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"I Find It Really Difficult to Control Myself Too": A Qualitative Study of the Effects on the Family Dynamic When Parent and Child Have ADHD

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Abstract: If having one child with Attention Deficit Hyperactivity Disorder (ADHD) contributes to family stress and dysfunction, then what happens when more than one family member has ADHD? This paper explores this question by drawing on findings from a multi-case study that explored the voices of stakeholders (child and parent/carer) affected by ADHD in Ireland. There were eight case studies (families) included. Each case had one parent/carer with ADHD and a child with ADHD. Eight children (aged 7–17 years; Mean = 12.6; S.D. = 3.4) and ten parents (2 males) participated. Four parentw/carers reported a diagnosis of ADHD themselves (2 females) and 6 mothers participated who had a spouse with ADHD. Triangulation was achieved using multiple interviews (parent/carers and child), a demographic survey, and creative methods with the children to contribute to a highly contextualised understanding of stakeholders' experiences. Research findings demonstrated that there may be positive and negative consequences when both parent and child have ADHD. On the one hand, it may contribute to greater dysfunction, when parents with ADHD struggle to stick to routines and remain calm and organised. On the other hand, children with ADHD may feel a sense of belonging and less different, parents believe they have greater understanding, and shared interactional preferences may have benefits. Findings will be discussed in terms of their implications for practice with families and future research.

Keywords: ADHD; parent; child; family; diagnosis

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1. Introduction

This paper presents findings from a qualitative study that explored the lived experiences of stakeholders affected by Attention Deficit Hyperactivity Disorder (ADHD) in an Irish context. We consider findings from eight case studies where both parent/carer and child had a diagnosis of ADHD. This paper will begin by clarifying the perspective adopted by the paper and the research, as well as the existing literature in the area. It will then move on to present the research methods and findings.

1.1. ADHD, Development, and Risk and Resiliency

ADHD is neurodevelopmental disorder that spans cognitive, behavioural and affective domains of attentional processing, executive functioning, response inhibition and/or increased levels of activity [1,2]. ADHD presents in one of three ways: predominantly innatentive, predominantly hyperactive-impulsive, or combined [1].

ADHD affects approximately 5% of children worldwide [3]. It is the most commonly diagnosed condition referred to the Child and Adolescent Mental Health Services in Ireland [4]. ADHD is associated with a range of challenges, across all functional domains, such as problematic relationships (peers, teachers, parents) victimisation (e.g., [5]), academic failure and are more likely to drop out of education, earn less money, and be unemployed [6]. ADHD is associated with a range of internalising and externalising difficulties, such as

poorer self-concepts and lower self-esteem, as well as higher levels of anxiety, depression, self-harm, and suicide [7].

The evidence-base would suggest that children with ADHD experience additional risks within their development and consistently poorer outcomes. A child's behaviour and other outcomes is shaped through a dynamic interactive process with other people (e.g., parents/carers, teachers, peers) in different contexts (e.g., school and home) across their lifetime [8] and the risks and protective/promotive factors therein. Child development inevitably includes some degree of risk/stress. It is necessary for positive development that there is a balance of risk/stress with factors (personal, social, familial) that protect or buffer against risk/stress and that promote positive development [9].

1.2. ADHD and the Family

The development and functioning of children with ADHD is heavily influenced by their family context [10]. Children with ADHD are often reliant on parents/carers for identification/diagnosis, seeking and engaging with healthcare services, decision making, and treatment implementation [11]. According to best-practice, parent training is frontline treatment for ADHD and families are viewed as integral to treatment planning and implementation [12]. Parenting skills are correlated with outcomes for children with ADHD, especially the development of conduct problems [13]. Problems at home can contribute to difficulties in other contexts [14]. Similarly, protective and promotive factors at home can contribute to resiliency in other contexts. Thus, it is important to consider risks and protective and/or promotive factors within families where there are children with ADHD.

1.3. Familial Risks: Stress and Dysfunction

An emergent body of research suggests ADHD is associated with more familial stress and dysfunction [15–18]. The cause-and-effective relationship between ADHD, child, and familial factors is unclear [15]. It has been suggested that parenting or family dysfunction causes ADHD; suggesting the ADHD-label provides an exonerating construct for parents [19]. However, it is difficult, if not impossible, to determine whether dysfunction is the cause or result of ADHD [20]. From a systemic perspective, ADHD affects the entire family system; and in turn, ADHD will impact upon the family's ability to cope, which will affect the child and their behaviour [10].

