

THESIS

PARENTS' COMMUNICATIVE PRACTICES WITH ADHD AND NON-ADHD  
CHILDREN

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## ABSTRACT

### PARENTS' COMMUNICATIVE PRACTICES WITH ADHD AND NON-ADHD CHILDREN

Attention Deficit Hyperactivity Disorder (ADHD) has become more commonly diagnosed in the U. S. over the last decade. Several theories exist for what causes ADHD and how to properly treat the disorder, with an increased emphasis on parenting and its effect on children's behaviors. To date, little research has examined the differences between parents' communicative practices with children diagnosed with ADHD versus non-ADHD children. The purpose of the present study was to determine if differences exist between the parenting practices of ADHD-diagnosed children and non-ADHD children. Specifically, this study examined verbal and nonverbal differences in parents' communication practices.

Ninety-five parents participated in an online survey, offering insight into the ways in which they parent during various situations. The Parenting Practices Interview (PPI) was used to determine the parenting practices parents used with their children. Additionally, the survey included demographic questions and questions requesting specific information regarding each child within the family. An independent samples *t*-test was conducted, as well as a series of Pearson correlations between the various categories of parenting practices.

Significant differences were found within the areas of parental monitoring, appropriate discipline, harsh and inconsistent discipline, and clear expectations. Parents of children diagnosed with ADHD tend to use more appropriate discipline, yet they also practice more harsh and inconsistent discipline. They also employ clearer expectations in their parenting practices. Parents of non-ADHD children tend to monitor their children significantly more than parents of children diagnosed with ADHD. No significant differences were found when examining physical punishment, positive verbal discipline, or praise and incentives. These results offer important areas of parenting to consider when looking at how parenting practices influence children's behaviors. Results are consistent with other research stating that differences exist between the parenting practices of parents with ADHD-diagnosed children and parents with non-ADHD children.

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## CHAPTER 1: INTRODUCTION

In the United States, the prevalence of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and treated with pharmacological drugs is increasing. Robison (1999) found that from 1990 to 1995 diagnoses of ADHD increased from 947,208 to 2,357,833 in children aged 5 through 18 years. More recently, the Centers for Disease Control and Prevention (2005) reported that an estimated 4.4 million youth aged 4 to 17 had been diagnosed with ADHD by 2003. Of these, approximately 2.5 million were taking medication for their ADHD. Most of the drugs used to treat ADHD are stimulants, such as Ritalin and Adderall. These medications affect the brain by stimulating neurotransmitters, thereby increasing the “alertness” of the nervous system (Wilens, 2008). Dunne (2000) asserted that the U.S. produces and consumes 85% of the world’s stimulants used in treating ADHD. This is raising concerns about how our society is choosing to deal with childhood issues. Are parents looking for quick-fix solutions for their children’s behavioral problems that may or may not be ADHD? According to the U.S. Public Health Service (1998), the majority of children being treated with stimulants for ADHD may not fit the criteria for a correct diagnosis. In addition to overdiagnoses and overly prescribed medication, there are people misusing and becoming addicted to these stimulants. The Drug Enforcement Administration (2000) held a congressional hearing in which they looked at poison control data, emergency room data, and high school surveys related to stimulant use. They found that the “abuse” of these stimulants “has increased significantly since 1990” (para. 3).

ADHD is defined within the medical community by the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM IV). According to Michigan State University's School Psychology Program (2004), the DSM IV lists three subtypes of ADHD: Attention-Deficit/Hyperactivity Disorder Predominantly Inattentive Type, Attention-Deficit/Hyperactivity Disorder Predominantly Hyperactive-Impulsive Type, and Attention-Deficit/Hyperactivity Disorder Combined Type. For each of these three subtypes there are five factors that must be present in order to conclude a diagnosis of ADHD: a) persistent patterns of inattention and/or hyperactivity-impulsivity must be more frequently displayed and is more severe than is typically observed in individuals at comparable level of development, b) some hyperactive-impulsive or inattentive symptoms must have been present before age seven years, c) some impairment from the symptoms is present in at least two settings (e.g., in school and at home), d) there must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning, and e) the disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorders and is not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder). Additionally, six or more of the following symptoms for inattention and/or hyperactivity-impulsivity must have persisted for at least six months.

*Inattention:*

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- (b) often has difficulty sustaining attention in tasks or play activity

- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

*Hyperactivity-Impulsivity:*

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or often acts as if “driven by a motor”
- (f) often talks excessively
- (g) often blurts out answers before questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)



Some research suggests ADHD is a biological disorder, ranging from complications with dopamine reuptake transporter genes to neurological chemical imbalances and even the effects of perinatal and prenatal nicotine exposure (Castellanos & Tannock, 2002; Faraone & Biederman, 1998; Hall & Gushee, 2000). In addition to biological causes, researchers have also examined possible causes of ADHD such as the number of hours children watch television, their school environment (teaching methods, low self-esteem, boredom, etc.), toxins in the environment, and other psychological problems, such as depression and anxiety (Dryer, Kiernan, & Tyson, 2006). The parent-child relationship also has received attention as a possible source of children's negative behaviors, including such areas as hostile parenting, ineffective discipline, and parents' mental health (Baumrind, 1966; Lifford, Harold, & Thapar, 2008; Poire & Dailey, 2000; Snyder, Cramer, Afsak, & Patterson, 2005; Yingling, 2004). These are all relational issues that come directly from varying communication patterns exemplified through parenting practices, the reason this study has chosen to focus on the communicative practices of parents with their children.

Yingling (2004) wrote about the relationship between parent and child and how it evolves from infancy to adulthood through relational dialogue. She asserted that parents are the "primary agents of socialization" and have the "greatest influence on children's interpretations and management of emotions" (p. 117). The reinforcement of parents' expectations serves as a model of the parent-child relationship that provides the child with proper behavioral management skills. According to Yingling (2004), children who express their negative emotions through displays of anger are less likely to receive sensitive caregiving, and by age two are often managed by the use of authoritarian

discipline (p. 156). This type of discipline creates a defiant response from the child, which then leads to “inconsistent parenting—first resisting, then giving in” (p. 156). Conversely, if parents comfort the angry or distressed child, the children are more likely to deal constructively with anger. Furthermore, Yingling (2004) contends that this authoritative style of parenting employs the kind of clear and consistent rules and limits that young children understand and appreciate, whereas authoritarian styles simply reinforce negative behavior.

A common behavior exhibited in ADHD children, and included in the criteria for ADHD in the Diagnostic and Statistical Manual of Mental Disorders, is impulsivity. Children commonly interrupt adult conversation, and although this is a negative behavior, it is due to their underdeveloped skill of “turn taking.” Yingling (2004) argues that children “are simply slower to process the available cues for an appropriate turn” (p. 167). Another common behavioral issue with hyperactive children is their whining and use of verbal attacks toward the parent. By the age of 2, hyperactive children will often nag and threaten in order to get what they want. It has traditionally been thought that the parents’ communication practices directly influences the behavior of their children. However, the relationship between child and parent as a bidirectional relationship, whereby both parent and child behavior can have an influence on the other, is worth considering.

According to Kuczynski and Parkin (2006), bidirectionality is an important factor in the socialization process of both parent and child. The authors stated that parents and children “have capacities to initiate purposeful behavior and strategically choose methods for influencing each other’s behavior,” such as asserting themselves, resisting demands

that threaten their autonomy, blocking their goals, and disregarding their self-constructed understandings of social situations (para. 3). The authors stated that, until recently, researchers only looked at the short-term goals of the bidirectional relationship, such as avoiding parental demands, but the influential capabilities of both parent and child are now being considered as an important agent to socialization. Kuczynski and Parkin (2006) discuss two ways in which the bidirectional influence is conceptualized in their research on socialization. First, bidirectionality is examined in terms of immediate reciprocal exchanges of behaviors producing “linear, incremental change” (para. 10). Second, the bidirectional relationship is defined in terms of a “dialectical process in which human agents construct meanings out of each other’s behavior and thereby, produce transformational change” (para. 10).

If children with ADHD share a common group of behaviors, parents may be using common communicative practices in their interactions. To date, there has not been a direct comparison between the communicative practices of parents who have children diagnosed with ADHD and parents without. This thesis will look at the differences in communication patterns between these two groups.

According to Baxter and Babbie (2004), communication is a process whereby people use symbols (both linguistic and nonverbal) in various social and cultural contexts in order to create meaning. Typically, there are three goals to studying communication. They are: 1) understanding the processes of message production, transmission, and meaning-making, 2) understanding the content or form of communicative messages, and 3) understanding the functions and effects of messages (Baxter & Babbie, 2004). In order

to examine what communication practices might be relative to ADHD versus non-ADHD parenting, reviews of parent-child relationship patterns follow.

### Literature Review

The field of psychology has given frequent attention to parent-child relationships when looking to explain various behavioral issues. Hostile parenting has often been the focus of explaining children's negative behaviors. Lifford, Harold, and Thapar (2008) conducted a longitudinal analysis looking at the relationship between child behavioral problems and hostile parenting as a bidirectional relationship, whereby not only does the parents' communication practices have an effect on the child, but the child's behaviors also shape the parents' communication (p. 287). The study looked, specifically, at the relationship between symptoms of ADHD and children's perceptions of "parent-child rejection" (p. 290). The study included 94 children and their parents, all living in the United Kingdom. Families were recruited from schools according to the schools' economic and social conditions as by their "catchment" area: specific geographic regions with a prescribed list of schools. Demographic statistics for the overall sample suggest that it is representative of British families living in England and Wales according to family structure, parent education and ethnic representation.

