An-Najah National University

Faculty of Graduate Studies

The Experience of Mothers and Teachers of Attention Deficit / Hyperactivity Disorder Children, and Their Management Practices for the Behaviors of the Child
A Descriptive Phenomenological Study

By

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Supervised

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الاهداء

باسم الله الذي لا يستعان ألا باسمه أحمده على نعمه التي لا تحصى

أهدي هذا العمل العلمي إلي كل من وضع حجر للبناء هذا البلد

إلى من علمني العطاء بدون انتظار .. إلى من أحمل أسمه بكل افتخار .. أرجو من الله أن يمد في عمرك لترى ثماراً قد حان قطافها بعد طول انتظار ...

والدي العزيز

إلى ملاكي في الحياة .. إلى معنى الحب ومعنى الحنان والتفاني

إلى من كان دعائها سر نجاحي وحنانها بلسم جراحي إلى أغلى الحبايب

أمي الحبيبة

إلى رفيق دربي وتوأم روحي إلى من ساندني بلا حدود ...أنا معك أكون أنا وبدونك أنا مثل أي شيء

زوجي الغالي...شكرا

إلى الأنامل الملائكية التي تحرك الأمل والحياة ...أطفالي ونبض قلبي محمود ويامن

إلى روح حماي الطاهرة ...دائما نذكرك فما زلت بيننا

إلى من ساندتني وساعدتني وكانت ولا زالت تمدنا بالحب والخير، لها مني كل الحب والتقدير حماتي الغالية

إلى كل من مد لي يد العون لأخطو في طريق العلم اهدي هذا البحث ...

الشكر والتقدير

أتقدم بالشكر أولا إلى الدكتورة عائدة القيسي المشرفة على هذا البحث لجهدها المتواصل ودعمها وإرشادها وكل ما قدمته لي من مساندة لإتمام هذا البحث....

فهل يمكن شكر الشمس لأنها تضيء على الأرض...

الى كل الأساتذة الأفاضل في الصرح العلمي الكبير(كلية التمريض في جامعة النجاح)

إلي وزارة التربية والتعليم ووزارة الصحة للمساعدة في الوصول الى المعلومات اللازمة لهذا البحث.

إلى مدراء المدارس والمدرسين الأفاضل والأمهات المشاركات، كل الشكر والتقدير للمساعدة في إتمام هذا البحث.

الإقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان :

The Experience of Mothers and Teachers of Attention Deficit / Hyperactivity Disorder Children, and Their Management Practices for the Behaviors of the Child
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أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم لنيل أية درجة أو لقب علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى .

Declaration

The work provided in this thesis , unless otherwise referenced , is the researcher's own work , and has not been submitted elsewhere for any other degree or qualification.

Student's Name : **اسم الطالب :**

Signature : **التوقيع:**

Date: **التاريخ:**

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List of Abbreviations

Abbreviation	Meaning
ADHD	**Attention Deficit Hyperactivity Disorder**
AD	**Attention Deficit**
CBCL	**Child Behavior Checklist**
DICA	**Diagnostic Interview for Children and Adolescents**
DSM-IV	**Diagnostic Statistical Manual for Mental Disorders**
ICD-10	**International Classification of Diseases**
TRF	**Teacher Report Form**
BPT	**Behavioral Parent Therapy**
M.O.E	**Ministry of Education**
M.O.H	**Ministry of Health**

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Abstract

Introduction: ADHD (attention deficit hyperactivity disorder)is a childhood disorder affecting children worldwide and has a major burden on the child, family and other caregivers.

Aim: The aim of this study is to investigate and describe the experience of the adults that interact on a daily basis with school-aged children with Attention Deficit Hyperactivity Disorder, which are mothers and teachers. This study aims also to understand management practices that are used by mothers and teachers to deal with the most prominent signs of ADHD, which are hyperactivity, impulsivity, and inattention in order to formulate a care plan.

Design :The study used a qualitative descriptive phenomenological method to explore the experiences of primary caregivers of ADHD children to capture as much as possible the way in which the phenomenon is experienced.

Data collection: Face to face, in-depth, semi-structured interviews were conducted with participants – the mothers and teachers of ADHD children.

The interview guide allowed mothers and teachers to express their experiences with the ADHD child.

Sample: Purposive sampling was used; four children diagnosed with ADHD were chosen. The sample was 4 mothers and 12 teachers (3 teachers for each child).

Setting: Interviews were conducted in schools and homes of children with ADHD.

Data Analysis: The data was analyzed by using Giorgi's phenomenological psychology method (1985).

Results: Three major themes emerged from the mothers' interviews and ten sub-themes; (1) *the burden of caring* (academic track burden, activities of daily living burden, psychological and emotional burden);(2)*inadequate support*(lack of support from spouses and relatives, lack of support from schools, lack of support from community);(3)*disturbances of the child's behavior* (hyper activity, inattention, impulsivity, hostility).

Five major themes also emerged from the teachers interviews and thirteen sub-themes; (1) *lack of information* (about the nature of the disease,about student health and follow-up, about the ideal method for dealing with child); (2)*child´s behaviors disruptive* (inability to follow class rules, inattention and impulsivity, using verbal and physical abuse);(3) *the lack of resources* (lack of time, lack of materials and experts); (4) *lack of support*

(lack of Ministry of Education support and school team, lack of parental support); (5) *the burden of having the child in the class* (burden of managing the safety of the child, burden to calm the child and the other students, emotional burden).

Conclusion : The findings of the study demonstrate the importance of understanding the experience of the mothers and teachers of ADHD children. It reflected the difficulties and issues of dealing and caring with ADHD children. There were clear defects in the knowledge, understanding, services provided for the children, and available support for the care givers. Improving services in terms of family and school care should be a major concern.

The recommendations made on the basis of the results of this study can be used as a guide to improve the delivery of care services for people who have children with ADHD.

Key words: ADHD, experience, descriptive phenomenology

Definition of Concepts:

- ADHD (attention deficit hyperactivity disorder):is a chronic behavioral disorder with three major symptoms including hyperactivity, impulsivity and inattention. It mostly starts in childhood, and is associated with impairment in the functioning of the child in school and at home, in social settings and at work.

-Hyperactivity: is defined according to DSM-IV as excessive motor activity of the child and the inability of the child to play quietly. It includes also the excessive movement with the hands and feet, climbing, jumping, and leaving the place or the seat frequently (Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV) 1994).

-Impulsivity: is the inability of the child to control his emotions and urges, which includes – according to DSM-IV –, interrupting others, difficulty to wait one's turn, and blurting out answers to questions. Children with ADHD are usually easily exaggerated emotionally (DSM-IV).

-Inattention: is a difficulty to sustain attention, according to DSM-IV. It includes: seeming not to be able to listen, usually forgetful, losing things, distracted by extraneous stimuli, and a failure to complete tasks (DSM-IV).

-DSM-IV: Diagnostic Statistical Manual of Mental Disorders, published by the American Psychiatric Association. It provides a common language and standard criteria for the classification of mental disorders.

-ICD-10: International Classification of Diseases is the international standard diagnostic classification for all general epidemiological diseases many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of

the individuals affected, reimbursement, resource allocation, quality and guidelines.

Chapter One

Introduction

1. 1 Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a childhood disorder that affects the children and places a heavy burden on the child, the family, and the other care givers around the child. The disorder can appear as early as at 2-3 years or later at about 7 years of age, but the confirmation of diagnosis will not happen before 6-9 years of age (Buitelaar & Montgomery, 2003).