According to one meta-analysis, parenting a child with ADHD is associated with higher levels of stress, which can be exacerbated by severity of the ADHD symptoms [21]. In addition, these parents have more depressive symptoms [22], anxiety disorders [23], unemployment, and financial difficulties [24], and marital conflict [25]. Adults with ADHD report more family stress and dysfunction, and have less coping resources [26]. If one adopts a neuro-biological perspective, then due to shared genetics, more than one family member may have ADHD. Despite the dearth of research in the area, it could be suggested that if one child with ADHD contributes to stress and dysfunction, then problems are exacerbated and coping resources are decreased when both parent/carer and the child have the condition [27,28].

According to Evans, Vallano, and Pelham [29], a child with ADHD has a 64% chance of having one or more parent with ADHD. However, research into parents with ADHD parenting a child with ADHD is largely absent. In one survey, when compared with controls, mothers with ADHD were less able to monitor their child's behaviour, less consistent with discipline, and experienced more difficulties with problem-solving [30]. A range of parental risk factors have been associated with negative outcomes for children with ADHD, including hostile or negative approaches to parenting and/or discipline and maternal depression [31,32].

Evidence suggests that, without a parental diagnosis, parenting a child with ADHD is stressful and (physically and psychologically) exhausting [15,17]. Familial conflict especially discordant parent–child relationships are common, and these represent additional risk factors [24,32]. Additional familial risk factors, such as ADHD-presentation, low

socio-economic status, co-morbidity (especially conduct disorder), and stigma contribute to familial dysfunction and developmental outcomes [15,33].

1.4. Familial Protective and/or Promotive Factors

There is a dearth of research into the strengths associated with ADHD, which includes an understanding of resources and protective factors associated with more positive outcomes for children with ADHD within the family. While Regalla et al. [34] found that adolescents with ADHD were less resilient than their non-disordered siblings and peers, others have found comparable levels of resilience in young people with and without ADHD [35]. An understanding of what family factors contribute to more positive outcomes, as protective (buffer against risks) and/or promotive factors, in children with ADHD could be used to promote resiliency in children with ADHD. As Dvorsky and Langberg [36] observed, the study of resilience in ADHD is "in its infancy" (p. 372), their systematic review identified familial factors, especially positive parenting, parental mental health, and cohesive family environments. Similarly, McMenemy and Nicholas' [37] study of family journies to overcome the challenges associated with ADHD as creating integrated and cohesive families that 'moved forward' together.

As evident from this review, the family system is important to understanding functioning and developmental outcomes for children with ADHD. An emergent body of evidence indicates a range of familial risk factors contributing to more negative outcomes for children with ADHD. Protective factors identified include a range of positive parenting, resources, and cohesion. However, to date, there is no research into what happens in terms of risks and protective factors when more than one member has ADHD.

2. Materials and Methods

The research project adopted a multi-case study design [38] which will be explored in greater detail in subsequent sections. Each case represented a family where two family members, a parent/carer and a child, had ADHD. Triangulation was achieved through a demographic survey, semi-structured interviews with at least one parent/carer and a semi-structured interview with the child, child interviews were facilitated using draw-and-dialogue method.

3. Research Sample

Following ethical approval from the researchers' host university, Trinity College Dublin, eight families were recruited through purposive sampling [39], which included ADHD family support groups and online advertisements.

Table 1 presents findings from the demographic survey regarding the characteristics of the child participants, as reported by parents/carers. eight children participated (five males and three females), aged between seven and seventeen years old (Mean = 12.6; S.D. = 3.4). All attended mainstream schools, from a range of socio-economic backgrounds and from both rural and urban communities across the Republic of Ireland. Based on parental reports, participants had a range of ADHD presentations (DSM5): two predominantly Inattentive (*I*) and six Combined (*C*). Five participating children had at least one co-morbid diagnosis: Dyspraxia (*DPX*: $n = 2$), Oppositional Defiant Disorder (*ODD*: $n = 2$), Asperger's Syndrome (*AS*: $n = 1$), and Dyscalculia (*DYC*: $n = 1$). All case studies contained one (or more) parent (N = 10).

Family demographics, based on participating parental reports, are presented in Table 2.

Table 1. Child Demographic Information.

	Case Name	Age	Male/Female	ADHD	Co-Morbidity	Parent (N)
1	John	7	M	C	DPX	1
2	Sam	10	M	C	AS and DPX	1
3	Jack	9	M	I		2
4	Tom	13	M	C		2
5	Alan	13	M	C	ODD	1
6	Sara	16	F	I	AS	1
7	Ann	16	F	C	DYC	1
8	Jill	17	F	C		1
Total	8	7–17	5 M/3 F			10

Table 2. Family Demographic Information.

