The Effects of ADHD on the Family Unit

Jennifer L. Baxter, BSN, RN

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EFFECTS OF ADHD ON THE FAMILY UNIT

To the Faculty of Washington State University:

The members of the Committee appointed to examine the master’s project of

Jennifer L. Baxter find it satisfactory and recommend that it be accepted.

Chair: Anne Mason, MN, ARNP, PMHNP-BC

Merry Armstrong, DNSc, ARNP, PMHNP-BC

Ryan Townsend, MN, ARNP, PMHNP-BC
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The purpose of this literature review was to examine the current literature on the impact of child and adolescent ADHD on the family unit. The results of the literature review indicate an increased rate of family dysfunction when a child or adolescent has ADHD. A gap in the literature reviewed indicated the need for research tailored towards interventions that the family Psychiatric Mental Health Nurse Practitioner can implement when working with this unique population.
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Introduction

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most prevalent disorders in childhood (National Institute of Mental Health [NIMH], 2009). In 2000, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev; *DSM-IV-TR*; American Psychiatric Association [APA], 2000) stated 3%-7% of school-age children were affected by the disorder. More recently, results from a parent-report included in the National Survey of Children’s Health in 2007 indicated the prevalence rate for the disorder was 9.5% for children aged 4-17 in the United States (US). The rate of ADHD affected children in Washington State is consistent with this at 9.5% (Centers for Disease Control and Prevention [CDC], 2007).

Researchers have consistently identified uniquely challenging family system issues when caring for children with ADHD (Foley, 2011; Kendall, Leo, Perrin, & Hatton, 2005; Salmeron, 2008; Schroeder & Kelley, 2009). Past research in this area has been primarily conducted by non-nursing specialties, including social workers, counselors, and psychiatrists. Although this research has been extensive and advanced our knowledge of ADHD and the effects on family, it has not provided the unique perspective of a family PMHNP. When treating a child with ADHD, the family PMHNP utilizes a holistic model taking into account the psychosocial and medical components of ADHD and providing the appropriate treatment through an advanced psychiatric nursing lens. Our role differs from that of a psychiatrist, because we utilize a holistic nursing model in combination with the biological component. This role also differs from the role of a mental health counselor in that we have the biomedical background and can prescribe psychotropic medication.

Purpose Statement
The purpose of this paper is 1) to review the current literature on the impact of child and adolescent ADHD on the family unit, 2) discuss potential interventions the family PMHNP can implement to improve the family environment in this population using a family systems approach, and 3) identify implications for future research in this area.

**Diagnostic Criteria**

A review of the DSM-IV-TR (2000) criteria for ADHD is provided here to illustrate the potential symptoms and behaviors that can occur. Criterion A of the DSM-IV-TR states individuals must have six or more of the symptoms for either inattention, and/or hyperactivity-impulsivity for a period of at least six months. During these six months, the symptoms must present as being maladaptive and not consistent with the individual’s developmental age. Inattention may include the child or adolescent having difficulty focusing on schoolwork; not following through with directions they are given; difficulty with organization of tasks; and forgetfulness in daily activities. Examples of hyperactivity are talking excessively, reported feelings of restlessness in the adolescent, and inability to remain seated in situations in which it is expected. Symptoms of impulsivity may include interrupting others and being intrusive (APA, 2000).

According to the DSM-IV-TR (2000), symptoms of hyperactivity-impulsivity or inattention must have been present before age seven and must have caused impairment in at least two settings. There must be sufficient evidence demonstrating impairment in two or more settings in the individual’s life, such as social and academics. ADHD symptoms must not be better accounted for by another mental disorder and cannot occur exclusively with a diagnosis of Pervasive Developmental Disorder, Schizophrenia, or other Psychotic disorder (APA, 2000).

**Conceptual Framework**
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The conceptual framework used to guide this literature review is based on Murray Bowen’s Family Systems Theory. This theory posits that the family should be viewed as a system or whole, rather than viewing the family members as distinct individuals without regard to their interpersonal relations with family. This notion is based on the premise that the majority of people are attached to their family in some way or another throughout life (Bitter & Corey, 2009). “In this sense, a family systems perspective holds that individuals are best understood through assessing the interactions between and among family members” (Bitter & Corey, 2009, p. 412). Behaviors of an individual are viewed as an interconnection with other family members. The symptoms an individual is experiencing may be the result of a dysfunction in the family unit, and not solely attributed to issues with psychosocial development or a particular disorder (Bitter & Corey, 2009). Family systems theory also proposes that negative behaviors may ultimately serve some sort of purpose within the family (Bitter & Corey, 2009), such as a child attempting to gain the attention of a distant parent through inappropriate behavior. The way in which a family coexists and interacts may hinder the progress of the affected individual without intentionally doing so. Throughout generations dysfunctional family patterns are developed, and without self-awareness the cycle continues (Bitter & Corey, 2009).

