inattentive, hyperactive/impulsive, combined) may help to clarify these relationships and provide more differentiated findings. It also would be important to study these relationships over time in longitudinal investigations. Moreover, increased stress levels and decreased marital satisfaction are not limited to parents of AD/HD children. Studies that examine parental stress and marital satisfaction in comparison groups may help to provide a broader understanding in these areas.

Summary

An extensive review of the literature did not reveal any studies that specifically dealt with the issues of parental stress and marital satisfaction. In terms of parental stress, the findings in this study supported findings from previous studies that found increased levels



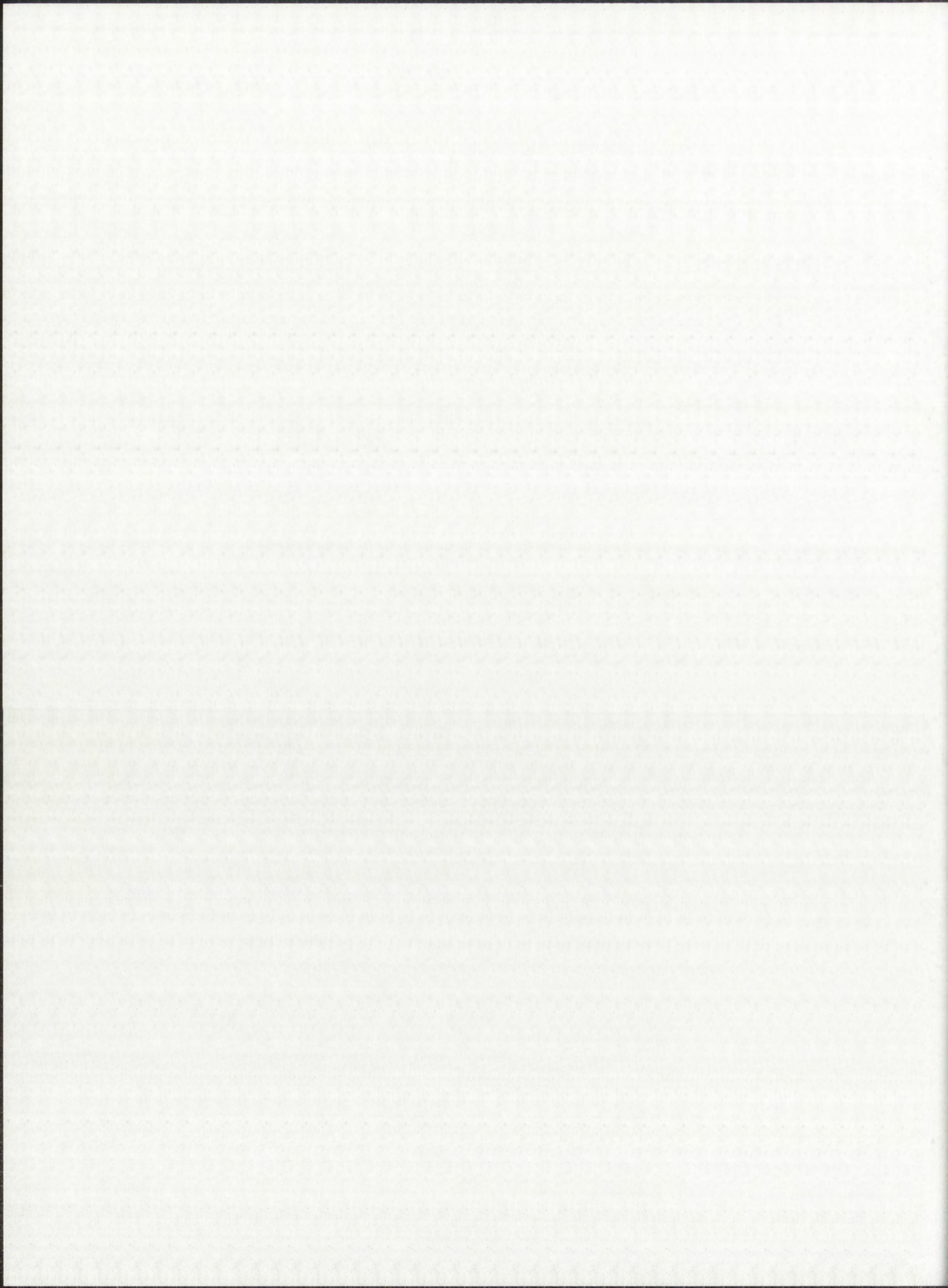
of parental stress in mothers of children with AD/HD and noted such stress in fathers also. A strong relationship was found between increased levels of parental stress and severity of reported child behavior symptoms. The limited research findings that have emerged in the area of marital satisfaction have been inconsistent. In the present study, in general parents of children with AD/HD reported levels of marital satisfaction within normal limits. However, the findings indicated that as perceived severity of child behavior symptoms increased, parental stress increased and marital satisfaction decreased, with a higher correlation found between parental stress and severity of child behavior symptoms.

The literature and research available on the definition, symptomology, treatment, and medication on children with AD/HD is abundant. However, there is limited research available that looks at the effects of AD/HD on the functioning of the family system. Studies of families with children with AD/HD provide us with a starting point for interventions and support. As this study indicates, interactions between subsystems affect other subsystems in the family. If we can continue to identify factors that influence family functioning, we will be better able to support these families.

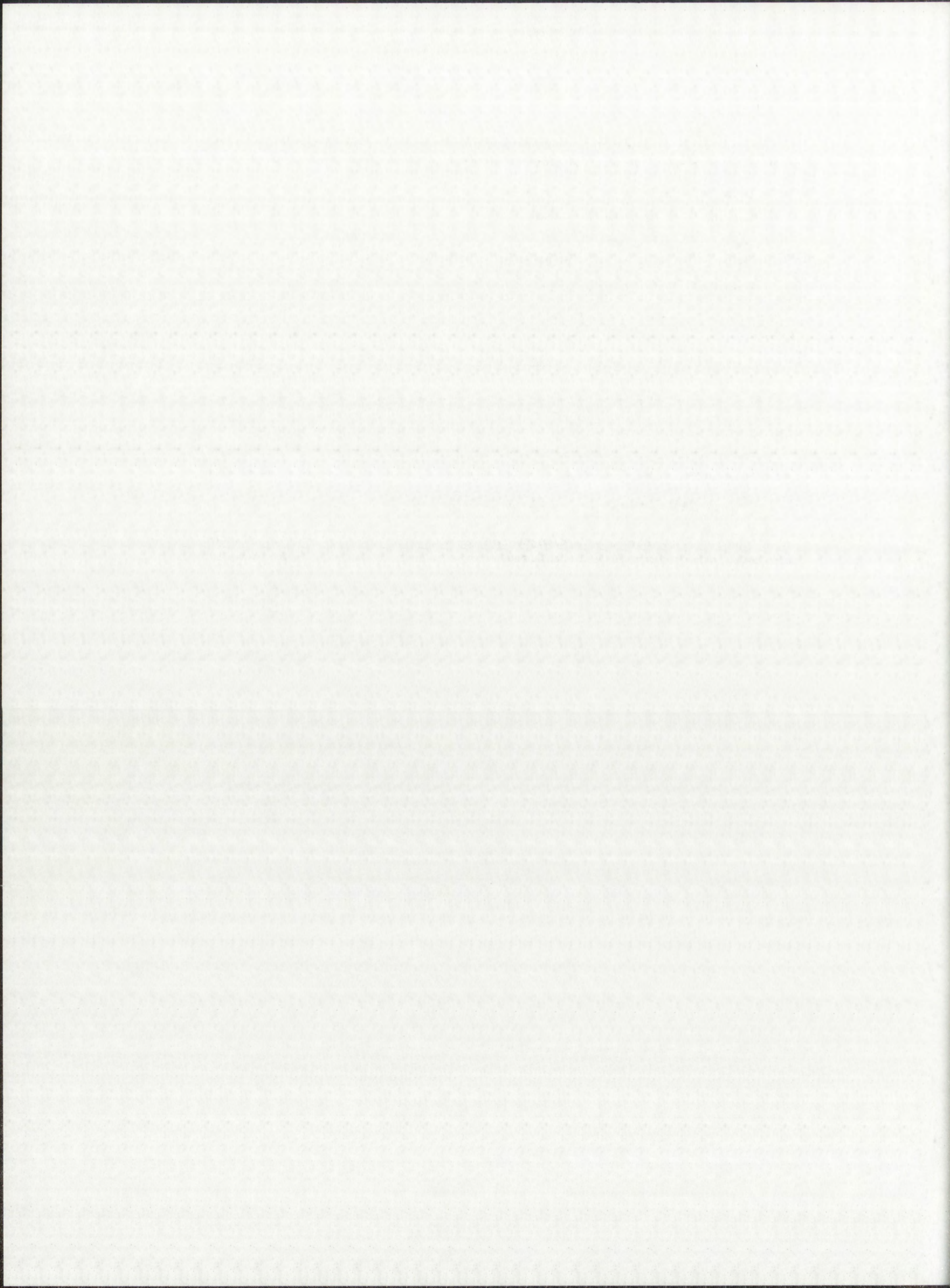


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APPENDIX A
PSI SHORT FORM



Instructions

This questionnaire contains 36 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response that best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the NS if you are not sure.

Circle the D if you disagree with the statement.

Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA A NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS D SD

Before responding to the statements, write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's date of birth, and today's date in the spaces at the top of the questionnaire.

PAR Psychological Assessment Resources, Inc./P.O. Box 998/Odessa, FL 33556/Toll-Free 1-800-331-TEST

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9876

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Name _____ Gender _____ Date of birth _____ Ethnic group _____ Marital status _____
 Child's name _____ Child's gender _____ Child's date of birth _____ Today's date _____

SA = Strongly Agree	A = Agree	NS = Not Sure	D = Disagree	SD = Strongly Disagree
---------------------	-----------	---------------	--------------	------------------------

- | | | | | | |
|--|----|---|----|---|----|
| 1. I often have the feeling that I cannot handle things very well. | SA | A | NS | D | SD |
| 2. I find myself giving up more of my life to meet my children's needs than I ever expected. | SA | A | NS | D | SD |
| 3. I feel trapped by my responsibilities as a parent. | SA | A | NS | D | SD |
| 4. Since having this child, I have been unable to do new and different things. | SA | A | NS | D | SD |
| 5. Since having a child, I feel that I am almost never able to do things that I like to do. | SA | A | NS | D | SD |
| 6. I am unhappy with the last purchase of clothing I made for myself. | SA | A | NS | D | SD |
| 7. There are quite a few things that bother me about my life. | SA | A | NS | D | SD |
| 8. Having a child has caused more problems than I expected in my relationship with my spouse (male/female friend). | SA | A | NS | D | SD |
| 9. I feel alone and without friends. | SA | A | NS | D | SD |
| 10. When I go to a party, I usually expect not to enjoy myself. | SA | A | NS | D | SD |
| 11. I am not as interested in people as I used to be. | SA | A | NS | D | SD |
| 12. I don't enjoy things as I used to. | SA | A | NS | D | SD |
| 13. My child rarely does things for me that make me feel good. | SA | A | NS | D | SD |
| 14. Most times I feel that my child does not like me and does not want to be close to me. | SA | A | NS | D | SD |
| 15. My child smiles at me much less than I expected. | SA | A | NS | D | SD |
| 16. When I do things for my child, I get the feeling that my efforts are not appreciated very much. | SA | A | NS | D | SD |
| 17. When playing, my child doesn't often giggle or laugh. | SA | A | NS | D | SD |
| 18. My child doesn't seem to learn as quickly as most children. | SA | A | NS | D | SD |
| 19. My child doesn't seem to smile as much as most children. | SA | A | NS | D | SD |
| 20. My child is not able to do as much as I expected. | SA | A | NS | D | SD |
| 21. It takes a long time and it is very hard for my child to get used to new things. | SA | A | NS | D | SD |

For the next statement, choose your response from the choices "1" to "5" below.

- | | | | | | | |
|-----------------------|---|---|---|---|---|---|
| 22. I feel that I am: | 1. not very good at being a parent | 1 | 2 | 3 | 4 | 5 |
| | 2. a person who has some trouble being a parent | | | | | |
| | 3. an average parent | | | | | |
| | 4. a better than average parent | | | | | |
| | 5. a very good parent | | | | | |

- | | | | | | |
|---|----|---|----|---|----|
| 23. I expected to have closer and warmer feelings for my child than I do and this bothers me. | SA | A | NS | D | SD |
| 24. Sometimes my child does things that bother me just to be mean. | SA | A | NS | D | SD |
| 25. My child seems to cry or fuss more often than most children. | SA | A | NS | D | SD |
| 26. My child generally wakes up in a bad mood. | SA | A | NS | D | SD |
| 27. I feel that my child is very moody and easily upset. | SA | A | NS | D | SD |
| 28. My child does a few things which bother me a great deal. | SA | A | NS | D | SD |
| 29. My child reacts very strongly when something happens that my child doesn't like. | SA | A | NS | D | SD |
| 30. My child gets upset easily over the smallest thing. | SA | A | NS | D | SD |
| 31. My child's sleeping or eating schedule was much harder to establish than I expected. | SA | A | NS | D | SD |

For the next statement, choose your response from the choices "1" to "5" below.