The parent-child relationship was considered a significant factor in accounting for variation in children's typical and atypical emotional, behavioral, and social development, while the quality of the parent-child relationship was thought to cause variation in children's long-term psychological development. ADHD was defined as a neurodevelopmental disorder thought to be influenced by family environmental factors

such as parenting, characterized by more conflict, less compliance from the child, and more controlling parenting.

The study covered a three-year time span, during which parents and children answered questionnaires twice. The questionnaires contained a variety of measures related to the quality of family interaction, parenting, marital satisfaction, parent and child psychological health, economic conditions and family demographics (Lifford, Harold, & Thapar, 2008). Each parent was instructed to take the questionnaire independently. Researchers conducted a debriefing with children following the questionnaires completion in which negotiating and resolving conflict was discussed. The intervening variable of the stability of ADHD symptoms and child perceptions of parent-child rejection across time was controlled for by testing models in which ADHD symptoms and mother-child or father-child rejection at Time 1 predicted each converse measure at Time 2. Further, to assess the relationship between ADHD symptoms and child perception of parent-child rejection within time, “a reciprocal effects model was tested whereby symptoms and parent-child rejecting behavior simultaneously predicted levels of each variable at Time 2” (p. 289).

ADHD symptoms were found to have “significantly greater influence on mother-child rejection across time and a marginally greater influence within time than they did on father-child rejection,” and conversely “father-child rejection had a marginally stronger influence on ADHD symptoms than mother-child rejection within time” (p. 291). So, for the mother-child relationship, children’s behaviors elicited negative responses from their mothers, whereas perceptions of rejection influenced children’s behaviors in the father-child relationship. Lifford et al. (2008) offered a possible

explanation for the differences, highlighting the “differing involvement” parents have with their children (p. 293). Mothers tend to be more involved in everyday activities, where ADHD behaviors may be more prominent (Lifford, et al., 2008). Fathers, on the other hand, tend to “engage in more play and task-focused behaviors,” proving to be a different type of relationship (p. 293). So clearly, the differing types of communication practices and daily involvement may influence children’s behaviors, as well as parents’ behaviors.

Snyder, Cramer, Afrank, and Patterson (2005) also looked at parents’ hostile attributions but examined the influence of ineffective disciplining as well. The authors’ study did not limit these relationships to the home, examining behavior problems at school in addition to the home environment. Parent attributions were defined as “verbal-cognitive rules about the sources of child misbehavior that are used to guide discipline efforts; these rules may ‘insulate’ parent discipline tactics from actual situational variation and developmental change in child behavior” (p. 31). Children’s behavior problems were identified as “difficult temperament, impulsivity-inattention, and temper tantrums,” all of which are affected by parenting (p. 31). However, these behavior problems could also be influenced by “peer coercion-rejection, selective affiliation, and deviancy training” (p. 31). The study included 134 boys and 132 girls with a mean age of five years at the start of the study.

When looking at behavior problems only within the home, the results suggest that frequent child behavior problems at home increase the likelihood that parents attribute intentionality to children’s misbehaviors, and this intentionality “places the locus of the problems in the child and minimizes parents’ use of environmental circumstances or

normative development as explanations for child misbehaviors” (Snyder et al., 2005, p. 38). In other words, parents fail to acknowledge the environmental or developmental factors that could be shaping their child’s behaviors and attribute the misbehaviors to the child’s own intentional actions. Frequent child behavior problems at home are also associated with ill-devised parent discipline tactics, as reflected by “parental irritability (frequent criticism, anger, and scolding) and ineffectiveness (inconsistency and non-contingency)” (p. 38). These finding indicate that “frequent child defiance, disruptiveness, and aggression” influence parental irritability and erode the use of effective disciplinary tactics (p. 38). Improved parental discipline practices reduce child behavior problems, which supports the idea that discipline encounters are really co-constructed by the parent and the child, again, suggesting a bidirectional relationship between parent and child.

Looking at behavior problems at home *and* school, the findings suggest that hostile attributions and ineffective discipline contribute to growth in behavior problems at school indirectly, via the facilitation of behavior problems at home that are then carried over to school (Snyder et al., 2005). It is unclear whether or not the parents’ communication practices have a direct effect on the child at school, or if parents may simply not be interested in what happens at school or fail to respond to feedback and requests from their child’s teachers (Snyder et al., 2005). Parents’ attributions may operate as rules that manage disciplinary reactions in a way that reduces the possibility of child behavior being linked to situational and developmental changes. It could also be that hostile parental attributions are directly communicated to children during parent-child discourse and “serve as a source of social scripts and working models of

relationship that children then apply to new social situations” (p. 39). Ultimately, improved parental discipline practices may reduce child behavior problems.

A study done by Woodward, Taylor, and Dowdney (1998) looked at the quality of family relationships and parenting experiences to understand the development and diagnosis of behavioral and interpersonal problems of children with hyperactivity. Differently from other studies, parents’ mental health, partner relations, and social support were factored into the research, as well as children’s verbal ability, socioeconomic status, and maternal education. This study was also different due to the naturalistic conditions. Much of the research in the area of hyperactivity has almost exclusively involved the direct observation of mothers and sons interacting under highly structured laboratory conditions (Woodward et al., 1998). Although this offers consistent results, “replication under naturalistic conditions is necessary before results can be generalized to everyday family interaction...to ensure that the performance demands of structured task conditions do not unfairly bias results in favor of control children who are better able to perform on sustained attention tasks compared to children with hyperactive behavior problems” (p. 161). Hyperactivity was defined as “less compliant, more off-task, more negative, more attention-seeking, more talkative, and demanding of their parents” (p. 161). A competent parent was considered to be child centered and able to express warmth and affection, reason and communicate openly, establish and enforce consistent rules and boundaries, and avoid the use of arbitrary, restrictive, or overly punitive methods (p. 162). The study stated that parenting and family problems seem to intensify the behaviors of hyperactive children and contribute to the persistence of difficulties (p. 162).



The sample included 30 boys with “pervasive” hyperactivity and 28 comparison boys, both between the ages of 7 and 10. All of the boys attended school in the London area. There were no significant differences between the groups for maternal age, paternal age, or ethnicity. Both groups included African, West Indian, Australasian, and Asian ethnicities.

In a community screening, hyperactive children were separated from children with emotional disturbances to eliminate any overlap between hyperactivity and other conditions that might have similar symptoms. The Rutter A and B Scales were completed by the children’s parents and teachers in order to identify hyperactive behavior. To reconfirm the hyperactivity diagnosis, the parent(s) were given the Parental Account of Children’s Symptoms Interview (PACS), and parent/teacher rating scales were derived from the DSM-III-R diagnostic criteria (Woodward, Taylor, & Dowdney, 1998).

Woodward et al. (1998) found results similar to other studies, suggesting that aggressive disciplinary tactics and hostility are significantly associated with hyperactivity. In addition, they also discovered that the mother’s mental health is an important “determinant of child behavior” (p. 166). Depressed mothers were found to be more critical and negative about their children. Finally, the authors suggest that parents of hyperactive children go through a particular mental process that “normal” children’s parents do not. First, the demands of a hyperactive child make it difficult to predict problematic situations in advance, whereas parents of comparison children may find it easier to anticipate and avoid conflict. As a result, the hyperactive child’s parent implements a “reactive parenting” method, leaving little room for “opportunities for learning new ways of controlling their own behavior” (p. 166). The emotions experienced

by parents “reflect their effectiveness in achieving child compliance and the extent to which they are able to fulfill their goals for their children,” leaving both parent and child with a high level of negative emotion (p. 166). As a result, parents’ feelings of satisfaction and confidence in their parenting role are diminished. These findings support the idea that parent training may be beneficial. As the authors suggest, a focus for intervention may be the “encouragement of more proactive and authoritative child management techniques to replace the use of more emotionally charged power-assertive ones” (p. 166).

Danforth, Barkley, and Stokes (1991) provided a critical analysis that looked at previous research comprised of observational studies that used medication and parent training as effective methods for improving the interactions between hyperactive children and their parents. The aim of the study was to show how medication for hyperactive children is related to a change in their parent’s behavior and how parent training can lead to improvements in the behavior of hyperactive children (Danforth et al., 1991). As predicted, the medication studies showed improved interactions between the children and their parents. While medicated, children’s attention spans increased and impulsivity was reduced. As a result, parents provided fewer negative comments and directions and offered more praise for appropriate behavior (Danforth et al., 1991). By manipulating the child’s characteristics, observations could be made of the parent’s corresponding changes. These results suggest that “the rate of parental attention did not necessarily decrease, but that differential attention was being contingently administered” (p. 715). Parents offer positive reinforcement when their children have good behavior and negative reinforcement for negative behavior.