Case	LS	PR	Mother		Father		Siblings		
			AA	D	AA	D	N	Age	D
John	F	M	JC	ADHD	LC		4	0–6	SpLD
Sam	F	M	LC	ADHD	UD		4	2–19	
Jack	F	M	LC		GD	ADHD	1	5	
Tom	F	M	LC	SpLD	LC	ADHD	0		
Alan	F	SD	LC		JC	ADHD	1	8	
Sara	F	W	UD		UD	ADHD	1	20	ADHD
Ann	F	M	LC		JC	ADHD	1	19	
Jill	F	M	LC		LC	ADHD	2	12–19	

All children's Living Situation (*LS*) was in the Family home (*F*). Parental Relationship (*PR*) reported were; six Married (*M*), one Separated or Divorced (*SD*), and one Widowed (*W*). The majority of parent's/carer's ($n = 9$) own Academic Achievement (*AA*) was completion of post-primary education, known as the Leaving Certificate examination (*LC*) in Ireland, but most cited additional qualifications (e.g., fireman or business diploma). Three parents/carers had completed the Junior Cycle (first three years) of post-primary education, known as the Junior Certificate Examination (*JC*), but many of these had subsequently received other training and qualification. Three parents/carers had Undergraduate Degrees (*UD*) and one had a Postgraduate (*PG*) qualification. The majority of families included more than the child with ADHD, with siblings' age ranging from zero to twenty years; one family was an only child (one had no siblings and one had a half-sister who lived with her estranged father). One case included a sibling with a Diagnosis (*D*) of ADHD and a Specific Learning Difficulty (*SpLD*). All eight families included participating parents/carers or their spouse who also had a diagnosis of ADHD, and one also reported an SpLD.

4. Procedure

Informed consent was obtained in writing from all parents/carers first, and while the children wrote their own consent form before the interview, informed consent represented an ongoing process of communication and clarification throughout the study. All participants took part in a semi-structured interview [40]. Where necessary, age-appropriate terminology was used to explore problems (stress) and solutions (coping) in participants' day-to-day lives. For each self-identified problem (or stress) the participant was asked how they "dealt with" or "coped with" it. Interview questions were informed by solution-focused questioning techniques (or "solution talk") drawn from Solution Focused Brief

Therapy [41]. Creative art-based techniques facilitated children's voice [42]. Children's interviews were facilitated using a research constructed, research-informed, draw-label-dialogue technique (see Figure 1 for a completed example).

Figure 1. Draw-Label-Dialogue Completed (Male Version).

All interviews (range 59–86 min) were recorded, transcribed, and then coded using the principles and procedures of Thematic Analysis [43].

5. Results

This section reports findings regarding the difficulties and strengths experienced by families when both parent/carer and child had ADHD. Two themes represented difficulties. First, "I find it really difficult to control myself too" demonstrated how difficulties at home were exacerbated for both parent/carer and child with ADHD when there was a dual diagnosis. The theme "Immature and unreliable" explored mothers' without ADHD experiences of becoming the lone parent. Two themes also emerged suggesting that protective factors also exist: "He is a carbon copy of me" considers children's reports suggesting a sense of belonging and acceptance emerging from having a parent/carer with similar difficulties. The theme "I'm at an advantage coz I like know what he's going through" refers to parent/carers with ADHD believing that they were better able to understand and so support the difficulties their child faced.

5.1. "I Find It Really Difficult to Control Myself too"

From the young participants' perspective, having a parent/carer with ADHD was something they tended to talk about with mixed (positive and negative) feelings. On the negative side, they felt that they could not rely on the parent/carer with ADHD: " . . . like you'd ask Mum coz like Dad wouldn't well like he'd not forget or or remember . . . " (Jill,

17 years). In a similar manner, another male (Alan, 13 years) reported that "Mam gives more chances . . . ", which suggests she was more patient. According to participants, parenting a child with ADHD was said to require similar skills as parenting a child without ADHD, but these skills were "more" essential, especially "routine", "structure", and "patience." However, parent/carers with ADHD, and their spouses, said that when a parent/carer also has ADHD they struggle with being consistent and keeping to a routine. For example, Sam's (10 years) father said, " . . . it's hard to keep up too, though I definitely found it hard with the consistency . . . ".