- | | | | | | |
|--|------------------------------------|---|---|---|---|
| 32. I have found that getting my child to do something or stop doing something is: | 1 | 2 | 3 | 4 | 5 |
| | 1. much harder than I expected | | | | |
| | 2. somewhat harder than I expected | | | | |
| | 3. about as hard as I expected | | | | |
| | 4. somewhat easier than I expected | | | | |
| | 5. much easier than I expected | | | | |

For the next statement, choose your response from the choices "10+" to "1-3."

- | | | | | | |
|---|-----|-----|-----|-----|-----|
| 33. Think carefully and count the number of things which your child does that bother you.
For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. | 10+ | 8-9 | 6-7 | 4-5 | 1-3 |
| 34. There are some things my child does that really bother me a lot. | SA | A | NS | D | SD |
| 35. My child turned out to be more of a problem than I had expected. | SA | A | NS | D | SD |
| 36. My child makes more demands on me than most children. | SA | A | NS | D | SD |

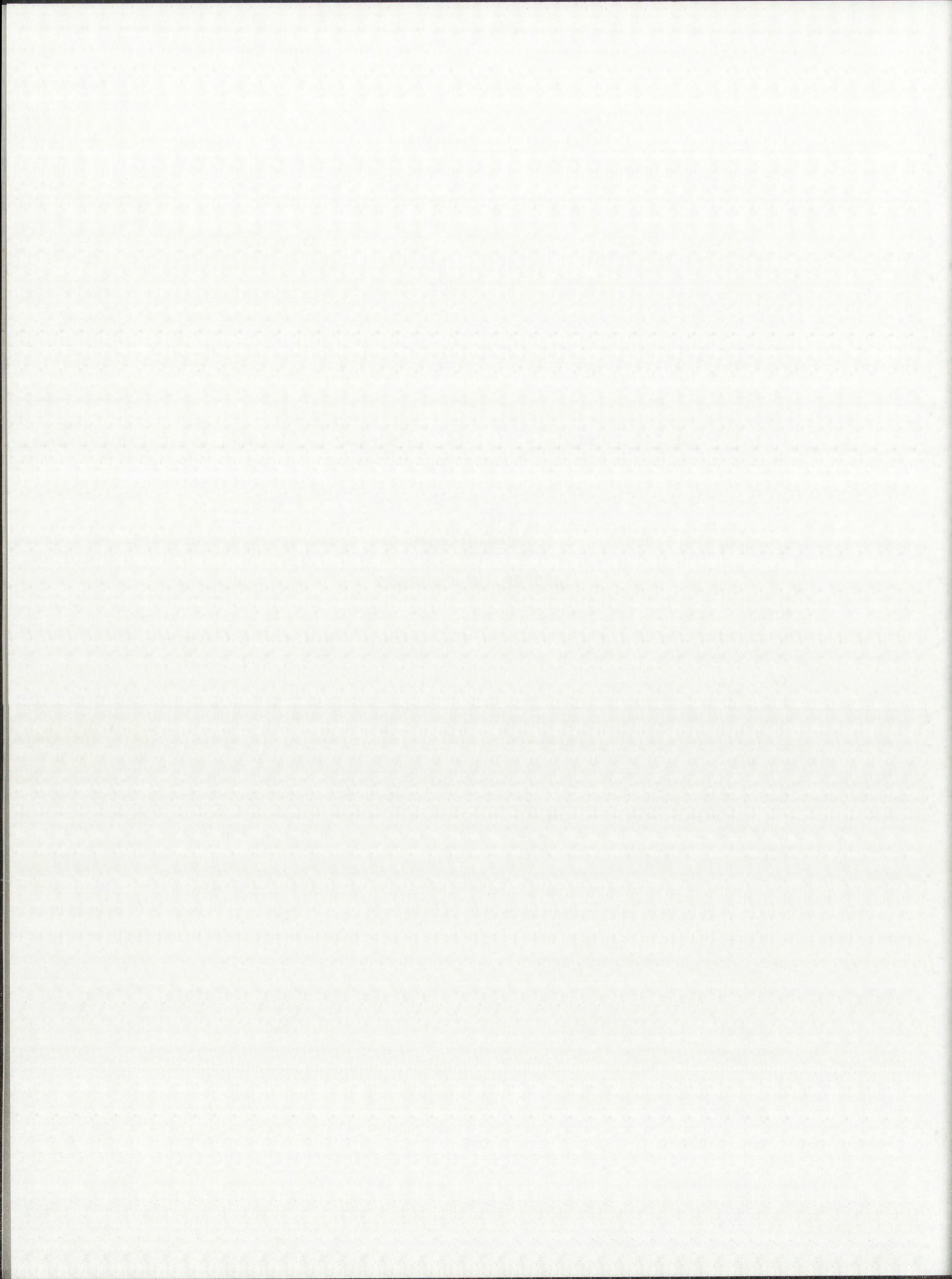
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APPENDIX B

LETTER OF CONSENT



October 20, 1999

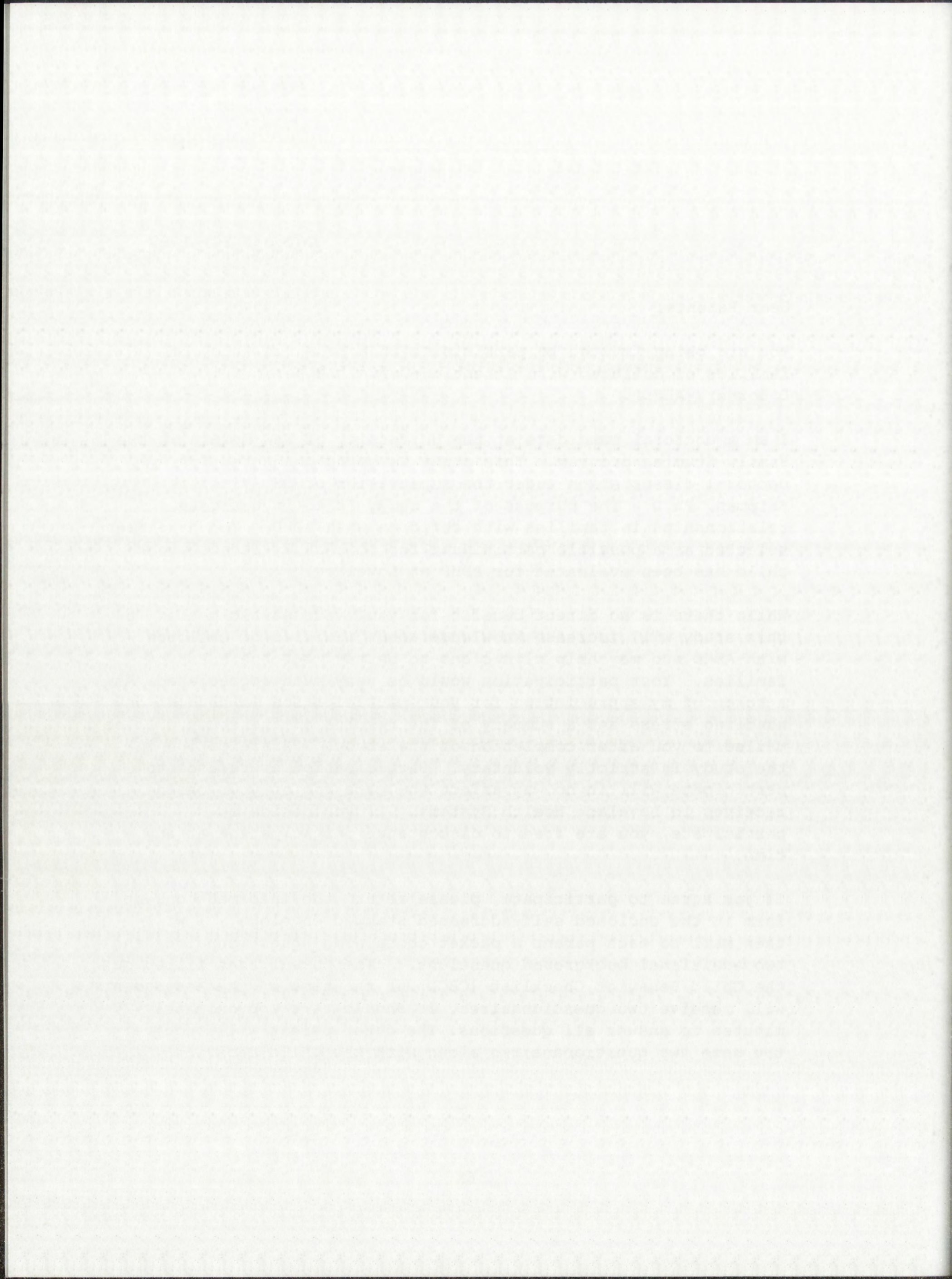
Dear Parents:

You are being invited to participate in a research study of families of children with Attention-Deficit/Hyperactivity Disorder (ADHD).

I am a doctoral candidate at the University of New Mexico in the Family Studies program. This study is being conducted for my doctoral dissertation under the supervision of Dr. Virginia Shipman, Ph.D. The purpose of the study is to investigate relationships in families with children with ADHD. You have been selected as a possible participant for this study because your child has been evaluated for ADHD at Lovelace.

While there is no direct benefit for you, your participation in this study will increase knowledge about families of children with ADHD and may help clinicians to better meet the needs of families. Your participation would be very much appreciated. As a token of my appreciation for your participation, a handout on handling stress and a summary of the results of the study will be mailed to you after completion of the study. Participation in the study is strictly voluntary. Participation or refusal to participate will in no way affect the care you or your child receives in Lovelace Health Systems. If you decide to participate, you are free to discontinue participation at any time.

If you agree to participate, please return the informed consent form in the enclosed self-addressed stamped envelope. I will then mail to each parent a packet containing questionnaires and two additional background questions. The parent that filled out the Child Behavior Checklist (CBCL) at the time of the assessment will receive two questionnaires. It should take approximately 20 minutes to answer all questions. The other parent will receive the same two questionnaires along with the Child Behavior



Checklist (CBCL). It is important that each parent individually answer the questionnaires according to his/her experience and feelings and not discuss answers until the questionnaires have been mailed back to the researcher. Self-addressed stamped envelopes will be provided for each parent.

Additionally, with your permission, the information filled out on the Patient Information Form and Child Behavior Checklist (CBCL) at the time of assessment will be used in the study. All provided information will be kept strictly confidential and will be recorded in a manner that does not identify you or your child.

If you have any questions, please call me, Peggy Morris, at 342-8400. If you have additional questions, please call Dr. Virginia Shipman Ph.D., Professor of Family Studies, or Dr. Jose Rivera, Ph.D., Chair of the Human Subjects Institutional Review Board at the University of New Mexico.

You will be given a copy of the consent form to keep.

You are making a decision whether or not to participate. Your signatures indicate that you have decided to participate having read the information provided. Such consent, however, does not waive any of your legal rights.

Thank you for your consideration.

Sincerely,

Peggy Morris, M.S., LPC



APPENDIX C
DYADIC ADJUSTMENT SCALE



DAS by Graham B. Spanler, Ph.D.

Name: _____ Sex: M F Marital Status: _____ Age: _____

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Circle the star under one answer for each item.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances.....	*	*	*	*	*	*
2. Matters of recreation.....	*	*	*	*	*	*
3. Religious matters.....	*	*	*	*	*	*
4. Demonstrations of affection.....	*	*	*	*	*	*
5. Friends.....	*	*	*	*	*	*
6. Sex relations.....	*	*	*	*	*	*
7. Conventionality (correct or proper behavior).....	*	*	*	*	*	*
8. Philosophy of life.....	*	*	*	*	*	*
9. Ways of dealing with parents or in-laws.....	*	*	*	*	*	*
10. Aims, goals, and things believed important.....	*	*	*	*	*	*
11. Amount of time spent together.....	*	*	*	*	*	*
12. Making major decisions.....	*	*	*	*	*	*
13. Household tasks.....	*	*	*	*	*	*
14. Leisure time interests and activities.....	*	*	*	*	*	*
15. Career decisions.....	*	*	*	*	*	*

	All The Time	Most Of The Time	More Often Than Not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or termination of your relationship?.....	*	*	*	*	*	*
17. How often do you or your mate leave the house after a fight?.....	*	*	*	*	*	*
18. In general, how often do you think that things between you and your partner are going well?.....	*	*	*	*	*	*
19. Do you confide in your mate?.....	*	*	*	*	*	*
20. Do you ever regret that you married (or lived together)?.....	*	*	*	*	*	*
21. How often do you and your partner quarrel?.....	*	*	*	*	*	*
22. How often do you and your mate get on each others' nerves?.....	*	*	*	*	*	*

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?.....	*	*	*	*	*

	All Of Them	Most Of Them	Some Of Them	Very Few Of Them	None Of Them
24. Do you and your mate engage in outside interests together?.....	*	*	*	*	*

	Never	Less Than Once A Month	Once Or Twice A Month	Once Or Twice A Week	Once A Day	More Often
How often do the following occur between you and your mate?						
25. Have a stimulating exchange of ideas.....	*	*	*	*	*	*
26. Laugh together.....	*	*	*	*	*	*
27. Calmly discuss something.....	*	*	*	*	*	*
28. Work together on a project.....	*	*	*	*	*	*

These are some things about which couples sometimes agree or disagree. Indicate if either item caused differences of opinions or were problems in the past few weeks.