In the parent training studies, parents were taught time-out, when to give attention, praise, physical affection, and how to tell their hyperactive child to stop “objectionable behavior” (Danforth et al., 1991, p. 716). In all of the studies, negative child behaviors decreased, and parents reported greater satisfaction in their interactions with their children. Results of the studies show that “improved child management skills serve to modify the way children respond to their parents and parents to their children” (p. 718). Again, the relationship between parent and child is considered a bidirectional relationship. This suggests that parent training effectively adjusts the way in which child and parent respond to one another. Although these studies fail to provide an answer as to why the hyperactive behaviors developed, they show that, through management, parents can have an influence on these hyperactive behaviors. This analysis, overall, suggests that the “conditioning and maintenance of behavior achieved via positive and negative reinforcement works in a bidirectional fashion, as the actions of hyperactive children affect their mothers as much as the actions of the mothers affect their children” (p. 719).

Clearly, the parent-child relationship is an important area to examine when looking at children’s behavioral issues. Whether hostile parenting, ineffective discipline, or parents’ mental states influences behaviors exhibited by children, it is essential to understand the differences that may exist between parents of children diagnosed with ADHD and parents with non-ADHD children. Identifying these differences could be an important step toward recognizing areas of parenting in which parents can focus their efforts in order to foster a healthy channel of communication between themselves and their children.

### Research Question

This study seeks to identify the differing communicative practices of parents with children diagnosed with ADHD and parents with non-ADHD children. The research question framing this study is the following:

What differences exist in the communication practices of parents with ADHD children and non-ADHD children?

## CHAPTER II: METHOD

This study surveyed parents of children aged 5 to 11 diagnosed with ADHD and not diagnosed with ADHD. This age limit was set for two reasons. First, the common age for diagnosis does not usually manifest until children reach the age of around 5 and are in school. Second, it allowed this research to be compared to previous research with the same age group.

To solicit participants, parents with non-ADHD children were asked to participate through the website momslikeme.com (<http://momslikeme.com>). This is a website designed for parents to connect and share information on a plethora of topics, ranging from schooling to ways to save money on grocery shopping. For the parents with children diagnosed with ADHD, participation was requested through the websites Daily Strength (<http://dailystrength.org>), Café Mom ([www.cafemom.com](http://www.cafemom.com)), Additude Mag ([www.additudemag.com](http://www.additudemag.com)), and ADHD News ([www.adhdnews.com](http://www.adhdnews.com)). These websites function as a place for a network of people to come together to share their knowledge, experiences, and support on various topics. Each of the four websites has support groups established for parents of children with ADHD. The solicitation letter assured participants of anonymity of responses and presented the purpose of the study as developing a better understanding of the relationship between children with ADHD and their families. The solicitation letter provided the internet link that parents could go to in order to complete the survey, which was created and provided through Survey Monkey. Identical surveys were administered to both sets of parents. Once the surveys were completed, data were

entered into SPSS.

### Participants & Procedures

The participants in the study were 95 parents (93 women, 2 men). The ages of the participants varied. Two participants (2%) were aged 20-24; 43 (45%) participants were 25-34; 36 (38%) participants were 35-44, and 15 (16%) participants were 45-54. Eighty-eight (92%) participants identified as White; 1 (1%) identified as Black or African American, 4 (4%) as Hispanic or Latino, 1 (1%) as American Indian or Alaska Native, and 2 (2%) participants identified as some other race. Seventy-six (79%) participants were married; 8 (8%) had never been married; 2 (2%) participants were separated; 9 (9%) were divorced, and 1 (1%) participant was a widow. The amount of education held by the participants varied widely. One (1%) participant had less than a 9<sup>th</sup> grade education; 3 (3%) had a 9<sup>th</sup>-12<sup>th</sup> grade education with not diploma; 5 (5%) participants were high school graduates; 21 (22%) had some college with no degree; 12 (13%) had earned an Associate's degree; 37 (39%) had a Bachelor's degree, and 17 (18%) participants had earned a graduate or professional degree. The annual household income of the participants varied widely, as well. Three (3%) participants earned less than \$10,000; 2 (2%) earned \$10,000-\$14,999; 2 (2%) earned \$15,000-\$24,999; 4 (4%) earned \$25,000-\$34,999; 11 (12%) earned \$35,000-\$49,999; 25 (26%) earned \$50,000-\$74,999; 21 (22%) earned \$75,000-\$99,999; 13 (14%) earned \$100,000-\$149,999; 8 (8%) earned \$150,000-\$199,999, and 6 (6%) earned \$200,000 or more. The participants were asked to identify whether or not any of their children had ADHD. Of the 95 participants, 39 (41%) had children who had been diagnosed with ADHD. Of those 39 children diagnosed with ADHD, 26 (67%) of them were first-born children; 10 (26%) were second-born children,

and 3 (8%) were third-born children. Although some parents had up to six children, none of the 4<sup>th</sup>, 5<sup>th</sup>, or 6<sup>th</sup> children had been diagnosed.

### Measuring Instrument

In this study, the Parent Practices Interview (PPI) (Webster-Stratton, 2007) (see Appendix B, questions 1-14) was used to determine the parenting practices parents use with their children. This scale was adapted from the Oregon Social Learning Center's discipline questionnaire (Pears, 1999) and revised for use of parents with young children by the University of Washington's Parenting Clinic (Baydar, Reid, & Webster-Stratton, 2003). It includes 73 items rated by the parents on a seven-point Likert scale with responses ranging from 1 (*never*) to 7 (*always*). There are seven categories that measure particular parenting practices. They are appropriate discipline, harsh and inconsistent discipline, positive verbal discipline, monitoring, physical punishment, praise and incentives, and clear expectations. Appropriate discipline is measured by looking at discipline methods such as making the child correct the problem, giving time outs, and taking away privileges. Harsh and inconsistent discipline is measured by how often parents raise their voice, threaten, show anger, give up, change their mind, and ignore the child's behavior. Positive verbal discipline examines how parents discuss problems with their children and praise their child's good behavior. Monitoring refers to the amount of supervised time versus unsupervised time their child has. Spanking, slapping, and hitting are measured to understand how parents use physical punishment with their children. Praise and incentives are described and measured by noting how often parents praise, compliment, hug, kiss, reward, or give extra privileges to their children for good

behavior. And finally, clear expectations are measured through examining rules about chores, fighting, and getting up and going to bed on time.

“The internal reliability coefficients (Cronbach’s  $\alpha$ ) of the scales constructed from these items were .73, .57, and .63, respectively. To assess the stability of these scales over time, correlations between pre- and post-assessments were estimated for parents who were in the control condition. The time between the two assessments was about 7 [sic] months. The correlation for the PPI Harsh/Negative Parenting scale was very high ( $r=.77$ , disattenuated  $r=.65$ ), indicating a high level of stability in this parenting style among parents who did not receive parenting training. The time series correlations for the PPI Positive scale and the PPI Inconsistent Parenting scale were .50 (disattenuated  $r=.44$ ) and .57 (disattenuated  $r=.49$ ), respectively” (Baydar, Reid, Webster-Stratton, 2003, p.1437).

To determine the content validity of the measuring instrument, items from the PPI were grouped into three categories relating to parenting practices: harsh/negative, supportive/positive, and inconsistent/ineffective. These categories were then evaluated separately, offering some “dominant factors that accounted for 50%, 44%, and 33% of their joint variance for harsh, positive, and inconsistent parenting” (Baydar, et al., 2003, p. 1437).

In addition to the PPI, the survey included demographic questions and questions requesting specific information regarding each child within the family (see Appendix B, questions 15-22). This information was requested to gain a better understanding of the participants’ background and the background of each individual child. The demographic questions were from the U.S. Census Bureau (2008). Participants were categorized into male or female categories. The age distribution was as follows: 15-19, 20-24, 25-34, 35-



44, 45-54, 55 years and over. The participants' ethnicity was White, Black or African American, Hispanic or Latino, American Indian or Alaska Native, Asian, Native Hawaiian and other Pacific Islander, or some other race. The participants' marital status was never married, married, separated, divorced, or widowed. The educational attainment of the participants was less than 9<sup>th</sup> grade, 9<sup>th</sup> to 12<sup>th</sup> grade (no diploma), high school graduate, some college (no degree), Associate degree, Bachelor's degree, Graduate or professional degree. The household income distribution was less than 10,000, 10,000-14,999, 15,000-24,999, 25,000-34,999, 35,000-49,999, 50,000-74,999, 75,000-99,999, 100,000-149,999, 150,000-199,999, 200,000 or more. Finally, the parents in the household were categorized as both parents present, mother only, father only, other (with the option to specify). For the questions requesting specific information for each child within the household, age, gender, whether or not diagnosed with ADHD, age of child at diagnosis (if diagnosed), and whether or not the child takes medication for ADHD (if diagnosed) were asked. A comparison of ADHD and non-ADHD parents showed one significant difference in demographics. Parents of non-ADHD children were slightly younger than parents with children diagnosed with ADHD.

#### Data Analysis

This study examined specific communicative practices of parents. To answer the research question regarding the differences between parents' verbal and nonverbal communicative practices with children diagnosed with ADHD and non-ADHD children, two statistical tests were completed on the data retrieved by the survey responses. First, a series of Pearson correlations was performed to show how specific parenting practices were correlated with one another. Independent samples *t*-tests were also conducted to

compare the parenting practices of parents of children diagnosed with ADHD to those parents with non-ADHD children.

