PARENTS' PERCEPTION OF THE USE OF
STIMULANT MEDICATION IN THE TREATMENT OF THEIR ADHD DIAGNOSED CHILD

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DEDICATION

This research study is dedicated to the children- the children who have been clinically diagnosed with Attention Deficit Hyperactivity Disorder and live and deal with this experience daily.
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ABSTRACT

The use of drug stimulation to treat children who have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) sparks much controversy. Parental perception of this practise is crucial since it is the parents that have the task of making this sensitive decision. In order to subjectively explicate parental feelings regarding this issue, a qualitative approach was considered appropriate in this study. The study sought to highlight the views of parents around the use of stimulant medication in the treatment of ADHD. In-depth interviews of the four participants were audio taped and then transcribed verbatim. The interviews were unstructured and an open-ended question guideline was utilised. The interviews underwent stringent thematic analysis. Amongst others, the major themes that emerged were those of guilt, frustration, resignation and the strained mother-child relations associated with infant behaviour and the diagnosis. Findings revealed mixed feelings around the use of medication with Ritalin being the most commonly prescribed. However, even though there are mixed feelings associated with medication use, the positive outcomes of this practise outweigh the negative aspects. Although the benefits are great, the future risk of long-term use of stimulant medication is unknown.
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CHAPTER ONE

1.1 INTRODUCTION

Few childhood psychopathologies have generated as much controversy or as much research as Attention Deficit Hyperactivity Disorder (ADHD). This phenomenon is in fact the most common diagnosis in child psychiatry clinics (Taublieb, 1997).

Since the 1940’s a multitude of diagnostic labels have been applied to children who are hyperactive and inordinately inattentive and impulsive, which is in fact a reflection of the changes in its conceptualisation over the past century. “Minimal brain damage and minimal brain dysfunction” were two of the previously used diagnostic terms that refer to brain pathology. Other previous experts in the field termed the agitated behaviour of these children, “hyperactivity syndrome; hyperactive impulsive disorder; hyperactive child syndrome; hyperkinetic syndrome, defective inhibition; impulsive insanity; brain injured child syndrome and attention deficit disorder,” (Barkley, 1998, and Taublieb, 1997).

Researchers in the field have developed many theories to explain ADHD. These include the Cognitive Interactional Model, the Behavioural Inhibition Model and the Transactional Neurodevelopmental Model. The cognitive interactional model explains that primary- process deficits (i.e., attention inhibition, arousal- modulation, and reinforcement deficits) cause secondary process deficits (i.e. deficits in reasoning, social interaction and academic difficulties) thereby causing disruptive, busy behaviour in the child.
The neurodevelopmental model suggests that biogenetic and environmental factors affect brain development and function. These affect cognitive-intellectual function like memory, language processes and attention; learning and academic performance; psychosocial adjustment within the family and interpersonal and environmental functions at home, school and social (Teeter, 1998).

ADHD is known to have a debilitating effect on individuals. The disorder causes functional impairments across multiple settings e.g. within the home; school; relationships and it has long-term adverse effects on the individuals socio-emotional development (Pediatrics, 2001).

1.2. MOTIVATION

Various forms of literature evidence indicate that ADHD is one of the most commonly diagnosed disruptive behaviour disorders of childhood (Barkley & Murphy, 1998). ADHD appears to be increasing in prevalence in the current environmental contexts. An interesting observation is that the use of stimulant medication, especially Methylphenidate (better known as Ritalin) to manage children who have been clinically diagnosed with ADHD, is a common practise in South Africa. It is around this experience that this master's thesis is based.

Research in this field within the South African context appears to be limited. The present study is directed towards creating an awareness of the prevalence of ADHD in South Africa, the factors that may serve as barriers to treatment efficacy, coping strategies employed by parents, and most importantly, parents thoughts about
stimulant medication treatment with special reference to its potential side-effects and its effectiveness.

1.3. AIM

The aim of this research was to determine parents' perceptions of the use of stimulant medications treatment for ADHD and by doing so highlight the positive and negative aspects of this practise.
CHAPTER TWO
LITERATURE REVIEW

2.1. EPIDEMIOLOGY

Even though ADHD is one of the most common Axis I childhood disorders (Kronenberger & Meyer, 2001), the true incidence of ADHD cannot be accurately determined because it cannot be accurately measured or strictly defined (Atikinson & Hornby, 2002). Researchers maintain that the rate of incidence of the disorder depends on the definition used, the population studied and the location as well as the degree of agreement amongst parents, teachers, and professionals. The vast apparent differences in the incidence rates of ADHD worldwide is suggestive of the confusion over diagnosis (Pennington, 1991; Atkinson & Hornby, 2002).

According to the Diagnostic and Statistical Manual of Mental Disorders IV-TR (2002), the prevalence of ADHD has been estimated at 3%-7% in school age children, while Barkley (1998), estimates that between 2% and 9% of all school age children worldwide have been diagnosed with ADHD, for which there is simply no scientific basis (Author, 2001).

2.1. CLINICAL DIAGNOSIS AND PRESENTATION

There is much controversy about the diagnosis. Experts disagree about the criteria used to define ADHD. On the other end of the spectrum there is actually evidence against it even being considered a distinct disorder (Atikinson & Hornby, 2002).
The disorder is characterised by developmentally inappropriate levels of inattention, disorganisation, concentration, distractibility, restlessness, impulsivity and hyperactivity. These symptoms are disruptive or create social-environmental problems for the child (Kronenberger & Meyer, 2001). Furthermore, this behaviour is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. Therefore children with ADHD have pronounced impairments (DSM-IV-TR, 2000).

The disorder has a debilitating effect on individuals. Clinically it causes functional impairment across multiple settings including home, thereby affecting family interaction and school, thus affecting academic performance, ability and peer relationship. Furthermore, ADHD has long-term effects on the individual’s socio-emotional development in terms of self-esteem and social skills, thus also affecting vocational success (National Institute of Mental Health, 1998 and Paediatrics, 2001).

Given the demonstrated academic and social outcomes associated with ADHD, the occurrence of this disorder in school-aged children represents a significant public health concern. Studies show that children diagnosed with ADHD are at high risk for continuing to have learning, behavioural and emotional problems throughout childhood and adolescence. They also have been shown to have difficulty with social interactions with peers and family members (Kollins, Barkley & DuPaul, 2001). Therefore the evidence available suggests that ADHD is a significant problem affecting millions of children worldwide and it is associated with a number of potentially adverse long-term outcomes (Barkley, 2000).
The hyperactive child syndrome, as it was previously referred to, has long been considered a psychopathological condition with there being great debates over the core symptoms of the disorder. However the DSM-IV decision to define ADHD along the two-core symptoms domain (i.e. inattention and hyperactivity-impulsivity) was based on a substantial amount of research (Adams & Sutker, 2001).

The DSM-IV-TR cites strict criteria that must be met in order to give a diagnosis of ADHD. It lists three empirically derived subtypes of ADHD viz., predominantly inattentive type, predominantly hyperactive type and the combined type (Kollins; Barkley & DuPaul, 2001; Kronenberger & Meyer, 2001). The inattention group consists of symptoms reflecting a lack of attention to details, difficulty sustaining attention, failure to listen, organizational problems, distractibility, failure to complete activities and forgetfulness. The hyperactivity-impulsivity group is defined by the display of excessive behaviour e.g., talking excessively, squirming e.g. being unable to sit in ones seat without wriggling, difficulty remaining seated, inappropriate noise/vocalisations and difficulty waiting i.e. impatience. It is required that a child have either six or more of the inattention symptoms or six or more of the hyperactivity-impulsivity symptoms or six or more symptoms from both categories in order to qualify for the diagnosis. The symptoms must also affect two or more situations e.g. school and home. They must persist for at least six months (DSM IV-TR, 2000).

Evidence suggests that those children with problems of inattention without high rates of impulsivity and hyperactivity i.e. primarily inattentive subtype, tend to show fewer conduct problems, less peer rejection, and are more anxious and shy than those children who are also impulsive and hyperactive. Furthermore the two subtypes show
differences in types of attentional processes that are problematic and the inattentive type shows a different response curve to stimulant medication. These points show clearly why distinguishing between the subtypes is critical (Adams & Sutker, 2001).

It has been observed that ADHD appears to be more common in boys than in girls (Kendall, 2000, Kaplan & Saddock, 1998), with ratios of 2:1 and 10:1 reported in some studies (Kronenberger & Meyer, 2001), while other studies show that ratios of boys to girls range from 4:1 in community samples to 9:1 in clinical samples. There is no conclusive evidence of gender-specific presentations of the disorder (Adams & Sutker, 2001). Research indicates that girls more commonly present with attention deficits and impulsivity problems without hyperactivity or conduct disorder problems. However, hyperactivity and/or conduct disorder problems in girls who have been clinically diagnosed with ADHD could possibly go unrecognised since they are easy to manage, while boys, on the other hand, present with physical hyperactivity and conduct disorder problems (Atkinson & Hornby, 2002).

This controversial phenomenon can persist into adulthood. Evidence suggests that adults who were diagnosed with ADHD as children receive fewer years of formal schooling, achieve lower overall occupational status and are more likely to have a range of psychiatric problems e.g., anti-social personality disorder and non-alcohol substance abuse (Kollins, Barkley & DuPaul, 2001). Long-term prospective studies suggest that many children enter young adulthood still experiencing core symptoms of inattention, impulsiveness and restlessness. ADHD has been associated with comorbid mood and affective disorders, substance abuse and personality disorders in young adulthood, as well as interpersonal difficulties, criminal behaviour, low self-esteem,
educational failure and occupational problems. Adults with ADHD show difficulties relating to inattention and impulsive behaviour, which can be seen when the adult with ADHD acts without reflection and may be incapable of planning ahead, may also be disorganised, forgetful and show poor time management skills. Adult sufferers also have a long history of underperformance and academic failure, which can lead to difficulties in the work environment. This long-standing history of failure is likely to result in low self-esteem and demoralisation. Adults may also display poor social adjustment skills which appears to be reflected in the difficulty they find maintaining relationships both personally, socially and with work colleagues (Young, 1999).

2.3. ETIOLOGY

Most literature studied maintains that there is no one, single agreed upon cause for ADHD. However it is suggested that a wide and complex array of influential factors, which include genetically determined predispositions, brain damage and dysfunction, diet and toxic substances and environmental factors are implicated (Atkinson & Hornby, 2002, Kendall, 2000).