	Yes	No
29. Being too tired for sex.....	*	*
30. Not showing love.....	*	*

31. The stars on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Circle the star above the phrase which best describes the degree of happiness, all things considered, of your relationship.

*	*	*	*	*	*	*
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship? Circle the letter for one statement.

- A. I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- B. I want very much for my relationship to succeed, and will do all I can to see that it does.
- C. I want very much for my relationship to succeed, and will do my fair share to see that it does.
- D. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to keep the relationship going.
- E. It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- F. My relationship can never succeed, and there is no more that I can do to keep the relationship going.

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APPENDIX D

THE CHILD BEHAVIOR CHECKLIST (CBCL)



Please Print

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

Office Use Only

Child's Full Name: First _____ Middle _____ Last _____

Boy Girl Age: 9 8 7 6 5 4 3 2 1 0

USE NO. 2 PENCIL ONLY

RIGHT WRONG

Grade in School: Preschool, Kindergarten, 1-12, Post High School, Not Attending School

Today's Date: Month _____ Day _____ Year _____

Child's Birthdate: Month _____ Day _____ Year _____

Ethnic Group: African American, Asian, Latino, Latina, Native American (American Indian), Pacific Islander, White Non-Latino, Other (specify): _____

Age: 9 8 7 6 5 4 3 2 1 0

Identification Number: _____

SES: _____

Agency: _____

PARENTS' USUAL TYPE OF WORK, even if not working now. Please be specific - for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY:

Mother (full name): _____

Father (full name): _____

Other - full name & relationship to child: _____

Please fill out this form to reflect your view of the child's behavior even if other people might not agree.

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None

a. _____

b. _____

c. _____

Compared to others of the same age, about how much time does he/she spend in each?

Don't Know, Less Than Average, Average, More Than Average

Compared to others of the same age, how well does he/she do each one?

Don't Know, Below Average, Average, Above Average

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include listening to radio or TV.)

None

a. _____

b. _____

c. _____

Compared to others of the same age, about how much time does he/she spend in each?

Don't Know, Less Than Average, Average, More Than Average

Compared to others of the same age, how well does he/she do each one?

Don't Know, Below Average, Average, Above Average

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None

a. _____

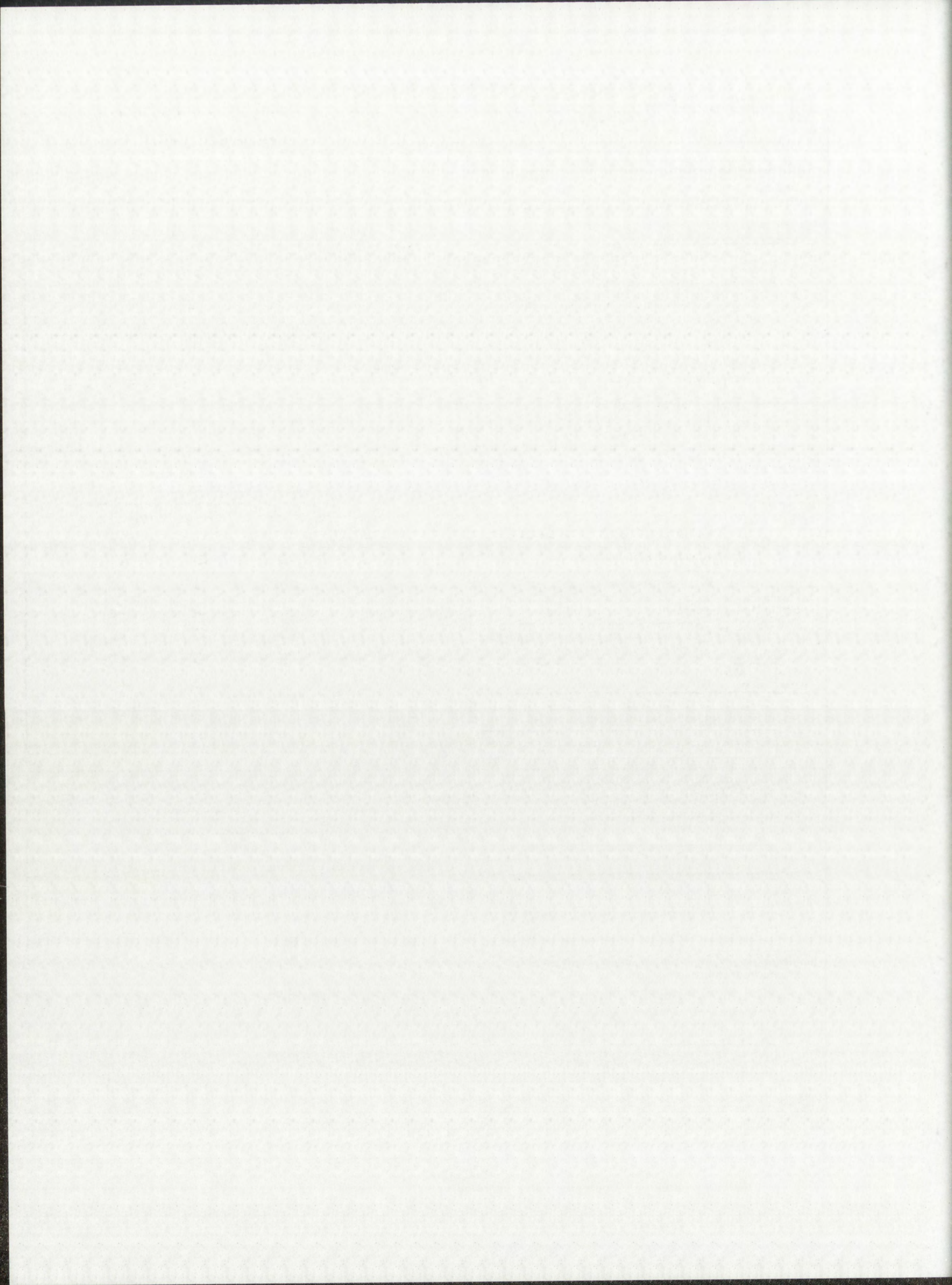
b. _____

c. _____

Compared to others of the same age, how active is he/she in each?

Don't Know, Less Active, Average, More Active

0 9 5 0 9
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IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store. (Include both paid and unpaid jobs and chores.) None

Compared to others of the same age, how well does he/she carry them out?

Don't Know Below Average Average Above Average

a.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

V. 1. About how many close friends does your child have? (Do not include brothers and sisters) None 1 2 or 3 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers and sisters) Less than 1 1 or 2 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	<input type="radio"/> Has no brothers or sisters
a. Get along with his/her brothers and sisters?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
b. Get along with other kids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
c. Behave with his/her parents?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
d. Play and work alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

VII. 1. For ages 6 and older - performance in academic subjects: Not attending school because:

	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. History or Social Studies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Arithmetic or Math	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Science	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other academic subjects - for example: computer course, foreign language, business. Do not include gym, shop, driver's ed., etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Does your child receive special remedial services or attend a special class or special school? No Yes - kind of services, class or school:

3. Has your child repeated any grades? No Yes - grades and reasons:

4. Has your child had any academic or other problems in school? No Yes - please describe:

When did these problems start?

Have these problems ended? No Yes - when?

Does your child have any illness or disability (either physical or mental)? No Yes - please describe:

What concerns you most about your child?

Please describe the best things about your child:

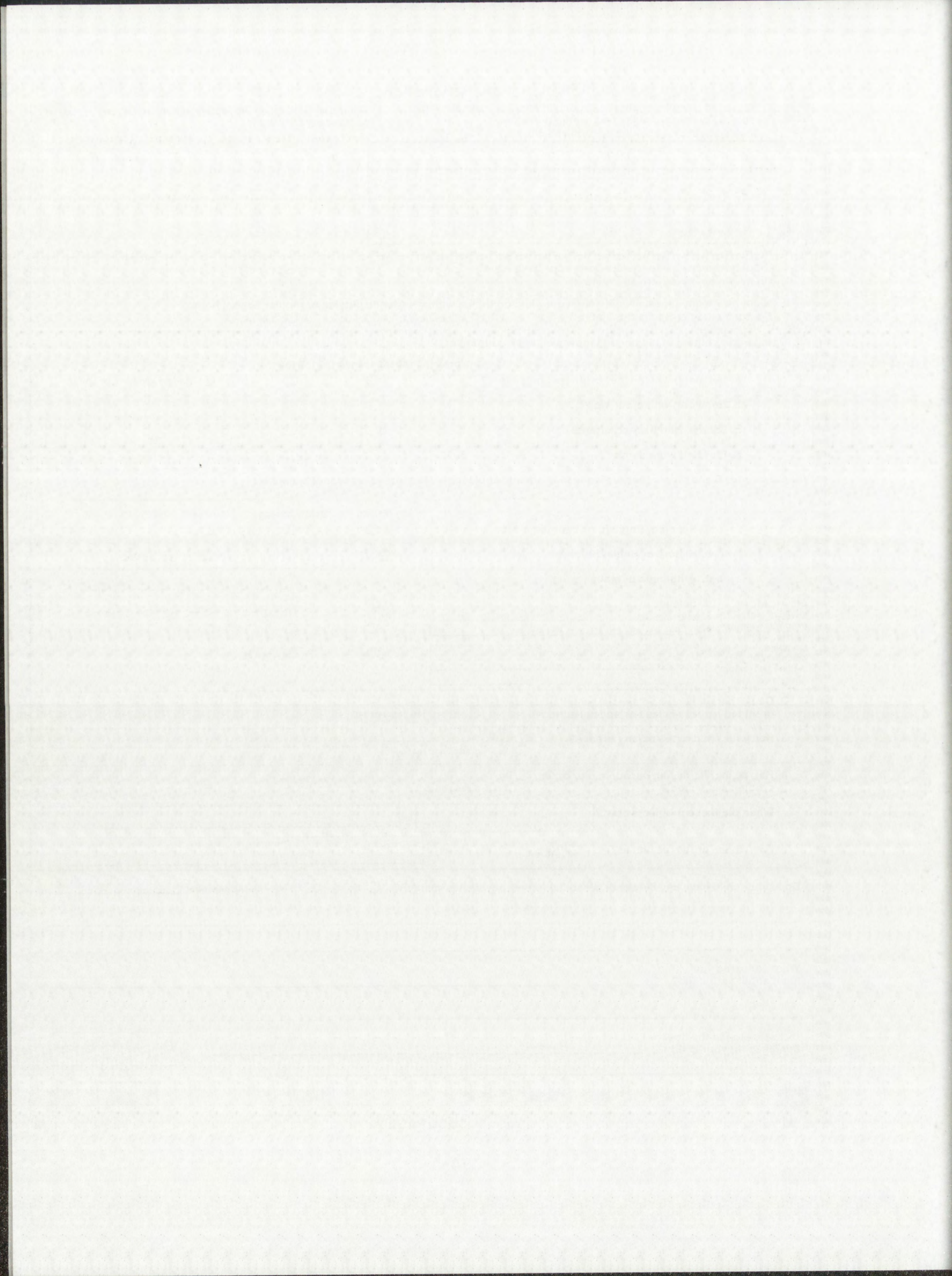
0	9	5	0	9
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Please Print

Below is a list of items that describe children and youths. For each item that describes your child *now or within the past 6 months*, please fill in the bubble under 2 if the item is very true or often true of your child. Fill in the bubble under 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, fill in the bubble under 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2
 1. Acts too young for his/her age
 2. Allergy (describe):

0 1 2
 3. Argues a lot
 4. Asthma
 0 1 2
 5. Behaves like opposite sex
 6. Bowel movements outside toilet
 0 1 2
 7. Bragging, boasting
 8. Can't concentrate, can't pay attention for long
 0 1 2
 9. Can't get his/her mind off certain thoughts; obsessions (describe):

0 1 2
 10. Can't sit still, restless, or hyperactive
 0 1 2
 11. Clings to adults or too dependent
 12. Complains of loneliness
 0 1 2
 13. Confused or seems to be in a fog
 14. Cries a lot
 0 1 2
 15. Cruel to animals
 16. Cruelty, bullying, or meanness to others
 0 1 2
 17. Day-dreams or gets lost in his/her thoughts
 18. Deliberately harms self or attempts suicide
 0 1 2
 19. Demands a lot of attention
 20. Destroys his/her own things
 0 1 2
 21. Destroys things belonging to his/her family or others
 0 1 2
 22. Disobedient at home
 0 1 2
 23. Disobedient at school
 24. Doesn't eat well
 0 1 2
 25. Doesn't get along with other kids
 26. Doesn't seem to feel guilty after misbehaving
 0 1 2
 27. Easily jealous
 28. Eats or drinks things that are not food - *don't* include sweets (describe):

0 1 2
 29. Fears certain animals, situations, or places, other than school (describe):