Family systems theory is applicable to the effects observed in these families, including those between the parent and child, child and siblings, and the family system as a whole. An example of this theory applied to the effects observed may include increased sibling conflict or the parents feeling more isolated from others and receiving less support from family. The affected family may not be aware of their family dysfunction when the child or adolescent presents to the clinical setting. Therefore, it is important to assess the interactions between the family members and increase their awareness of these issues. The family PMHNP must consider
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the impact ADHD has on the family unit and implement tailored interventions based on a thorough assessment of family dynamics.

**Literature Search Strategies**

A comprehensive literature search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database, PubMed, and Google Scholar. Key words used in the search included *ADHD in children, ADHD in adolescents, effect of ADHD on the family unit, relationships of children with ADHD, and relationships of adolescents with ADHD*. The search was limited to full-text journal articles in English. Articles pertaining to adults with ADHD were excluded. Initially only articles within the last five years were reviewed, but that resulted in less than 10 relevant articles. The search was expanded to include articles from 2000 to 2013, which revealed a greater selection of articles pertaining to this topic. One study from 1999 was included in the review due to the unique perspective and recount it provided on the effects of ADHD among siblings. In addition to this search, articles that were consistently found amongst the reference list of initial articles were utilized. A total of 32 articles were reviewed and 13 were chosen for this literature review based on the research conducted on how ADHD can affect the family unit, including family adversity and characteristics, sibling relationships, and the child’s relationship with the parent. It should be noted there is a lack of advanced psychiatric-mental health nursing, as well as nursing related, primary research articles on assessment, interventions, and care for the family with a child or adolescent with ADHD, which will be discussed later.

**Literature Review**

The articles utilized in this literature review were categorized according to themes. Three themes became evident when applying a family systems theory approach to the reviewed
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literature. The system within the family is based on relationships from three standpoints: (1) the family unit, (2) siblings, and (3) parent-child. Five of the articles were categorized into family dynamics, four into sibling relationships, and the remaining four into parent-child relationships.

Family Dynamics

Researchers have demonstrated higher levels of family dysfunction in families of children with ADHD (Foley, 2010; Lifford, Harold, & Thapar, 2009; Pressman et al., 2006; Schroeder & Kelley, 2009). The associated symptoms and behaviors of the disorder can impact the child’s life and also cause dysfunction for the child’s parents and siblings (Harpin, 2007).

In a qualitative study conducted by Counts, Nigg, Stawicki, Rappley, & Von Eye (2005), the degree of family adversity in ADHD subtypes and behavioral issues was explored and compared to families without an ADHD child. The authors hypothesized that levels of family adversity would be increased among children with ADHD combined type (ADHD-C) versus control groups. It was further hypothesized that there would be a distinct correlation between the behavioral problems of ADHD and comorbid disorders, including conduct disorder (CD) and oppositional-defiant disorder (ODD), with the degree of family adversity. Symptoms of ADHD in association with maternal psychopathology and marital conflict was also explored (Counts, Nigg, Stawicki, Rappley, & Von Eye, 2005).

The study sample included 206 boys and girls, who ranged in age from 7-13 years old. A total of 337 parents (206 mothers, 131 fathers) were included. The children were categorized into three groups depending upon diagnosis of ADHD or those without ADHD. Ninety-six children were placed in the ADHD-C group; 38 in the ADHD primarily inattentive type (ADHD-PI); and the remaining 72 children in the control group. The family adversity index was created for the study and one point on a scale of 0 to 5 was given for each measure of adversity. The
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categories for adversity included low socioeconomic status, parental psychiatric disorders, marital conflict, and stressful events. Socioeconomic factors included education level of parents, occupation, and salary. Parental psychopathology included determining the presence of lifetime psychiatric disorders, with the exclusion of an ADHD diagnosis for the parent. Marital conflict was evaluated through the child’s perception of several factors, including the frequency, intensity, resolution, and content of arguments between the child’s parents. Examples of stressful events included the death of a relative or loss of a job over the last one year (Counts et al., 2005).