The causes of ADHD sparks major controversy, which according to Taublieb (1997), is far from over. Kendall (2000) notes that the growing consensus is that people with ADHD have a biological predisposition and that the disorder may be exacerbated by environmental forces, therefore making both biological disposition and environmental forces implicatory aspects in the disorder. Atkinson and Hornby (2002) suggest that genetic forces, brain differences, family and social factors, diet and levels of lead in the bloodstream are factors that influence the disorder.
2.4. STIMULANT MEDICATIONS TREATMENT

Various treatments have been used for ADHD including psychotropic medications, psychosocial treatment, dietary management, herbal and homeopathic intervention, biofeedback and perceptual stimulation and training (National Institute of Health, 1998). Most recently there has been an increase in the number of children diagnosed with ADHD, leading to increasing numbers of children that are being placed on medication (Kendall, 2000).

The most controversial aspect of this disorder is in fact its treatment. More specifically, the widespread use of stimulant medication in treating childhood behaviour problems has been associated with substantial controversy. However it must be noted that stimulant medication is the most well known, most widely used, and one of the most effective interventions for ADHD (Kollins, Barkley & DuPaul, 2001).

Evidence suggests that psychostimulant medications that are frequently prescribed show improvement rates of 70%-80%. The number of prescriptions for children with ADHD has more than doubled over the past two decades, rising from two million in 1990 to five million in 1994 in the United States alone (Swanson, Lerner & Williams, 1995). Safer, Zito, and Fine (1996) indicate that currently, as many as 1.5 million children in North America receive medication for ADHD. Quay and Hogan (1999) report that the prevalence of stimulant use in the treatment of ADHD in Europe and Australia is far less than in the U.S and North America, however their use is steadily
increasing. This increase in the use of medication to treat ADHD may be attributed to physicians, educators and parents greater familiarity with and acceptance of medication and the lack of convincing evidence that alternative treatments or non-pharmacological interventions are as effective as those involving medication (Wilens, 1999).

There appears to be a dramatic increase in the use of stimulants in order to manage and treat ADHD to the extent that medical practitioners writing out prescriptions for the primary medications has literally tripled with approximately 750,000 to 1.6 million individuals currently on medication. Given the controversy surrounding stimulant medication use, noteworthy is the observation that this dramatic increase could be a sign of better clinical detection and diagnosis of the disorder and increases in the number of adults with ADHD seeking treatment, rather than a sign of misuse (Everett & Everett, 1999).

Stimulant medications work primarily by increasing the action of certain chemicals that occur naturally in the brain (Barkley, 2000). The stimulant medications most widely prescribed for the treatment of ADHD are Methylphenidate (Ritalin); Dextroamphetamine (Dexedrine); Pemoline (Cylert), and Mixed Amphetamine Salts (Adderall), (Kollins, Barkley, & DuPaul, 2001).

*Ritalin*, the best known and most widely prescribed of the stimulant medications, has been used for over sixty years to treat ADHD (Diller, 2001). According to Henderson (2000), Ritalin accounts for 84% of the medication prescribed for ADHD. However Kendall (2000), points out that 30-50% of those taking Ritalin may not even have
ADHD. The effects of this medication can be observed within thirty to ninety minutes after the dose is administered. The effective duration of this stimulant is fairly short (approximately two to four hours), and it therefore needs to be taken consistently in order to avoid the “rebound” effect, which occurs when the level of the medication begins to wear off, before the next dose is administered. This can induce increased hyperactivity, headaches, and irritability. Evidence indicates that in a controlled study of 83 ADHD children taking Ritalin, only three experienced side-effects that were severe enough for them to discontinue the medication.

Ritalin has been effective in improving academic productivity, accuracy, parent teacher behaviour ratings, antisocial behaviour, social functioning and peer relations. *Dexedrine* is nearly twice as potent as Ritalin and it is effective for at least three to four hours. This stimulant can produce an initial “spike” effect whereby agitation or sedation symptoms may present. Other side-effects can include dry mouth, loss of appetite, weight loss, sleep disorders, anxiousness, sadness, and nightmares. This drug has been shown to improve school performance, and teacher and parents ratings of behaviour problems. *Cylert* appears to be less commonly used. It is usually prescribed when children do not respond to other stimulants or when multiple daily dosing is not practical. It can take up to eight weeks to reach its full potency. It has been reported that this medication showed effectiveness in only a small proportion of ADHD patients. Its side-effects include anorexia, abdominal discomfort, headaches, insomnia and potential liver problems. This medication is seen to be effective in improving academic performance, on-task behaviour, and teacher ratings. Cylert reportedly has a longer lasting effect and is less addictive when administered in higher doses. However a side effect of this drug is its implication in liver damage and it is
not more effective than other stimulants. Therefore it is rarely prescribed (Kronenberger & Meyer, 2001). *Adderall* appears to have a similar effect in terms of action and side-effects to that of Ritalin or Dexedrine, but studies show that Adderall has a longer lasting effect than Ritalin when administered doses are more than 5mg, than Ritalin. Adderall has been shown to be effective in reducing problem behaviour in the classroom, improving parent-teacher ratings of behaviour and improving academic performance. Its side-effects include insomnia, loss of appetite, sadness, proneness to crying and picking at the skin or fingers (Kollins, Barkely & DuPaul, 2001, and Everett & Everett, 1999).

There appears to be an abundance of adverse effects associated with the use of stimulant medication, which can naturally be expected since these medications are of high potency. The most commonly reported side-effects which are related directly to the drug therapy are decreased appetite, weight loss, headache, increased crying, heart rate elevation, slowing of growth, irritability, increased tension, insomnia, anxiety, increased blood pressure and occasional motor tics (Kendall, 2000, and Kronenberger & Meyer, 2001), and rebound hyperactivity (Atkinson & Hornby, 2002). Behavioural rebound effects can be identified by the presentation of irritability, hyperactivity and excitability. The patient can be given an additional dose of the psychostimulant or the child can be given a longer lasting stimulant. The more severe side-effects are the development of tics and an increase in hyperactive behaviour (Kronenberger & Meyer, 2001).

Literature indicates that adverse effects usually occur early in treatment. The less severe side-effects tend to be mild and short lived and most can be successfully
managed through adjustments in the dosage or schedule of the medication (Pediatrics, 2001).

Research indicates three shortcomings of the psychopharmacological interventions viz.,

- **Stimulant medication treatment does not work for all children diagnosed with ADHD and even when it is effective, there appear to be limitations in terms of interpersonal and academic performance.**

- **The beneficial effects are only observed when the drug is at a certain level in the child’s system thus indicating that there’s only a certain period during which the child can benefit from the medication without the administration of subsequent doses.**

- **Empirical studies do not support improvement and/or efficacy on a long-term basis (Taublieb, 1997).**

The National Institute for Mental Health (1996), maintains that ADHD does not have clear physical signs and can be identified by looking for certain characteristic behaviours which vary from person to person. The core symptoms of ADHD i.e., inattention, hyperactivity and impulsivity, may result in multiple areas of impairment and dysfunction in the home, school or community. Given this potential for these adverse outcomes, effective treatment for ADHD is critical. The primary goal of treatment should be to optimize functioning of the child. The desired results of intervention include improvement in relationships with parents, siblings, teachers and peers; decreased disruptive behaviours; improved academic performance, particularly in terms of volume of work, efficiency, completion, and accuracy; increased
independence in self-care or homework; improved self-esteem and enhanced independence in the community e.g., crossing roads, riding bicycles and general play etc. (Pediatrics, 2001).

Everett and Everett (1999), maintain that there is consensus among most experts that stimulant medication has been, and continues to be, the single most effective treatment for ADHD. Statistically 80% of children on stimulant medication experience highly effective results, but there are no studies that have been carried out long enough to reveal long-term effectiveness of drug therapy. There are usually rapid improvements but repeat doses are required since its effectiveness only lasts a few hours (Atkinson & Hornby, 2002).

2.5. PARENTAL PERCEPTIONS

What do the parents of a child struggling with ADHD understand and think about their child and the use of stimulant medication as a treatment option for this particular childhood disorder? Many short-term studies have documented the efficacy of stimulants in treating the presenting symptoms of ADHD. However, as mentioned before, there is also the substantial controversy surrounding its use. Concern around the use of stimulants is valid because of the degree of potency of these drugs. The long-term risks and side-effects are great and the decision by the parents to use this as an intervention for their children must be based on substantial information (Barkley, 2000).
Despite ongoing controversy regarding its use, converging evidence suggests that well monitored pharmacological intervention is a critical component for managing the symptoms of ADHD. A long-term study of the use of medication noted that there were continued clinical benefits from medication treatment fourteen months after initiating treatment. Some other studies even report that stimulant medication treatment can have long-term protective effects against the development of other kinds of problems like substance abuse disorders (Kollins, Barkley & DuPaul, 2001).

According to the National Institute of Mental Health (1998), parents and families who have children with ADHD experience increased levels of parental frustration, marital discord and even divorce. The complicated decision making process to determine appropriate treatment for these children is often made substantially worse by the media war between those who overstate the benefits and those who overstate the dangers of stimulant medication treatment in ADHD.

ADHD has a profound impact on the individuals and their families. Therefore even though there are potentially damaging side-effects of the use of stimulant medications, most parents report being unable to cope and therefore submit to the use of stimulant medication (Author, 2001). According to Manos, Short, and Findling (1999), parents report that the use of medication significantly improves their child’s behaviour and thus believe it to be effective. Despite the efficacy of stimulant medication in improving behaviours, many children who receive them do not necessarily demonstrate fully normal behaviour (Pediatrics, 2001).
Interaction between parents and their child with ADHD can be strained. However, Whalen and Henker (1997), state that parental perceptions and the relationship with the child is strengthened over time in children who are participating in long term stimulant treatment regimens. These findings have implications for understanding parenting practices and treatment intervention choices in that parents who do not view their child as capable of intentional self-regulation may be less willing to apply appropriate behaviour change strategies and more likely to rely on medication as the sole treatment modality (Quay & Hogan, 1999).

It may be safe to assume that parents are devastated when they are told that their child has ADHD. They are even more traumatised when they are advised that drug therapy may be the only course of remedial action because for many children this is the only alternative (Kozlowski, 1999).