The disorder has a major behavioral disturbance that affects the child's daily activity function (hyperactivity, impulsivity, and inattention) and those symptoms mostly begin at early ages (LaForett & Murray, 2008). As these symptoms develop with age, it become more prominent and this makes the family uncertain how to deal with the child, especially when entering school. ADHD has a significant impact on a child's development, including social, emotional and cognitive functioning, and it is responsible for considerable morbidity and dysfunction for the child, their peer group and their family. Affected children are often exposed to years of negative feedback about their behavior and suffer educational and social disadvantage. It is estimated that up to two thirds of children affected by hyperactivity disorders continue to have problems in to adulthood (Barkley, 1998). In addition, there can be a dramatic effect on family life (Goldman 1998, Taylor 1996, Lahey 1998). Cumulative effects of these difficulties can be overwhelming and cause significant burdens of illness associated with ADHD, which is clarified in the reduce quality of life for patients and

their families. This burden warrants consideration and action by the managed care stakeholders to promote good practice and optimal care (Minkoff, 2009). Families of children with ADHD may be dealing with challenges that go beyond the symptoms of ADHD alone. The struggles that parents are experiencing are important to consider with respect to intervention, as parents typically play a major role in working to change children's behavioural symptoms (e.g. through parent training and behaviour therapy programs). Therefore, understanding different family contexts and their impact on developmental trajectories for children with ADHD is crucial to the success of these interventions (American Academy of Paediatrics 2010). In addition, children with ADHD need guidance and understanding from their parents and teachers to reach their full potential and to succeed in school.

The aim of this study is to investigate and describe the experience of the adults that have the most interaction on a daily basis with school-aged children with Attention Deficit Hyperactivity Disorder, which are mothers and teachers. This study aims also to understand management practices that are used by mothers and teachers to deal with the most prominent signs of ADHD, which are hyperactivity, impulsivity, and inattention in order to formulate a care plan.

1.2 Problem Statements

Extensive literature exists about ADHD being the most commonly diagnosed childhood disorder (Firmin & Philip, 2009). Great inconsistencies exist in the knowledge of families of ADHD children (Johnston & Mash, 2001). Research has focused on children with ADHD and little attention has been given to the experience of parents in raising a child with ADHD (Cosser, 2005).

A problem statement for a phenomenological study might note the need to know more about people's experiences, which are mothers and teachers, who have the most interaction on a daily basis with school-aged children with ADHD and the meanings they attribute to those experiences. The research findings will help to address the problem of caring for ADHD children in schools and at home, and this will also reflect the awareness of the mothers and teachers about the management that should be used to manage the behavior disturbances of the ADHD child and to obtain information relating to the child's presentation in order to formulate a care plan.

1.3 Significance of the Study

Understanding how mothers and teachers deal with a child's ADHD would provide additional information from which to create effective interventions. Understanding how mothers and teachers deal with a child's ADHD can elicit important information about family and teacher

functioning and may assist understanding of the child-family, and child-teacher interaction that in turn facilitates the development of a care plan and helps children diagnosed with ADHD on the educational level, and to create an understanding of ADHD problems in society. At school, there are several areas of significant deficiencies and poor resources to meet the needs of children with different diagnoses.

1.4 Background

1.4.1 Definition of ADHD

ADHD is amongst the most commonly diagnosed behavioral disorders in children and young people. Core symptoms include developmentally inappropriate levels of activity and impulsivity and an impaired ability to sustain attention. Affected children and young people have difficulty regulating their activities to conform to expected norms and as a result are frequently unpopular with adults and peers. They often fail to achieve their potential and many have co morbid difficulties such as developmental delays, specific learning problems and other emotional and behavioral disorders (Hill, 1998).

The American Academy of Pediatrics, in 2010, produced a guideline for the definition and the core symptoms of the disorder, and it is defined it as the most common neurological behavioral disorder affecting school-age children with the three core symptoms (inattention, hyperactivity and impulsivity).

1.4.2 Diagnosis of ADHD

Diagnosis requires that there be clear evidence of clinically significant impairment in social, academic, or occupational functioning. This requirement is essential not only for ADHD, but also for all mental disorders, in order to differentiate disorders from ubiquitous symptoms and variations of behavior. Impairment implies not only a higher severity or frequency of symptoms but also interference with functioning in the life domains of the child, e. g. at home, at school, with friends or elsewhere (Taylor & Dopfener et al, 2004).

The source of information about symptoms and impairment is from parents or teachers, and the method used to gather diagnostic information is a behavior checklist, a structured interview, etc. Some symptoms, for example hyperactivity and impulsivity, tend to decline with age, though others, for example inattentive symptoms, are more persistent (Biederman et al, 2000).

The diagnosis is usually done at 6-9 years of age depending on many diagnostic criteria according to Diagnostic and Statistic Manual of Mental Disorders (DSM-IV) (American Psychiatric Association Diagnostic Criteria for ADHD, 1994).

A. Either 1 or 2

A.1 Six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the developmental level:

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 activities.
- **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)** Often easily distracted by extraneous stimuli.
- **i)** Often forgetful in daily activities.

A.2 Six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the developmental level:

Hyperactivity:

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) Often “on the go” or often acts as if “driven by a motor”.

f) Often talks excessively.

Impulsivity

g) Often blurts out answers before questions have been completed.

h) Often has difficulty waiting a turn.

i) Often interrupts or intrudes on others (e.g., butts into conversations or games).

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before 7 years of age.

C. Some impairment from the symptoms is present in 2 or more settings (e.g., at school or work or at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or personality disorder).

1.4.3 The epidemiology of attention-deficit/hyperactivity disorder (ADHD):

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurodevelopment disorder of childhood. However, basic information about how the prevalence of ADHD varies by race/ethnicity, sex, age, and socio-economic status remains poorly described. One reason is that difficulties in the diagnosis of ADHD have translated into difficulties developing an adequate case definition for epidemiologic studies. Diagnosis depends heavily on parent and teacher reports; no laboratory tests reliably predict ADHD. Prevalence estimates of ADHD are sensitive

to who is asked what, and how information is combined. Consequently, recent systematic reviews report ADHD prevalence estimates as wide as 2%–18%. The diagnosis of ADHD is complicated by the frequent occurrence of co-morbid conditions such as learning disability, conduct disorder, and anxiety disorder. Symptoms of these conditions may also mimic ADHD. Nevertheless, researches suggested that developing an adequate epidemiologic case definition based on current diagnostic criteria is possible and is a prerequisite for further developing the epidemiology of ADHD. The etiology of ADHD is not known but recent studies suggest both a strong genetic link as well as environmental factors such as history of preterm delivery and perhaps, maternal smoking during pregnancy. Children and teenagers with ADHD use health and mental health services more often than their peers and engage in more health threatening behaviors such as smoking, and alcohol and substance abuse. Better methods are needed for monitoring the prevalence and understanding the public health implications of ADHD. Stimulant medication is the treatment of choice for treating ADHD but psychosocial interventions may also be warranted if co-morbid disorders are present. The treatment of ADHD is controversial because of the high prevalence of medication treatment. Epidemiologic studies could clarify whether the patterns of ADHD diagnosis and treatment in community settings is appropriate. Population-based epidemiologic studies may shed important new light on how we understand ADHD, its natural history, its treatment and its consequences.(Andrew, s., Catherine, a., Ann, J.2002).

1.4.4 Prevalence of ADHD

The reported prevalence of ADHD in school-age children in the United Kingdom (UK) varies from 1.7% to 17.8% depending on the diagnostic criteria used (Elia, 1999). In the United States (US) estimates have historically been higher than UK estimates, due presumably to the application of narrower diagnostic criteria by UK authors (Taylor et al, 1991). Three studies of English populations have shown a prevalence rate of between 2% and 5%, depending on whether DSM-IV or ICD-10 criteria were applied (McArdle, 1995). The male to female ratio in ADHD prevalence is at least four to one (Gaub, 1997).