Results of the study concluded that children with ADHD had greater family adversity than children without a diagnosis. An association of greater family adversity was also noted in children with ADHD-C versus children with ADHD-PI or the control group. Interestingly, the results indicated the highest rates of family adversity was observed in girls with ADHD-C. Greater adversity was noted when child conduct problems were associated with ADHD; however, results concluded higher adversity scores were seen in ADHD categories even when the CD symptoms were controlled. Results also indicated the child’s perception of marital conflict and maternal mental illness were related to a higher degree of ADHD symptoms. This study provided support for the necessity of a comprehensive psychosocial assessment of adversity and family issues for the ADHD child. If compelling evidence of parental mental illness or marital conflict is found in the assessment then psychosocial interventions should be performed (Counts et al., 2005).

This study provides support to the literature reviewed throughout this paper in that greater family adversity is present in families when there is a child with ADHD. It also contributed the interesting finding that rates of family adversity were highest among girls with
ADHD-C. This study differed from the following studies in that the child was allowed to describe their perception of marital conflict, which was related to a higher degree of ADHD symptoms. It is unclear whether there clearly was increased marital conflict or the ADHD child’s perception of conflict was greater.

Foley (2010) utilized a descriptive comparative design to investigate dysfunction and adversity among families who had a child with ADHD and compared findings to families who did not have a child with ADHD. A total of 55 children (36 boys and 19 girls) were selected. Their ages ranged from 6 to 11 years. Of these 55 children, 32 had a diagnosis of ADHD. The remaining 23 children were chosen as the comparison group. Primary caregivers (52 biological mothers, 3 adoptive mothers, and 2 biological fathers) were included in the data collection. Family adversity variables were explored, including socioeconomic status, family size, history of criminality on paternal side, history of maternal mental disorder, and foster-care placement. Family adversity variables were measured through a questionnaire developed for this study that included open-ended questions as well as questions that required a yes or no answer. Examples of these questions included asking the child’s parent if the father had ever been in jail and how many children live in the home. Family dysfunction variables were measured by using the General Functioning subscale of the McMaster Family Assessment Device. The subscale is a 12-item self-report instrument completed by the child’s parents, which measures variables including communication, relationships, and problem solving (Foley, 2010).

Results of the study conducted by Foley (2010) indicated higher levels of family dysfunction in families whose child had an ADHD diagnosis. Foley (2010) concluded there was poorer family function in homes where there was a child diagnosed with ADHD, and parents in these homes may have more difficulty with the organization and cohesiveness of the family.
Foley (2010) states that due to the participants in this study being primarily Caucasian, middle class children, there was not a significant difference in family adversity variables. The author recommended the evidence of family dysfunction be applied to nursing practice through a range of comprehensive intervention strategies. The strategies should be aimed at enlightening the family on possible difficulties they may have within the family environment, and also providing support services to the family and child, such as classes aimed at managing anger, building social skills, management of certain behaviors, and general parenting classes. Family intervention strategies, such as family and marital therapy are encouraged (Foley, 2010).

The results of this study differed from the previous study in that the degree of family adversity was not significantly different between the ADHD and control groups. However, the participants in this study were primarily Caucasian and middle class. This study contributed to the results of the previous study by helping to identify intervention strategies for the family.

Hurtig et al. (2007) used a population sample (n = 457) from a large birth cohort study (n = 6622) in 1986 to evaluate the relationship of comorbid disorders to adolescent ADHD, severity of symptoms, and family characteristics. The relationship of symptoms severity to family characteristics was also investigated. Results of the study concluded ADHD adolescents were more likely to have comorbid disorders, such as conduct disorder or oppositional defiant disorder, than adolescents without ADHD. Furthermore, the severity of ADHD symptoms was directly related to the presence of one or more comorbidities. Family environmental characteristics identified by Hurtig et al. (2007) to be contributing factors to increased risk of comorbid ADHD included non-intact or low-income families, parental inattentiveness to adolescent activities, and parental stress and dissatisfaction. Hurtig et al. (2007) suggest an evaluation of the family environment be conducted when adolescents present with ADHD.
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symptoms, because of the increased risk for comorbid disorders. Although the purpose of this study was not to explore the impact of family interventions, it did establish a foundation for further research on evidenced-based treatments for families in which there is a child or adolescent with ADHD.

Although the aim of this study differed from the previous studies, the clinical implication of conducting an assessment of the family environment was similar. This study also added the component of comorbid disorders seen in ADHD.

Utilizing a combination of clinical assessment tools, Kepley & Ostrander (2007) researched children with ADHD and co-occurring anxiety and their family environments. They hypothesized that there would be a difference in family environment and parenting characteristics between ADHD children with anxiety, and also those without, from non-ADHD controls. The researchers also hypothesized the parenting characteristics, parental psychopathology, and family environment of ADHD children with comorbid anxiety would differ from the non-anxious ADHD group (Kepley & Ostrander, 2007).