There seem to be very few studies that have been conducted to document whether parents are satisfied with pharmacotherapy for their children. One study showed that parents viewed behavioural treatment as a more acceptable course of action than the use of drug therapy. A follow up study revealed that if parents knew more about ADHD, they were in fact more accepting of the use of Ritalin. Other studies show that parents are generally happy with the use of medication in treating ADHD, but the children report a negative response. According to experts the decision to use medication should be clearly considered (Kollins, Barkley & DuPaul, 2001).

The relationship between parents and a child with ADHD is more negative, stressful and strained. The child receives more punishment than praise. Medication treatment in
turn influences how the child behaves (Barkley, 2000). It is reported that parental perceptions and parent-child relations may be strengthened over time if the child is participating in long-term stimulant treatment regimens (Whalen & Henker, 1997).

It is understood that parents should proceed with drug therapy with caution. The child must be closely monitored. It is evidenced that drugs do not cure hyperactivity but only manage this behaviour for a particular time period. It has been noted that drug treatments make parents less motivated to find and use alternative treatments to manage hyperactive behaviour. Drug therapy makes the child easier to control sometimes and thus it is supported by parents. Some studies show that a child is more likely to respond favourably to stimulant medication when the parents are competent, good managers and when they are able to maintain a positive relationship with the child (Lahey, 1979).

Research does indicate that the parent-child relationship is a good predictor of how the child responds to the medication. Research indicates that if the mother and child have a good relationship then the response to the medication is better. The medication creates a positive change in the behaviour of the child and their mothers. Mothers who maintain a positive disposition regarding their child and who are more rewarding of those initial positive behaviour changes, appear to induce further positive progress associated with the treatment. Furthermore, mothers who are quite interactive with their child and who reward compliance with the medication, appear to have children who show greater positive changes in behaviour due to the medication (Kollins, Barkley & DuPaul, 2001).
Both the children and their mothers give each other more praise and less criticism when their children are medicated for ADHD. Furthermore, it was also noted that hyperactive children interact differently with other people when they take medication as opposed to when they are not on medication, and these behavioural differences may directly influence adult perceptions of the child's competence (Whalen & Henker, 1997).

When children were managed effectively on stimulant medication, their mothers adopted a much less commanding and more rewarding style of interaction with them. It has been suggested that mothers do not appear to be totally devoid of appropriate management skills of the children, but mothers of these ADHD children may lack the opportunity to express them because of the high rate of inappropriate behaviour exhibited by their unmedicated children (Knights & Bakker, 1980).

Wender (1987) maintains that an ADHD child's relationship with his/her parents is certainly affected because of the difficulties experienced during development. This leads to tensions in the family; thus bonding between child and parent is at risk.

An interesting comparative investigation looked at the opinions of non-parental adults towards the use of stimulant medication with children diagnosed with ADHD and children with epilepsy. It was perceived that parents who use medication to treat children with epilepsy were justified in doing so. Perceptions were different about parents who use stimulant medication to treat a child diagnosed with ADHD. It was felt the use of medication to treat ADHD only exacerbated negative behaviour (Everett & Everett, 1999).
It is suggested that to effectively treat ADHD a multimodal treatment approach combining the various interventions may prove to be most effective (Adams and Sutker, 2001).
CHAPTER THREE
RESEARCH DESIGN AND METHOD

3.1. RESEARCH DESIGN

The research design for this study was qualitative in nature. The in-depth or unstructured interview was employed as the main method of data collection. This method of data collection is described as a form of conversation with a purpose, with the researcher an active player in the development of data and of meaning. The in-depth interview allows knowledge to be constructed through collaboration between interviewee and researcher (Ritchie & Lewis, 2002).

In order to inform the development of relevant questions the Attention Deficit Hyperactivity Support Group of Southern Africa (ADHASA) and the Attention Deficit Hyperactivity Foundation of Southern Africa were contacted telephonically. These organisations offered critical input, which assisted in the development of appropriate questions.

3.2. PARTICIPANTS

In order to locate participants for the study two local schools were contacted upon the advice of a community social worker. Educators interested in ADHD from these schools, assisted by calling the relevant parents. They explained the nature of the study to them. The researcher was then provided with their details after which interviews were set up.
The study comprised four mothers whose children were clinically diagnosed with ADHD. Two of the mothers were parents of girls and the other two were parents of boys who had been clinically diagnosed with ADHD. The children were in junior schools currently.

3.3. DATA COLLECTION INSTRUMENT

In order to address the objectives of the study a few relevant questions were devised to ensure breadth and depth of the topic. Questions focused on background information, birth history, infant development and developmental milestones, family history of childhood mental disorders, relationships and interaction within family before and after the use of stimulant medication, feelings about the use of stimulant medication, the related side-effects, the positive aspects of the treatment etc. Further questions were generated for use as the in-depth interview progressed.

In order to become familiar with the interview process and the subject at hand the researcher consulted with identified experts in the fields of research methodology and ADHD and reviewed data collection instruments from relevant empirical studies. Furthermore the researcher consulted with experts from ADHASA (as mentioned) and the relevant drug company i.e., NOVARTIS SA telephonically. These individuals were targeted on the basis that they had a good understanding of ADHD, the use of stimulant medication, the controversial aspects of this issue and also the effectiveness of the medications.
Furthermore, a review of literature suggested that the following contents would be important for inclusion in the questions in the interview:

- Parent's knowledge of and feelings about the side-effects that their child endures on the medication
- Comorbid disorders and the type of medication the child uses for that
- How aware the child was of his or her diagnosis
- Perceptions of the stigmas attached to such a diagnosis

The questions that were designed by the researcher were appraised by a supervising clinical psychologist who was in private practise, an intern clinical psychologist working in the local psychiatric hospital and a school teacher who took a keen interest in ADHD and who was a mother of a child who had ADHD.

The in-depth interview was then piloted on a volunteer as a practise run to see how the interview would work.

Guideline of questions focussed on in the interviews

1. Background history- included identifying data about the parents i.e., age, employment, number of children and also background information about the child.
2. Birth history- the pregnancy, the delivery, the baby when s/he was born viz., weight, number of weeks old etc.
3. Development of the child- as a baby viz., developmental milestones, sleep patterns, eating and as a toddler focussing on behaviour patterns.
4. Family history of mental illness.

5. Diagnosis- when was the child diagnosed, where, who diagnosed the child, most importantly feelings of the parent about the diagnosis.

6. The family- how did the ADHD impact on the family.

7. The use of stimulant medications- what medication is or was the child on for the ADHD, feelings about that specific medication before it was tried it, what are your feelings about the medication since you tried it, what changes were induced in your child because of the medication, what do you feel about the use of drug stimulation to treat your child.

8. The side-effects- knowledge and feelings about the possible side-effects.

9. Relationships- before the child was on medication, since the medication, and relationship the child had with other siblings.

3.4. PROCEDURE

In developing a conceptual framework for the study and in devising a realistic plan of action within a reasonable timeframe, the researcher consulted with experts in the fields of research methodology and ADHD. In addition, a detailed literature search was undertaken utilising the MEDLINE database.

The researcher contacted the relevant parents telephonically. Appointments were scheduled at the convenience of the participants. As mentioned previously, the data were collected by means of unstructured, in- depth interviews. The present author acted as the interviewer. Each interview was recorded using a Dictaphone. When the
participants were ready to begin, the Dictaphone was switched on and the participants were asked the relevant initial question. Prior to the scheduled formal interviews, the researcher conducted telephonic meetings with each of the four participants in order to explain the interview procedures and to establish a certain degree of rapport. This procedure certainly proved helpful as this process eradicated their anxieties. Some participants were concerned about who would have access to the audiotapes. Thus it was important for the researcher to explain the purpose of the practical use of the audiotape and explain that it was their experiences that would be analysed and that their identities would remain anonymous and thus the use of pseudo-names were in order. Two of the interviews were conducted at the homes of the participants. Another interview took place at a participant's workplace. The forth participant came to the home of the researcher. The one-on-one interviews lasted between 45 to 60 minutes each.

During the interviews the interviewer used probing questions, clarifications and a relaxed conversational tone in order to engage and encourage comfortable divulgence. Although all four participants were Afrikaans speaking, the interviews were conducted in English since the participant's were fluent English speakers as well. The data was analysed in English.

3.5. ETHICAL CONSIDERATIONS

Informed consent was obtained verbally from all research participants in the study. All participants were appraised of their right to withdraw from the study at any stage
of the interview, if they so desired. They were assured of anonymity in that they
would not be identified by their individual responses.
Unlike psychometric procedure, a thematic method of analysing the data enabled the researcher to capture emerging feelings. Rather than objectifying or quantifying data, qualitative research based on the phenomenological position requires an exploration of phenomena in all their complex glory whilst still embedded in natural context. Qualitative explanation is infinite and discovery multidirectional. A phenomena seen through several eyes will have a multitude of emergent patterns and the complexity during it’s dissection, becomes visible with each attempt at description. By emersing oneself in the phenomena of interest, the researcher ‘fluent’ its language, in order to convey with confidence. Qualitative research is saturated in the world of the phenomenon of interest and its description, and although altered through the voice and vision of the researcher, must retain complexity in order to maintain it’s realness, it’s trustworthiness. Precipitating phenomenological description is observation and intricate inspection of emergent patterns (Lincoln & Guba, 1985).

In order to create qualitative meaning of the feelings of the devoted mothers who have experienced the devastating diagnosis of ADHD and the need to use medication in order to fully feel the realness of that experience, the researcher opted to use a qualitative methodology. To the researcher, objectifying this deep, sensitive experience would totally diminish its realness.
4.2. DATA ANALYSIS

The researcher transcribed all the in-depth, unstructured interviews verbatim. This process was most time-consuming since it required a stringent attention to details.

After being typed, copies were made and the transcriptions were given to three investigators. One is a clinical psychologist in private practice for a number of years who also supervises clinical internships, another is a practising clinical psychologist who works for a well known rehabilitation centre and the third is an intern clinical psychologist working for a large psychiatric hospital, who was also completing a qualitative research study.

The investigators received and analysed the data independently. The researcher then met personally with the clinical psychologist in private practice and the intern separately and engaged in a telephonic discussion with the third investigator. The researcher discussed with each their findings. During these discussions the researcher also divulged her own findings. After this the researcher looked at all views independently and found a degree of synthesis amongst the themes selected by each investigator.

Themes that were common across all participants emerged during the re-reading of the transcripts and the themes identified by the investigators and the researcher.
Interview one

This interview took place at a school where the participant works. It was scheduled for 8:30am.