There have been a number of studies on the prevalence of ADHD from Arab countries, e.g. 1.3% in Yemen (Alyahri, 2008) and 1.0% in the United Arab Emirates (Eapen, 1998). Rates were found to be high, even among female pupils, in Oman and were associated with aggressive behavior, school under-achievement and learning difficulties (Al-Sharbati, 2004). High co-morbidity rates were found among clinically referred children with ADHD in Saudi Arabia (La-Haidar, 2004).

A study on ADHD in Palestine aimed to investigate the prevalence and distribution of ADHD symptoms and other associated co-morbid mental health problems in Palestinian school children. It was found that 4.3% of the children rated above the established cut-off scores by both the parent and teacher on the DSM-IV Checklist (Thabe, 2010).

1.4.5 Long term prognosis:

The onset of ADHD symptoms particularly hyperactivity can appear as younger as 2-3 years, respective studies have shown that clinically referred preschoolers of about 3 years of age who present with severe hyperactivity, irritability, and/or impulsiveness are at high risk to be diagnosed with ADHD or related externalizing disorders at the age of 6 to 9 years (Pierce et al., 1999 Campbell et al., 2000). The long-term outcome is poor, with an increased risk of social isolation, academic underachievement substance abuse, and persistent psychopathology in adolescence and adulthood affecting up to 60% of cases (Hansen et al., 1999; Mannuzza et al., 1997, 1998).

> Reviews controlled prospective follow-up studies of children with attention deficit hyperactivity disorder (ADHD) into young adulthood and adulthood. In their late teens, those with ADHD as children, compared with non-ADHD comparisons, show relative deficits in academic and social functioning. In addition, about two-fifths of these children continue to experience ADHD symptoms, and a significant minority demonstrates pervasive antisocial behaviors, including drug abuse. Many of these same difficulties persist into adulthood. Compared with the comparisons, former ADHD propend complete less formal schooling, hold lower ranking occupational positions, and continue to exhibit poor social skills, antisocial personality, and symptoms of the childhood syndrome. On the other hand, as adults, nearly all former

cases are gainfully employed, some in higher level positions, and a full two-thirds show no evidence of any mental disorder. Although relative deficits are seen in early to middle adolescence, young adulthood, and adulthood, childhood ADHD does not preclude achieving one's educational and vocational goals, and the majority of these children do not experience emotional or behavioral problems by their mid-20s.

1.4.6.Heritability and neuroimaging findings

evidence from heritability and Neuro imaging studies suggests that ADHD are neuropsychiatric illnesses with biological components

There is a considerable amount of evidence from family pedigree, twin, adoption and molecular genetic studies of the heritability of ADHD. Estimates of heritability range as high as 80–90% (Gilger et al., 1992). There is also significant evidence that non-genetic factors are important in determining the phenotype and that these non-genetic factors interact with the genotype in producing the observed phenotype.

Family studies consistently indicate a 2- to 8-fold increased likelihood that the parent of an ADHD child will also meet the diagnostic criteria for ADHD (Biederman et al., 1990; Schachar and Wachsmuth, 1990; Frick et al., 1991; Faraone et al., 1992). Siblings of an ADHD child are meeting ADHD criteria.

Adoption studies support the theory of a genetic basis to ADHD. Biological relatives of ADHD children have higher rates of ADHD than do adoptive relatives Likewise, twin studies support the heritability of ADHD, but also indicate that impulsivity/hyperactivity appears to be a more heritable trait than attention-related deficits (Sherman et al., 1997). Collaborative plans designed to help treat the youngster. If the genes involved in ADHD and the other Disruptive Behavior Disorders (DBDs) can be elucidated, then it may be possible for future treatments to be developed that selectively target the sites of action of these susceptibility genes within particular neurochemical systems. Furthermore, the study of polymorphisms in the genes involved in the disorders and in the genes involved in the neuro-chemical systems relevant to the pharmacokinetics of medications may also help determine optimal therapeutic doses for individual patients, and may help predict side effect profiles of such treatments.

1.4.7 Environmental factors that might increase the risk of Developing ADHD

Prenatal exposure to nicotine and alcohol was found to increase the incidence of ADHD (Abrantes, 2005; Knopi, 2005; Palacio, 2004). Low birth weight (LBW) has also been evaluated as a potential risk factor for ADHD.

There is clinical evidence that three-quarters of the children who receive Phenobarbital for febrile seizures or epilepsy develop hyperactivity

symptoms, but it is not clear if this phenomenon is caused by the medication or the seizures. gender, family size and living in an area of socioeconomic deprivation were variables associated with ADHD symptoms (Thabet, 2010).

1.4.8 Interventions of ADHD

1.4.8.1 Family Psychosocial Interventions

Children with ADHD present management problems in the home and community, therefore equipping parents with effective management skills has intrinsic appeal as a treatment strategy. Children with ADHD have also been demonstrated to evoke negative parenting, and this has been shown to become part of a coercive cycle in which parents and children maintain each others' negative patterns of interaction (Patterson 1982).

Behavior management training has been shown to reduce conflicts and non-compliance in children with ADHD (Barkley, 1992; Pisterman, 1992; Pisterman, 1989; Stray Horn, 1989). Even where treatment achieves significant improvement between groups, there is considerable variation between and within individuals (Barkle, 1992). Behavioral management training for children with behavior problems has been evaluated and shown to reduce non-compliant or oppositional behavior (Patterson, 1975; Webster-Stratton, 1990; Forehand, 1981).The inclusion of parent training has been shown to increase the acceptability of treatment packages and to improve parental well-being (Barkle, 1992; Anastopoulos,1993).

1.4.8.2 School-based Psychological Intervention

Meta-analysis has shown that management strategies and academic interventions are more effective for behavior change than cognitive-behavioral strategies (Abikoff, 1984). Children with ADHD require an individualized school intervention program including behavioral and academic interventions.

The short term effects of behavioral interventions are typically limited to the periods when the programmers are actually in effect. When treatment is withdrawn, children often lose the gains made during treatment. Although in the short term, behavioral interventions can improve targeted behaviors, they are less useful in reducing inattention, hyperactivity or impulsivity (Abikoff, 1984). Studies of attending have revealed that smaller class size, use of resource rooms vs. regular classrooms, direct vs. indirect instruction, and entire class engagement have resulted in increased levels of concentration in students with ADHD (Abramowitz, 1998).

The class teacher is the main manager of educational intervention in most cases. Most teachers have only limited knowledge of the condition, and will require information and guidance. The involvement of an educational psychologist in the treatment programs and its evaluation is highly desirable (Eilen, 2008).

1.4.8.3 Social and Community Intervention

Families of children affected by ADHD are subject to considerable pressures associated with the disorder on a day to day basis. Buitelaar suggests that families have differing capacities to cope that fluctuate over time. The provision of support other than what may be available from extended family and friends may be an important part of a multimodal intervention package. The need for social support must be considered for individual families. Various forms of social support are available, including friends, respite, self help groups and financial assistance (Buitelaar, 2003).

1.4.9 Pharmacological Treatment for Attention Deficit Hyperactivity Disorder

In terms of the number of controlled studies showing the efficacy of psychopharmacologic treatment for ADHD, psycho stimulants outrank all other classes of medication (Spencer et al., 1996). Within this class, within-subject comparison studies have not found significant differences in either the safety or the efficacy of these two psycho stimulants (Arnold, 2000). Pemoline is no longer recommended due to its association with hepatotoxicity.