The sample initially consisted of 248 children who were divided into ADHD-C (109 children), ADHD-PI (123 children), and ADHD-hyperactive/impulsive type (16 children). Of these 248 children, 110 met the criteria for the non-anxious ADHD group and nine percent (n=22) met the criteria for anxiety. Only the non-anxious ADHD group and anxious-ADHD group were included in subsequent analysis. Parents involved in the study completed the Behavioral Assessment System for Children-Parent Personality Profile (BASC-PPP). This is a 95-item questionnaire used to assess the personal characteristics of parents and their perceived relationship with their child (Kepley & Ostrander, 2007).

Kepley & Ostrander (2007) report:
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The scales include Coping (coping with parenting tasks), Communications/Involvement (communication and closeness between a parent and child), Depression (parental depressive symptoms), Marital Satisfaction (satisfaction with their marital relationships), and Parental Control (the degree parents were able to control their child’s behavior), p. 319).

The Family Environment Scale (FES) was utilized to assess a variety of social-environmental characteristics of families. Only 101 families of the sample involved in the study were randomly selected for the Structured Clinical Interview for DSM-IV, due to budget constraints. This diagnostic tool was used to assess a history of or present diagnosis of parental mental illness. The ADHD Checklist for Adults was administered to assess for a history of or current presentation of ADHD (Kepley & Ostrander, 2007).

A higher degree of family conflict issues and decreased family cohesion was noted in the ADHD groups in comparison to the control group. Results were consistent with other studies in that family conflict is greater in families where there is a child with ADHD. In the anxious-ADHD group, results indicated families exhibit less independence, assertiveness, and a decreased ability to remain self-sufficient. The incidence of having a mother with substance abuse issues was greater in the anxious-ADHD group. In both ADHD groups there was greater report of parental characteristics that included depression, decreased involvement within the family, and impaired coping skills. The anxious-ADHD mothers were noted to exhibit greater control of the family environment, which included adhering to rules and procedures. This finding may be explained by the mothers wanting to feel they had a greater influence on their anxious-ADHD children (Kepley & Ostrander, 2007). This study established preliminary
findings of a difference between anxious-ADHD maternal and family characteristics when compared to non-anxious ADHD families or control groups.

Thompson et al. (2004) studied a protocol that had been established for the care of children who were taking psychostimulant medication prescribed by clinicians in a community clinic and their family profiles. The aim of the study was to determine specific treatment needs for these families. The sample consisted of 191 children and adolescents, of which 87.4% were male. The age for children and adolescents ranged from 5 to 17, with the mean age being 10.5 years. Twenty-four percent of parents were unemployed, and 53% of children lived with both of their biological parents. Children and adolescents with divorced or separated parents made up 36% of the sample, and those living with adoptive or foster parents were 5% (Thompson et al., 2004). Family psychosocial characteristics included decreased levels of social functioning for the child and family, blaming the child with ADHD for family issues, decreased warmth from the parents to the affected child, and an increase in life stressors, such as bereavement and parental discord. Of significant concern was that 22% of children were thought to have been a victim of abuse. Implications for psychosocial interventions included parenting skills, family therapy, and therapy for the child were provided by Thompson et al. (2004).

These studies have identified there is greater family adversity, more dysfunction, and increased conflict in ADHD families. Factors that may contribute to family dysfunction may include a child having ADHD with a comorbid disorder, such as anxiety, CD, or ODD; parental inattentiveness, or non-intact families. The clinical implications provided by these studies highlight the importance of assessing for family dynamic issues when treating the child with ADHD.

The negative impact ADHD has on the family unit is clearly evident in the literature.
The family system is comprised of smaller parts, including siblings and parents. In order to understand the effects on the family unit, it is important to review the potential dysfunction for each individual member.

**Sibling Relationships**

Sibling relationships may be affected when there is a child with ADHD. Siblings of ADHD children have reported feeling victimized through violent and aggressive behaviors, and manipulation. Jealousy is often felt by siblings, because of the increased time required with the ADHD child to parent them (Salmeron, 2009). Although the negative impact ADHD can have on siblings is an emerging theme, studies show this area is lacking in research (Listug-Lunde, Zevenbergen, & Petros, 2008; McDougall, Hay, & Bennett, 2006).