Unsurprisingly, some of the more significantly challenging behaviours were reported when participants had (a) predominantly hyperactive-impulsive or the combined presentation of ADHD, and/or (b) a co-morbid behavioural disorder (e.g., ODD). However, these problems were also more frequently attributed to a parent/carer having ADHD. According to Ann's (16 years) mother, her daughter's behaviour may have been due to witnessing her father with ADHD responding to stress in a similar way: " . . . her father would throw a tantrum . . . so in fairness that's what she has seen . . . ". Her daughter described how similar she and her father were, in terms of managing their emotions and behaviour, which caused conflicts: " . . . like I'm just like me Dad . . . we're always fighting . . . " (Ann). Indeed, parent/carers with ADHD and their spouses also described difficulties with self-regulation, including emotional-regulation. For example, one mother reported that "I find it really difficult to control [myself] too because . . . I have my little meltdowns and when he's pushin' every button . . . " (John, 7 years).

As one mother described, parenting a child with ADHD may lead to parents/carers re-living the challenges they experienced growing up. On the one hand, this could have contributed to greater understanding and empathy. However, on the other hand, she was also concerned that as a result of her own experiences she was intrusive, which was not always constructive:

> "... like I know it I see myself in him SO much, I know how that feels so I suppose I'd always be tryin' to fix it for him and that's no good he needs to learn himself and he'd get thick too, saying why did why was a calling him in...". (John, 7 years)

5.2. "Imature and Unreliable"

Having a child with ADHD was always described in terms of the stress and chaos it caused within the family system. However, this was said to be exacerbated when both parent/carer and child had ADHD. For example, one mother described how her son (Alan, 13 years) and husband both had ADHD, which caused conflict and distress, due to the son's behaviour and the father's lack of patience with the son, and as a result the family unit was fractured, " . . . so it's a bit like there's a . . . split yeah a split in the family where we can't be do things together".

Spouses frequently discussed the difficulty of having both a child and a husband with ADHD. This often placed a strain on the relationship. Furthermore, spouses with ADHD were often described as being "immature" and "unreliable". For example, one mother (Ann 16 years) reported that her husband " . . . can be very childlike to do with money and things not very adult about money . . . ". Other parenst/carers reported that their spouse had contributed to financial problems in some way, such as gambling, taking out loans, or shopping. This was a significant problem, because nearly all parents/carers described how having a child with ADHD was a financial burden, in terms of replacing lost items, paying for treatment, or being unable to work due to having to care for the child with ADHD. As a result of this "unreliability" the spouse without ADHD reported feeling like they became a single or "lone" parent, where all responsibility fell to them. As one mother (Jill, 17 years) described: " . . . I was always the one who said well you need to go to school every day, you need a uniform, you need your homework . . . ".

5.3. "He Is a Carbon Copy of Me"

Themes emerged which suggested that the impact was not always negative, and there may be protective factors associated with parent/carer and child having ADHD. Indeed, the children who participated in the study were keen to tell the researcher that their mother or father also had ADHD. Their reports suggested that having a parent/carer with ADHD seemed to contribute to feelings of being understood, which was evident in comments, such as "he knows" (Jill 17 years) and "we're so alike" (Sara 16 years). As a result, they did not appear to feel as isolated and different. Indeed, they may have even perceived themselves to be members of some exclusive club within the family system. For example, Ann (16 years) described her relationship with her brother, whom she desperately sought approval from but perceived as "hating" her, she rationalised her experiences in terms of different groups (ADHD vs. non-ADHD) within the family.

> " . . . we never really got along . . . he's my brother I love him . . . but any problems or fights like he'll always blame me everything is my fault . . . He's the complete opposite to me he's like my Mam whereas I'm like my Dad . . . my Dad has got ADHD . . . he is the exact same he is a carbon copy of me . . . ".

5.4. "I'm at an Advantage Coz I like Know What He Is Goin' through"

Parents/carers also identified protective factors. They described how they could discuss their shared difficulties and experiences, which decreased feelings of isolation and being misunderstood. As one mother explained how she could talk to her son (John 7 years) about his challenges, which she also experienced: " . . . anger-wise I say 'look John you just get angry because you find things harder but Mammy's the exact same' . . . ". She went on to describe, as many other parents/carers who had experienced similar difficulties did, that there were benefits associated with understanding what their child was going through, she said: " . . . I'm at an advantage coz I like KNOW what he is goin' through . . . ". As a result, parent/carers believed they had more understanding, which facilitated more positive interactions and support, both at home and in school. For example, one father (Tom 13 years) said, " . . . I know what it's like . . . how hard it can be when you're in school and you have to get extra help".

