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Prevalence of attention deficit hyperactivity symptoms in parents of children diagnosed with the condition

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Abstract

Background: ADHD is estimated to affect 3 – 5% of British children with evidence of persistence into adulthood. Evidence for a genetic component underscores the importance of understanding the impact on families. **Aim:** To examine ADHD symptoms in parents attending clinic with an affected child. **Method:** The Adult Self Report Scale (v1.1) was given to a sample of parents. General mental health questionnaires (GHQ-12) and demographic factors were also collected. **Results:** 45.83% of parents showed ADHD symptoms. Family size greater than four correlated to high symptom scores. **Conclusion:** ADHD rates in parents were higher in this sample than general population rates of adult ADHD.
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Keywords: ADHD; parents

1.1. Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is characterised by hyperactivity, inattention and impulsivity (DSM-IV). The prevalence of adult ADHD was found to be 2.5% (Simon, 2009). Children of affected adults have ADHD in 40-54% of cases (Biedberman, 1995). The most commonly implicated gene is the dopamine transporter, (Nigg, 2006). Biedberman reports that 50 - 65% of children with ADHD experience symptoms in adulthood.

Barkley (2009) suggests 9 diagnostic symptoms for adult ADHD; distractibility, impulsive decision making, poor task organisation, lack of task completion, poor compliance with previously arranged engagements, difficulties terminating already initiated plans when required to, difficulty paying attention to tasks, initiating activities before understanding what they fully entail and increased likelihood of driving fast. Barkley notes that ADHD can co-exist with mood disorders (38%), and substance abuse (15%). ADHD can increase the risk of adverse life events, Chronis-Tuscano et al (2008a) found low levels of maternal involvement and harsh, inconsistent discipline. A separate study found that when taking medication, inconsistent discipline and harsh punishments reduced (Chronis-Tuscano et al 2008b). To optimise care for children with ADHD, their parents could be assessed and offered treatment.

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1.2 Aim

To identify symptoms in parents of children attending an ADHD clinic.

1.3 Method

Having obtained ethical approval, 20% of families attending Manchester ADHD clinics were invited. Thirty-nine children were due to attend in the study period, 9 did not and 6 declined participation or were unrelated to the child. Parents received study information and signed consent forms. The GHQ-12 is a validated assessment of mental health (Goldberg, 1997; Pevalin, 2000). The 18-item adult ADHD self-report scale (ASRS-v1.1) is a self-report scale identifying adult ADHD (Adler, 2006; Kessler, 2005). There was also a questionnaire eliciting demographic details, clinic attendance, criminality, cigarette, drug and alcohol use. Data was entered into Stats Direct 2009.

1.4 Results

Most participants were female, 21 (87.5%) with 3 (12.5%) males, mean age was 38.1 years. Overall, 91.6% of the adults were White British, and 83.3% of the children. Other parents were British Caribbean and Mixed White and Black African (4.1% each). All participants were from Manchester, children ranged from 7-15 years, with a mean age of 10.3 years (S.D. = 2.3). Mean clinic age was 11.5 years, (S.D. = 2.5), with a range 7-16 years. Family composition ranged from 1 child to 5 with 33.3% of parents being single. Notably 18 (75%) participants had no permanent income, although 50% of these unemployed had a partner who supported them. Three set of data were incomplete, 2 lacked clinic attendance information and 1 did not contain a family composition.

No participants reported having ADHD, although one father was thought to have ADHD and several thought they or their partner had symptoms, one participant reported depression. The ASRS-v1.1 result suggests that 45.83% of the sample had ADHD symptoms, 100% of those with positive ASRS results were female. Unemployed people in the sample had the highest proportion of symptoms; however there was no significant correlation between employment status and ASRS high scores. Of note, 37.5% of participants scored highly on the GHQ12, over half of these also scored highly on the ASRS-v1.1. Psychopathology indicated by high GHQ scores was equally likely in either sex. When ASRS-v1.1 scores were compared against family size it was seen that more symptoms were seen in those with more children. In 18 of the 20 missed appointments parents displayed ADHD symptoms, although 10 were from 1 person. Smoking was the most common lifestyle variable found with 14 people smoking. Drug abuse and convictions were the 2 most under-represented factors with 1 person each.

1.5 Conclusion

Our results support the hypothesis that parents of diagnosed children have unmet needs, 45.83% of parents showed symptoms of ADHD. Adults with ADHD have more difficulty adapting to challenges posed by society, work and child rearing. We suggest that a screening service might have a positive impact on the family. As 20.8% of the sample scored highly on both questionnaires, it is possible that they were suffering from two psychiatric conditions. Overall 37.5% scored highly enough to be suggestive of psychiatric morbidity. As many of the adults with symptoms of ADHD were unemployed it might indicate how adults with ADHD have difficulty keeping jobs and progressing in their careers. Symptoms of ADHD were more common in those with four or more children. The increased number of children may cause added stress leading to an increase in the severity of adult ADHD symptoms.

Adults with ADHD have increased levels of impulsivity, possibly increasing the risk of unplanned pregnancy, specific family planning may be helpful. Furthermore, symptom control could enhance the family environment. It is theorised that clinic non attendance could be linked to parental symptoms exacerbating delays in receiving and modifying medications and reducing monitoring. Alcohol abuse, smoking, substance misuse, criminality and car accidents are more common in adults with ADHD which our study did not reflect. Possibly, because of the small sample size, or parenthood, reduces such behaviours. As parents completed the questionnaire in front of their child this could increase false negatives. The question regarding drug use could be enhanced by the addition of tick boxes naming drugs.

Four participants reported a car accident, 50% scored highly on the ASRS. Owing to the small sample size in this pilot, further research requires a larger sample with control group of unaffected families. Questions may have been misunderstood by the participants, tick boxes would have been a clearer alternative to free text. Although this study found that a high number of parents had symptoms, it did not directly diagnose. We suggest there is a need for a screening process for affected children's parents.

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