R: I'd like to start with some background information about yourselves and your child.

P: We actually have three ADD kids— all three— the eldest one is Maya— she’s the oldest she’s sixteen, we have one of thirteen and a little boy of eleven. My husband is fifty two and works for a security company, I’m forty eight, I’m trained as a nurse but I’m working here. I’m teaching and we help parents at the hostel. We couldn’t have children, okay so Maya and Angela are both gift babies.

R: That would be the first two.

P: The, the two girls, ya, and the little boy, kind of just came on his own’ he was our little, another gift, our little ‘pasela’, the little, Will, I think was the worst, he’s very hyperactive, he never slept as a baby, he screamed for the first nine months, nothing really worked. We thought it was colic but once we got to know more about ADHD, we actually realised that it was just like that. None of my kids actually slept during the day, you know babies are supposed to fall asleep every four hours during the day, mine never did. They, if they’d, nap for five or ten minutes we were lucky and I mean they used go to bed at probably eight o’clock and wake up at five o’clock in the morning, and having woken up during the night. The kids never slept through, my son
slept through for the first time when he was in grade two, I mean it's just to give people an idea of how busy they are and when the kids actually can't fall asleep at night, they so hyped up, you hear them lying on the bed and you hear them, the, the legs going against the sheets. It's like the body can't, it takes a long time to rest, and then in the morning when when they wake up they actually tired. Its almost like they haven't had their sleep, then they don't get up easily.

R: And can you describe them growing up?

P: Because our kids were so busy we were told to take them off all sugars and colorants, we actually got a diet sheet from Cape Town, from the Red Cross hospital. We tried all that but nothing really worked, or none of that worked. We went to the route of all vitamins when they were little, which didn't work either. Well our kids may be different from others, they tend to be accident prone, Will had seven lots of stitches by the time he was seven, they don't see danger especially when they little like that, they'll just walk straight into the sea and they'll say they swimming with the dolphins, that's just an example. My son did that when we were at the coast, he just started walking in, we said where you going and grabbed him by the scruff of his neck. He says, “no I'm going to the dolphins, I'm going to go and swim,” and I mean he could hardly swim, he was two years old, so they, they don't have a, this concept of danger, they'll stand on a rock and they'll balance themselves, you can see they going to fall, they'll play with things that are dangerous. They are, they like to investigate and they tend to get into trouble because they do that. They get hurt. All three showed similar sorts of behaviour, and also in a sense that, “its my turn now,” poops, I push the other one out the way, and he falls down the wall and breaks an arm. You know its not that they aggressive, most ADHD kids are aggressive but I must say
that, one little thing God really was good to us in that sense that we don’t have kids that are aggressive.

R: Is any family history of mental illness?

P: Yes, I’m like that. I was like that as a child, so it’s inherent.

R: Before having children did you know about ADHD, I mean were you diagnosed as a child?

P: No, I don’t think there was such a thing as ADHD. You were just a naughty child and yet as a child I can remember how difficult it was to control myself, just actually sitting still was difficult. People have a misconception about ADHD. My kids have the physical side as well as the mental side, some of them with a mental side they hear too many noises at once and then they can’t focus and I think most parents don’t put their kids on drugs because the kids can’t, are, maybe busy. It’s because the kids can’t focus and if they can’t focus academically, they are weak.

R: So did you try other interventions before trying drug stimulants?

P: Yes, we went to an O.T., a physiotherapist, psychologist, a remedial person, a homeopath, a, what’s a name, psychologist, a educational psychologist, we went to different paediatricians, we tried ‘reflectology’, we tried, what’s the other one with the needles, acupuncture. I don’t think there, I wouldn’t know what else to mention.

There is, I don’t think there isn’t anything else, in fact the pharmacist who knows us well, she told us to stop throwing our money away, cos anything that came on the market, she would tell us, and we were the first to buy, the first to try and we actually found that those things don’t work at all. When we took one of our kids to Dr. Voster, Professor Voster in Bloemfontein, he actually said that if the kids don’t have allergies, if they weren’t asthmatic then the vitamin route and the ‘omegas’ and things wouldn’t work because that specifically worked with kids that are asthmatic and that have
allergies. My kids have learning disabilities. It is cos of their inability to be attentive-so its due to the ADHD, but Will has a bit of dyslexia to. But if you go into ADHD, there are seventeen different ones, and some of them they say...

R: Seventeen different?

P: Seventeen different ways in which it can go, if you read up the different literature, and some of them do say there could be a spelling problem. Now my two kids have severe problems with spelling, so whether it is because they cant focus for long enough or whether it is because of its dyslexia, at this stage, but they have been diagnosed as dyslexia.

R: Around what ages were they diagnosed with ADHD?

P: Maya was two, she went to a very good nursery school and the nursery teacher picked it out immediately, and we took her to Dr. Moss in Bloemfontein and when the next one came we just knew.

R: When you found out, how did that make you feel?

P: First you wanna know were it comes from, and then you want to blame yourself, but you, but you realise you can't blame yourself, cos its an inherent thing. Its just nobody can blame themselves for something that happens to anybody else. But you do feel angry because people look at these kids and they just think you know, there's no brain there, they don't realise that these kids actually have a problem. And all our kids were tested for IQ and they have an above average IQ. They say most ADHD have an above average IQ and yet at school Angy doesn't cope at all she battles just to pass so, I mean were does that, how do you actually explain that. If you actually think about it, its to do with focus and concentration, they cant focus on something because something will distract them, at that time something specific might have been said in the class, but they've heard some other noise which has distracted them, so they
haven’t picked up what the teacher said— they lose the track of what’s been taught and I think that’s their biggest drawback. And you find at nursery school too, the teacher said the kids were saying that Will’s the naughtiest in the class and then she’d turn round and say, “he’s not the naughtiest, he’s the busiest boy.” But because he’s busy and he can’t sit still, the teacher keeps calling out that child’s name so eventually that child is perceived as being naughty. And when they went to a party in grade one, and a mother said, “Oh so this is the naughtiest kid in the class,” so I said, “no, no, he’s not the naughtiest child, he’s the busiest child,” because there’s a difference. At the age of eleven now he’s still very busy. ADHD kids want to get out of their seats, they want to get out cos they have to move, some kids learn by moving. And also lots of colour, lots of bright colour stimulates kids and makes them hyped up and kids with ADHD like structure, as soon as something changes they, they, they go totally out of it, they out of their tree if you can put it that way.

R: So when did you decide to use medication?

P: Well it was in conjunction with our doctor and academically. The eldest one was falling of the bus. She was in grade one and things weren’t going to well, she actually didn’t do well on Ritalin. She went onto Lamictin because they did all the tests when they took her to a paediatrician, and he found that eh, anything that flashes, a light that flashes makes her, she doesn’t have fits but she, but she cuts out for like a second and he put her onto Limictin. And he says for most people they don’t actually give any medication but he finds that kids that have ADHD and are hyperactive, because they have a problem focussing that second, they actually need medication. We put her on Limictin and we found a big difference. It’s for people who have convulsions and the Limictin also helps with the focus and it’s a multifunctional one. It helps for both. The second one we put on Ritalin, it didn’t work, in fact nothing worked, so she’s just had
to go cold turkey and she’s the one battling the most at school because of her focus. It’s a huge problem.

R: How does it make you feel to have your kids on medication for ADHD?

P: I don’t think any parent would do it willingly. You do it as a last resort because you’ve tried everything else. No parent would willingly put their child onto Ritalin. But if nothing else works you as a parent don’t have a choice because otherwise you’re going to have a delinquent on your hands. What do you do with a child that doesn’t cope at school and you don’t give him any medication. Those kids are clever ‘cos they have a high IQ so they become delinquents and those are the guys that go to jail. Those are the guys that become our masterminds with, with, with crime- are the HD, HD kids, I’m so sure of it. Because if you look at the schools and wherever you go, I mean I deal with kids, you can pick those kids out, the kids that haven’t been helped and I’m saying they must be helped, specifically with the drugs they need to go the whole route, they need an O.T., a physiotherapist, you need everything to make the child whole, but then at the end if there’s nothing else left, then you, then you go the drug route and it either works or it doesn’t work because for my child when he takes Ritalin you can see it by the handwriting, so it shows the focus is there. It either, Ritalin is a funny drug, it either works brilliantly, or it doesn’t work at all and of course there are side-effects. One does worry about the side-effects, one doesn’t want as a parent, think you, you turning your child into a drug addict, but if you treat your child while he’s young hopefully by the time they 12 or 13 when they go through, especially the boys go through puberty, that they could come of the drug. But most parents are stubborn and they won’t do anything until it’s too late. The eldest child, she’s now in grade eight, she’s getting a 60% average, which we are very happy with. Will is more hyperactive then the girls and he is very, very bad in terms of
inattention, not as bad as the middle one cos she gets absolutely no medication and the oldest is on nothing now but we decided that if she needs it we'll put her back on. But you can see the difference in her, as a little girl the teacher couldn't cope with her in class and the teacher said she can't teach a child like that, at least she was honest.

R: Before Will started Ritalin how was your relationship with him?

P: I think by the time he came along we were used to the hyperactivity so it wasn't something new to us, we coped quite well.

R: So with the first child how did you manage?

P: Well we didn't really know, we thought kids were supposed to be so busy and I only really realised that there was a huge problem when I took her to preschool and saw, gee, but other kids aren't this busy, then I said now listen there's a problem. We also found then when Will was little and he screamed like that, we didn't have friends, it was inconvenient to go anywhere cos people didn't like a crying child cos he just screamed you know and that put stress on the whole household. When you've got this screaming child all you're trying to do is hang in there, just get through the day. Those kids don't see danger. You know, they'll go flat out with a bicycle and go straight into a ditch. They are very daring.

R: Can you describe the relationship between the kids?

P: There wasn't any sort of excessive fighting, normal arguing or quabbling happened but certainly nothing excessive.

R: What are your thoughts on the use of medication to treat ADHD?

P: I think it depends on the child, they must go onto like a Connors and check to see if that child can take it or can't take it, it definitely works with some kids.