Positive functioning may also be facilitated when the parent/carer and child share similar characteristics or styles of interaction. As can be seen from the two examples below, people with ADHD may experience rapid shifts in emotions. As a result, when both the parent/carer and child have ADHD they may rebound from emotionally provocative events; whereas, when the parent/carer does not, they may require more time and be more distressed for longer periods.

> " . . . in a half an hour he'll have forgotten that I was up to 90 and I'll still be and it'll take me a while to unwind then it'll take me a long long while . . . ". (mother of Jack 9 years)

> " . . . so I just leave him and let him have his wee meltdown and then go up to him later and he'll have totally forgotten about it. So in a sense I'm like that too like when it's over I just forget about it too, whereas my husband would still be like grr . . . ". (mother of John 7 years)

Findings reported here suggest there may be both positive and negative consequences associated with a family system when both parent/carer and child have ADHD. It may contribute to further dysfunction, both children and parent/carers (with and without ADHD) suggested it contributed to further dysfunction and distress. Children suggested that it leads to more conflicts and they feel they cannot rely on the parent/carer with ADHD. Parents/carers with ADHD experienced additional challenges, such as difficulties with consistency, routines, patience, and regulating their own emotions. Mothers described how having a spouse with ADHD meant they become the lone parent/carer without someone they could rely on and how their spouse could cause additional problems, such as contributing to financial difficulties. However, participants also identified advantages

when both parent/carer and child have ADHD. Children may feel a sense of belonging, more understood, and accepted. Parents/carers with ADHD believed that their shared experiences provided them with a greater understanding of their child, and so could support them better. They also identified shared characteristics and preferred interactional styles, which enabled them to cope with, and recover from, conflict more easily.

6. Discussion and Conclusions

This study highlighted some of the ways parent–child ADHD dyads may impact on the experiences, and so the development of the child and parent/carer, as well as the functioning of the family as a whole. There is a dearth of research on the effects of having both parent/carer and child diagnosed with ADHD. Findings from the current study demonstrate that there are both positive and negative consequences associated with a family system having both a parent/carer and a child with ADHD.

In this study, parents/carers with ADHD may struggle to provide routine, structure, and consistency. This supports previous research [30] finding that mothers with ADHD may be less consistent. However, these skills are emphasised by parent training programs, which best-practice guidelines [12] and Irish research [44] suggest are vital indicators for positive outcomes for young people with ADHD. Findings reported here also suggest that parents/carers with ADHD may struggle to regulate their behaviours and emotions, which may contribute to more distress and dysfunction within the family system, but may mean they do not demonstrate positive role modeling for their child/children. Previous research has shown that parent/carers' ability to stay calm and be patient is necessary when raising a child with ADHD [20]. Parents/carers with both a child and a spouse with ADHD consistently reported feeling like a lone parent. However, prior research [20] found that mothers reported feeling like a 'single parent' even when they had a partner without ADHD. Therefore, there is perhaps even more need for additional structures and supports when both parent/carer and child have ADHD. This may include the parent/carer with ADHD receiving support and/or treatment for their own ADHD-related difficulties, for their own well-being, but also to support their child and contribute to familial functioning. In addition, both ADHD and non-ADHD members of the family (e.g., wife, husband, siblings) may require support, such as family counselling, to decrease conflict and dysfunction and contribute to familial functioning.

The current study also identified protective factors associated with both parent/carer and child having ADHD. The young person may feel a sense of belonging and less isolation. The parents/carers with ADHD believed they were at an advantage, because they understood what their child was going through, and so were better able to support them. Parent training and/or psycho-education courses could enhance these factors by drawing parents/carers and children's' attention to them. Furthermore, if the parent/carer and child share characteristics and interactional styles, then they may bounce back from distressing events and conflicts more easily. Drawing on his work with people with schizophrenia, Szasz [45] developed his 'ideology of normalization' which maintains that there is no such thing as 'normal' but rather interactional preferences. He would argue for greater acceptance for different ways of being in this world. Findings reported here suggest that preferred interactional styles, if shared by all, may alleviate some of the impact of so-called deviant behaviours. Furthermore, it has a wider implication, one which asks the wider community and society to question and challenge assumptions about social behaviour, and understanding and including other ways of being and interacting, as valuable and respected differences (not deficits).

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