0 1 2
 30. Fears going to school
 0 1 2
 31. Fears he/she might think or do something bad

0 1 2
 32. Feels he/she has to be perfect
 33. Feels or complains that no one loves him/her
 0 1 2
 34. Feels others are out to get him/her
 35. Feels worthless or inferior
 0 1 2
 36. Gets hurt a lot, accident-prone
 37. Gets in many fights
 0 1 2
 38. Gets teased a lot
 39. Hangs around with others who get in trouble
 0 1 2
 40. Hears sounds or voices that aren't there (describe):

0 1 2
 41. Impulsive or acts without thinking
 0 1 2
 42. Would rather be alone than with others
 43. Lying or cheating
 0 1 2
 44. Bites fingernails
 45. Nervous, highstrung, or tense
 0 1 2
 46. Nervous movements or twitching (describe):

0 1 2
 47. Nightmares
 0 1 2
 48. Not liked by other kids
 49. Constipated, doesn't move bowels
 0 1 2
 50. Too fearful or anxious
 51. Feels dizzy
 0 1 2
 52. Feels too guilty
 53. Overeating
 0 1 2
 54. Overtired
 55. Overweight

56. Physical problems *without known medical cause*:
 0 1 2
 a. Aches or pains (*not* stomach or headaches)
 b. Headaches
 c. Nausea, feels sick
 d. Problems with eyes (*not* if corrected by glasses) (describe):

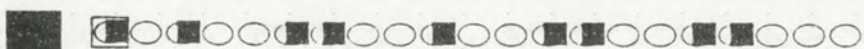
0 1 2
 e. Rashes or other skin problems
 f. Stomachaches or cramps
 g. Vomiting, throwing up
 h. Other (describe):

0 1 2
 57. Physically attacks people

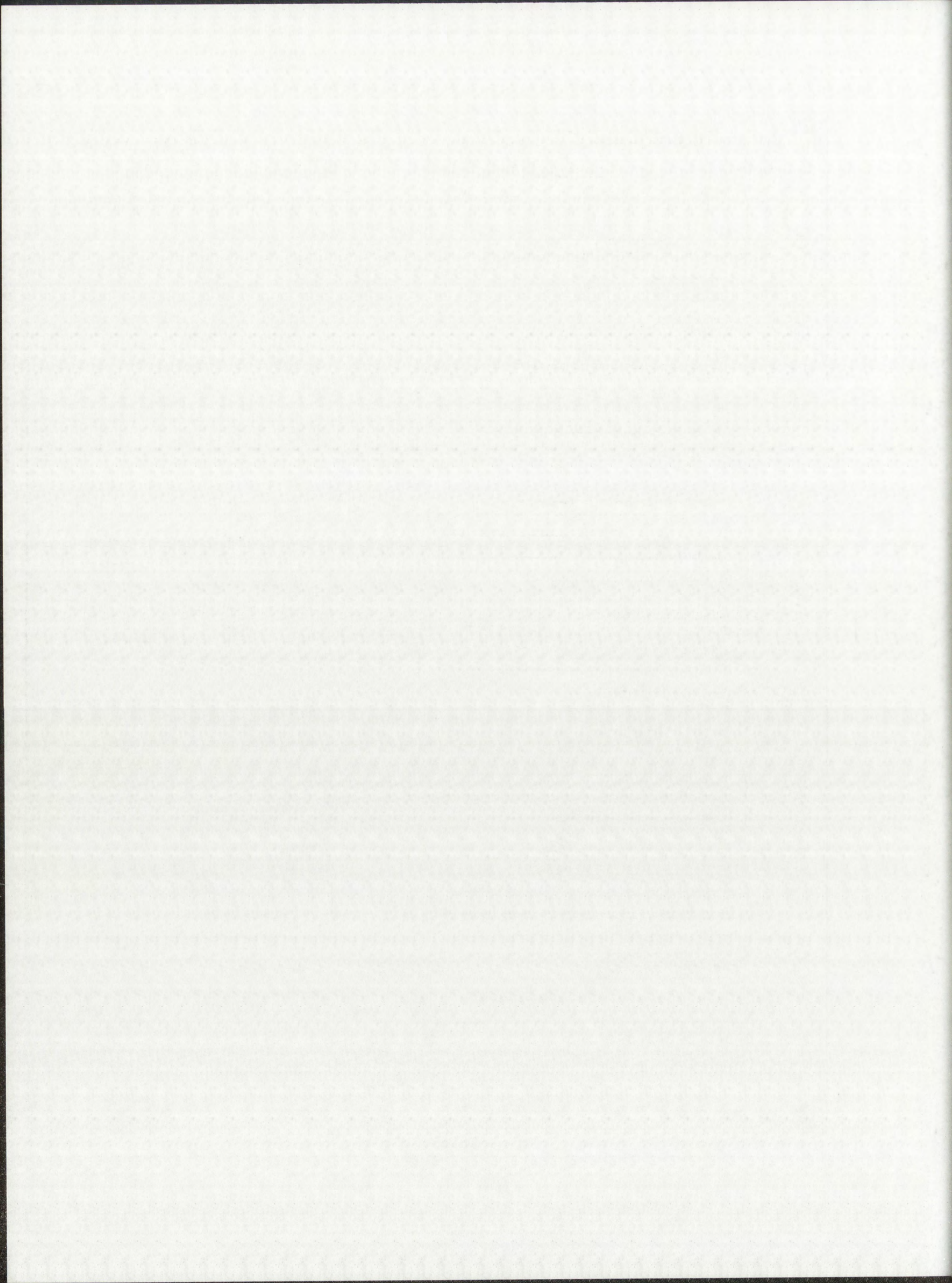
0 9 5 0 9

Please see other side

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Please Print

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2
 58. Picks nose, skin, or other parts of body (describe):

0 1 2
 59. Plays with own sex parts in public
 60. Plays with own sex parts too much

0 1 2
 61. Poor school work
 62. Poorly coordinated or clumsy

0 1 2
 63. Prefers being with older kids
 64. Prefers being with younger kids

0 1 2
 65. Refuses to talk
 66. Repeats certain acts over and over; compulsions (describe):

0 1 2
 67. Runs away from home
 68. Screams a lot

0 1 2
 69. Secretive, keeps things to self
 70. Sees things that aren't there (describe):

0 1 2
 71. Self-conscious or easily embarrassed
 72. Sets fires

0 1 2
 73. Sexual problems (describe):

0 1 2
 74. Showing off or clowning

0 1 2
 75. Shy or timid
 76. Sleeps less than most kids

0 1 2
 77. Sleeps more than most kids during day and/or night (describe):

0 1 2
 78. Smears or plays with bowel movements

0 1 2
 79. Speech problem (describe):

0 1 2
 80. Stares blankly

0 1 2
 81. Steals at home
 82. Steals outside the home

0 1 2
 83. Stores up things he/she doesn't need (describe):

0 1 2
 84. Strange behavior (describe):

0 1 2
 85. Strange ideas (describe):

0 1 2
 86. Stubborn, sullen, or irritable

0 1 2
 87. Sudden changes in mood or feelings
 88. Sulks a lot

0 1 2
 89. Suspicious
 90. Swearing or obscene language

0 1 2
 91. Talks about killing self
 92. Talks or walks in sleep (describe):

0 1 2
 93. Talks too much
 94. Teases a lot

0 1 2
 95. Temper tantrums or hot temper
 96. Thinks about sex too much

0 1 2
 97. Threatens people
 98. Thumb-sucking

0 1 2
 99. Too concerned with neatness or cleanliness
 100. Trouble sleeping (describe):

0 1 2
 101. Truancy, skips school
 102. Underactive, slow moving, or lacks energy

0 1 2
 103. Unhappy, sad, or depressed
 104. Unusually loud

0 1 2
 105. Uses alcohol or drugs for nonmedical purposes (describe):

0 1 2
 106. Vandalism

0 1 2
 107. Wets self during the day
 108. Wets the bed

0 1 2
 109. Whining
 110. Wishes to be of opposite sex

0 1 2
 111. Withdrawn, doesn't get involved with others
 112. Worries

113. Please write in any problems your child has that were not listed above:

0 1 2

0 1 2

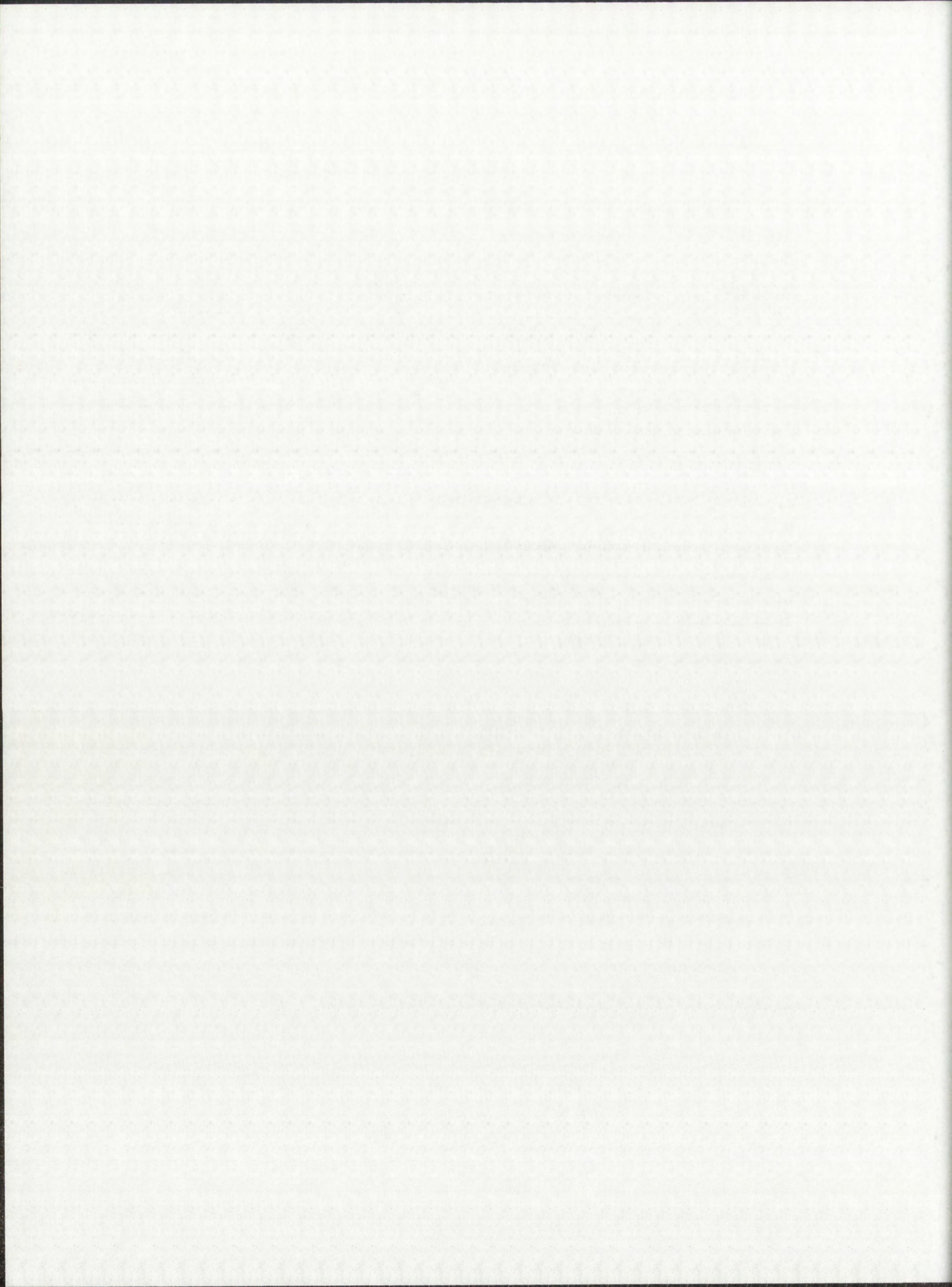
0 1 2

0 9 5 0 9

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APPENDIX E
CHILD AND ADOLESCENT SERVICE
PATIENT INFORMATION FORM



**ParkCenter
Child and Adolescent Service
Patient Information Form**

Date Filled Out: _____ Lovelace # _____

Identifying Information

Child's name: _____ Birthdate: _____ Age: _____

Person filling out form: _____ Relationship to child: _____

Address: (mother) _____ (father) _____

Phone: (mother) _____ (father) _____

Name of school: _____ Grade: _____

Primary care physician: _____ Referred by: _____

List of problems that resulted in the referral: _____

Approximately how long have the problems been noticed? _____

Please describe previous treatment by mental health professionals (include use of medications for behavior/emotions).