### CHAPTER III: RESULTS

As discussed in Chapter 2, the measuring instrument included items at seven different categories of parenting practices. The means and standard deviations found for these categories are as follows: (a) appropriate discipline ( $M = 4.443$ ,  $SD = .725$ ), (b) harsh and inconsistent discipline ( $M = 2.539$ ,  $SD = .719$ ), (c) positive verbal discipline ( $M = 5.606$ ,  $SD = .726$ ), (d) monitoring ( $M = 6.009$ ,  $SD = .899$ ), (e) physical punishment ( $M = 1.373$ ,  $SD = .552$ ), (f) praise and incentives ( $M = 4.129$ ,  $SD = .725$ ), (g) clear expectations ( $M = 4.132$ ,  $SD = 1.029$ ).

A series of Pearson Correlations between the seven parenting practices were performed, as reported in Table 1. This yielded several significant findings. Appropriate discipline was positively related to physical punishment ( $r = .244$ ,  $p < .05$ ) and clear expectations ( $r = .530$ ,  $p < .01$ ). Harsh and inconsistent discipline was negatively related to positive verbal discipline ( $r = -.326$ ,  $p < .05$ ) and monitoring ( $r = -.326$ ,  $p < .05$ ), and approached a negatively significant relationship with praise and incentives ( $r = .207$ ,  $p > .05$ ). Positive verbal discipline was positively related to monitoring ( $r = .320$ ,  $p < .01$ ). Monitoring was positively related to clear expectations ( $r = -.206$ ,  $p < .05$ ). Last, physical punishment was positively related to clear expectation ( $r = .268$ ,  $p < .01$ ).

To answer the research question, what differences exist in the communication practices of parents with ADHD children and non-ADHD children, independent samples  $t$ -tests were conducted, comparing parents with ADHD-diagnosed children to parents with nondiagnosed ADHD children with regards to the seven parenting practices

previously mentioned. Parents with ADHD-diagnosed children ( $M = 4.707$ ,  $SD = .695$ ), relative to parents of non-ADHD children ( $M = 4.278$ ,  $SD = .698$ ), report significantly higher use of appropriate discipline,  $t(79) = -2.724$ ,  $p < .01$ . Parents of ADHD-diagnosed children ( $M = 2.873$ ,  $SD = .800$ ), relative to parents of non-ADHD children ( $M = 2.427$ ,  $SD = .634$ ), reported significantly higher use of harsh and inconsistent discipline,  $t(79) = -2.787$ ,  $p < .01$ . Parents of ADHD-diagnosed children ( $M = 4.711$ ,  $SD = 1.128$ ), relative to parents of non-ADHD children ( $M = 3.827$ ,  $SD = .900$ ), reported significantly higher use of clear expectations,  $t(81) = -3.996$ ,  $p < .01$ . Parents of ADHD-diagnosed children ( $M = 1.436$ ,  $SD = .501$ ), compared to parents of non-ADHD children ( $M = 1.370$ ,  $SD = .640$ ) reported significantly higher use of physical punishment,  $t(78) = -.504$ ,  $p = .01$ . Results indicated that parents of non-ADHD children ( $M = 6.244$ ,  $SD = .702$ ), compared to parents of ADHD-diagnosed children ( $M = 5.555$ ,  $SD = 1.053$ ), reported significantly higher use of monitoring,  $t(79) = 3.537$ ,  $p < .01$ . There was no significant difference between parents of non-ADHD children ( $M = 4.106$ ,  $SD = .673$ ), relative to parents of ADHD-diagnosed children ( $M = 4.121$ ,  $SD = .818$ ), when looking at praise and incentives,  $t(78) = -.089$ ,  $p = .93$ . There was also no significant difference between parents of non-ADHD children ( $M = 5.703$ ,  $SD = .673$ ), relative to parents of ADHD-diagnosed children ( $M = 5.418$ ,  $SD = .818$ ), when looking at positive verbal discipline,  $t(81) = 1.743$ ,  $p = .08$ .

Table 1

*Pearson Correlations between Parenting Practices Used with Children*

	1.	2.	3.	4.	5.	6.	7.
<b>1.Appropriate Discipline</b>	—	-.072	.168	.079	.244*	.042	.530*
<b>2.Harsh/ Inconsistent</b>	-.072	—	-.326*	-.326*	.151	.207	-.089
<b>3.Positive Verbal</b>	.168	-.326	—	.320*	-.090	.170	.009
<b>4.Monitoring</b>	.079	-.326	.320	—	.030	.082	-.206*
<b>5.Physical Punishment</b>	.244	.151	-.090	.030	—	.140	.268*
<b>6.Praise/ Incentives</b>	.042	.207	.170	.082	.140	—	-.139
<b>7.Clear Expectation</b>	.530	-.089	.009	-.206	.268	-.139	—

*Note.* \* $p < .05$ .

## CHAPTER IV: DISCUSSION

Many studies have examined the roles of parents in relation to children's development. This study sought to broaden the scope of research, examining the specific differences in parenting practices between parents of ADHD-diagnosed children and parents of non-ADHD children. By examining these different parenting practices, the primary goal of this study was to analyze whether various parenting practices were associated with the diagnosis of ADHD.

The findings of the study suggest some significant differences between the parenting practices of parents with children diagnosed with ADHD and parents of non-ADHD children. Parents of children diagnosed with ADHD use more appropriate discipline, yet also practice more harsh and inconsistent discipline. They also employ clearer expectations in their parenting practices. Parents of non-ADHD children monitor their children significantly more than parents of children diagnosed with ADHD. Essentially, there appears to be two main differences between these sets of parents. Parents of ADHD-diagnosed children seem to offer a higher degree of both appropriate discipline and clear expectations. However, this same parenting group also utilizes more harsh and inconsistent discipline practices.

These two factors, at first glance, seem to be incongruent but provide a cohesive pattern that makes sense when considering ADHD children. Families in which one or more of the children possess special needs must make adaptations to their daily lifestyles so that by accommodating they can function more efficiently (Firmin & Phillips, 2009).

A study done by Firmin and Phillips (2009) found that parents of ADHD children develop strategies for addressing the unique needs of their children, mainly centered on routine and structure. Parents of ADHD children find balance and success within their family only when they can implement routine and structure, and these routines have to be reinforced. The families rely on lists, calendars, planners, reward charts, and post-it notes. These strategies all seem to be overtly visual in nature.

Of the families studied by Firmin and Phillips (2009), less than half used verbal, nontangible methods, such as offering praise and encouragement or verbal demands, to enforce and maintain structure and routine. The attention required to use these verbal, nontangible methods of structure happened only through constant monitoring of the children by the parents. Over time, these parents grow tired of being a “compliance enforcer rather than a more traditional parent figure” (Firmin & Phillips, 2009, p. 1169). When the parents of ADHD children attempt to enforce and maintain the structure and routine of the household through verbal strategies and monitoring, they may become frustrated, harsh, and more inconsistent. By exemplifying these negative parental communication practices, the unwanted behaviors of their child may be exacerbated. If this cycle continues, it may lead to an unhealthy pattern of parents using inconsistent discipline tactics whereby they utilize both harsh and nurturing ways of communicating and disciplining their children. In turn, this can cause the child’s behavior to become more disruptive with an increased effect on the parent.

One theory that seeks to explain this relationship whereby inconsistent discipline tactics and children’s negative behaviors mutually affect one another is Inconsistent Nurturing as Control Theory. Inconsistent Nurturing as Control Theory (INC) aims to

understand and explain how the blending of family members' actions affects the continuation of undesired behaviors by other family members (Le Poire and Dailey, 2005). This theory looks at a dyadic relationship made up of a functional member and an afflicted member, whereby the functional member unknowingly enables undesired behaviors of the afflicted member. The primary assumption is that functional members have competing goals. They want to control the afflicted person's behavior, yet they feel the need to nurture the other in order to maintain the relationship. These competing goals lead to the inconsistent use of reinforcement and punishment strategies, thereby undermining the functional member's attempts to decrease the behavior. Le Poire and Dailey (2005) looked specifically at substance abuse users and their functional partners; however, INC theory extends to include all relationships in which one family member tries to decrease unhealthy behaviors of another family member.

Le Poire and Dailey (2005) pointed to three paradoxes in the functional-afflicted relationship. The first paradox entails questions of control. Initially, the functional member seemingly has control in this relationship as a result of the afflicted member's behavioral problems. However, because the afflicted's behavior restricts the choices available to the functional partner, the afflicted partner is actually in control (LePoire & Dailey, 2005). The second paradox deals with sacrifice and dependency. The functional family member sacrifices his or her own personal needs to take care of the other (LePoire & Dailey, 2005). This leads the afflicted member to feel obligated to the functional member, thereby changing their own behavior to compensate for the obligation. So in the regard, "the functional person is placed in a position of control and achieves it through behavior that would normally be indicative of a lack of control" (p. 85). For example, a



child approaches his/her mother with a loving hug after yelling at her, an acknowledgment of her devotion to him/her. Thus, by the mother subordinating her frustrations to the child's behavior, she has actually succeeded at controlling his/her negative behavior. She, therefore, controls the child's behavior "through submission" (p. 86).