Mikami & Pfiffner (2008) studied the relationships of ADHD children with their siblings and compared them to a control group. The aim of the study was to enhance the limited research on the topic of sibling relationships among children with ADHD. It was hypothesized that sibling relationships among ADHD children would have more conflict, and less warmth/closeness; comorbid conditions would be associated with a higher degree of sibling conflict, and that comorbidity would contribute to the explanation of differences between the two groups.

The sample consisted of 91 children (75 boys, 15 girls). Their ages ranged from 5 to 11 years old. This population was selected, because each had a sibling involved in the study, ranging from age 4 to 18. The majority of siblings were older than the ADHD affected sibling (66%). The ADHD group consisted of 77 children, and the remaining 14 were in the control group. The *Sibling Relationship Quality (SRQ) Brief Version* was utilized to measure degree of conflict and warmth/closeness between siblings. The conflict portion consisted of questions
related to fighting and antagonism of siblings, while the warmth/closeness section measured feelings related to closeness and positivity among siblings (Mikami & Pfiffner, 2008).

Results of the study supported that sibling relationships in the ADHD group have significantly higher levels of conflict versus the control group. The researchers were not able to demonstrate compelling evidence of decreased warmth between both groups. It is recommended that future research be conducted to assess how sibling relationships can diminish the effects of negative relationships with parent-child issues and problems among peers. Interventions targeted towards strengthening sibling relationships should be designed, and increased understanding of social impairments is especially important in this population (Mikami & Pfiffner, 2008).

McDougall et al. (2006) examined the psychosocial consequences between twins in which one child had ADHD. Specifically, the researchers looked at anxiety in the twin pairs, the effects an ADHD child can exert on their twin or siblings depending upon the type of ADHD diagnosis and whether there is an increased effect on the twin versus non-twin siblings. The sample consisted of 501 dizygotic twin pairs (DZ) ranging from ages 6 to 15 years old. Participants were assigned to one of three groups depending upon diagnosis. Those selected for the ADHD-PI group (n=63) had to exhibit five or more symptoms of inattention and four or less symptoms associated with hyperactivity/impulsivity. For the ADHD-C (n=55), the ADHD twin needed to exhibit five or more symptoms of inattention and hyperactive/impulsive behaviors. The non-ADHD affected twin needed to have two or less associated ADHD symptoms. The largest group (n=383), or control group, consisted of children that had less than two ADHD symptoms.
Results of the study concluded the ADHD-C twin experienced a greater degree of separation anxiety (SA) and generalized anxiety (GA) than their co-twin. The ADHD-C group also demonstrated more symptoms consistent with SA and GA than the ADHD-PI group. Both ADHD-PI and ADHD-C twins also demonstrated increased symptoms of generalized anxiety than their co-twin. An increased rate of SA and GA was noted in co-twins of children with ADHD-C than in non-ADHD twins. The co-twins in the ADHD-C group also displayed a higher chance of having SA than co-twins in the ADHD-PI group. According to the researchers, this was the first study of its kind that specifically addressed the psychosocial impact of having a co-twin with ADHD (McDougall et al., 2006). This study builds on the importance of identifying the effects on siblings when treating the child with ADHD.

Researchers sought to explore the impact ADHD has on the emotional and behavioral functioning in siblings of ADHD children. Listug-Lunde et al. (2008) hypothesized that children who had a sibling with ADHD would have greater emotional and behavioral issues than children without a sibling with ADHD. It was also hypothesized that children who had an ADHD sibling with increased severity of symptoms would have greater emotional and behavioral issues than participants who had a sibling with fewer ADHD symptoms.

The sample included 41 children who had a sibling diagnosed with ADHD-C, and 30 children with a sibling without a psychiatric diagnosis. Both groups ranged in age from 9 to 14. Those selected for the ADHD-C group were further categorized depending upon the severity of their siblings ADHD. Seventeen children in this sample were categorized into the high symptom severity children (SHSSC) group based on the fact their siblings had at least six or more symptoms of ADHD-C. Twenty-four children who had a sibling with fewer than six ADHD-C symptoms were placed into the low symptom severity children (SLSSC). Researchers utilized
four assessment tools in this study, which included the *Child-Behavior Checklist (CBCL)*, *Disruptive Behavior Rating Scale (DBRS)*, *Children’s Depression Inventory (CDI)*, and the *Multidimensional Anxiety Scale for Children (MASC)*, in order to assess the psychological impact ADHD has on siblings of the affected child.