Child's Development

1. Pregnancy

Was the child's birth planned? Yes No

How many months was the pregnancy? _____

If known, describe the mother's use of cigarettes, alcohol, and/or illegal drugs during the pregnancy:

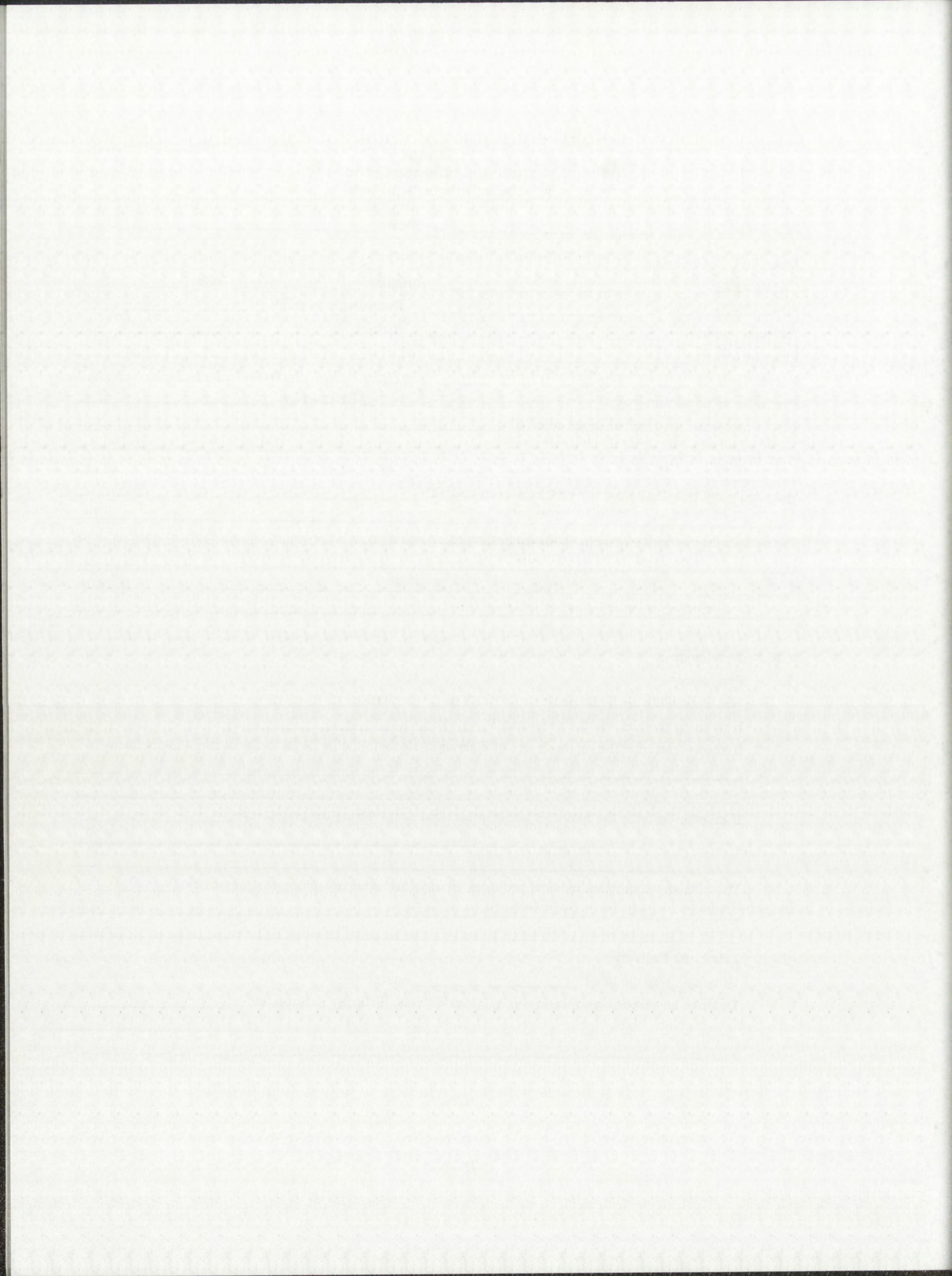
If known, describe the mother's use of prescribed drugs during the pregnancy: _____

Describe any significant medical problems (if any) that occurred during the pregnancy: _____

2. Labor and Delivery

How long was the labor? _____ hours

Describe any labor complications (e.g., fetal distress, difficulty position, etc.): _____



Describe delivery special interventions (induced, Cesarean section, use of forceps, etc.): _____

3. Birth

Birth weight: _____ pounds, _____ ounces

Early medical problems (breathing, sucking, swallowing, jaundice, meconium staining, etc.)? _____

Did the baby require intensive care? yes no

4. Infancy

Please describe any behavioral and/or medical problems in the first year of life: _____

5. Early development

Age began walking? _____ Age he/she said first words? _____

Age he/she spoke in sentences? _____

Describe any speech abnormalities: _____

Describe his/her response to affection/cuddling during the "toddler" years: _____

Describe his/her response to other children: _____

Temperment: During preschool years, was the child especially (✓):

- Fearful Yes No If yes, describe: _____
- Shy Yes No If yes, describe: _____
- Aggressive Yes No If yes, describe: _____
- Hyperactive Yes No If yes, describe: _____
- Passive Yes No If yes, describe: _____

Describe any other behavioral/emotional problems noted during the preschool years: _____

Medical

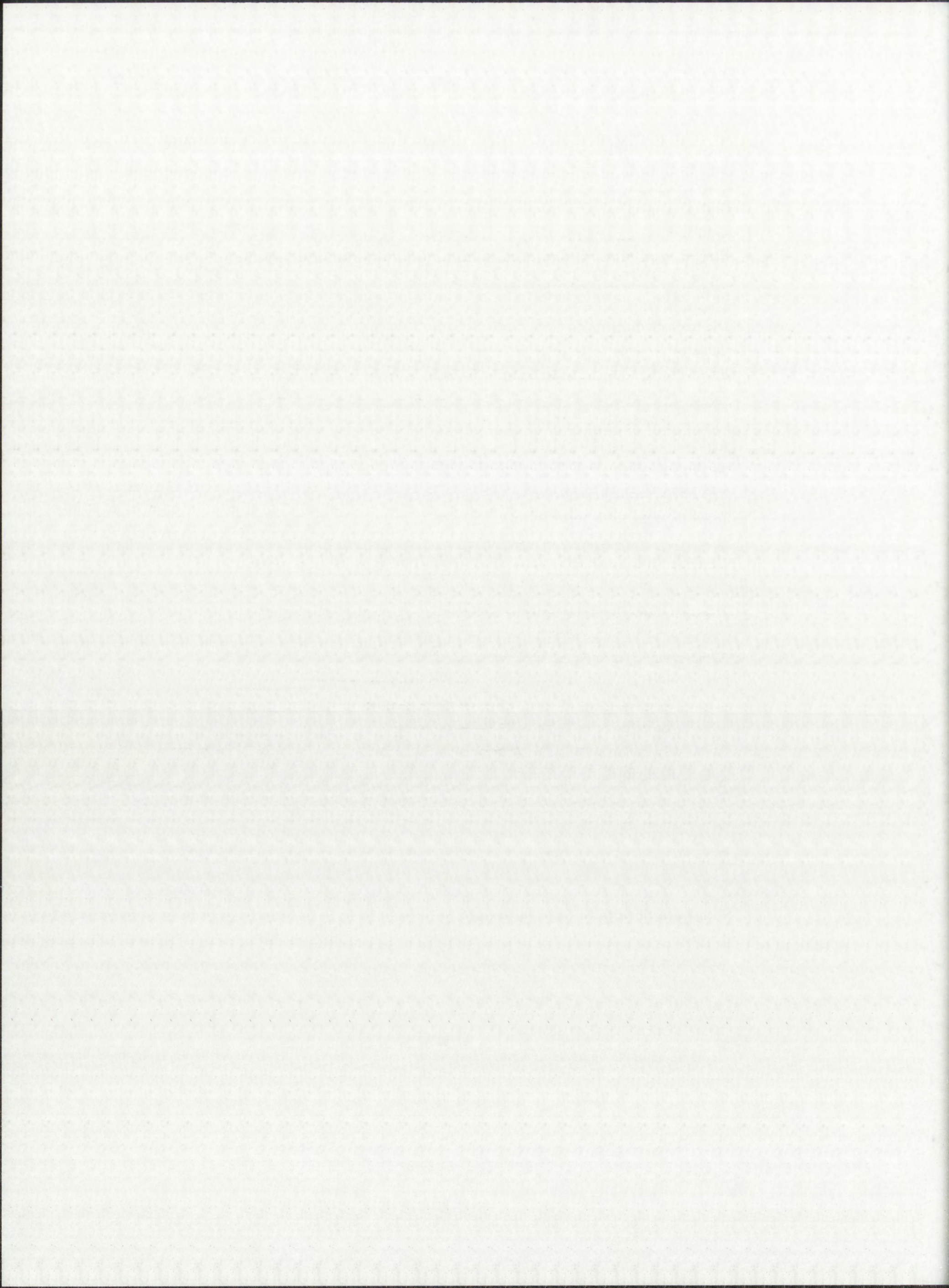
1. Please describe the child's history of:

Surgery: _____

Serious or chronic medical problems: _____

Seizures: _____

Head injuries/loss of consciousness: _____



Medical - Continued:

2. Is the child currently on medication? Yes No
If yes, what? _____
3. List any allergies to medications: _____
Other allergies: _____

Educational History

1. Has the child ever been held back a grade? Yes No If yes, what grade(s): _____
Reason(s): _____
2. Is the child or has he/she ever been in a gifted program? Yes No
Any special education program(s): Yes No
If yes, what kind (A-level, B-level, etc., side by side)? _____
3. What kinds of complaints (if any) do the teachers have about his/her behavior or academic performance?

4. What kinds of grades does he/she tend to get? _____

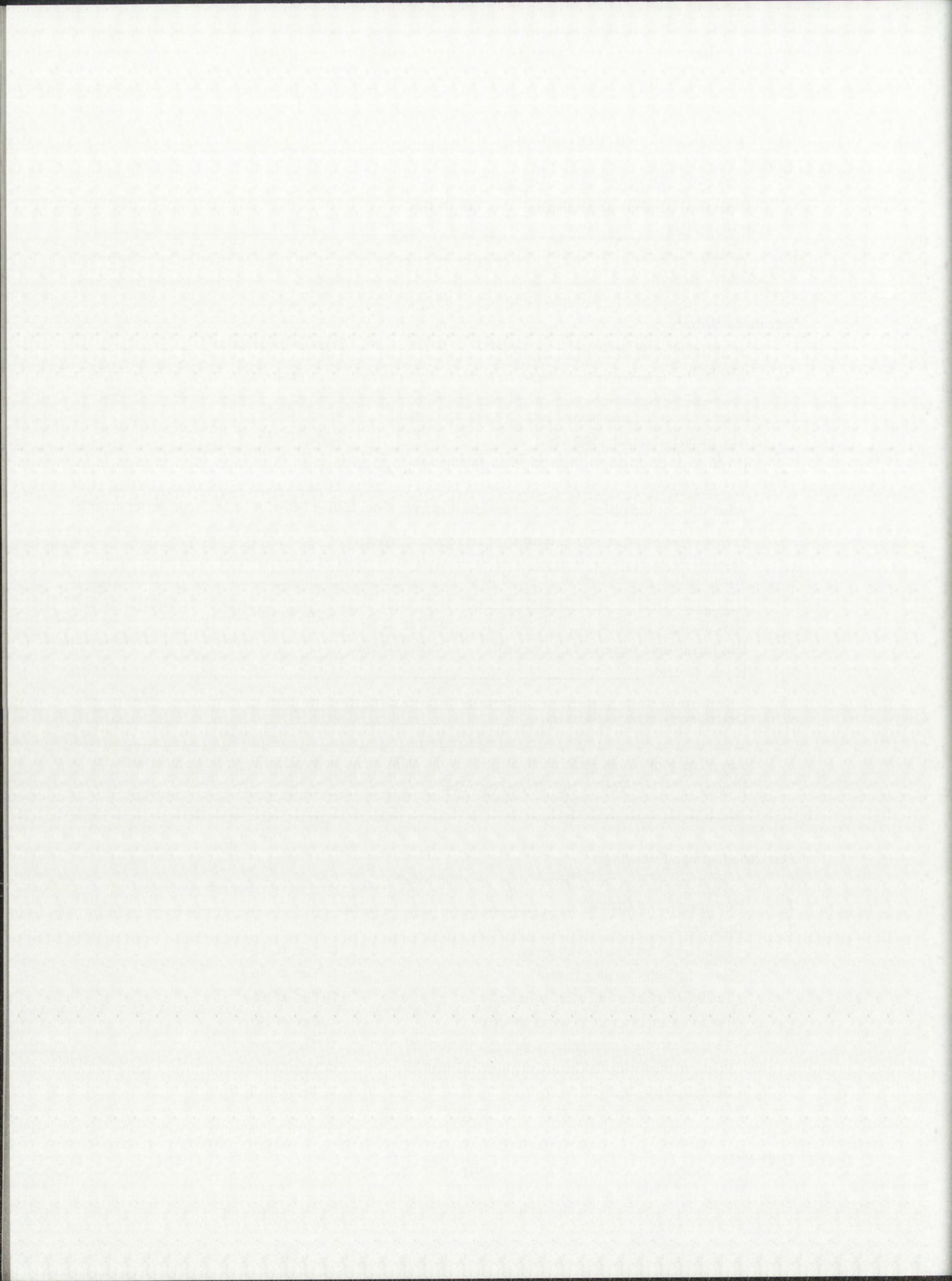
Have they gotten worse this school year? Yes No
5. Has he/she been suspended or expelled? Yes No
If yes, describe: _____