The final paradox deals with the status of the relationship. The functional partner longs to maintain a good relationship with the afflicted member, while at the same time wanting to remove the negative behaviors of the afflicted. However, there is often guilt after harsh punishment, which leads the functional to nurture the afflicted, thereby providing rewarding behavior to the afflicted. This nurturing behavior allows the afflicted to continue this dysfunctional behavior, because to lose the negative behavior would mean to lose this nurturance (Le Poire & Dailey, 2005). This paradox has an important consequence. As the functioning member nurtures the afflicted, the negative behavior is actually reinforced and thus increases the likelihood that the behavior will be repeated. The functional is intermittently reinforcing the behaviors they want to extinguish (LePoire & Dailey, 2005). However, the functional may become resentful and eliminate their reinforcing behavior, and they may, in fact, refuse to nurture the afflicted in future scenarios, resulting in a punishment in the same situation. Thus, the functional partner may be attempting to get the afflicted partner to avoid punishment in the future by discontinuing the negative behavior (LePoire & Dailey, 2005). But INC theory argues that "the intermittent nature of this punishing behavior should actually *increase* the likelihood of the negative behavior" (p. 87).

Through research grounded in INC theory, analyses show that “partners typically cycle from reinforcing to punishing communication strategies following labeling their partners” as having a negative behavioral problem (Le Poire & Dailey, 2005, p. 88). In a three-step process, functional members in a relationship (a) reinforce negative behavior more before their determination that the behavior was problematic than after; (b) punish negative behavior more after they labeled the behavior as being problematic than before; and (c) in a postfrustration period, they employ a mix of reinforcing and punishing strategies, resulting in an overall pattern of inconsistent reinforcement and punishment (Le Poire & Dailey, 2005). For example, when a child is young and first begins to whine or cry for something, the parent’s natural instinct is to give the child what he/she wants. By the time children become toddlers, they are beginning to be reprimanded for using that same crying or whining as a tool to get what they want. Mothers commonly have guilt over not pacifying the child’s desires, or they may feel they have overreacted by reprimanding the child. This leads a mother to comfort a child, thereby sending a mixed message about the altercation. During this “cycling” process, functional partners will sometimes “use verbal abuse, make rules pertaining to the behavior, punish, get a third party involved, threaten, avoid, or withhold something from the other as a form of punishment” (p. 88). The results of this study support Inconsistent Nurturing as Control theory in that parents of children with ADHD struggle with dichotomous discipline practices. They use more appropriate discipline yet also practice more harsh and inconsistent discipline. While trying to maintain structure and routine these parents may become exhausted and overwhelmed, leading them to resort to harsher discipline and

more inconsistent discipline methods. This cycle creates a pattern of inconsistent reinforcement and punishment.

Another theory that examines the relationship between parents and their children is Coercion Theory. Coercion Theory suggests that unwanted behaviors are learned through the reinforcing events within a child's social environment (Fisher and Kane, 1998). Coercion Theory came about as an extension of Social Learning Theory which focused on social relationships as a system of rewards and positive reinforcement. What Social Learning Theory did not account for was that some relationships may not have a rewards system and may utilize aversive reactions whenever conflict arises out of these relationships. The main tenet underlying Coercion Theory is that "negative reinforcement occurs when aversive behaviors are not met with adverse consequences" (Fisher and Kane, 1998). This repeating process led Patterson (1982) to hypothesize that family interactions could result in the development of aggressive behaviors in children.

Patterson (1982) defined a coercive behavior as one that had to meet three criteria: a) the behavior must be aversive; b) it must consistently follow specific behaviors; and c) it must produce a consistent reaction in the victim that ultimately serves the aggressor. Under these circumstances, parents can unknowingly reinforce coercive behaviors in their aggressive children by "nagging, scolding, and yelling when the child misbehaves" (Fisher and Kane, 1998, p. 131). These are the behaviors that actually initiate the coercive interaction. If a child continues to misbehave despite parents' aversive behaviors, eventually the parent reaches a point of exhaustion. At this point, negative reinforcement of the child's misbehavior occurs, because the parent fails to follow through with adverse consequences (Fisher and Kane, 1998). Whenever a parent

backs down and fails to discipline a child adequately, children learn that they can coerce the parent into meeting their needs. Consequently, children become aware that, if they continue to misbehave or respond to their parent with increased aggression, they can shape the parents' behaviors to their own benefit (Patterson, 1982).

Other principles of Coercion Theory involve the frequency of coercive interactions and the payoffs related to the use of coercive behaviors. As the frequency of aversive events increases, the interaction between parent and child is likely to escalate (Fisher and Kane, 1998). Also, as the duration of the conflict increases, the greater the chance that physical aggression will result (Reid, Patterson, & Loeber, 1981). When coercive interactions occur over time, the child learns to move quickly to intense levels of aggressive and aversive behavior. Ultimately, the child learns to control the parent, and as a result, the parent begins to doubt his or her ability to effectively manage confrontational situations and eventually withdraw from the interaction. The result is that children receive constant negative reinforcement and become free to explore a plethora of aversive strategies without fear of consequence.

Researchers have focused on these coercive relationships and acknowledge the detrimental effects on both the parent and child. Kandel and Wu (1995) found that harsh discipline, a common outcome of coercive relationships, can lead to an intensifying effect of a child's behavior problems. Children's control responses lead to the parent's increase of harsh punishment, which results in a reduction of feelings of closeness and ability to control their child (Kandel and Wu, 1995). Research demonstrates the need for interventions to manage coercive interactions between parents and their children. Instead of reinforcing aggression by engaging in power struggles, efforts need to be made to

model caring and supportive behavior. According to Fisher and Kane (1998), children, as well as parents, must learn to control their impulses and emotions. Children need to be allowed choices regarding the decisions about their behaviors. Negotiation and collaboration foster self-esteem, and through the development of decision-making skills and self-control, these interventions instill confidence in children (Fisher and Kane, 1998). Children should be allowed choices in deciding what consequences will be applied for negative behavior and what privileges for positive behavior. Such opportunities can result in interventions that teach children about their own behavior. The results of this study support Coercion Theory, suggesting a link between children's aversive behaviors and a negative reinforcement of these behaviors by the parent. As parents may reach a point of exhaustion and fail to discipline a child adequately, the child learns that if they continue to misbehave or respond to their parent with increased aggression, they can shape the parents' behaviors to their own benefit.

Both Inconsistent Nurturing as Control Theory and Coercion Theory are relevant to children diagnosed with ADHD and their parents, especially if the parents are not able to maintain structure and routine through alternative methods, such as charts, calendars, etc.

### Limitations

Limitations to the generalizability of the results of this study include: a) the study's sample size, b) the use of a questionnaire survey online, c) the lack of diversity within the participants, d) the lack of information regarding how the parenting practices of parents with ADHD-diagnosed children differ with the ADHD children and their non-ADHD siblings, and e) possible confounding variables. Only 95 participants were used in

this study, which limits the statistical significance of social science quantitative research (Baxter & Babbie, 2004). Also, because the survey was a questionnaire taken via the internet, versus in person, the respondents did not have a chance to ask questions of the researcher, so there is no guarantee that all participants interpreted the questions as the researcher intended, thereby creating a possible lack of clarity. Another limitation to this study was the lack of diversity of both sex and ethnicity. The majority of the participants were Anglo-European women; only two men completed the survey, and men may have offered a differing perspective on the role of parenting an ADHD child. Additionally, 92% of the participants were Anglo-European, thereby creating an unequal representation of different U.S. American co-cultures and their ways of parenting. Finally, some of the respondents to this survey had both ADHD-diagnosed and non-ADHD children, and there was no way to distinguish parenting practices specific to only ADHD children. The survey did not offer a way for parents to answer differently depending on whether or not their child had ADHD, therefore, it was impossible to judge if the parent was answering the questions with their ADHD or non-ADHD child in mind. Finally, this study did not examine the influence of possibly confounding demographic variables such as age. However, income, ethnicity, marital status, and education were not significantly different between the two groups of parents.

#### Future Research

In order to develop our understanding of parents' communicative practices in relation to ADHD diagnoses, an important area to consider is increasing the size and diversity of the parent sample. While some interesting findings resulted from this study, the limited sample size and lack of diversity minimizes the generalizability of the

findings. By including more men and multiple ethnicities, a greater understanding of the differences in parenting practices between men and women and also between various cultures can be gained.

Using an online questionnaire may have led to questions being interpreted differently than the researcher intended, and limited possible responses to questions. Future studies could perform face-to-face interviews and allow for more open communication regarding parenting, which is rarely either/or. Being able to clarify questions and allow for more open responses may benefit the study of the relationship between the communicative practices of parents and their children.

This study was helpful in understanding how the communicative practices of parents shape children's behaviors. Children who are diagnosed with ADHD have specific needs, which must be addressed by parents if the parents are to successfully maintain order and control within the home. However, this study was not able to directly compare the parenting practices of those parents who have both ADHD-diagnosed and non-ADHD children. Future research in this area would be beneficial to understanding the differences in how parents communicate with their ADHD children versus their non-ADHD children.