Results of the study were indicative of increased internalizing emotions and behaviors in the SHSSC group versus control group. An example of internalizing emotions and behaviors can include withdrawal, somatization, anxiety, and depression. There was not a significant difference among the three groups in relation to increased externalizing behaviors. Examples of externalizing behaviors include delinquent and aggressive behaviors (Listug-Lunde et al. 2008). The researchers concluded it is important to explore the family functioning in those with a child with ADHD.

In a study conducted by Kendall (1999), sibling accounts of the experiences associated with having a sibling with ADHD were examined. The sample consisted of 43 individuals of 11 families where there was an ADHD child. The 43 participants included non-ADHD siblings (n=13), biological mothers (n=11), biological fathers (n=5), 2 stepfathers (n=2), and boys with ADHD (n=12). The non-ADHD sibling group was made up of seven boys and six girls, of which eight were younger than their brother with ADHD. The average age for the ADHD male group was 10 years. The study did not include any ADHD affected girls. Five of the ADHD boys had comorbid ODD. Kendall (1999) utilized a unique combination of journal keeping for the non-ADHD siblings over an eight-week period in addition to in-depth parent and child interviews to gather qualitative data regarding the accounts of experiences related to having a sibling with ADHD.
Kendall (1999) identified three major categories of the sibling experience, including disruption, effects of disruption, and strategies for managing disruption. The seven types of disruptive behaviors identified from the results as being most disruptive included excessive hyperactivity, aggression, learning difficulties, immaturity, family conflicts, poor peer relationships, and difficulties in the relationship with extended family members. Disruptive patterns that were evident in the study were the ADHD sibling requiring immediate attention, the non-ADHD sibling mirroring disruptive behavior or seeking revenge, and parents allowing out of control behaviors. The non-ADHD siblings reported feeling as though the focus of their family was on their sibling with ADHD. Siblings also identified feeling victimized through aggressive acts or manipulation; needing to take care of their sibling due to expectations of the parents; and experiencing feelings of loss and sorrow (Kendall, 1999).

A limitation of this study was the small sample size, which may not be truly representative of every sibling of an ADHD child. Kendall (1999) suggests increased social and mental health services be implemented for each member of the family.

These studies have identified increased sibling conflict and dysfunction in ADHD families. It is important to understand the effects of ADHD on siblings, including emotional and behavioral issues. This suggests strengthening sibling relationships should be a component to addressing the needs of the family unit.

**Parent-child Relationship**

Significant stress can be placed on the parent-child relationship when a child has ADHD. Parents may experience symptoms of depression, social isolation, and marital discord (Kendall et al., 2005). Parents can also feel less competent when dealing with the behavioral problems of ADHD children and adolescents (Johnston & Mash, 2001). The stress of parenting an ADHD
child may be worsened by lack of coping skills, decreased social and spousal support, and lower socioeconomic status (Theule, Wiener, Rogers, & Marton, 2011).

Lifford, Harold, and Thapar (2008) conducted a 1-year longitudinal analysis of ADHD symptoms as reported by the parents of children with ADHD, and the perception of rejection by the parents as reported by the child with ADHD. The sample for this study was taken from a study conducted in the United Kingdom, consisting of 387 schoolchildren, parents, and teachers. The focus of the original study was to explore the family life and socioemotional development of children. The current study consisted of 194 children (girls=105, boys=89) ranging in age from 11 to 13 years old. Families who did not meet the criteria for having a two parent home were excluded from the study. Assessment tools utilized in the study included the attention problems scale of the Child Behavior Checklist and the Child’s Report of Parental Behavior Inventory.

The results of this study concluded that ADHD symptoms experienced by the child have an influence on mother-child rejection. In contrast, the results indicated father-child rejection is influenced by the child’s ADHD symptoms. This study establishes a foundation for further research on the mechanisms of parent-child rejection and ADHD symptoms. The authors conclude this research is necessary for the development of interventions for the parent-child relationship (Lifford, Harold, & Thapar, 2008).

Riley, Lyman, Spiel, Döpfner, Lorenzo, & Ralston (2006) evaluated the reliability, validity, and factor structure of the Family Strain Index (FSI) administered to families of children with ADHD from the Attention-Deficit/Hyperactivity Disorder Observational Research in Europe (ADORE) study. A total of 1,477 parents of children with ADHD completed the FSI questionnaire. The age of children with ADHD in this study was 6-18 years. The majority of
respondents were mothers (90.2%) with children between the ages of 6 and 12 (87%). Male children with ADHD (84.1%) comprised the majority of the sample (Riley et al., 2006).