R: Tell me about the side-effects.
P: They tend to have a problem in the morning. If they take Ritalin we normally make sure they have a big breakfast, they do get headaches, and they can get horrific stomach cramps. Will has it at times but not all the time, now and again he’ll complain about a headache. I normally find it goes in a cycle, like for a week he’ll complain he’s got a headache and then like three weeks he won’t have a headache, you know. And then another problem they do have being so hyperactive, they tend to be underweight, cos of all the moving and Ritalin suppresses the appetite, ya. Those are the only side-effects we’ve had. You do get restlessness and that but I mean my kids never had that and you can get depression. Maya was in grade one and so was Will when they started on medication around six, seven. The medication doesn’t change the personality and it doesn’t slow them down, people just have a misconception, it just makes them focus for longer on something they are doing. I think people have a misconception of what the drug actually does, they think it’s a behaviour, make them 100% attentive, 100% of the time and that’s not what it does. Drugs made ours more focussed on what they were doing but it certainly didn’t slow them down. It helped them in a learning situation but they will still move around, pick up a pencil, but he’ll be more focussed on what the teacher was saying. Before, in grade one his pencil grip was poor, the writing was poor, cos they cant focus and they cant hold the pencil for long and the O.T. said there was definitely a change when he went on Ritalin, you know, with, with the handwriting and things like that.

R: What are your thoughts on Ritalin now after having tried it?

P: To me there’s a grey area in Ritalin, I’m not actually pro Ritalin but in some cases I feel it is necessary, but, I just worry about long term effects if you take it over a period of time, nobody can say if you take it for eight or ten years what the effect will be like, you know, nobody seems to know. There’s always a grey area in a lot of these
things. I think in cases where it's necessary you go to have to use it but I don't think any parent is happy about giving their child any sort of medication. But I think in a situation where they are AHD and it's working you got to use it. It might not be ideal situation. And also I don't think that you can say that because he's on Ritalin he's going to take cocaine. I think that's the type of obsessive personality people who say, often I've been told, and I mean I, we were given a hard time by the family when we put him on Ritalin. They have this concept of giving him Ritalin you might as well give him cocaine, cocaine is a matter of choice. Ritalin, to me is a necessity now, its something he needs to cope in life, and I also think that with hyperactive kids, when they get older, they almost learn to control themselves. Ritalin helps them with the structure, they have to learn academically. I'm not saying a child must go on Ritalin and they haven't been assessed and they haven't got all the other help they need, it must be part of a whole system, it must be your last choice. Try all other avenues before you go onto something like this.

R: How is the relationship with your daughter who isn't on medication?

P: My worst relationship was with her maybe because she's not on medication but she has the most difficult personality.

R: So Will's dosage?

P: Ya he's on the slow release 20mg once a day only. But I must say Ritalin has helped, it's not a miracle, people think it's a miracle but it makes it better then it was.

R: I think we've covered everything, thank you.
Interview Two

The interview took place at the home of the participant at 17:30. The interviewer and participant sat in the lounge.

R: I'd like to start by asking you to give me some background information about you and your husband and thereafter about your son.

P: I'm, I'm thirty nine years old and my husband forty two. I'm a conveyancing secretary in a legal firm and my husband's a manager at a cash n' carry. Cris is one of a twin; he's eight years old and he's in grade two. He started taking Ritalin last year in August because he had major, major problems in school. We, we have to really watch him so that's the reason why.

R: Okay, can you tell me about the your pregnancy and birth.

P: Okay well first of all we, we couldn't have children so my children are gift babies. We attempted gifts three times. And I found out I was expecting a twin and of course I was over the moon and ecstatic. My pregnancy was uneventful. I continued exercising I didn't drink coffee because I believed that I got to look after these babies because they're so special and we moved when I was about thirty four weeks pregnant, and that set off my, my hypertension and I ended up in hospital and they released me. I was here in Queenstown when they test my urine and discovered there's protein in my urine and they feared for the babies safety so they sent me to East London and that day they said to me the babies will have to be born because when we were driving down to East London I realised Cris wasn't moving anymore. I was beside myself. About the time they admitted me they said to me I could have had a stroke that's how high my blood pressure was. Matt was fine. His APGAR was nine out of ten, ten out
of ten, at thirty five weeks gestation, but Cris didn't breath so the paediatrician didn’t even look at Matt he came out they left him. And I had a caesarean, an emergency caesarean section but Cris didn’t breath so they had to help him along. His APGAR was seven out of ten, eight out of ten, spent the night in the incubator and he was fine. After that, they came out strong babies and when we took him home the little problems started with Cris, like for instance he used to bring up his milk quite a lot, he used to vomit quite a bit but they treated him for that and he was fine. At eighteen months my problems started with him when he had his first seizure. He had a viral infection and he had his first seizure, and the behavioural problem, I can't tell you, even begin to describe you what kind of life I've had with this child, I ended being depressed, I suffered from depression. We had no normal family life, we couldn't take him out he was, he was just an impossible child, his behaviour was abnormal, always abnormal, and we used to look at him, and we loved him so much but we couldn't understand what this was. And even as a baby his behaviour was odd, it was different. He was difficult, he was a demanding child he used to cry a lot, for instance if, if he got hold of a, of a set of keys, he would hang on to that key you couldn't take it away from him, he would scream blue murder as if, as if he's been hurt. If we for instance get into a car, then we take him out the car, obviously now he enjoyed the ride, it wasn't worth getting into the car only to take him out because of the way he used to carry on, he used to just cry. He was about two years. As a baby he was just a demanding baby, cried a lot and he only wanted his mom. If strangers for instance looked at him he would start screaming, if you tried to take a photograph of him he would start screaming, always a very clingy demanding baby and that's the way he was, but it was this behaviour that was so abnormal this, this, this crying, always crying and then of course the seizures. He used to wake up frequently at night, he
never used to sleep very well he'd sleep two to three hours even when he was a bigger baby he would wake up so frequently. But until he was four he used to wake up at night and then he started getting into a routine but I think the medication that he was given for his epilepsy had a lot to do with the fact that he that he used to sleep better. At that stage he was on Phenobarb. What I've read is that Phenobarb actually contributes to the ADHD but if I had known that then, obviously I wouldn’t have given my child Phenobarb, you're between the devil and the deep blue sea. And then they said when he goes to school we have to get him of the Phenobarb because it causes mental retardation in children. Then I took him to the neurologist, we did all the right things, we put him on Lamictin and the Lamictin didn't control him and he had an awful amount of seizures the year before last for four months. Some days he'd have two then they added a bit of Epilim and he settled down and the seizures stopped. Then the pre-primary school, he’s always had this kind of anti-social behaviour and withdrawing, just walking out of a class, taking a pen and colouring in a toy and he would do that here at home to, he'd never complete his work, he would start something and not complete it, the quality of his work was shocking, I realised there's a problem and I started taking him to an occupational therapist, the year before he started school and I thought if this child's not working at school we going to have to start working at home. We've got to get him school ready. That was my main concern because he was going to be seven, he has to be school ready, so we did occupational therapy for a year, then he went to school. Well the school started the Tuesday, the Friday they had assembly, my Cris, in front of the whole 550 boys and teachers puts up his hand and tells the principle, in front of all these people in assembly, where you never open your mouth, that the song is being sung wrong! Then the next day somebody shouted at him at after care, he just walked home. Well the
next day I was in the principles office and I have been ridiculed and my parenting skills questioned, they told me he wasn’t progressing at school you couldn’t teach him anything. Eventually they called me in and said to me my child needs to be sent to another school. I can’t do that; these kids are everything in my husbands and my life. So we took him to the paediatrician Dr Paul in East London, and he just, he didn’t assess him, he just spent 10 minutes looking at him while he did a test. He said my son has Asperger’s syndrome with the ADHD and he said he treats Asperger’s syndrome with Lamictin and would try and help the ADHD with Ritalin. The first day I gave the Ritalin to Cris I will never forget, its like his eyes opened it was like a blind person seeing, and he could do his school work which he could never ever manage before. You could never have a conversation with Cris, at least now we’re having a conversation with him. Things are starting to or it seems that things are falling into place at school. He’s going to occupational therapy he’s seeing the educational psychologist, everybody’s trying to help. The handwritings improved greatly. I thank God how he’s actually, improved. That’s the good side of Ritalin. The bad side, the only bad thing about Ritalin that I have noticed thus far is like for instance if he didn’t want to eat what was cooked he’ll refuse to eat it, he’ll cry like a baby and I mean he’s eight years old. But it’s the reaction he has. He’s fine but all of a sudden when the Ritalin starts wearing out of his system he has this real come down effect and he’s weepy its like he, he becomes distressed, he becomes sad and he cries, he cries very easily. Before he would do things not realising it was dangerous, like he would run into the road, that’s how our puppy was killed, him running after it.

R: When was he first diagnosed with ADHD you said?

P: That was last year.

R: How did it make you feel, this diagnosis?
P: You know I knew there was something wrong from when he was little. The ADD I kind of suspected because I’d been reading about it and I saw all the symptoms in Cris. I was handed two blows that day the ADD and the Aspergers, I couldn’t deal with it, that’s what sent me into depression. The thought of giving my child Ritalin, that was hard, because I don’t even drink a headache tablet for a headache, I don’t have children were you have to feed medicine to all the time, Cris has his medication simply because he has to, he has epilepsy I don’t want him to have fits, because its dangerous so obviously he must take medication simply because he has to. But having to give him the Ritalin was the hardest thing for me simply because people say its like cocaine, and this and that and that and the next thing you are labelled as a bad parent, the easy way out and if that is the easy way out for me then I don’t know because I have tried, I’ve spent everyday of my life, a Saturday and Sunday making him read, making him do maths, I believe if you stimulate his brain for a half an hour, you add that up over a period of time, how much extra you’ve done for your child. Now if I was a failure as a parent, which I believe I’m not, yes you can say I gave my child Ritalin. I didn’t give my child Ritalin to take the easy way out, I gave my child Ritalin to keep my child at home because I can’t send him away.

R: I know we touched on it a bit before, how did you feel about giving your child medication for the ADHD?