### Summary

This study examined the differences in the parenting practices of parents with children diagnosed with ADHD compared to families with non-ADHD children. Specifically, it aimed to understand if certain parenting practices may be associated with an ADHD diagnosis. Findings suggest that there are no significant differences when looking at physical punishment, as well as praise and incentives, between parents of

ADHD-diagnosed children and parents of non-ADHD children. However, there are some differences in other areas of parenting. Parents of ADHD-diagnosed children tend to use more appropriate discipline and clearer expectations than do parents of non-ADHD children. This seems to aid in the need for routine and structure within the home. Rules, chores, and expectations are consistently emphasized with the use of lists, charts, calendars, etc.

Parents of ADHD-diagnosed children also display a higher use of harsh and inconsistent discipline, which may be a result of the frequent micromanaging that is necessary of ADHD-diagnosed children. Rarely do parents of ADHD children rely on verbal cues to maintain routine and structure in the home, because the need for constant reinforcement can lead to exhaustion and frustration for the parent, which may lead to harsher and inconsistent discipline practices.

Finally, parents of non-ADHD children monitor their children significantly more than do parents of ADHD children. Generally, ADHD children spend more time throughout the day unsupervised by their parent, which could be due to a number of reasons. Parents may work later into the day; children may be allowed to play outside or at someone else's home, or children may be involved in after-school activities that do not require the parent's supervision. Nonetheless, non-ADHD children are under the watch of their parent significantly more often.

This study suggests there are differences between the parenting practices of families with ADHD-diagnosed children and non-ADHD children. This study does not conclusively show that specific communicative practices are directly related to an ADHD diagnosis, but rather, that differences exist and that parents with ADHD children function



somewhat differently than parents with non-ADHD children. The dynamics within the home of each group seem to offer insight into the ways that parents must adapt to varying needs of children.

## CHAPTER 5: IMPLICATIONS

The results of this study lead to larger questions about labeling children as ADHD. The social construction of ADHD and how the discourse in everyday language shapes our realities and the realities of our children should also be considered. Parents and teachers work to instill and shape the expectations they believe constitute a “good” child. Parents expect their children to do what they are asked, mind their manners, finish their chores, and not question parental authority, all without questioning the validity of the demands put upon them. Teachers expect children to sit still, focus on learning, and maintain excellent behavior for extended amounts of time. From the parent’s or teacher’s perspective, if a child does all these things, they will make good grades, earn rewards, achieve accomplishments, and excel academically. These are the things, in the parent/teacher mind, that constitute a “good” child. But how does the child understand these things? Would homes and schools not benefit from considering alternative forms of achievement? Cheney (2008) uses the term “intersubjectivity” to describe the need to acknowledge contextual differences; individual variations in understanding (p. 145). If parents and teachers could find a way to work within the differences among children, would their relationships not change as a result, thereby illuminating a better understanding that is more individualistic and genuine?

The real question lies in understanding the effect of children NOT living up to the expectations of their parents and teachers. If children do not succeed in molding their behavior into what is expected of them, do they then accept the negative labels put upon

them and allow the relationship to dominate who they are as individuals, securing a self-fulfilling prophecy? Cheney (2008) asserted that satisfying relationships are one of the most “stable and influential predictors of subjective well-being” (p. 160). Without these stable relationships to encourage a child to flourish into the person he/she desires to become, children are merely copying the behaviors of adults, which serve no one but the adult. Work, for a child, should be understood as a “direct source of personal expression and worth---a basis of achievement, personal growth, and self-efficacy” (Cheney, 2008, p. 147). If children were allowed to express themselves freely, would their relationships with others promote a more optimistic and extraverted sense of self? Children find out who they are supposed to be through personal relationships. To some degree, parents and teachers must guide children’s behaviors in a way that prepares them for the next stages of life. Nonetheless, each child is different from the other and constitutes another piece of what our society is grounded in: individualism. The relationships that build the character of a child should foster stimulating and creative thinking, acting, and ways of being. So, why then, do parents and teachers continue a cycle of negative control?

Deetz and Mumby (1990) consider the ways in which social relations are produced and reproduced. Their argument is that organizations are not simply given in their current form and persist through time. They believe that organizations have to be produced continually and reproduced by someone “in a way that is not autonomous or anonymous” (Deetz & Mumby, 1990, p. 22). If we look at schools as organizations, who dictates how and what the students learn in the classroom? Is it the teacher, principal, school district, administrative agencies, or the government? The answer is all of them. Each role in the construction of education has its own agenda. Multiple needs must be

satisfied, such as standardized test requirements/satisfactions, enrollment assuredness, control within classrooms, and reputation. Deetz and Mumby (1990) state that in order to understand how organizations (re)produce their rules and regulations, one must understand “the political and ideological realms of the organization” (p. 22). To understand these things, Deetz and Mumby argue that the following questions must be considered: a) do different interests have an equal opportunity for impact on decision making, and b) are there processes that suppress conflict among potentially competing interests (Deetz & Mumby, 1990, p. 29)?

Often, there become competing interests between the schools and the parents, with the parents feeling as though their children are being marginalized due to their inability or non-compliance to adhere to the strict rules within the classroom. This leads to the argument as to whether or not schools have the children’s best interests in mind. As schools and parents battle over their interests, often the “student changes from seeking learning to seeking grades” (Deetz & Mumby, 1990, p. 26). Unfortunately, this limits a student’s potential for what he/she could be gaining from their education. When the grade becomes the final validation for a child’s worth, it sets limits on the boundaries of where their intellect could venture. Ultimately, within the power relations communication functions ideologically to (re)produce these particular structures (Deetz & Mumby, 1990). Children learn from the communication of authority figures the things that are important and valid in our society.

Clearly, the social relationships of a child’s life can affect their social identities, but it is also important to examine the ways in which individuals make sense of the information they receive about ADHD. Graham (2006) addresses the ways in which the

fields of medicine, psychology, and schooling all play a part in the construction of ADHD-and also looks at how the interdependency of these three fields has been constructed to serve political ends. In drawing her analysis, Graham (2006) claims that ADHD reflects a combination of medical and psychological knowledges, with schools playing the part of the partner (p. 2). According to Graham (2006), the medical model speculates that the “excessive display of a particular constellation of behaviors is said to reflect neurological dysfunction in the frontal region of the brain, an area thought to be responsible for inhibition and attention control” (p. 2). The solution to this problem, according to doctors, is through the use of psychostimulant medications. In 2000, ADHD was redefined by the medical field as a “lifetime disorder,” which both expanded and extended the market for these “needed” medications, thereby benefiting the pharmaceutical companies who produce them (Graham, 2006, p. 3). A common question that has arisen regarding treatment for ADHD is why parents do not choose counseling services as an alternative to psycho-pharmaceutical medications. The answer, simply put, is cost.

Graham (2006) contends that counseling can cost between \$100-160 per hour, whereas stimulant medication can be obtained for as little as \$4.70 (p. 5). Graham (2006) states that the “pressures of economic rationalism are affecting how psychiatrists deal with the children and parents who arrive in their practice,” particularly in the U.S. where governmental control via “managed care” “mandates the quicker, cheaper solution of a drug instead of the longer process of psychotherapy, family counseling, or looking for/at other contributing factors” (p. 5). There are certainly those within the psychological sphere that express concern that drugs are being over-prescribed and have the potential to

cause long-term side effects. However, for very specific reason psychologists conceal their concerns, because “it is difficult for psychological practitioners to challenge the medical treatment of a *medical* concept without damaging public acceptance of that concept and thus, the need for intervention via associated psychological services” (Graham, 2006, p. 6). And why would parents also agree to this surge of medicalization? The medicalization of behavior and administration of psycho-stimulants “promises absolution through a discursive shift: from bad mothers to bad brains” (Graham, 2006, p. 7). Also playing on the heartstrings of parents is the doctor who claims that by NOT putting their child on psycho-stimulant medication, the parent is in effect doing damage by not giving their child the medicine they “need.”

A clear connection has been drawn, highlighting the relationship between the medical practitioners and the field of psychology. In addition, there is the role of the school in shaping how parents understand ADHD. Graham (2006) states that most academic literature in the area of education focuses predominantly upon the management of ADHD as “deviant behavior and the preservation of institutional equilibrium through mechanisms of student/classroom control” (p. 14). Clearly, this emphasizes the “need” to “control” children with behavioral issues. Rather than considering the possibility that children may simply learn differently and require a bit more effort, the focus is primarily on taking control over “deviant” children. Research in the U.S. shows that in the majority of cases, teachers are the first to suggest a diagnosis of ADHD (Graham, 2006). This raises the concern as to why teachers would choose to operate this way. Graham (2006) addresses the possibility that maybe “chronic under-funding of public schools and bureaucratic red-tape tying resources and classroom support for underpaid and

overworked teachers to disability category criteria is influencing how teachers describe and refer the children in their classes” (p. 14). Their discourse places labels onto these children, causing their differences to be seen as a negative thing.