Tricyclic antidepressants (TCAs) would rank second in terms of number of controlled studies, but their associated safety problems—potential cardiotoxicity, in particular—result in TCAs rarely being recommended. Furthermore, their efficacy in treating symptoms of ADHD is considered to

be lower than that of the psycho stimulants, (Biederman et al., 1989).The efficacy of the noradrenergic antidepressant, bupropion, has been evaluated in at least one large multisite controlled study (Conners et al., 1996), as has that of the norepinephrine reuptake inhibitor, atomoxetine, (Michelson et al., 2001), and trials with various antihypertensive medications (e.g. clonidine, guanfacine) are currently underway Psycho stimulants have consistently been shown to improve the core symptoms of ADHD (inattention, hyperactivity and impulsivity), and to improve oppositional behaviour, impulsive aggression and social interactions. Analogue classroom studies also demonstrate increased academic productivity and academic accuracy (Swanson et al., 1998). However, it has yet to be shown that in the absence of psychosocial intervention, psycho-stimulants alone can yield genuine academic gains (e.g. improvement in school grades). The most common side effects of psychostimulants are:

- loss of appetite.

- insomnia.

- headache.

- stomach ache.

- appetite suppression may result in reduction in weight gain.

However, most of these side effects can be managed by making minor changes to diet and/or to the timing of medication doses, in some cases tics syndrome arise although they are usually mild and/or transient, and do not necessitate cessation of treatment. In a long-term (up to

24 months) open-label study with once-a-day OROSRMPH in children (6–13 years) with ADHD, no clinically important effects were observed on height, weight, blood pressure, heart rate, hematologic or liver function tests (Wilens, 2002). When psycho-stimulant medication is stopped abruptly, withdrawal reactions may occur. Then, 4–12 h after the last dose, 'rebound' symptoms of ADHD including increased activity, excitability, irritability and insomnia occur. In the longer term, depression and extreme fatigue may be seen.

Clinicians and patients require medications that are safe, effective, well tolerated and have high compliance rates so that they can be administered as a long-term form of treatment, being prescribed for years rather than months. Another concern is that many youngsters receiving psycho-stimulant treatment for ADHD are not dosed appropriately to achieve full-day coverage from their medication. The common practice of twice-daily dosing with short acting preparations may ameliorate symptoms during school hours, but these benefits do not extend into evening hours when homework tasks need to be tackled and family interactions are more prominent. If short-acting preparations are prescribed, dosing should generally be thrice daily.

Alternatively, long-acting preparations, or a combination of short- and long-acting agents, may be used to ensure coverage of appropriate duration

Benefits of long-acting psycho-stimulant preparations

Psycho-stimulant medication are becoming available in many countries. Most of these provide a dose of psycho-stimulant that lasts for 8 h or more, such as: Adderall XR, Concerta, Metadate CD and Ritalin LA. A significant benefit of these preparations is that the need for a midday dose in school is removed. This is desirable because many youngsters feel stigmatized by having to take medication in front of their peers, and also because it removes the possibility of diversion (i.e. medication being given away or sold to peers) and allows all medication administration to be supervised by the parent. Clinical studies have demonstrated a smoother ascending/descending pharmacokinetic profile in long-acting agents compared to thrice-daily MPH dosing, with comparable safety and efficacy. This may prove to reduce patients' experiences of cycling 'on' and 'off' medication throughout the day, which is a problem associated with thrice-daily dosing regimens. The single dose aspect is expected to be preferable to patients and families, improving compliance rates, and should simplify the titration process for healthcare providers.

1.4.10. Psychiatric Co-Morbidities with ADHD

Both clinical and epidemiological studies have found that some 50% of all children with ADHD also have co-morbid disorders (oppositional defiant disorder, conduct disorder). The presence of other co-morbid conditions is the rule rather than the exception with depressive disorders, anxiety disorders, bipolar disorder, learning disorder, and tic disorder frequently reported (Kadesjo & Gillberg, 2001).

The presence of ADHD in childhood is a major risk factor for the development of aggressive and antisocial behavior (Taylor et al, 1996). The long-term outcome is poor, with an increased risk of social isolation, academic underachievement, substance abuse, and persistent psychopathology. There is some evidence of efficacy for symptoms in adolescence and adulthood affecting up to 60% of cases of hyperactivity, impulsivity and inattentiveness with tricycle (Hansen et al, 1999; Mannuzza et al, 1997, 1998).

Two studies in the Arab World examined co-morbidity with ADHD. Fayyad et al (2001a) in Lebanon showed that ADHD in a clinical sample of children and adolescents was often co-morbid with one other psychiatric disorder. The most common co-morbid conditions were mood disorders (Major Depression, Dysthymia, Bipolar Disorder, Cyclothymia) (19.1%), Learning/Language or Communication Disorder (18.8%), anxiety disorders (Separation Anxiety Disorder, Generalized Anxiety Disorder, Obsessive

Compulsive Disorder, Social Phobia, Panic Disorder (15.6%), enuresis (14.8%), and encopresis (3.0%). In addition, this study showed that 11.8% of ADHD subjects in this clinical sample had borderline intellectual functioning, and 11.1% had mental retardation.

1.4.11 The Burden of the Illness

ADHD has been described in the research to be one of the most disturbing and stress causing within the family. Many researches have focused on the direct and indirect burden and costs of the disorder. Neil & Minkoff (2009) in their study which described the burden of illness showed that the burden of ADHD could be direct, which included the costs of treatments and follow up , or indirect, like decreased academic and workplace performance and ultimately, loss of income and revenue.

Studies have shown that, compared with individuals without ADHD, those with ADHD had lower educational achievement. Furthermore, patients with ADHD with a high school degree earn significantly less than their counterparts without ADHD.

Many others researches focus on the psychological burden on the parents of ADHD children. Mesh and Johnston (1983) believe that parenting stress is significantly high in all domains in the mothers of ADHD children especially in the mothers of preschool children.

Caregivers of children with ADHD report experiencing intense emotions and a sense of a loss of control related to the nature of their children's symptoms and behaviors, delays in receiving a diagnosis, and conflicting diagnostic opinions from health care professionals (Lam & Mackenzie, 2002; Nelson, 2002). They experience an urgent need for timely, accurate, and complete information regarding their child's illness and need the information to be repeated a number of times (Scharer, 2002). These parents desire support from both professionals and other parents with similar experiences.

The caregivers of children with ADHD often share a mistrust of the health care system that they find to be insensitive, negative, and uncaring toward their child, although some also experience gratitude for individual professionals who provide support and take time to listen to them (Lam & Mackenzie, 2002). Based on teacher reports on children's scholastic performance in Sharjah (UAE), Bu-Haroon et al (1999) observed that children with ADHD symptoms did not achieve as well as other children academically.

1.5. Aims of the Study

The aim of this study is to investigate and describe the experience of the adults that have the most interaction on a daily basis with school-aged children with Attention Deficit Hyperactivity Disorder, which are mothers and teachers. This study aims also to understand management practices that

are used by mothers and teachers to deal with the most prominent signs of ADHD, which are hyperactivity, impulsivity, and inattention in order to formulate a care plan.

1.6. Research Questions

1. How could a teacher respond to child with ADHD in education and how does she / he handle the situation?
2. How could a mother respond to child with ADHD at home and how does she handle the situation?
3. What were the difficulties that care providers have faced with the most prominent signs of ADHD, such as hyperactivity, impulsivity and inattention?
4. To what extent was there a need for social support?