The FSI is a six item, 5-point Likert scale questionnaire measuring the stress and demand placed on parents and families when there is a child with ADHD. The questionnaire assesses the affective or emotional stress of the parent or caregiver of the child, along with social limitations of the family. Results of the study indicated the percentage of parents reporting their child was the cause of conflict or tension within the family “at least sometimes” was nearly 75%. The number of parents reporting feelings of stress and worry in the past four weeks as a result of their child having ADHD was 52.3%. In addition, the feelings of stress and worry were “always” or “almost always” present. Data concluded that 43.5% of parents denied their child made them feel uncomfortable inviting friends and family to their home. A little less than half (40%) of parents reported their relaxation or social activities were “almost always” or “always” interrupted by their child with ADHD. The percentage of parents reporting their child regularly interrupted daily outings was 17.8%. Parents reported that 10.7% of planned activities were interrupted.

Riley et al. (2006) concluded the FSI appears to have reliability and validity when administered to parents of children with ADHD and, although the purpose of this study was to test the FSI, the results indicated parenting a child with ADHD can be difficult and have a major impact on the family’s home and social life. A limitation of the study was that other members of the family may have a different opinion on the challenges they experience (Riley et al., 2006).

According to Lench, Levine, & Whalen (2013), the level of stress and conflict experienced by parents may be correlated to the parents’ analysis of the child’s behavioral issues. In order to test this theory, Lench et al. (2013) researched the perception parents had of their child and how their negative interactions with the child could possibly be related to the
understanding of symptomatic behavior. The children’s ages ranged from 7 to 13 years old. The parents were placed into three categories: those who had a child with ADHD and labeled them as having the disorder (n=41); parents in which their child had a diagnosis of ADHD but interpreted their behaviors as positive or holding a special ability, also known as Indigo children (n=36); and parents whose children did not have a disorder (Lench, Levine, & Whalen, 2006).

Research findings indicated the amount of negative interactions between parents and their ADHD child were directly correlated to their perception of the symptoms. The ADHD-Indigo group was found to have less negative interactions with their children than the ADHD group who interpreted their child’s behaviors as negative. The parents in the ADHD-Indigo group also reported their child would have a more positive future than those reported by the other ADHD group. Both ADHD groups were found to have a higher degree of reported negative childhood events versus the control group. Lench et al. (2006) conclude the impact of ADHD on the family may be softened by having a more positive outlook on ADHD.

Peters & Jackson (2008) utilized a narrative-based feminist approach in their qualitative research on the experiences of mothers’ with an ADHD child in order to gain a better understanding of mothering a child with ADHD. The feminist approach was used to validate the mother through listening to their stories and advocate for societal attitudes towards ADHD to change.

Eleven mothers of children with ADHD volunteered to participate in the study through in-depth interviews. The mothers ranged from 30 to 60 years old, and the children were between the ages of 3 and 15 years old. Four of the eleven mothers were single parents and the remaining seven were in a relationship with their child’s father.
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Results of the study illustrated the difficulties mothers have in the parenting of their child with the disorder. These mothers experienced increased social isolation, and expressed a lack of support from family, friends, and community services. Feelings of being overwhelmed were expressed as a common theme in the interviews, even in the mothers who had a partner to co-parent their child with ADHD. Mothers also reported the stigma associated with ADHD caused them to not want to divulge their child’s diagnosis and attribute their behaviors to disorders with less stigmatism associated with it, such as Asperger’s Syndrome. Participants also reported having received criticism for parenting skills and in the way they managed the behaviors of their children. The participants identified that the result of these criticisms was a negative impact on their emotional health. Another common theme in the research was that mothers often blamed themselves for their child’s diagnosis, and some regretted having their child diagnosed with ADHD, because it labeled them (Peters & Jackson, 2008).

Although the sample size was small the researchers stated it was sufficient to meet their aim and are normal for qualitative studies on the topic. The sample was composed of middle-class mothers who were in the dominant culture. The research findings cannot be generalized, but coincide with findings in other studies. Implications from the researchers include educating those in the healthcare field to provide information on the best treatment strategies. Nurses and healthcare professionals need an increase in their awareness on the topic of how ADHD can negatively affect the mother of the child in order to implement support for them. The researchers also note there is a lack of nursing specific literature on ADHD.

The studies emphasized the difficulties of parenting a child with ADHD and how it negatively impacts the parent-child relationship. One study specifically addressed parent-child rejection and concluded ADHD symptoms can affect and also be affected by rejection. Two of
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the four above studies suggested symptoms can have an effect on the family’s social life, as well as cause the mother to feel more isolated from others. An interesting finding in one of the above studies was that there were more reported negative interactions between the parent and child when the parent perceived the child’s behaviors as negative. It is important to understand the effects ADHD has on each unit of the family, in order to accurately apply a family systems theory to guide interventions for the family.