How, then, has discourse shaped our realities regarding ADHD? Holmer-Nadesan (1997) examined the discourse of personality testing in organizational practice and formulated two rationales for why organizations would participate in such testing. One was to predict job performance, and the other was to differentiate between “normal” and “abnormal” individuals. Although Holmer-Nadesan’s research focused on personality testing within organizations, the findings are relevant to understanding why schools, psychologists, parents, etc. would use these types of normal/abnormal dichotomous relationships when considering children’s behaviors. Holmer-Nadesan (1997) states that the assumption of a “normative ideal” is a discursive construction that “borrows from historically contingent biological and psychological discourses” (p. 199). However, she argues that these constructed identities are “fictitious” and simply stereotypes used to assess the “normative” or “deviant” behaviors of individuals (Holmer-Nadesan, 1997, p. 199). As fictitious as they are, however, they have real implications for both those evaluating and those being evaluated. These discourses, according to Holmer-Nadesan (1997), do not necessarily describe a “pre-given reality” but participate in the creation of a reality by “delimiting the sayable and the doable” (pp. 199-200). In essence, this separates the “unruly” from the “manageable” and reduces each in a neat and tidy set of universal variables that can be “objectively measured and controlled for” (Holmer-Nadesan, 1997, p. 203). There is only a certain amount of allowable deviation from the “normative” behaviors before a person is considered “abnormal.”

This is often the result for children who display behaviors within schools and homes that adults deem uncontrollable. The children are then forced to undergo psychological testing and therapy. The power of these tests reaches far beyond just an analysis of an individual's behavior. Going back to the issue of self-esteem, once "judgment" has been placed upon an individual, there is a heightened sense of "self-knowledge" and "self-transformation" (Holmer-Nadesan, 1997, p. 205). Children are able to recognize their difference from others, which could easily be understood as a good thing but, unfortunately, is often not viewed in this way. As Holmer-Nadesan (1997) asserts, the constructed identities revealed through these types of personality tests are really more of a "paper doll," "a discursive object constructed by the personality exams," which "reduce personality to a limited number of objectified traits or characteristics" (p. 207). It is amazing that living in a society where so much emphasis is put on the value of individualism, members of our society so easily characterize a particular human being by a number of traits from a personality test. Sadly, once others begin to see a child in this way, the child, too, begins to see him/her self in this same way. These labels and expectations become a self-fulfilling prophecy. Ultimately, these tests serve to force individuals to reflect on themselves as merely constructed identities which constrain their potential for self-examination and/or self-exploration.

Danforth and Navarro (2001) examined how the discourse of ADHD in everyday language serves to socially construct ADHD in the minds of individuals. They did a study, using university special education students, looking at the various ways ADHD was referenced via spoken or written language- as well as mediated messages. The students were to record daily events in which they witnessed any message related to



ADHD. They found two dominant discourse genres related to ADHD: school and medical (Danforth & Navarro, 2001). In their analysis, Danforth and Navarro (2001) conclude that individuals have to “deal somehow with the concepts and terms that have been created by medical and other mental-health professionals” as a way of framing childhood behavior problems (pp. 173-174). Whether speakers addressed the topic with acceptance or resistance, they had little choice but to refer back to the medical discourse in order to talk about such things.

Whereas medical discourse provided the primary conceptual/linguistic framework of the disorder, school discourses seemed to supply the ideological rationale that fueled parent concerns (Danforth & Navarro, 2001). The study found that much of whom a child is and how the child is viewed by interested adults comes down to “vocalized interpretations of that child’s performance in school” (Danforth & Navarro, 2001, p. 174). Focusing on the school as a discursive sight, there are two areas where schools focus their priority: behavioral conformity and academic achievement. These are the two goals of schools-- to assimilate students to adult authority and codes of behavior-- as well as the requirements of achievement on assessment activities (Danforth & Navarro, 2001). The logic behind these two frameworks goes back to “the good life,” which consists of “a community in which individuals compete for scarce resources,” as well as to school success “as income stratification correlates to years of schooling completed” (Danforth & Navarro, 2001, p. 174). Efforts to seek an ADHD diagnosis are framed as typically arising from problems with school environments and complaints from teachers. Things such as inability to stay focused, to sit in seats for an expected time, to complete worksheets independently, to turn in homework on time, to keep lockers organized, or to

cooperate with classroom rules and procedures were a few of the reasons listed for why teachers have increased suspicions of ADHD (Danforth & Navarro, 2001). Clearly, the shaping of our realities goes hand-in-hand with shaping our social identities, and the cost of school success raises bigger issues of individual freedom in constructing our own sense of “self.” So, what can be done to address this issue, even a small part of it?

I would like to turn the focus to ways in which we can begin to understand ADHD as a socially-constructed issue; one that can be modified through a critical look at two things: a) how schools address behaviors commonly equated to ADHD, and b) how language crafts cultural meaning that may or may not be a constructive framework within society. To address the issue of the schools’ role in framing ADHD, I will focus on Graham’s (2006) look at the role of schooling in the construction of “behaviour disorder” and the production of ‘disorderly objects.’ While most of the research done on ADHD has focused primarily on biological aspects, parental shortcomings, poor diet, and too much television, Graham (2006) examines the influence that the discourses and practices of schooling might bring to bear upon the “constitution of ‘disorderly behaviour’ and subsequent recognition of particular children as a particular kind of ‘disorderly’” (p. 1). Her main question emphasizes the importance of understanding whose interests “disorderedness” serves. In one way, she states that ADHD becomes a “label of forgiveness,” absolving teachers and/or parents of responsibility for their actions (Graham, 2006, p. 2). Equally to blame, according to Graham, is the educational institution itself. Graham (2006) states that if children were still working in the mines, their energy levels would be considered a bonus. However, “the modern and increasingly unnatural demands of schooling have resulted in the re-articulation of normal childhood

exuberance, curiosity and energy as ‘unnatural’ (Graham, 2006, p. 15). If teachers are the most common source for a suggestion of ADHD testing/diagnosis, then it is clear why young children often fall victim to the label of being ADHD. As a parent, I can say that there is not a single one of the criteria listed in the DSM IV that I do not deal with on a daily basis; however, I believe that these are simply normal practices and learning points for children, not disordered behavior.

Another issue to consider in schools is the problem of teacher subjectivity. Teachers make up their own minds about what they think constitutes “giftedness” and also about what behaviors they think are ‘normal.’ The problem is that teachers treat children accordingly, and “the bright little boy tapping his fingers on this desk and daydreaming as he stares out of the window, disengaged from the business of learning is appreciated for neither his discerning taste nor his boundless energy” (Graham, 2006, p. 15). He becomes labeled as ADHD, because in that moment, his teacher has decided that his behavior fits the mold of “disordered” behavior.

The danger is that by medicalizing the educational “problem” of disruptive behavior, schools come to view ADHD as something biological and, therefore, outside of their expertise (Graham, 2006). ADHD becomes a problem completely unrelated to teachers’ choices of pedagogy or ability to engage children in learning. This study’s intent is not to suggest that ADHD is not a legitimate concern but, rather, what can be done to facilitate a more open place for understanding children and ADHD.

Various outside sources can play an influential role in guiding parents in their expectations of how children should and should not behave. Teachers and medical practitioners play an influential role in the eventual diagnosis of ADHD in children. Due

to a lack of acceptance for different learning styles in the classroom and the need for a unified “way of doing things,” many children can be labeled as “different” or “difficult” if they do not fit into the mold that schools and the medical realm set out as a guideline for appropriate child behaviors. Often, children take the blame for what is actually a broken system. Medical practitioners rely on pharmaceutical companies in order to remain on the cutting edge of new medicines and practices, whereas teachers rely on total control within the classroom and on pre-determined test scores to achieve successful ratings within the school districts. Ultimately, these systems affect how parents view and understand their own children, and the effects that happen as a result appear to lead to an overly-diagnosed and overly-medicated society, with an ADHD diagnosis being the answer to all our problems.

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## APPENDIX A

Hello, my name is Shani Canillas-Rucker, and I am a graduate student in the Communication Studies department at Colorado State University. I am conducting a study on the communicative practices of parents and am hoping you can help me. I need approximately 120 parents to take a short survey consisting of 22 questions. It takes roughly 15-20 minutes to complete and offers valuable information that I am hoping will lead to a better understanding of the communication practices between children and their parents.

The questionnaire will ask about different issues relating to how parents communicate their expectations to their children, as well as how they utilize various discipline practices and reward systems. If you choose to participate in this study, your questionnaire will be kept anonymous and confidential. Your name will not appear in the questionnaire, and I will not use your name in any publications. The purpose of this study is to gain a better understanding about how parents and children communicate with one another. If you have any questions regarding the study, please do not hesitate to contact me via email at [Shani.Canillas-Rucker@rams.colostate.edu](mailto:Shani.Canillas-Rucker@rams.colostate.edu). Just click on the following link to participate in the questionnaire and submit it once you are finished:

[http://www.surveymonkey.com/s.aspx?sm=eFvbDGjx784UD\\_2bbktZbV5Q\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=eFvbDGjx784UD_2bbktZbV5Q_3d_3d)

Thanks in advance,

Shani Canillas-Rucker

## APPENDIX B

### Communication Practices of Parents

1. The following is a list of things that parents have told us they do when their children misbehave. In general, how often do you do each of the following things when your child misbehaves (that is, does something s/he is not supposed to do)?