Chapter Tow
Literature Review

2.1 Literature Review

Yousefia & Soltani (2011) conducted a study in Iran. The purpose of this study was to compare parenting stress among mothers of children with ADHD and mothers of normal children. Results showed that there was a significant difference between parenting stress in mothers of children with ADHD and mothers of normal children. There was also a significant difference between parenting stress levels and styles of parenting in mothers of children with ADHD and mothers of normal children. It was found that parenting stress level had an effect on the choice of authoritative parenting styles in children with ADHD. In other words, the higher parenting stress, the more arbitrary parenting styles may be, and the parent stress can exacerbate the problems of the child's life.

Podolski and Nigg (2010) examined the role of parent distress and coping in relation to the childhood of ADHD in both parents of 66 children aged 7-11 (42 males, 24 females). Results showed that parents of children with ADHD expressed more dissatisfaction than parents of control children. The parent coping with greater use of positive reframing was associated with higher role satisfaction for both parents. Community support was associated with higher distress for mothers only.

A study was carried out by Marian & Gerkensmeyer (2011) in India to explore the experience of primary caregivers of children with special mental needs such as ADHD, oppositional defiant disorder, and mental

retardation. It was a qualitative descriptive study with semi-structured interviews with a focus group of 20 female primary care providers. Five themes emerged: struggling with the healthcare system, living in fear, burdened and exhausted, worry about the rest of the family, and good things happen sometimes. The study concluded that there are many unmet needs to be addressed to improve the wellbeing of these caregivers, their children, and their families. The study findings suggest a number of recommendations for clinical practice. And that there is a need for future studies that will include the perspectives of caregivers and family members.

Lin & Y Huang et al (2008) performed a qualitative research using a phenomenological approach. Face to face interviews were used to collect data to understand the experience of primary caregivers who raise school-aged children with ADHD. Three themes and seven sub-themes emerged from this study: the burdens of caring (parenting burdens, emotional burdens and conflicts of family), lack of adequate support systems (lack of support from professionals, spouses and other family members) and the mechanisms of coping (cognitive coping strategies and social coping strategies). The results of this study show the importance of understanding the experiences of primary caregivers bringing up school-aged children with ADHD. Improving professional services in family care should be an important issue for all health care professionals.

Kadesjö (2002) has shown that it is important for all schools to have the right support, such as a student welfare team and a teaching assistant.

The assistant helped many times teaching ADHD students when the problem occurred by taking one or two of the classroom to a study room where ADHD students could sit alone. Kadesjö declared also that the teachers used to meet parents of ADHD students often. It is clarified here that teachers are involved in working with ADHD students.

Gillberg et al (1996) suggests that one should work out an approach for each individual student where all students are different and are individuals. When they interviewed the teachers, they found noticeable gaps in the teachers' knowledge of ADHD. This may be due to the fact that the teachers had no training in special education.

A descriptive phenomenological study by Cynthia (2010), aims to examine the experience of five black parents raising children with ADHD. The themes that emerged from the data were about the experience of their children, a sense of self, and experience with ADHD. Parents saw their children as hyperactive and un-controlled. They experienced that their children were socially isolated and withdrawn, inattentive, not listening and not being able to concentrate in school and at home. The results of the study suggest that ADHD is still misunderstood in the black population, the support from professional experience is not satisfactory, they feel guilty and ashamed, blame themselves for the child situation, felt trapped, frustrated, alone, and sometimes depressed.

In an article review of psychosocial treatments for preschool-aged children with ADHD in the context of the developmental and contextual needs of this population (e.g. increased parenting demands, differences in classroom structure and the child's emerging developmental capacities). Discussions of the findings are provided for parent-training approaches, classroom management strategies, and multimodal treatments. Parent-training intervention has the greatest overall support for improving behavioral outcomes, with a variety of different approaches having best moments effectiveness. The data show promising results for teacher training and consultation intervention (LaForett & Murray 2008).

Huang & Lu et al (2009) investigated the effectiveness of behavioral parenting therapy (BPT) programs for children with ADHD using multidimensional assessments, Child Behavior Checklist (CBCL) and a Teacher Report Form (TRF) between 2001 and 2005 in Taiwan. The parents of 21 preschool children with ADHD were divided into six groups and participated in a series of 11 BPT sessions. Before and after BPT parents completed the CBCL, and teachers completed the TRF.

The behavioral and emotional problems in children showed improvement after BPT sessions, especially for the following categories: internalizing problems, anxious / depressed syndrome, thought somatic complaints, outsourcing problems, rule-breaking behavior, aggressive behavior, social problems, and attention problems. The DSM-oriented scale of the CBCL and affective problems, anxiety problems, somatic problems,

ADHD problems, oppositional defiant disorder problems, and conduct problems disease showed significant improvements. The DSM scale TRF improved inattention syndromes significantly after BPT sessions, whereas other syndromes showed non-significant changes. The authors concluded that the BPT program significantly improved children's behavior problems at home and inattention problems in school.

McLaughlin & Harrison (2005) examined the relationships among child behavioral and parent characteristics in understanding the effectiveness of parenting practices used by mothers of children diagnosed with ADHD. They interviewed 150 Australian mothers of children diagnosed with ADHD and asked them to assess the severity of their child's disruptive behavior, their own parenting sense of competence, perceptions of social isolation and parenting practices. They found that the severity of the child's disruptive behavior, lower parental sense of competence and greater social isolation would be associated with the use of less effective parenting practices.

Deault (2009) performed a systematic review study to investigate the contribution of parenting factors, such as psychopathology, parenting practices and family conflict to various development outcomes in children with ADHD. Of the 22 studies identified in the review were 18 studies focused on teasing apart the family contribution factors with ADHD disorders. Results from these studies suggest that parental psychopathology and family conflict tend to be more strongly associated with oppositional

and conduct symptoms than with inattentive or hyperactive symptoms. Few studies that have been identified in the review that grant parenting factors in other aspects of child development in ADHD, such as academic or social function.

Conlon & Strassle (2008) used the family management styles (FMS) typology with children and adolescents with ADHD with the aims of demonstrating that FMSs could be reliably identified in a different clinical sample and clarified changes in FMS that occur with treatment. FMSs were reliably identified in the sample and more than half of the families (56.3%) improved to a higher functioning FMS with treatment.

The findings suggest that FMSs can elicit important information about family functioning and may assist clinical understanding of the child-family interaction that in turn facilitates treatment.

Swensen and Birnbaum et al (1998) conducted a study in the United States of America to estimate the direct (medical and prescription drugs) and indirect (work loss) costs of children treated for ADHD and their families. Data collection was performed by using an administrative database from a national, Fortune 100 manufacturer that included all medical, pharmaceutical and disability claims for beneficiaries. The analysis involved four samples. The ADHD patient sample included individuals 18 years or younger with at least one ADHD claim during the study period (1996-1998). Resource utilization of ADHD patients

contrasted with a matched control sample of patients with no diagnosis for ADHD. ADHD and non-ADHD family samples included non-ADHD family members of ADHD patients and their matched controls. The results showed that the annual average expenditure (direct cost) per ADHD patient was $1,574 compared with $541 in matched controls. The annual average payment (direct plus indirect costs) per family member was $2,728 for non-ADHD family members of ADHD patients compared to $1,440 for family members of matched controls. Both patient and family cost differences were significant at 95% confidence level. They conclude in this study that ADHD represents a significant financial burden based on the costs of medical care and work loss for patients and relatives.