P: Well had heard bad things and I heard good things, about, about the Ritalin. I was so fearful that he might have the negative side-effects because there are children who just cant take it, so that was my only fear, the fear that he might not be able to take it. When I started giving it to him and there were no bad side-effects, I was relieved because I knew at least I’m doing something to help him, although you, people will still tell me they don’t believe in Ritalin even some of the teachers. But they’ve
accepted it; it’s obviously my choice as a parent. I still don’t like the fact that he has to take it. I’d prefer if he didn’t but to be quite honest with you I think the Ritalin has helped him overcome that severe attention deficit that, that he had because his social skills have improved as well, so when I look at him now I’m thinking to myself he’s so much better, he’s truly better. Ritalin has improved him. Look, homework time was a nightmare, I used to battle to get him to focus, he’d keep on trying to distract, distract, distract not wanting to do the task at hand and all of a sudden since he started taking Ritalin, now think about it Ritalin he’s given in the morning, about 12 o’ clock its out of his system, but in the evening slowly but surely I noticed him being more co-operative even though he doesn’t have the Ritalin in his system its like he’s, he’s become more focused towards the learning process, so the effect, even though the Ritalin has worn of, seems to carry on. Seems like he’s developed a habit now. Its not a struggle anymore, so there’s a vast improvement from what he was to what he is now, it can only be the Ritalin. I mean I give him vitamins as well; the doctor said to me I’m wasting my money. I do give him Calmin, it’s a vitamin endorsed by ADHASA, I belong to ADHASA too, we tried the diet but, but I mean we generally don’t eat a lot of preservatives so I wouldn’t say it’s the diet and I wouldn’t say it’s the vitamins. I believe it can only be the Ritalin that’s helped him to the extent and all the therapy he’s getting with it because I don’t believe in just the Ritalin.

R: How is the relationship between the brothers?

P: They very close, you know they twins, Matt will always look out for his brother they always had a very close relationship even before he went on Ritalin. But Cris was always aggressive he would always overreact, and he would shout at his brother and things like that, I think that the Lamictin improved that. We can talk to Cris now; you can have a conversation with him, before you couldn’t.
R: How does it make you feel to have your child live with this?

P: Okay, a mother with a child like Cris, you are judged by your family, by his teachers, by everyone you come into contact with, people say you’re a bad mother, you don’t discipline your child, or he needs a good hiding, he needs to be hit so that he can come right, you must hit him into submission. My husband judged me, he often told me Cris is the way he is because of you because he didn’t know what he was talking about, my husband and I would fight like cats and dogs.

R: What is his dosage?

P: He’s on 10mg once a day only. I also had to consider, you see the Ritalin can cause seizures as well, so I had to worry about that as well so it was hard for me to give it to him. We used to just pray everyday that he won’t have a seizure and he hasn’t, 6 months down the line.

R: So in conclusion then would you say that the decision to use medication was good or not?

P: No definitely, it was the right decision; it takes one day at a time. If its cocaine like people say it is, I’ve got to, I’ve got to look at a lot of stuff. We love him and he has our support. I keep the dosage as low as possible, I’m not going to give more and more and more, I give him just as much as he needs. He’s improved his work and that’s because of the Ritalin.

R: Is there any family history of such a disorder?

P: I think my brother had a problem, I think he was autistic from all the things that I read now.

R: Thank you for your participation.
Interview Three

The interview took place in the home of the researcher since the participant lives far out of town. It took place at 7:30 am for the convenience of the participant.

R: I'd like to start with a bit of background information, you and your husband and your daughter.

P: Okay, I'm thirty seven years old, I'll be thirty eight in April, my husband will be forty in May. I was twenty nine when I had, no, I was thirty when I had Jill. She was a normal vaginal delivery although it was an induction. I was thirty seven weeks, thirty eight and a half weeks pregnant, they didn't want me to go into labour because I wouldn't have made it, they induced me and, at first it didn't work, I had a suppository put in that didn't work and then the labour was only two hours and twenty minutes. I had a third degree tear so the pressure on her head was a lot at birth, she was, she had a APGAR score nine of ten. I breast fed although I battled to breast feed, I breast fed her for sixteen months, I battled to breast feed because, I only found out afterwards I had implants so I had very little breast tissue, and supplement fed and rehydration solution because she became dehydrated, she slept very well, I actually had to wake her she never woke up for a feed I had to wake her up, she would sleep. She was a very good baby. She did everything too early, she crawled at about six months, she walked, she took her first independent steps at eight and a half months, she was running by ten months, she spoke early as well. I, we didn't we thought we had the perfect child, that was a genius. I took her at two years to a child psychologist in Bloemfontien and she checked her and said she was fine, she was alright and then when she started school she had a, she started to fidget and she wouldn't concentrate, well she couldn't, she would like sit very unhappy and she would rock herself,
battling to concentrate and so we took her to and occupational therapist in
Bloemfontien and she gave the diagnosis having ADD.

R: Just to go back, you said you took her to a psychologist, what made you take her to
one?

P: We took her to the psychologist because in preschool the teacher said to us that
she’s disruptive in the classroom, so we took her to the psychologist because we
thought that there was something bugging her, you know, so the psychologist said she
was normal. You know there’s times when she’s fidgety and she said she didn’t have
enough stimulation, because she didn’t actually physically, the preschool we thought
was preschool, the teacher wasn’t qualified and we only found that out when she
actually went to school. Anyway so Jill went to the psychologist and the psychologist
said nothing and she went again now at seven years old, when she was diagnosed as
having ADD. She doesn’t have hyperactivity she just, she just, she doesn’t do it all the
time, there’s days that she’s fine, and there’s days that she’s, she’s totally out of it,
were she gets nothing right, there’s weeks that she’s fine and there’s weeks won’t,
she’ll do the, the same thing tentatively over and over whereas the week before the
first few minutes she’s got it. Now they put her onto Ritalin, at first only 5mgs in the
morning, and she started to, she, the Ritalin did help with the concentration, she
calmed down, she started to listen more, her work improved, but she started to vomit
in the morning she had stomach ache, she was depressed. So we carried on with the
Ritalin, just helping her and encouraging her more, then she was battling with her
homework in the afternoons, so they put her on five mills in the morning and 5mg’s in
the afternoon, at about say about twelve o’ clock they’d give it to her. And that would
cover her and then she, she improved remarkably, the, the, the improvement in her
schoolwork was you could see, was fantastic. Then this year because of the side-
effects that she had, the depression and the nausea, I took her off it and I tried something called Calm-Alert or something like that, it didn’t work, but now she’s on a herbal thing but if it doesn’t work we’ll have to go back onto Ritalin, she does need help. The teacher told us at the parent teacher meeting she really is battling with the concentration, there’s times that she concentrates and there’s times that she just can’t.

R: How long was she on Ritalin?
P: She was on Ritalin for six to eight months. The side-effects would happen in the morning. She would get sick and feel nauseous and she also cried a lot, if she had breakfast she definitely would throw it up. She definitely had stomach aches and then when I took her off the Ritalin, because I never gave it to her weekends and I never gave it to her during holidays—maybe incorrectly but my paediatrician never told me to do that and had subsequently heard that you should give it all the time— but in the December holidays she was actually like a zombie, she complained of terrible stomach aches, this was when she was not getting it, she walked around in like a daze and she slept a lot of the time, so instead of her only sleeping at night—like she would, she would never catch a nap in the day—she would be sleeping twice or three times in the day. You’d find her sleeping and also holding her stomach and complaining that she had stomach ache. Now, that was when she was when she was off the Ritalin so it was worse, it only lasted for about a month and then she was fine. So that was like, like December, and then the last two weeks of the holiday she was fine, no stomach aches, without the Ritalin. So she’s been off it since the end of November, about the twenty-seventh of November. She daydreamed a lot, she never had hyperactive behaviour. At school, like, she would sit rocking herself, she never climbed on things or got agitated she would just sit there and I don’t know how to put this, but clock out, she would actually just take leave of the classroom and just go
somewhere else in her mind. According to the teacher she wouldn’t concentrate but also she doesn’t ever, she doesn’t complete tasks. If you tell her to do something she has all intentions of doing it but she doesn’t do it, she forgets, she’ll go and do something else. When she was little she never caused havoc in the classroom but everyone else would sit and paint and she would just go do something else.

R: Is there any history of childhood disorders in the family?

P: Ya, I had ADD as well and my husband most probably has it too, I have dyslexia as well and my father had it, my father-in-law has it, my brother has it, so it’s a strong family history of, of that.

R: When Jill was diagnosed, how did that make you feel?

P: Ah, I felt terrible because I know that it came from me. If the gene didn’t run so strongly on my side of the family my children would possibly be normal. It’s a very, very tough life. I’m a nurse, my husband’s a farmer and its, its, very, very difficult, especially, I didn’t have any assistance, I didn’t have Ritalin there wasn’t such a thing, you just have to learn to cope.

R: How do you feel about having had to use medication with Jill?

P: I’m a nurse, I don’t like it because it’s a schedule seven drug, or schedule six now but it was a seven, that’s the reason I don’t like it. Its, its on par with, with all the heavy stuff, you know, I mean in, in my nursing field I know drugs are okay but they not good to give the child every single day for the, for seven years or twelve years, or fifteen years, you know and Ritalin is paramount to cocaine one is fat soluble and one is water soluble. Ritalin’s water-soluble, cocaine’s fat-soluble. It has, cocaine, you know, if you crush Ritalin and you sniff it, it has the exact effect that the cocaine has. It worries me because of the drug aspect. No that’s, its heavy and I mean she’s seven years old, I know the professors say that if they take Ritalin they’ll never ever actually
take drugs later on in life, it sorts out the neuroreceptors or what ever’ s not making contact.

R: It must have been a tough decision to make to put her on Ritalin.

P: Yes, but, because I know how, if somebody had helped me I would’ ve appreciated it. So I have to do everything in my power even if I don’t like it, if it’s going to help my child I’ ve got to do it.

R: How was your relationship with Jill before Ritalin and after?

P: My relationship with her, she’s a very lovable child, she likes to be hugged and kissed but our relationship was very strained because I get impatient with her. When she doesn’t do, I understand her better now and our relationship is better now since she was diagnosed because I understand she’s not just doing it because she’s lazy or being arrogant or whatever. I’m not disciplining her or reprimanding her because I understand. I am more understanding of her, which has changed her way of treating me as well, not because of the Ritalin but because of the diagnosis. Before that we used to fight a lot because I didn’t understand why she just didn’t do what I tell her to do.

R: How is the kid’ s relationship with each other, you said you’ ve got another little girl and a little boy?

P: Fine they fight a bit but not more then others, she is actually very protective and loving towards the other two especially the little one, Jill’s the oldest.

R: How do you feel about Ritalin now?