**1 = Never, 2 = Seldom, 3 = Sometimes, 4 = About half the time, 5 = Often, 6 = Very often, 7 = Always**

- a. Ignore it.
- b. Raise your voice (scold or yell).
- c. Get your child to correct the problem or make up for his/her mistake.
- d. Threaten to punish him/her (but not really punish him/her).
- e. Give him/her a brief time out away from family.
- f. Send child to room for at least 60 minutes.
- g. Take away privileges (like TV, playing with friends).
- h. Give your child a spanking.
- i. Slap or hit your child (but not spanking).
- j. Give your child extra work chores.
- k. Discuss the problem with child or ask questions.

2. If your child *hit* another child, how likely is it that you would discipline your child in the following ways?

**1 = Not at all likely, 2 = Slightly likely, 3 = Somewhat likely, 4 = Moderately likely, 5 = Quite likely, 6 = Very likely, 7 = Extremely likely**

- a. Ignore it.
- b. Raise your voice (scold or yell).
- c. Get your child to correct the problem or make up for his/her mistake.
- d. Threaten to punish him/her (but not really punish him/her).
- e. Give him/her a brief time out away from family.
- f. Send child to room for at least 60 minutes.
- g. Take away privileges (like TV, playing with friends).
- h. Give your child a spanking.
- i. Slap or hit your child (but not spanking).
- j. Give your child extra work chores.
- k. Discuss the problem with child or ask questions.

3. If your child *refused to do what you wanted him/her to do*, how likely is it that you would use each of the following discipline techniques?

**1 = Not at all likely, 2 = Slightly likely, 3 = Somewhat likely, 4 = Moderately likely, 5 = Quite likely, 6 = Very likely, 7 = Extremely likely**

- a. Ignore it.
- b. Raise your voice (scold or yell).
- c. Get your child to correct the problem or make up for his/her mistake.
- d. Threaten to punish him/her (but not really punish him/her).

- e. Give him/her a brief time out away from family.
- f. Send child to room for at least 60 minutes.
- g. Take away privileges (like TV, playing with friends).
- h. Give your child a spanking.
- i. Slap or hit your child (but not spanking).
- j. Give your child extra work chores.
- k. Discuss the problem with child or ask questions.

This section asks questions about different ways of disciplining children and teaching them right from wrong.

4. In general, how often do the following things happen?

**1 = Never, 2 = Seldom, 3 = Sometimes, 4 = About half the time, 5 = Often, 6 = Very often, 7 = Always**

- a. If you ask your child to do something and s/he doesn't do it, how often do you give up trying to get him/her to do it?
- b. If you warn your child that you will discipline him/her if s/he doesn't stop, how often do you actually discipline him/her if s/he keeps on misbehaving?
- c. How often does your child get away with things that you feel s/he should have been disciplined for?
- d. If you have decided to punish your child, how often do you change your mind based on your child's explanations, excuses or arguments?
- e. How often do you show anger when you discipline your child?

- f. How often do arguments with your child build up and you do or say things you don't mean to?
  - g. How often is your child successful in getting around the rules that you have set?
  - h. How often does the kind of punishment you give your child depend on your mood?
5. This is a list of things that parents might do when their child behaves well or does a good job at something. In general, how often do you do each of the following things when your child behaves well or does a good job?
- 1 = Never, 2 = Seldom, 3 = Sometimes, 4 = About half the time, 5 = Often, 6 = Very often, 7 = Always**
- a. Ignore it.
  - b. Praise or compliment your child.
  - c. Give your child a hug, kiss, pat, handshake or "high five."
  - d. Buy something for him/her (such as special food, a small toy) or give him/her money for good behavior.
  - e. Give him/her an extra privilege (such as cake, go to the movies, special activity for good behavior).
  - f. Give points or stars on a chart.
6. In an AVERAGE week, how often do you praise or reward your child for doing a good job at home or school?

- **Less than once per week, ○ About once per week, ○ A few times per week, but not daily, ○ About once a day, ○ 2-5 times per day, ○ 6-10 times per day, ○ More than 10 times per day**
7. Within the LAST 2 DAYS, how many times did you:
- **Never, ○ Once, ○ Twice, ○ 3 times, ○ 4 or 5 times, ○ 6 or 7 times, ○ More than 7 times, ○ Not with my child in the last 2 days**
- a. Praise or compliment your child for anything s/he did well?
  - b. Give him/her something extra, like a small gift, privileges, or a special activity with you, for something s/he did well?
8. Please rate how much you agree or disagree with the following statements.
- 1 = Strongly disagree, 2 = Disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree**
- a. Giving children a reward for good behavior is bribery.
  - b. I shouldn't have to reward my children to get them to do things they are supposed to do.
  - c. I believe in using rewards to teach my child how to behave.
  - d. It is important to praise children when they do well.
  - e. I would like to praise my child more often than criticize him/her, but it is hard to find behaviors to praise.
  - f. If I give my child praise or rewards to encourage good behavior, s/he will demand rewards for everything.

g. If a child is having trouble doing something s/he is supposed to do (such as going to bed, picking up toys), it is a good idea to set up a reward or an extra privilege for doing it.

9. Please rate how much you agree with the following statements:

**1 = Strongly disagree, 2 = Disagree, 3 = Slightly disagree, 4 = Neither agree nor Disagree, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree**

- a. I have made clear rules or expectations for my child about chores.
- b. I have made clear rules or expectations for my child about not fighting, stealing, lying, etc.
- c. I have made clear rules or expectations for my child about going to bed and getting up on time.

10. Please rate how likely you are to do the following things.

**1 = Not at all likely, 2 = Slightly likely, 3 = Somewhat likely, 4 = Moderately likely, 5 = Quite likely, 6 = Very likely, 7 = Extremely likely**

- a. When your child completes his/her chores, how likely are you to praise or reward your child?
- b. When your child does NOT complete his/her chores, how likely are you to punish your child (such as taking away a privilege or grounding him/her)?
- c. When your child fights, steals, or lies, how likely are you to punish your child?
- d. When your child goes to bed or gets up on time, how likely are you to praise or reward your child?



11. About *how many hours in the last 24 hours* did your child spend at home *without adult supervision*, if any?

- None, ○ Less than ½ hour, ○ ½ - 1 hour, ○ 1 – 1½ hours, ○ 1½ – 2 hours,
- 2 – 3 hours, ○ 3 – 4 hours, ○ More than 4 hours

12. Within the LAST 2 DAYS, about how many total hours was your child involved in activities outside your home *without adult supervision*, if any?

- None, ○ Less than ½ hour, ○ ½ - 1 hour, ○ 1 – 1½ hours, ○ 1½ – 2 hours,
- 2 – 3 hours, ○ 3 – 4 hours, ○ More than 4 hours

13. Please answer the following:

**1 = None or almost none, 2 = About 25%, 3 = About 50%, 4 = About 75%, 5 = All or almost all**

- a. What percentage of the time do you know *where your child is* when s/he is away from your direct supervision?
- b. What percentage of the time do you know exactly what your *child is doing* when s/he is away from you?
- c. What percentage of your child's friends do you know well?

14. How much do you agree or disagree with the following statements?

**1 = Strongly disagree, 2 = Disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree**

- a. It is very important for me to know where my child is when s/he is away from me.
- b. Parents who check up on how their child behaves at friends' houses are too anxious about their child.

c. Giving children lots of free, unsupervised time helps them learn to be more responsible.

d. Children who are not supervised by an adult are more likely to develop behavior problems.

15. Please provide the following information for all of your children in order of age.

<u>Child</u>	<u>Age</u>	<u>Sex (M/F)</u>	<u>Ethnicity</u>	<u>ADHD (Y/N)</u>	<u>Age of Diagnosis</u>	<u>Meds(Y/N)</u>
<u>1</u>	_____	_____	_____	_____	_____	_____
<u>2</u>	_____	_____	_____	_____	_____	_____
<u>3</u>	_____	_____	_____	_____	_____	_____
<u>4</u>	_____	_____	_____	_____	_____	_____
<u>5</u>	_____	_____	_____	_____	_____	_____
<u>6</u>	_____	_____	_____	_____	_____	_____

16. Are you?

- a. Male
- b. Female

17. What is your age range?

- a. 15-19
- b. 20-24
- c. 25-34
- d. 35-44
- e. 45-54
- f. 55 and over

18. What is your ethnicity?

- a. White
- b. Black or African American
- c. Hispanic or Latino
- d. American Indian and Alaska Native
- e. Asian
- f. Native Hawaiian and other Pacific Islander
- g. Some other race

19. What is your marital status?

- a. Never married
- b. Married
- c. Separated
- d. Divorced
- e. Widowed

20. What is your educational attainment?

- a. Less than 9<sup>th</sup> grade
- b. 9<sup>th</sup> to 12<sup>th</sup> grade; no diploma
- c. High school graduate
- d. Some college; no degree
- e. Associate degree
- f. Bachelor's degree
- g. Graduate or professional degree

21. What is your household income?

- a. Less than 10,000
- b. 10,000 – 14,999
- c. 15,000 – 24,999
- d. 25,000 – 34,999
- e. 35,000 – 49,999
- f. 50,000 – 74,999
- g. 75,000 – 99,999
- h. 100,000 – 149,999
- i. 150,000 – 199,999
- j. 200,000 or more

22. Who are the parents in the household?

- a. Both parents present
- b. Mother only
- c. Father only
- d. Neither parent present: specify \_\_\_\_\_