Pineda & Palacio et al (2007) conducted a study to identify potential environmental risk factors for ADHD. 486 children between 6 and 11 years of age were entered in the study. This group included 200 children with ADHD (149 boys and 51 girls) and 286 healthy controls (135 boys and 151 girls). ADHD DSM-IV diagnosis was obtained using the Diagnostic Interview for Children and Adolescents (DICA) and the Behavior Assessment System for Children (BASC) evaluation instruments, and the children's mothers or grandmothers filled out a questionnaire on each child's exposure to prenatal, neonatal and early childhood disease. The analysis of data shows that the risk factors associated with development of ADHD include premature birth, maternal respiratory infection during

pregnancy, smoking, alcohol, asphyxia or anoxia, moderate brain injury, and febrile seizures.

A study conducted in Arab world by Farah & Fayyed et al (2009) aims to review epidemiological studies on ADHD in all the Arab countries. To achieve the aim of the study, all epidemiological studies on ADHD conducted from 1966 through the present were reviewed. Samples were drawn from the general community, primary care clinical settings, and populations of traumatized children. Data on prevalence, gender differences, risk factors, co-morbidity, and burden of ADHD were reviewed. The results of the study showed that ADHD rates in Arab populations were similar to those in other cultures. Comparisons within Arab studies were difficult given the variability of methodology and instruments used. They concluded that there is an important need for research on ADHD in the Arab World, not only to assess the national prevalence in children and adolescents, but also to look at the differential burden and treatment of this disorder, which has high levels of mental co-morbidities and high impact across the life span.

Table.1: Articles Matrix- Literatures of ADHD

Author/s, Year	Title of the Study	Aim of the Study	Results of the Study
Swensen and Birnbaum, 1996	Attention-Deficit/Hyperactivity Disorder: Increased Costs for Patients and Their Families	To estimate the direct (medical and prescription drugs) and indirect (work loss) costs of children treated for Attention-Deficit/Hyperactivity Disorder (ADHD) and their families.	ADHD represents a significant financial burden based on the costs of medical care and work loss for patients and relatives.
Kadesjö, 2002	ADHD in Children and Adults	To investigate the needs of ADHD children in the classroom	It is important for all schools to have the right support, such as student welfare team and a teaching assistant. The assistant helped many times teaching ADHD students when the problem occurred by taking one or two of the classroom to a study room where ADHD students can sit alone.
McLaughlin & Harrison, 2005	Parenting Practices of Mothers of Children with ADHD: The Role of Maternal and Child Factors	To assess the relation between the severity of child behaviors and parent characteristics for ADHD sample of children and their parents.	They found that the child disruptive behaviors lower the parents' sense of competence and decrease the social relationship.
Pineda & Palacio, 2007	Environmental Influences that Affect Attention Deficit Hyperactivity Disorder	To identify potential environmental risk factors for ADHD.	The risk factors associated with development of ADHD include premature birth, maternal respiratory infection during pregnancy, smoking, alcohol, asphyxia or anoxia, moderate brain injury, and febrile seizures.

Conlon & Strassle, 2008	Family Management Styles and ADHD: Utility and Implications	To demonstrate that FMSs could be reliably identified in a different clinical sample and clarify changes in FMS that occur with treatment for children and adolescents with ADHD.	FMSs can elicit important information about family functioning and may assist clinical understanding of the child-family interaction that in turn facilitates treatment.
Lin & Y Huang, 2008	The Experiences of Primary Caregivers Raising School-Aged Children with ADHD	To understand the experience of primary care givers raising school aged children with ADHD.	The results of this study show the importance of understanding the experiences of primary caregivers bringing up school-aged children with attention-deficit hyperactivity disorder. Improving professional services in family care should be an important issue for all health care professionals.
LaForett & Murray, 2008	Psycho Social Treatments for Preschool-aged Children with Attention Deficit Hyperactivity Disorder	To review the effect of preschool psychological intervention for children with ADHD and the training for the families.	Providing parent-training approaches, classroom management strategies, and multimodal treatments, parent-training intervention has the greatest overall support for improving behavioral outcomes.
Farah & Fayed, 2009	ADHD in the Arab World : Review for Epidemiological Studies	To review epidemiological studies on ADHD in all the Arab countries.	The results of the study showed that ADHD rates in Arab populations were similar to those in other cultures.
Deault, 2009	Systematic Review of Parenting in Relation to the Development of Co-Morbidities and Functional Impairments in Children with	To investigate the contribution of parenting factors, such as psychopathology, parenting practices and family conflict to various development	Results suggested that parental psychopathology and family conflict tend to be more strongly associated with oppositional and conduct symptoms than with inattentive or hyperactive symptoms

	Attention-Deficit/ Hyperactivity Disorder (ADHD)	outcomes in children with ADHD in previous studies.	
Huang & Lu, 2009	Effectiveness of Behavior Parent Therapy in Preschool Children with Attention Deficit Hyperactivity Disorder	To investigate the effectiveness of behavioral parent therapy (BPT) programs for children with ADHD using multidimensional assessments.	The behavioral parenting therapy (BPT) programs significantly improved children's behavior problems at home and inattention problems in school.
Cynthia, 2010	Raising a Child with Attention Deficit Hyperactivity Disorder: Exploring the Experience of Black Parents	To examine the experience of black parents raising children with ADHD.	The results suggested that ADHD is still misunderstood in the black population, the support from professionals is not satisfactory, and it showed the emotional distress of the parents due to child conditions.
Podolski and Nigg, 2010	Parent Stress and Coping in Relation to Child ADHD Severity and Associated Child Disruptive Behavior Problems	Examine the role of parents' distress and coping in relation to the childhood of ADHD.	The parents of ADHD children express more dissatisfaction.
Marian & Gerkensmeyer, 2011	The Described Experience of Primary Caregivers of Children With Mental Health Needs	To explore the experience of primary care givers for special needs children such as ADHD children.	There are many unmet needs to be addressed to improve the wellbeing of these caregivers, their children, and their families. Five themes emerged: struggling with the healthcare system, living in fear, burdened and exhausted, worry about the rest of the family, and good things happen sometimes.

Yousef, sh., Soltani,A 2011	Comparison between Parenting Stress and Parenting Styles in Mothers of ADHD with Mothers of Normal Children	To compare parenting stress among mothers of ADHD children and mothers of normal children.	There were significant differences in the stress level and parenting style between the ADHD mothers and mothers of normal children, using authorities style of parenting was found between ADHD parents.

Chapter Three

Methodology

3. Methodology

The epistemological position taken by the researcher for this study is phenomenological because it is the belief of the researcher that the specific data regarding the experience of raising a child with ADHD are contained within the care givers (mothers & teachers) that raise children with ADHD. Such caregivers know best how to describe such an experience. The researcher has therefore chosen phenomenology as a theoretical basis for this study.

3.1 Design

The design used was qualitative phenomenological descriptive design. This design used to study the lived experience of the people by describing the aspect of this experience by focusing on what exists. This design does not focus on interpretation for the experience but it will be an indicator for the people's thoughts and feelings (Wilson & Buttery Worth, 2000). Semi-structured interviews were conducted with teachers and mothers of each child.

Our chosen design is primarily based on a descriptive approach where our primary goal was to provide some explanation of how the mothers experience their daughter/son with ADHD and how the teachers experience ADHD children in the classroom. Since our underlying purpose is to alert a group at risk of being neglected and contribute the knowledge and

information of people who, through work or otherwise, come into contact with children with ADHD and their families (Egidius, 2006).