P: I feel it, it’s is good, okay but if you could manage the side- effects, okay its actually excellent if you could manage the side- effects, although it scares me because of the fact that it’s a schedule seven drug but I really do think there is a place for it because it really does help. It is clear that it does help, the only reason I, I want to go
down another field, route, is because um, it is a drug that is quite potent. If there’s something else that would help my child the same and its natural I would, I would like to try it but if there’s nothing I will go back to Ritalin because it definitely, definitely does help her to concentrate more and when she concentrates more it makes her happy because the teacher is happier with her. She tries so very hard that it is rewarded you know, with the Ritalin it’s rewarded because she gets her results for trying. Before she was on the Ritalin the psychologist actually said she, she went through a bout of sleeping a lot and she said she liked sleeping and the psychologist said, “why do you like sleeping?” and she said, because she, she’s actually tired from work, she’s got to work double the work that other children do, she’s got to do double to just get on the same plain as them. So the Ritalin definitely, definitely does help that, how can I say, lessen the burden of that.

R: How does it make you feel to see your child experience the side-effects that you mentioned earlier nausea, vomiting and the depression?

P: Ya, that’s the reason also I’ve tried to find something alternative, she needs help but if possible I don’t want to go back on Ritalin because of the side-effects because anyone who has morning sickness knows that nausea is debilitating at best and then also the stomach ache and I mean you can’t function with a stomach ache all the time its just impossible.

R: To conclude I’d just like to know what did you think of the use of Ritalin before?

P: I used to think that it was something for somebody else’s child not for me, my child. That was my attitude. I knew people on it and I just thought okay, its what he needs, I wouldn’t use for myself, now I don’t have a choice.

R: Thank you very much for your time.
Interview Four

The interview took place in the home of the participant. It took place at five thirty in the afternoon after the participant had come home from work. We sat in the lounge were there would be no interruptions.

R: I’d just like to start with some background information.

P: Okay, well my husband and I, our ages at the moment, my husbands forty, I’m thirty seven. My daughter was born in 94, I had a difficult pregnancy. I had toxemia, I was huge I looked like a elephant. She was born at thirty-eight weeks because I, you know, I was so big, so much water I was carrying. I had a Caesar, and everything went fine, the Caesar and all the rest, what else didn’t I say.

R: How old were you when she was born?

P: I was, when I fell pregnant, I was twenty seven. And she, she was the second child, ya.Where was I now, I didn’t breast feed her, that’s right, she was a bottle-fed baby. She was a very difficult baby; she never slept, hardly ever slept. She didn’t eat badly at all, you know I thought she, she fed quite well.

R: When you say she was a difficult baby can you describe what you mean?

P: She used to cry all the time, permanently. She was not a colic baby according to the doctor. She, she was very restless; she didn’t sleep and would cry and cry and cry. She was terrible, the doctor just said it was not colic- he said I was spoiling her and every time she cried I used to get up and pick her up etcetera and he suggested that I leave her to cry and eventually she’ll get out of the habit, which I did but it didn’t work. She screamed the whole night without fail; she never stopped till five o clock that
morning. We eventually got up and picked her up, ya, she just carried on and on and on.

R: And when you picked her up?

P: She stopped crying, well not immediately you know, I had to pacify her for some time and then she stopped. But she would not and we did it two or three times and eventually I said no, because I used to get so worked up, I mean I'm lying in the other room and I hear this kid screaming blue murder and she just she wouldn't let up, she would not. And even today, if she, if she's naughty, and you give a hiding, you can, you can hit her until she's blue if she's decided she's gonna do that she will do it. That's it. It's quite strange. You've got to find other ways of trying to punish her. You can't like for instance put her in her bedroom and punish her that way cos she would just stand there and scream forever and ever.

R: So to go back, how many kids do you have?

P: I've got, my husband was married before so he's got a son from his previous marriage he's eighteen now. And then we have got a son, he's ten turning eleven in November and then of course Chantel she's the second one and she'll be ten now in March. She was 4.6kg when she was born. The doctor eventually put her on medication, it was called Antrax to help her to sleep, to get her into a sleeping pattern. While she was on it it did help she still didn't sleep right through you know. It did help but I mean you can't keep her on that forever you know. That was supposed to be for like two or three weeks to get her into a sleeping pattern but I mean as soon as I took her of it, it was the same story. She's now nine she'll be ten on the second of March.

R: At what age was she diagnosed?
P: It was a doctor Venter from Bloemfontein. She was, she must’ve been about seven, she was in grade one. I took her up there and they did, what you call those things, a CAT scan to see if there was any abnormalities and epilepsy and all that but that was all fine. And then he got her to, to write and do all sorts of things and whatever and then he said to me, look, I don’t know how he even saw that, but he said to me that she’s ADH, ADD and she’s hyperactive as well and she’s dyslexic, how he knew from the drawings I don’t know.

R: When that happen how did that make you feel?

P: Oh I’s devastated I went, I actually took her to see a psychologist, or I took her but I saw the psychologist myself, because I was devastated. And at the same time the teacher said to me I couldn’t teach your child, I don’t know how to teach your child. I thought you know, what am I going to do now. I mean if they cant teach her, I mean what’s going to happen to her kind of thing. I went to go see the psychologist and she did a, a brain, a brain test or a I don’t know what they call it cos I said to her I, I didn’t want to believe it obviously. I said to her, look I’m not sure if you know this professor is got the thing right anyway she did some tests and she came back to me and she said its definitely so. Because while I was in Bloem this doctor said to me she’s got to go on to Ritalin, which I obviously wasn’t happy about. But anyway when I came down here I spoke to the psychologist and I asked her and she did her own tests with the child and she said to me she’s definitely ADHD, she’s definitely dyslexic and she would suggest that she would have to go to a special school, that they not equipped at the school she was at to teach her. So well ya I was devastated but I had to accept it for my child’s sake so that we could try n’ help her. It was pointless going against it.

R: And did you know about ADHD before this?
P: Never heard of it didn’t have a clue. I could always see that she was different to other children. For instance she was very active, she even today, she doesn’t get tired she’ll go from this sport to that sport to the next sport, she’s forever running around were other kids they’ll run, you can see them tiring, she just doesn’t tire. She’ll eventually get tired, so it takes a long time, and she’s very active and she cant, she’ll like build whatever puzzle here and move on and do something else. She never finishes anything. She’s always busy here there and everywhere you know, she just doesn’t finish anything.

R: In your experience how would you describe ADHD?

P: Well, what I would say is that kids that cant sit still and concentrate for any span of time, I mean your concentration is extremely um limited so, um and they always on the move you know. They, if they reading through their book, they, they look here and they look at the picture and they’ll just start talking about the picture and then they jump back to were they were reading you know the entire thing and ya just being, just not being able to concentrate, I would say that that’s the main thing.

R: How is she at school?

P: Well she’s on Ritalin at the moment. Before she was terrible, she would sit up, jump up, walk, talk to this one, do this. She was unruly really and I mean people who don’t know about it obviously label those children as undisciplined children, naughty children whatever just, I mean, they couldn’t, she cant help herself you know, she doesn’t mean to do that while the teachers talking.

R: Before you put her on Ritalin how did you feel about it?

P: I was dead against it. In actual fact when the doctor said to me that she had to go on Ritalin I said to him, there’s no ways I’m putting my child on Ritalin and he says well, if that’s how you feel you must be more intelligent than me, then I’ll have to say
that I can't help you and well there's the door. That's what he basically said to me. And then I said to him, well can he help me because there's been a lot of negative publicity about Ritalin and he just said to me that its because its, its used incorrectly if you use it correctly its actually, there's nothing wrong with it, its actually good for the child, it helps the child.

R: And did you know about the side effects at that time?

P: No, I knew nothing about side-effects, in actual fact he said to me that I mustn't worry too much about side-effects. If he put her on it and I have a problem I must phone him and we'll deal with it as the problem arises. So he didn't actually tell me anything. When I put her on it, it was soon after we came back from Bloem, she was seven at the time, we put her on it, she was on 10mg fast release I think its called, and she had one tablet in the morning. And I found when she was on that it didn't last the whole day it only lasted a little while and also she didn't eat properly. It almost took her appetite away and while she was on this we sent her to a school in East London, to Arcadia, and they don't have a boarding school so she was boarding with private people. I don't know if this also had something to do with it, that she seemed to become very depressed, in actual fact she became suicidal, because the one day she said to me "ah mommy I wish I can just die," and that concerned me and I phoned him and he said no well the dosages are wrong, blardy, blardy, blardy, and we must now give her one in the morning and one in the afternoon at one o’ clock. So we did that and it just didn't come right and we played around and then she went onto 20mg slow release, which was supposed to last for the whole day, which still did not work properly. And now very recently last year some time, it was probably June, we put her onto the long action 30mg, and since she's been on that she's been a different child. She's now quite normal. She, if you look at her she's not different to other children...
anymore. She can sit down, she can complete her task. She doesn't jump around that much. Look she still does it but not, I wouldn't say she's any different to another child if I can put it that to you way. Ya she's, she can hold a conversation with you, before she couldn't, I mean she can sit and watch TV programmes till its finished etcetera. I mean, in the classroom I've only had good reports from her teachers, they say she works well, far more attentive, if you look at her. We actually did a test last year we took her of the Ritalin 'cos I was wondering, I thought to myself, you know, maybe she'll be fine now, lets take her of and see how she is. You can see a day and night difference in her work, it's a mess. The days she didn't have Ritalin, the writing was an absolute mess and obviously her teacher said well she was totally out of reach, so we decided to put her back and just leave it.

R: What do you mean when you say unruly?
P: I mean just being disruptive, jumping up and down, asking things out of turn, she can't wait, she just sort of shouts out, you know, that kind of thing.

R: What are your feelings about Ritalin now?
P: I actually don't think there's anything wrong with Ritalin to be honest with you. I think it's actually very good, if it's given in the right circumstances, the right dosages. I can't see anything wrong with it really. I think its wonderful. Well it, its done a lot for my child without it I don't know what we would have done with her. She's much happier now, she's a different child. There absolutely no side-effects now.

R: So she's been on Ritalin since she was seven, and its been about two years now, and she's on the right dosage now since June last year and is completely free of side-effects.

P: Ya she's a normal child now.

R: How would you describe your relationship with her before she was put on Ritalin?
P: I wouldn't say it was to good because, like I said she was a very difficult baby and I don't know its like a, its not a hatred that you have but you, just you feel that you've got this baby and its ya you know, its, its not working, its an irritation, you cant do anything, its always screaming you cant go anywhere, its always screaming, so I don't think I have the same relationship I had with my son, I wasn't as close to her because of the, the problem. And even today, I wouldn't say that we're not close, but we're not as close as I am with my son, because she, she's different, she we treat her differently you know. For instance she's not a very lovable kinda child, she doesn't like to be hugged she doesn't like to be close to people you know she, she wants her space, so its, its difficult to sort of you know, be close to her, you know, even now that she's on, on Ritalin. You know even in a hall, if, if the kids are sitting cross-legged, she she doesn't like anyone to touch her, you know, she'll push them away, she doesn't like to be confined. I don't know if its got something to do with ADD or whatever you know, ya, she's not a lovable kinda person. We don't have a very close relationship. We've got a good relationship but its not very close.