6. Describe any history of truancy: _____

Any history of school phobia/refusal (i.e., is the child afraid or avoidant regarding school and stays at home)? Yes No If yes, describe: _____

Peer Relationships/Friendships

1. Approximately how many friends does the child have? _____
2. How many close friends? _____
3. Does he/she:
- Fight/argue frequently with peers? Yes No
 - Have difficulty keeping friends? Yes No
 - Tend to associate with older children? Yes No
 - Tend to associate with younger children? Yes No
 - Tend to associate with children who get in trouble? Yes No
 - Prefer to play with children of the opposite sex? Yes No
 - Get teased by other children? Yes No



Peer Relationships/Friendships - Continued:

4. Do you approve of his/her friends? Yes No

5. Describe other peer problems: _____

Activities

1. Please list (if any) the organized (school, little league, etc.), sports in which the child is involved: _____

2. Please list the unorganized athletic activities (e.g., skateboarding, skiing, hiking, etc.) in which the child participates: _____

3. Please list any organized group activities (e.g., school, church, community): _____

4. Please list other activities at home or in the community (e.g., videogames, computers, reading, music, etc.): _____

5. Approximately how many hours of television does he/she watch per week? _____

6. How many hours of sleep does he/she average per day? _____

7. What is his/her bed time? Weekdays _____ Weekends _____

8. What time does he/she awaken in the morning? Weekdays _____ Weekends _____

9. How does he/she obtain money (allowance, work, etc.)? _____

Adolescence (If applicable)

1. Has pubertal development (body hair, voice changes, breast development, growth spurt, etc.) begun? Yes No

2. If the child is a female, has menstruation begun? Yes No If yes, when? _____

3. Does he/she "date" or go out with members of the opposite sex? Yes No

4. As far as you can determine, is he/she sexually active? Yes No

5. Does he/she have a history of arrests? Yes No
If yes, please list the offense(s) with the year(s): _____

Please list (if any) charges that are pending: _____



Adolescence - Continued:

Has he/she been in detention (D-home) or incarcerated (YDDC, Springer, etc.)? Yes No

Who is his/her probation officer? _____

What county? _____

6. Please describe his/her alcohol and drug use patterns (to the best of your knowledge) and indicate whether you think he/she has problems with chemical dependence: _____

7. Does he/she smoke/chew tobacco? Yes No If yes, how much? _____

Family Data

1. List parental figures:

	Name	Age	Education	In the Home?		Profession
				Yes	No	
Natural/adoptive mother				<input type="checkbox"/>	<input type="checkbox"/>	
Natural/adoptive father				<input type="checkbox"/>	<input type="checkbox"/>	
Stepmother(s)				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
Stepfather(s)				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)				<input type="checkbox"/>	<input type="checkbox"/>	
				<input type="checkbox"/>	<input type="checkbox"/>	

2. If the child is adopted, at what age did this occur? _____
 Where was the child before adoption? _____

3. When natural/adoptive parents married? _____ Separation? _____ Divorced? _____
 When mother married? _____ Separation? _____ Divorced? _____
 When father married? _____ Separation? _____ Divorced? _____
 What was the child's reaction? _____
 What is the visitation/custody arrangement? _____

 Who has legal custody? _____
 Is there a custody dispute at this time? Yes No



Family Data - Continued:

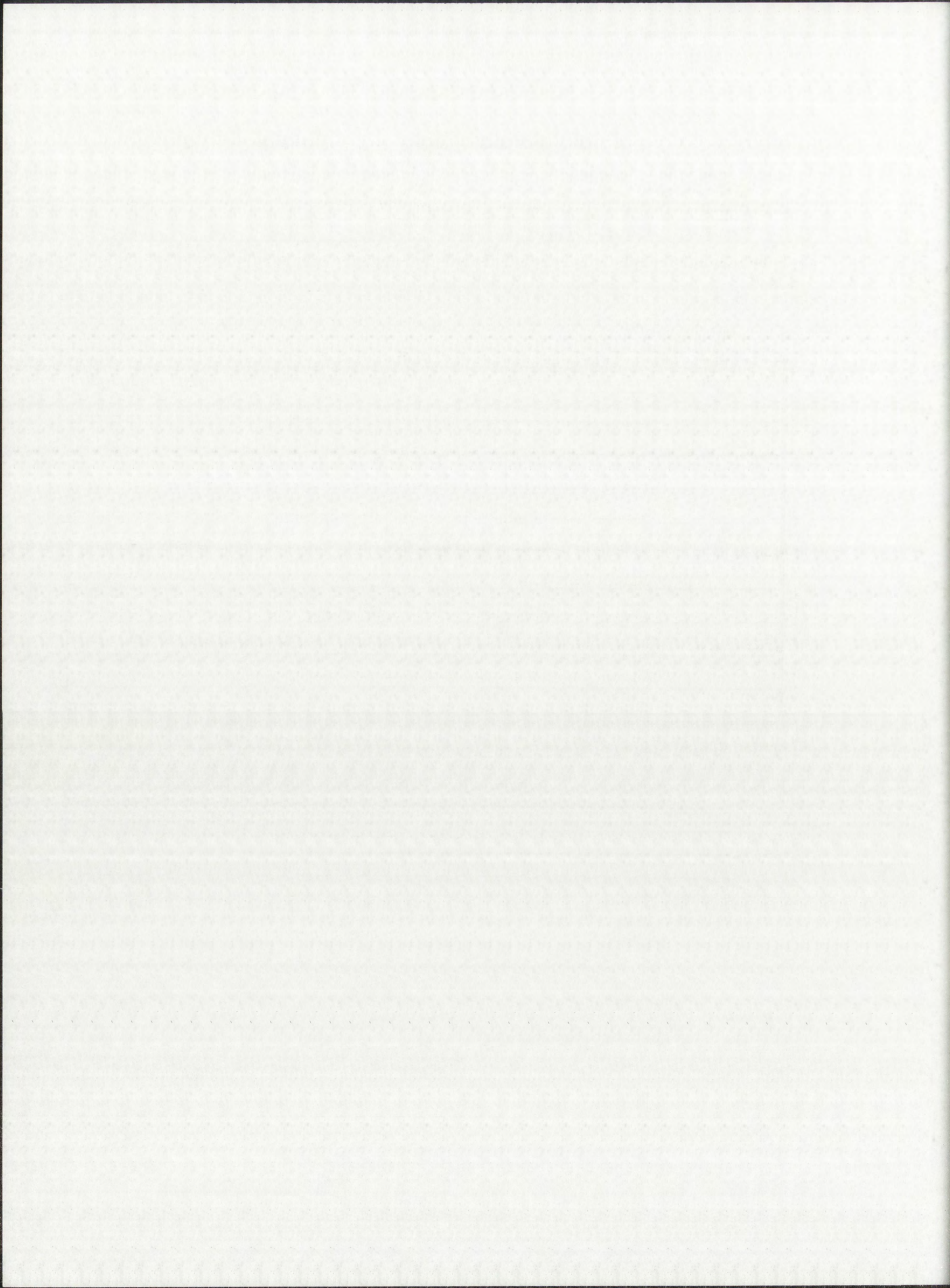
How cooperative are the divorced parents in making decisions/arrangements? _____

How does the child relate to the step-parent(s) and/or boyfriend(s)/girlfriend(s), if applicable: _____

4. List of sibling(s):

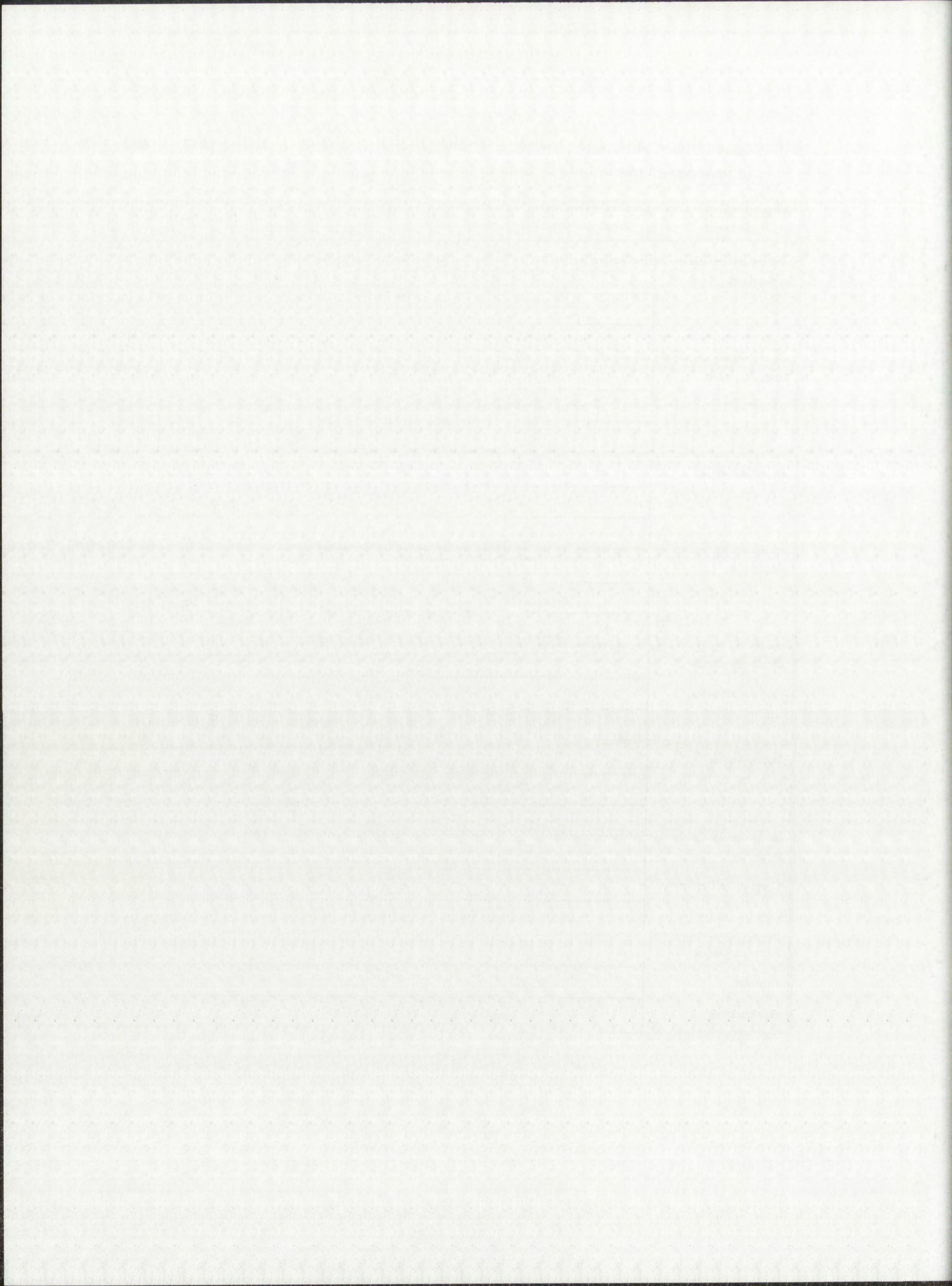
Name	Age	Relationship	How Do They Get Along	Behavioral/Emotional Problems

5. Please describe any sibling-related issues you think are important: _____



6. Family history, please note if any biological relative has been known to have any of the following disorders (if relative is on maternal or paternal side, please specify):

Disorder	Who? Relationship to Child	Outpatient Treatment	Psychiatric Hospitalization	Psychiatric Medication (If yes, what?)
Alcoholism				
Drug Addiction				
Imprisonment/Jail				
Depression				
Manic-depression (bi-polar disorder)				
Schizophrenia				
Obsessive/ Compulsive Disorder				
Attention-Deficit Disorder (hyperactivity)				



Family history: Continued

Disorder	Who? Relationship to Child	Outpatient Treatment	Psychiatric Hospitalization	Psychiatric Medication (If yes, what?)
Agoraphobia/Panic Disorder				
Tourette's Disease				