3.1.1 Giorgi – Phenomenological Psychology

The method used is descriptive phenomenological human science, which was found by Giorgi (1985). The aim of phenomenological psychology following Giorgi (1971) is to produce accurate descriptions of human experience. For this reason, phenomenologist operating within this tradition mainly utilise descriptions provided by others (obtained through interview) (Giorgi, 1985).

The purpose of Giorgi's phenomenological research is to capture as closely as possible the way in which the phenomenon is experienced (Giorgi & Giorgi, 2003b; Robinson & Englander, 2007) In Giorgi's work, phenomenology is used to look for the psychological meanings that constitute the phenomenon in the participants' life world. The idea is to study how individuals live, that is, how they behave and experience situations (Giorgi, 1985). Their descriptions are based on their experiences within the context in which the experience is taking place.

Central to this research is the lived context of the individual. The meaning of the phenomenon such as the experience of the adults that interact on a daily basis with ADHD child can only be revealed in its totality and its relationships with its particulars and therefore essences can only be seen in every constituent of the meaning. The role of the

phenomenological analysis is to discern the psychological essence of the phenomenon (Giorgi, 1985; 1989).

The process of research in phenomenology starts with the description of a situation as experienced in daily life (Giorgi, 1985). In trying to obtain these descriptions, a researcher sets aside any prior thoughts or judgment about the phenomenon under study. In so doing, the researcher brackets the phenomenon. The bracketing or the epoch is primarily undertaken in order to reveal the personal reality of the individual for whom the phenomenon under study appears (Ashworth, 1999). What need to be bracketed are those presuppositions that have to do with claims made from objective science or other authoritative sources (Giorgi, 1986; Ashworth, 1999). Phenomenology attempts to offer insightful descriptions of the way the world is experienced perfectively rather than the way it is conceptualized, categorized or reflected on (Van Manen, 1990). In this context, the ADHD is at the centre of the inquiry.

3.2 Study Participants

Phenomenology captures the phenomenon as it appears in daily life (Cosser, 2005). The participants sample was the primary custodian of the four children with ADHD, including mothers and teachers from the children's schools. The sample was purposive sampling in order to achieve the study goals. Four schools were chosen with children with ADHD. One student was chosen from each school, the mother of each child and three

teachers for each were chosen. In total, there are four mothers and twelve teachers (16 persons). Teachers who were selected are those who interact the most with the child in school.

3.3 Sample Size

The sample for this study is a purposive sampling (Polit, 2006). Purposive sampling refers to precisely what the name suggests in that the sample is chosen with a purpose in mind (Ritchie et al, 2003). The researcher chose participants because they have particular features that will enable understanding of the phenomenon under study (Ritchie et al, 2003). We have, through contacts and acquaintances, found the 16 informants (mothers &teachers) who can give their consent to participate in the study. According to the Giorgi method, three interviews are sufficient to achieve the purpose of the study (Giorgi, 1985). Semi structured interviews were conducted with the mothers, and with three teachers for each student. The total number of participants was16.

3.4 Inclusion Criteria

The mothers and teachers of :

- The children are between 7 -10 years of age, because the actual diagnosis cannot be done before that age.

- The diagnosis of ADHD has been done at least 6 months prior to interview.

3.5 Setting

The setting of data collection was both the school of the students and their homes.

3.6 Selection of the Study Instruments

The interview process followed a semi structured interview guide with different themes and underlying issues designed from the research purpose and question. The interview guide acted as a support for those important issues. It also served as a designator of the order in which different themes were to be addressed. We used the interview guide as a checklist to ensure that all the themes were brought up instead of letting the interviewer guide the conversation. This contributed to the relaxed and natural aspect of the interviews, as opposed to a form of hearing.

3.7 Data Collection

Interview subjects included both mothers and teachers to male and female children. The interviews were done in an isolated room in the school and at the home of every child.

The informants we interviewed obtained a consent form, which we retained, and an information form, which they had to keep. Collection was done through recorded interviews with 16 persons. Each interview was between 45-60 min, but even shorter descriptions exist, which in this study is that the interview began with a question about which the informant was

allowed to speak freely. We used as few questions as possible in order not to project the interviewer's own assumptions. Follow-up questions were asked only to get a more detailed and deep description (Robinson & Englander, 2007).

Sound quality was good on all recorded interviews which allowed that the interviews were easily transcribed. The interviews were transcribed verbatim and all identifying features were removed to ensure anonymity. All interviews were first listened through, printed and then similarities were recorded in a meaningful merger operation. Some quotes were saved in their original form.

Trustworthiness of the data was ensured by appropriate sample selection to ensure credibility, showing the logic flow of the data collection and analysis, and by verifying the findings with the informants to demonstrate fittingness, or transferability of the findings (De Laine, 1997; Holloway & Wheeler, 2002).

The semi-structured interviews with teachers reflected the experience of the teacher with the child. The interview focused on information about: performance in the school setting, including details of academic achievement as well as social functioning in relation to other children and staff; the ways and behavior the teacher used to address the inattention, impulsivity and aggression; the resources available in class to help the teacher to meet the needs of the child; pedagogical methods, resources, and

support; and social relationships and routines in relation to the students in question. The interview also focused on if the teacher made use of special methods or approaches, special materials or other resources to work with these students, what methods or approaches were used by the teacher to include students with ADHD in a regular class, and what aids in the form of materials, methods and resources were needed for students to develop their learning.

In the interviews with the mothers, the experiences of the mother's condition, its impact, handling (coping of parenthood / life), perceptions of social support in everyday life and family patterns were present. Issues surrounding the student's day-to-day life were explored, focusing on their styles to manage the child's behavior, we asked for details of the history of the child's current problems, the nature of the symptoms (frequency, duration, situational variation) and sleep disorders may be reported in up to 50% of children with ADHD and any associated behaviors. Information about the importance of students' daily routines, and interaction between school and home was also solicited. As a result, research focused on the holistic approach that provides for the child in school and at home. We avoided asking leading questions, but rather sought concrete descriptions of events, feelings, etc.

The initial question to the mother was: What is your experience of being a parent of a child with ADHD?

The initial question to the teacher was: What is your experience of having a child with ADHD in your classroom?

3.8 Data Analysis

Phenomenological psychologists analyse the data utilising a systematic and rigorous process. Data analysis consists of four consecutive steps where each step is a prerequisite for the next (Robinson & Englander, 2007; Giorgi, 1985b, 1997). Prior to the analysis each interview is transcribed verbatim. All steps in the analysis must be performed within the phenomenological reduction (Robinson & Englander 2007; Giorgi, 1997). Phenomenological reduction is used in descriptive phenomenological analysis and requires bracketing as a first step (Kleiman, 2004). According to Giorgi, bracketing/epoch implies not taking a stand for or against but allowing the phenomenon to emerge (Groenewald, 2004).

Phenomenological reduction also requires withholding any existential claims and presenting data as it present itself rather than making one's own conclusions about what is presented (Kleiman, 2004).

For essay writing, we continuously address theory, method and purpose of the essay and the question as coherent and not as separate parts. The analysis of the material was already in progress from the time we started the collection of material. The thought of how we will analyze the collected material had been with us from the beginning of the choice of

qualitative method. Designing the interview guide is a breakdown of the various themes in addition to background information.

Step 1: Getting the sense of the whole statement by reading the entire description

The entire interview protocol was read several times in order to get a sense of the whole experience. The idea was to obtain a description, not to explain or construct (Giorgi, 1989). Wertz (1985) suggests that readers should see raw data as well as processed data.

The first reading, done in the natural attitude (i.e. the everyday attitude) told the researcher to more actively identify and critically examine his/her own interests, creditors learned, theories, hypotheses and existential assumptions about the phenomenon and then set them in brackets (Giorgi, 2005).