Discussion

The research presented in this literature review defines the effect of ADHD on the family unit and highlights the various disturbances the disorder can cause. This paper adds to the current existing literature by viewing the child with ADHD through a family PMHNP and system lens, which has not been studied before. Appropriate interventions to utilize with this population were identified, and included therapy, enlightening the family about the dysfunction that is present, teaching social skills and communication techniques, and referring the child’s family members for mental health services if mental health issues are suspected.

The three themes presented in this review were consistent with previous literature of what areas ADHD can impact a family, including the family unit, sibling relationships, and parent-child relationships. Families in which there is a child with ADHD have an increased risk of family dysfunction and this risk increases if the child has ADHD-C or comorbidity. Psychosocial issues that place these families at risk for greater dysfunction can include non-intact families, decreased socioeconomic issues, and parental ADHD. Impairment in the sibling relationship is also affected by ADHD. Siblings experience higher levels of conflict and an increased risk of internalizing emotions and behaviors. Parents report an increase in strain placed on their relationship with their ADHD child. Mothers in particular may be at an increased
risk of internalizing emotions and behaviors, because they are often the primary care taker of their child.

Although there have been no actual studies of the effect ADHD has on the family unit from a psychiatric nursing or family PMHNP perspective, research indicates ADHD can severely impact the life of the child and their family. The family PMHNP plays an important role in the assessment, diagnosis, and treatment of children with ADHD. The family PMHNP perspective differs from that of a psychiatrist, social worker, or counselor, in that it views the affected family through an advanced psychiatric nursing lens and takes all psychosocial aspects into account.

Family Systems Theory is a useful framework for the family PMHNP to apply in their work with the ADHD family. Based on a systems perspective, it allows the family PMHNP to consider the whole system (child, siblings, and family) and how the parts of the system interact with one another to either cause dysfunction or positive interactions.

When the ADHD child and their family present to the family PMHNP for assistance, the family PMHNP should conduct a thorough assessment of how the disorder may impact the child’s life and the impact it can have on relationships within the family, adversities the family faces, and their awareness of the impact. The family PMHNP can utilize tools, including the family adversity index, to identify the areas that may be contributing to some of the system issues. The family may not be aware of the dysfunction present in their home, which necessitates the practitioner to enlighten them. By utilizing the family adversity index to provide an objective view of the issues being faced within the family unit, the family PMHNP can provide the results to the family for review and discussion.

Once treatment needs are identified, the family PMHNP should spend time with the child discussing how their symptoms may impact not only the child, but family members as well. The
PMHNP can then assist the child in strengthening their relationships with others in the family unit by teaching the child social skills and how to communicate better with other family members. The family PMHNP should designate certain appointments for the child and family to address conflict issues and assess how the members interact with each other. The PMHNP can then educate the family on how to better communicate their needs with each member and the importance of routine and organization in the family unit when there is a child with ADHD. If the family PMHNP detects marital discord, or parental and sibling mental health issues, then referrals should be made to other treatment providers who can address these specific needs. Once the family PMHNP identifies the needs of the individual and family system, then interventions, such as family therapy, individual therapy, and parenting classes may be suggested.

**Implications for Future Research**

The psychiatric nursing profession is a key player in working with the ADHD population, specifically the family PMHNP. However, there is a definite lack of research in the area of psychosocial interventions the family PMHNP can provide to the family unit. There were only two nursing related research articles identified in the literature, but they were not specific to the family PMHNP, or psychiatric nurses. Future research should be designed to inform how the family PMHNP can best serve the family unit in order to provide the greatest outcome for the child and family. Following are suggested questions for future research:

- What are the most effective strategies, tools, and instruments the family PMHNP can utilize when assessing the psychosocial needs of the ADHD family unit?
- How well did the identified interventions work when the family PMHNP implemented them compared with results from a psychiatrist, social worker, or counselor standpoint?
Conclusion

The purpose of this literature review was to examine the current literature on the impact of child and adolescent ADHD on the family unit. The results of the literature review indicate there is an increased rate of family dysfunction when a child or adolescent has ADHD. The symptoms and associated behavioral issues place strain on the family, as well as the affected child, and cause disruption in the family unit. The gap in knowledge displayed in the literature indicates the need for future research to guide the family PMHNP in the care of ADHD children and adolescents, with special regard to the family unit.
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