R: And sibling relations?

P: Well listen, they want to kill each other, the little one now, Rob, they want, they fight like cats and dogs he's got a very dry sense of humour and he like plays with her but she takes stuff the wrong way all the time, so there's always a fight and they always just about throttling each other.

R: Is there any family history any sort of mental disorder?

P: Yes, strangely enough about two years ago my brother, he was then thirty three, he was diagnosed with it, which is really strange, but he was also a difficult child and I mean, when we were in school no one really knew anything about this. They always labelled him as being naughty. And he's on Ritalin, which is, ya quite strange.
R: When she had these side-effects how did it make you feel?

P: Devastated ya, it was very worrying, especially when she started becoming suicidal
you know, that, that was extremely worrying but I did take her to a psychologist and
they worked through, it and well we’ve come out tops now.

R: So about Ritalin, all you knew was what the doctor told you?

P: Ya and at a seminar, people say that Ritalin has the same side-effects as cocaine
but the ones water soluble and the ones fat soluble so in actual fact it's not a problem.
And she’s on it all the time and there’s a remarkable difference. I cannot say anything
bad about Ritalin, really. I mean before the Ritalin she was failing maths for example
but now she’s getting like twenty out of twenty. I wasn’t able to manage her when she
wasn’t on Ritalin, she makes you tired.

R: I think we’ve covered everything. Thank you so much for your time and co-
operation.
4.4. DISCUSSION

A common theme was the strong family history of mental disorder or medical condition. Disorders like dyslexia and ADHD itself, were identified across all participants. Two participants confirmed that they had ADHD as children but were never clinically diagnosed. They seemed to recognize the symptoms in themselves when their children were diagnosed. There was one participant who said that both she and her husband and both their fathers probably have or had ADHD. So there is a strong genetic link that is of significance. Co- morbid disorders in the children were also common.

Conception, pregnancy and birth difficulties were also common across participants. Participants stated, “We couldn’t have children,” and considered their children ‘gift babies.’ Another participant said, “I had a difficult pregnancy, I had toxaemia, I was huge, I looked like an elephant.” “I wouldn’t have made it, they induced me,” said another. All participants reported complications in the conception, pregnancy and birth of their child who was clinically diagnosed with ADHD.

What came through strongly is the fact that all participants were extremely knowledgeable about ADHD. They had saturated themselves with information about ADHD and appeared to know the disorder fluently and personally. Their empowered experience of the disorder made them experts. It appeared that the participants had taken the time to know about ADHD so that they could provide the best care for their children.
A major emergent theme was that all participants had tried various forms of interventions before resorting to the use of stimulant medication. "We went to an O.T.; a physiotherapist; psychologist; a remedial person; a homeopath; a, what’s a name, a psychologist, an educational psychologist; we went to different paediatricians; tried ‘reflectology’; we tried- what’s the other one with the needles? Acupuncture," was the response from one of the participants. Said another, "I tried something called CalmAlert or something like that, but now she’s on a herbal thing, but if it doesn’t work we’ll have to go back to Ritalin." Another mother said, “He’s going to occupational therapy, he’s seeing the educational psychologist, everybody is trying to help.” The participants seemed to have tried all other available and possible routes before going the route of medication. Some were giving their child Ritalin in combination with other interventions as well.

Within this commonality amongst participants came also the knowledge of the potency of this commonly prescribed drug, Ritalin. Participants were well aware of the adverse effects associated with Ritalin. All participants mentioned the comparison of Ritalin to cocaine. One participant’s response was, “We were given a hard time when we put him on Ritalin, they have this concept of giving him Ritalin you might as well give him cocaine.” Another parent said, “but having to give him the Ritalin was the hardest thing for me simply because people say it’s like cocaine.” What then emerged strongly here was the feeling of resignation that these parents displayed- resignation- the last resort. Enmeshed in that was the feeling of helplessness. Comments within this theme included, “If there’s something else that would help my child the same and it’s natural, I would like to try, but if there’s nothing, I will go back to Ritalin,” and, “Cris has his medication simply because he has to.” Another
very frank comment was, “I don’t think any parent would do it willingly. You do it as a last resort because you’ve tried everything else.” Previous studies also reported that even though there were potentially damaging adverse effects related to the use of stimulant medications parents submitted to it’s use because for many children it may be the only alternative (Author, 2001 & Kozlowski, 1999).

Through this theme of resignation radiated a very characteristic aspect of all participants- their strength. They all showed a sense of strength that seemed to carry them through this experience. It appears they are strong for their children. Their strength in dealing with what they experience everyday seeing their children go through this was an important part of themselves.

The diagnosis appeared to have damaged these families on various levels. In addition to the feeling of devastation when finding out that their children had been diagnosed with ADHD, all the participants had difficulty in parenting these children. Interaction between spouses became strained. The family social life was affected in terms of going out or visiting friends etc. Some participants complained that the relationship between the children was stressed. Fighting between spouses was mentioned. Therefore the common theme here that all participants spoke of was the stress that families felt as a whole in dealing with this diagnosis. Some participants even commented that their relationship with their child is strained and not the same as with their relationship with the other child/children. In earlier studies the National Institute of Mental Health (1998), also reported an increase in levels of parental frustration, marital discord and even divorce as a result of the difficulties related to the diagnosis of their children. Furthermore, the relationship between mother and child appeared to
become strained. Some mothers even stated that the relationship that they had with their child with ADHD was different and not as close as it could be. As maintained by Wender (1987), apart from causing tensions within the family, such a diagnosis may in fact pose a risk to the bonding experience between parent and child.

Even though participants did have a difficult time parenting these children, they still had mixed feelings about the use of medication. Ritalin was the drug most commonly prescribed and parents were well aware of its potency and related adverse effects but they also appreciated its positive aspects. It proved effective because their children showed real progress academically and their social behaviour improved. For some its benefits outweighed the negative aspects associated with stimulant medication use. Some participants even said that they could actually have a conversation with their child now that they’re on Ritalin. One parent commented, “She’s quite normal, if you look at her she’s not different to other children anymore,” and she went further to say, “The days she didn’t have Ritalin, her teacher said well she was totally out of reach.”

The theme of guilt was also strongly emergent. The participants felt guilty about having to put their children onto Ritalin. They felt that others would see them as failures and taking the easy way out in terms of handling their child’s behaviour.

A major theme that emerged from the reading and re-reading of the transcripts and from the independent conversations with the investigators was how these parents especially the mothers of the children had to adapt themselves to the special context of such a diagnosis in order to bring up their ADHD children. The devastating diagnosis brought with it this sense of not knowing what to expect and the need to
know the disorder. Maternal care plays a vital role in terms of child rearing. Object relations theory describes the mother as the facilitating environment that adapts to provide optimal maternal care to the infant which strengthens bonding that is required for healthy development. The theory goes further to say that the infant will grow and succeed in terms of maturation if the facilitating environment provides adequate support (Fromm & Smith, 1989). Kollin, Barkley and DuPaul (2001), maintain that mothers who maintain a positive disposition regarding their child and who are more rewarding of those initial positive behaviour changes, appear to induce further positive progress associated with treatment. St. Clair (1986), argues that it is the parent’s responsibility to adapt to the needs and maturational process of the child. In such a situation the child obviously needs special care. The bonding between mother and child is crucial and in this situation participants complained of parenting difficulties, where the infant would cry and cry causing frustration, which is another major theme common to all participants experiences. So although the mother as the facilitating environment attempted adaptation to the needs of the infant, it was strained because, it appears, that the mother had difficulty handling the behaviour of the infant and thus lacked the opportunity to provide a positive facilitating environment (Fromm & Smith, 1989, St. Clair, 1986):
CHAPTER FIVE
CONCLUSION

This study has investigated the perceptions parents had of using stimulant medication to treat their children who have been clinically diagnosed with ADHD. A qualitative research method was used in order to understand the real and deep experience the mothers have of having to administer stimulant medication to their very young children. The identified themes were reflective of the interpersonal nature of the dialogue between the interviewer and interviewees.

The participant’s feelings seemed to favour the use of stimulant medication despite the controversial aspects related to this practice. This study and previous studies have shown that parents have great difficulty coping and dealing emotionally with this diagnosis (Barkley, 2000).

The emergent themes of guilt, frustration and resignation described the feelings that the participant’s have since the diagnosis was made. Their telling of the stories seemed to show how empowered they were with knowing ADHD the way that they did. Although the aspect of bonding since infancy was tampered the participant’s show perseverance.

The researcher resides in a small town which in itself seemed to limit the study in that participant’s live out of town and they were only the few participant’s that were willing to take part in the study. All participants were working parents who had to
make time for the interview, which only allowed 45 minutes to an hour for each interview.

There was a strong need for support to these parents in the form of maybe a support group structure which all participant's reiterated the need for. A support group with parents who are experiencing the same things in terms of coping with ADHD would greatly improve the strength these parents need everyday. Parent training programmes should also be run in order to give further support to the parents and to provide them with greater skill in managing their children whether they are on or not on medication. It is thus evident that they need to tell their stories, to talk and have people listen.

Education about ADHD is required at all levels. There is great a need for teachers to be trained to recognise the symptoms of ADHD instead of assuming that the child lacks discipline. Furthermore, teachers need to be trained in ways of handling these children in the classroom. The public needs to be educated about ADHD so that they can recognise the difference between a child who lacks discipline and one who has ADHD.

Big organisations like ADHASA should be more accessible to people in small towns such as this with affiliations located in these areas so that they can also provide information and education programmes to support the parents of children with ADHD.

Very little research of this nature has been conducted in South Africa. It is therefore recommended that further research be conducted especially longitudinal studies, which tell parents of the long-term effects of stimulant medication use.
This study concurs with findings by Manos, Short and Findling (1999) and Author (2001), who maintain that parents feel that the use of medication significantly improves their child’s behaviour and thus believe it to be effective and therefore even though there is great controversy around its use, the positive change it brings makes it worth using.
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