Other Issues

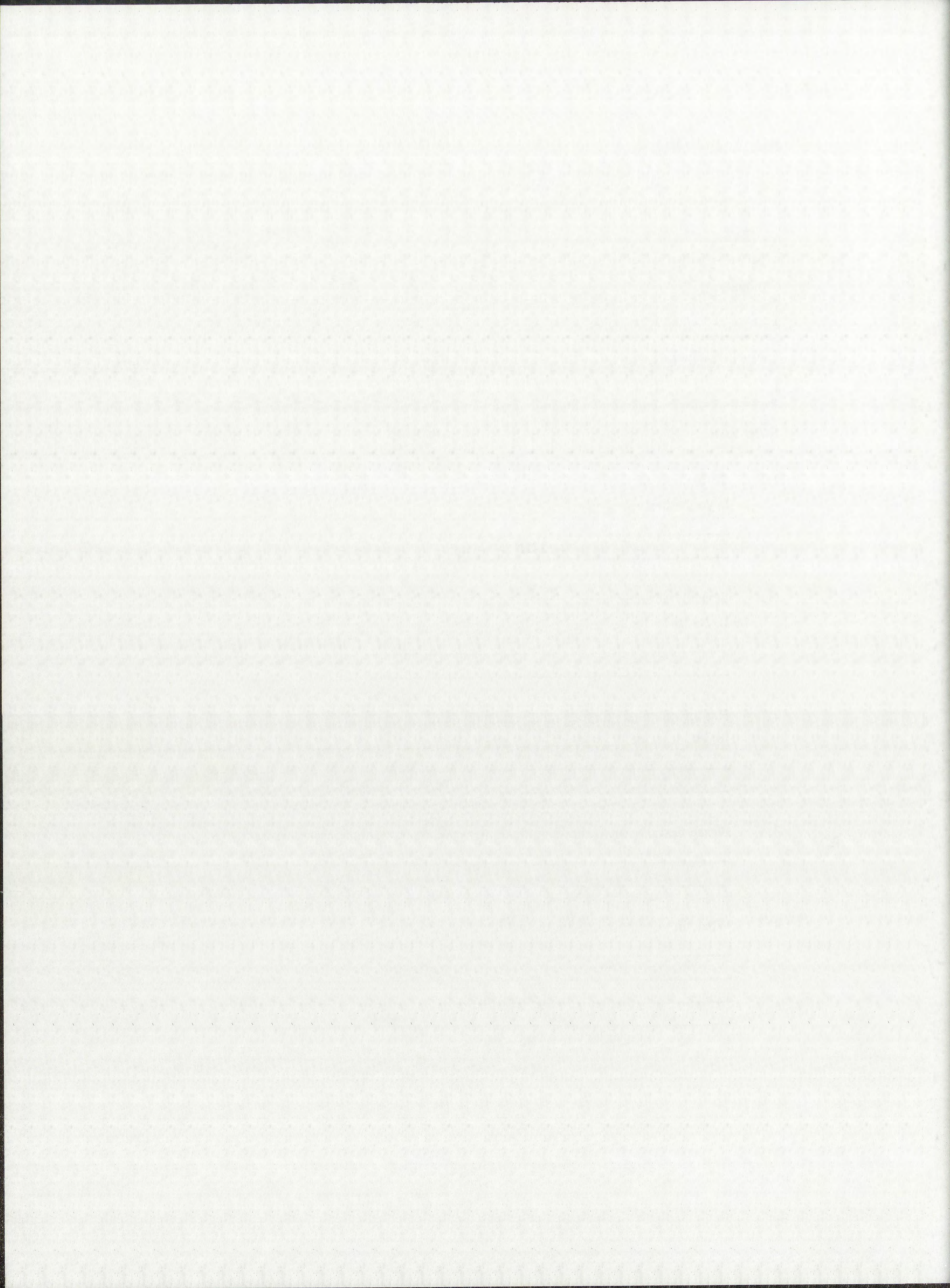
1. To the best of your knowledge, has the child been physically abused? Yes No
 If yes, describe: _____

Sexually abused? Yes No
 If yes, describe: _____

2. Has anyone close to your family recently died? Yes No
 If yes, describe: _____

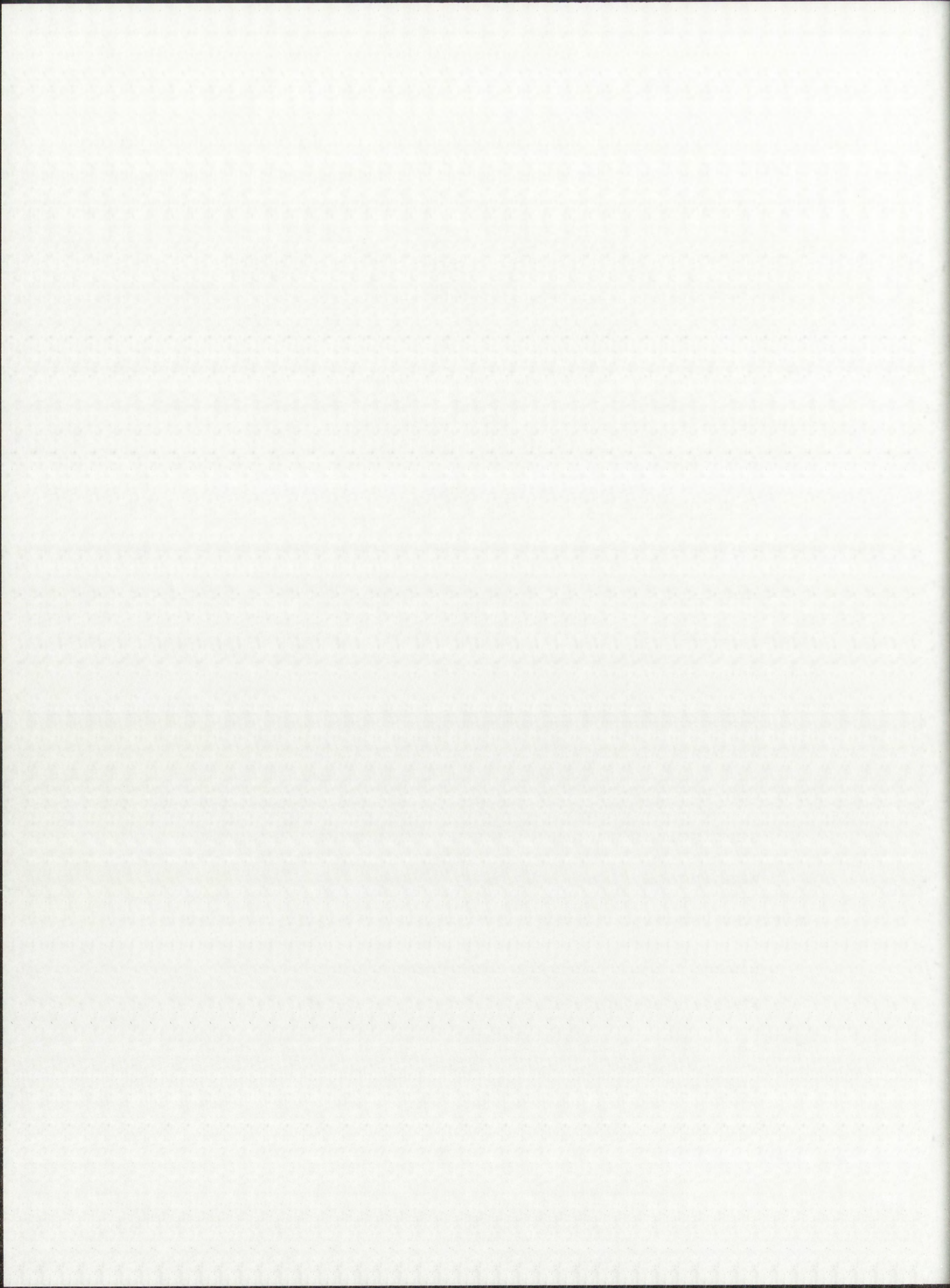
3. Please describe any other significant negative and/or traumatic experiences: _____

4. What, in your opinion, are the child's strengths/assets? _____



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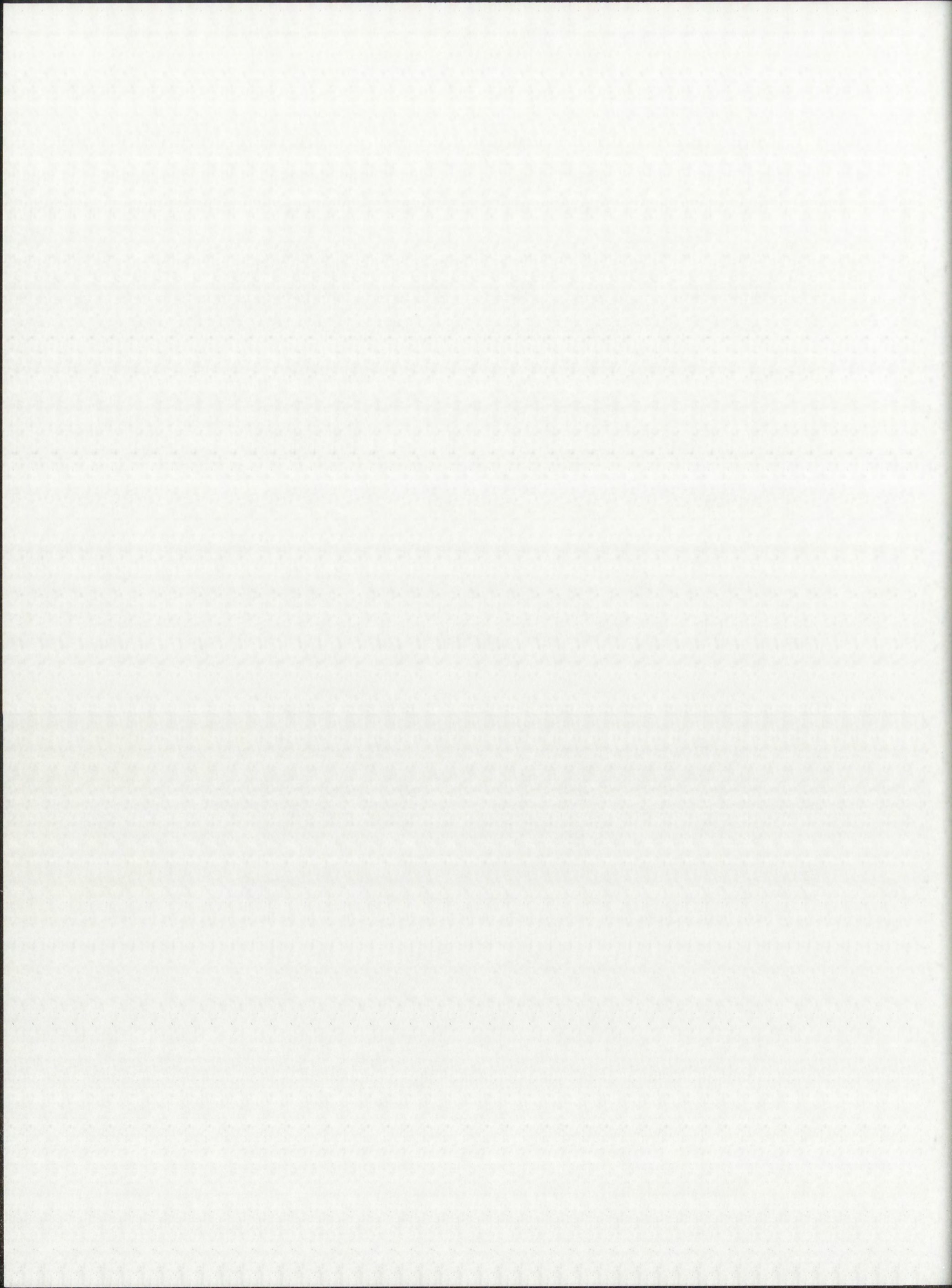
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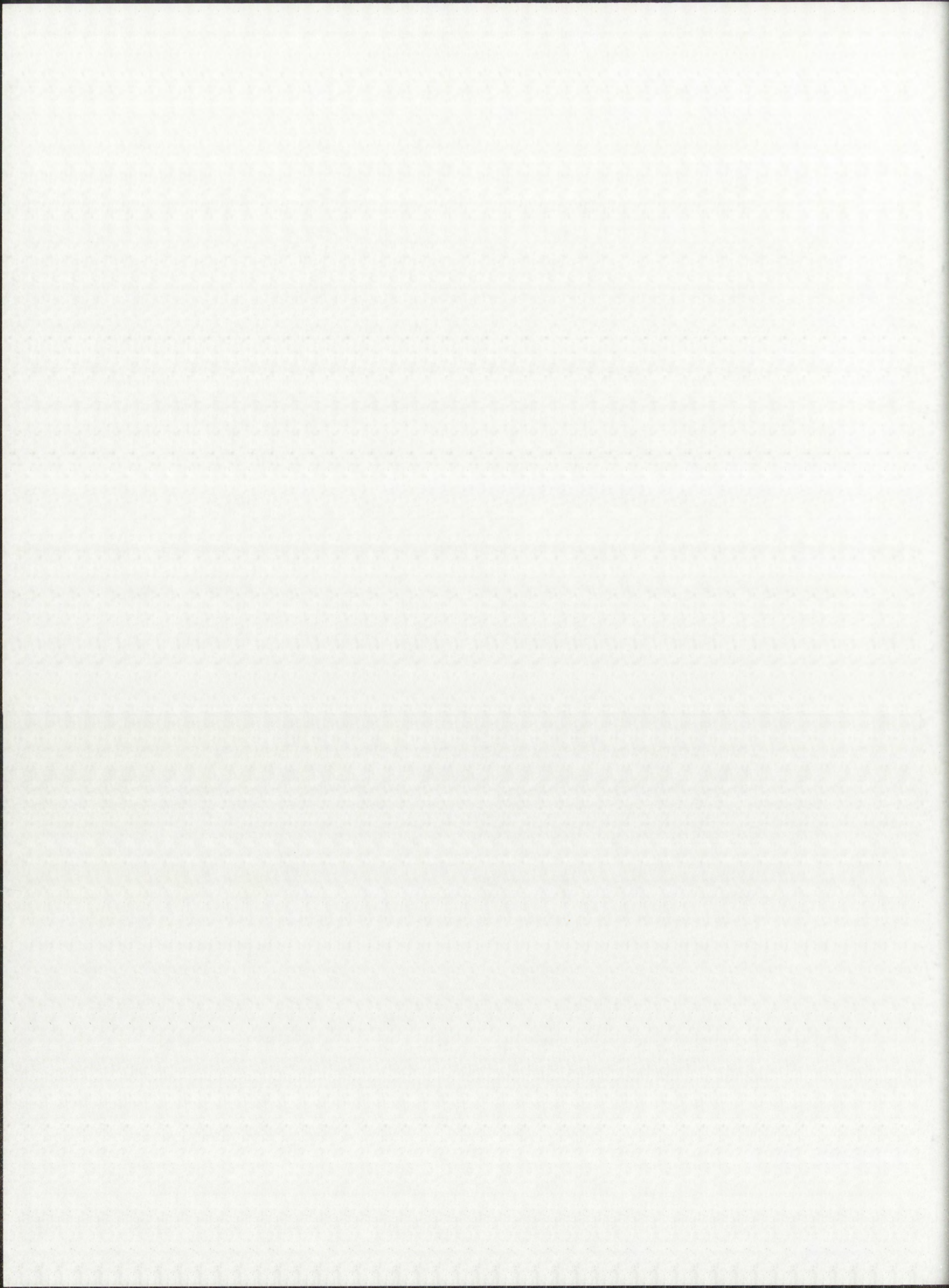
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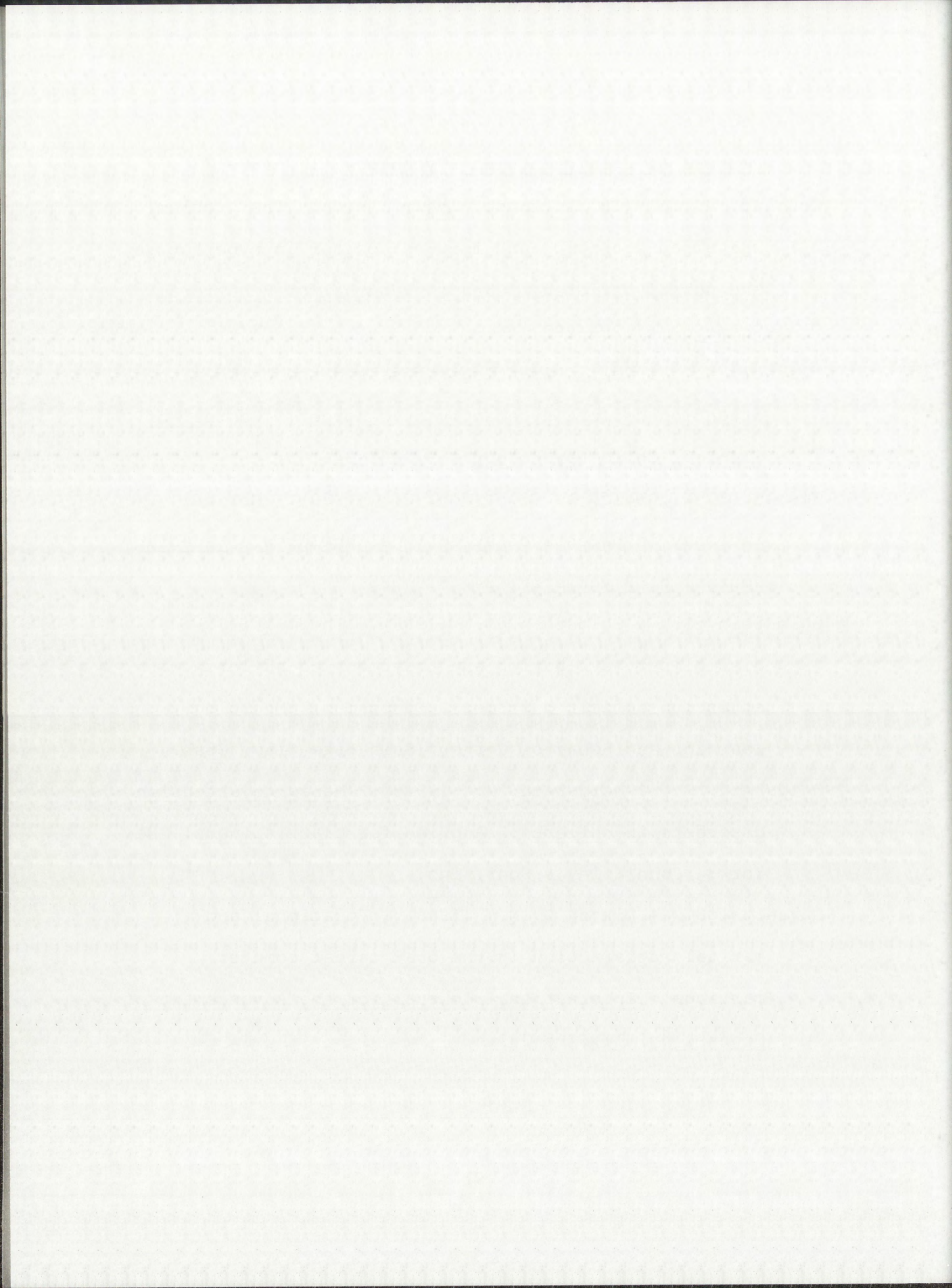
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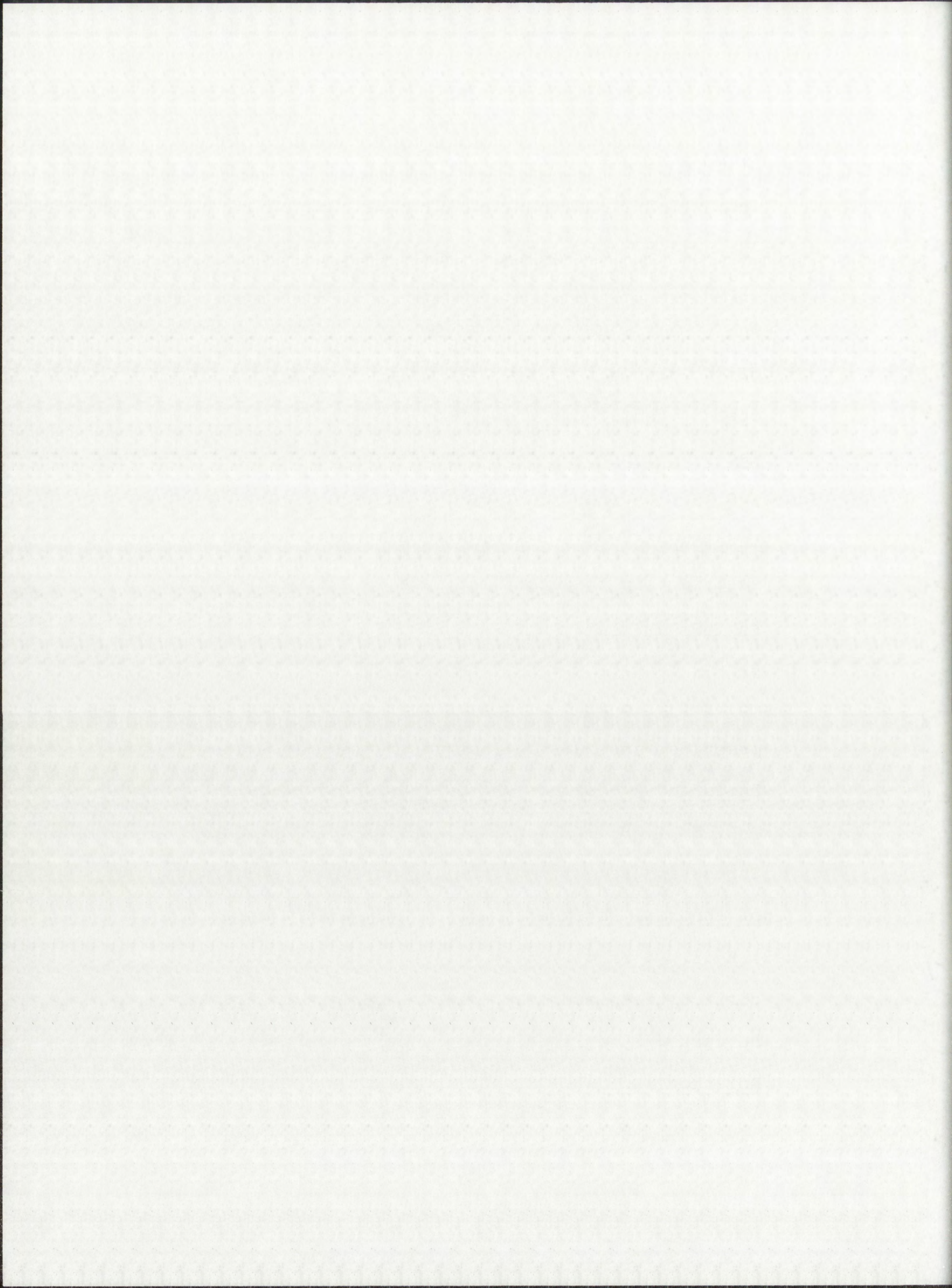
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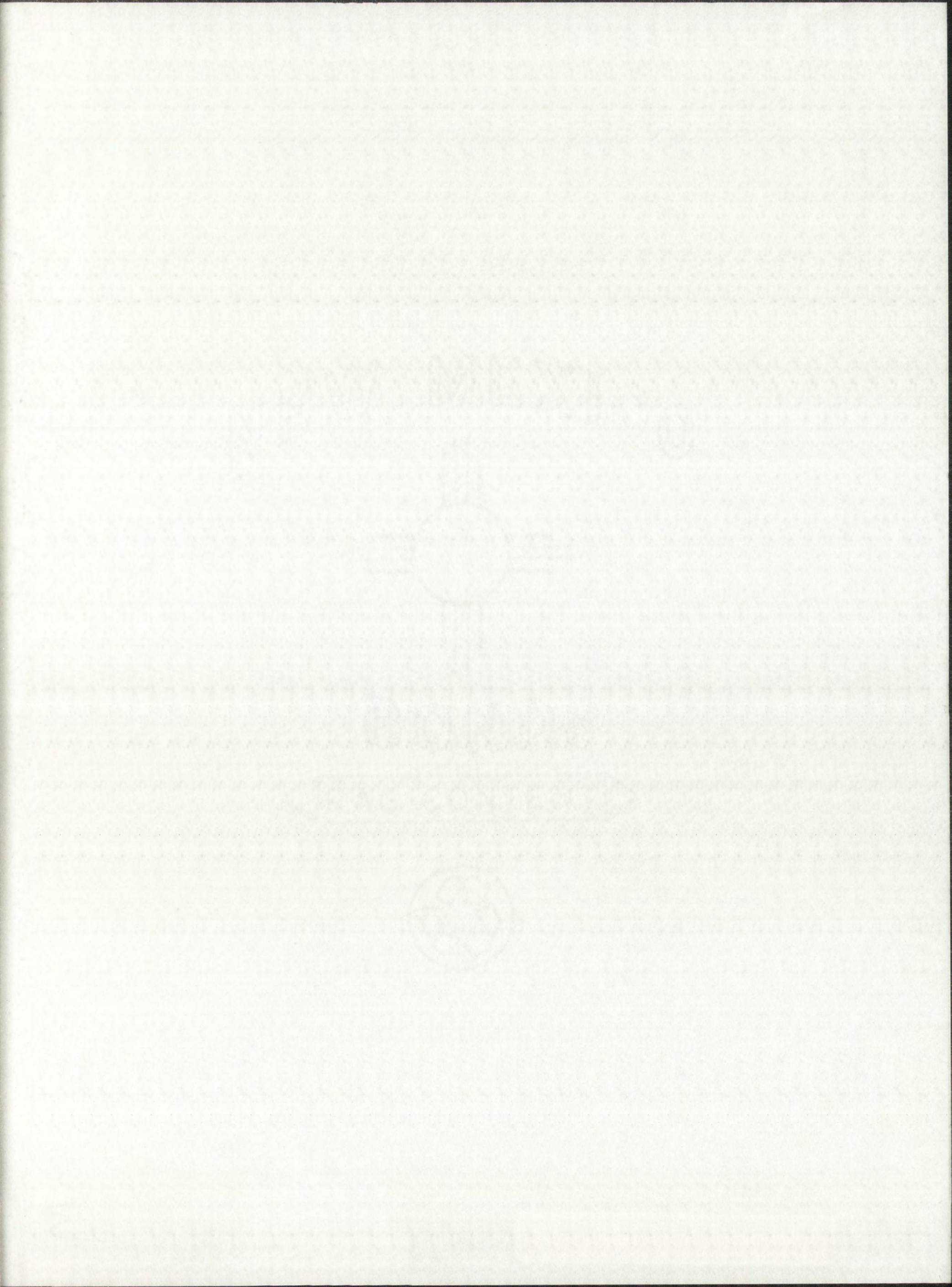


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