If certain passages of the collected material are unclear, it is important that the author does not pad them with their own interpretation, but instead goes back to the interviewee and asks for clarification descriptions. If the author is unable to collect further information about them, he/she will be later forced to describe the uncertainties that exist in the data. Ambiguities and contradictions in the data may not be reduced or declared the basis of possible interpretations, but must always be described as such (Robinson & Englander 2007; Giorgi, 1985, 1997).

Step 2: Discriminating meaning units within a psychological perspective

After going through the first step, Giorgi (1986) suggests that the whole description should be broken into several parts to determine the meaning of the experience and these are expressed by the slashes in the texts (Giorgi, 1985) or by numbering of lines (Wertz,1985). Parts that were relevant to the phenomenon that is being studied were then identified. The process of delineating parts is referred to as meaning units, they express the participant's own meaning of the experience, and they only become meaningful when they relate to the structure of all units (Ratner, 2001). A word, a sentence or several sentences may constitute a meaning unit.

Each meaning unit is constituent and therefore focuses on the context of the text (Giorgi, 1985). The meaning units are correlated with the researcher's perspective and therefore two researchers may not have identical meaning units (Giorgi & Giorgi, 2003a). This process takes place within what is called reduction. It is important in phenomenological psychology to withhold the existential judgment about the experience of the participant.

Step 3: Transforming the subject's every day expressions into psychological language

The researcher returns to all of the meaning units and interrogates them for what they reveal about the phenomenon of interest. Once the researcher grasps the relevance of the subject's own words for the phenomenon, the researcher expresses this relevance in as direct a manner as possible. This is called the transformation of the subject's lived experience into direct psychological expression. This is the step that makes it clear through the description of the intrinsic meaning in the material. Furthermore, the researcher must make clear the implicit meaning of meanings which the text points to, i.e. make explicit what is implicitly given. For that, transformation must be kept at a descriptive level. It is essential, however, that it does not go beyond what is directly given in the data.

Step 4: Synthesising transformed meaning units into a consistent statement of the structure of the phenomenon.

This step is to make the meaning units coherent and synthesized by relating them to each other to have meaning statements. Specific statements are written for individual participants and a process of analysis is used whereby common themes across these statements are elicited and then form a general structural description, which becomes the outcome of the research. (Robinson & Englander 2007; Giorgi 1985, 1997).

Sentence structure consists of the elements identified in the previous step and understood through their relationships and the way in which they are related to each other. Sentence structure is achieved by the researcher as in step three, making use of imaginary variations to arrive at the final sentence structure that cannot vary. All data must be considered and the researcher must also have been adhering to a purely descriptive language. If there are contradictions or ambiguities in the material, this shall be described but not explained or understood in terms of interpretations, theories, hypotheses or other existential assumptions. If the context and other contextual factors are relevant to the phenomenon, this must also be described. There are three levels at which the structure can be described. The first level is the individual structure that is based on a description from an informant. The second level is the general structure that can be achieved by having multiple descriptions (usually three). At the third level we find the universal structure, which is located on a philosophical level. To find the general structure is always desirable when it can be generalized to other people experiencing the same type of phenomenon.

Once the description of the psychological structure of each individual had been identified, the researcher looks at statements that can be taken as true in most cases.

3.9 Pilot study

The above method was tested in the pilot study. The pilot study involved one informant. The school director chose one teacher of an ADHD child who asked to participate in the study. We contacted the teacher and informed him about the study orally and submitted in writing information for research (Annex I). The agreement was available at interview. The interview was done in an isolated room in the school. The interview was taped and the text was treated in accordance with the above analysis. This pilot interview might be included in the study sample.

3.10 Trustworthiness

Trustworthiness of the study focuses on methods to ensure that the researcher has performed the research process correctly (Sparkes, 1998). Trustworthiness criteria include credibility, transferability, dependability and confirmability (Sparkes, 1998).

3.11Credibility and dependability

Matters relating to the implementation of interviews and analysis can say something about the survey's reliability. Before the interviews, the authors write down what they expected to find in the survey and be conscious of how their backgrounds might color the survey. The authors could thus limit their expectations by bracketing their previous knowledge (Robson, 2002).

The authors may, by making themselves aware of their own attitudes, become better listeners who try to put themselves aside and take the dialogue partner seriously. All interviews were recorded on a tape and transcribed verbatim. This made the survey more credible than if the authors had only taken notes during the interview (Robson, 2002).

Credibility refers to the trustworthiness of the data collection, analysis and conclusion (Sparkes 1998). To ensure credibility, the researcher therefore relied on the supervisor as a critic (Cosser, 2005). Furthermore, the participants were informed through the consent form that they would receive written feedback on the research report should they so wish. Credibility of the data may also be related to whether respondents tell the researcher the truth (Malterud, 2003). In this study we are looking for experiences of mothers and teachers of ADHD children. An experience is subjective and thus true for the one who tells it.

The teachers and the mothers were asked if the authors really got something out of this when she had told her history. The analysis and presentation of findings were made in a credible manner.

We followed analysis model of Giorgi (1985) as described and tried to be true to the stories of the mothers and teachers. We selected in this study the phenomenological approached to the theme, which gave us more aspects to the findings. Using a developed analytical model gave us the opportunity to test the analysis that was done (Robson, 2002).

The author could discuss interpretations and reflections with their supervisor and another specialist in clinical psychology at the transcription and interpretation of material which increased the reliability of the survey (Kvale, 1997). The author has also tried to ensure reliability by clearly defining a purpose and clear questions. Reporting methodology, selection criteria and implementation of interviews and analysis of the collected material is likely to increase the reliability of the survey.

Having ensured credibility, which is more concerned about the validity of the study, it is not necessary to demonstrate dependability separately (Babbie & Mouton, 2001).Where there is credibility, dependability is also ensured. Dependability deals with the reliability of the findings. For findings to be dependable, they must be predictable and stable (Lincoln & Guba, 1985).

3.12 Evaluating the quality of phenomenological research

When presenting phenomenological research, its value is established by honoring concrete individual instances and demonstrating some fidelity to the phenomenon (Wertz, 2005). Research reports may, for example, contain raw data such as participants' quotations providing an opportunity for readers to judge the soundness of the researcher's analysis.

The quality of any phenomenological study can be judged in its relative power to draw the reader into the researcher's discoveries allowing

the reader to see the worlds of others in new and deeper ways. Polkinghorne (1983) offers four qualities to help the reader evaluate the power and trustworthiness of phenomenological accounts: vividness, accuracy, richness and elegance. Is the research vivid in the sense that it generates a sense of reality and draws the reader in? Are readers able to recognize the phenomenon from their own experience or from imagining the situation vicariously? In terms of richness, can readers enter the account emotionally? Finally, has the phenomenon been described in a graceful, clear, poignant way.

3.13 Ethical consideration

The study was approved by the Ministry of Education and An-Najah National University's Institution Review Board (IRB). Consent was obtained from informants to take part in the study (Annex II).

The informants who wished to attend were informed both verbally and in writing (Annex I & II) for the purpose of the interview and study. At the same time, the agreement was made at the time of the interview. The informants were informed that the interview would be conducted in a private room with just the informant and the interviewer present and that the interview would be recorded by tape recorder and that no individuals would be identified after text processing. Information on all bands and prints of the text would be stored under the current rules in locked cabinets. The informants were also informed of the voluntary nature to participate in

the study and that at any time they could stop the interview and that this would not affect them in any way.

On the information sheet there are telephone numbers of the interviewer and supervisor in the case that any issues would arise if the informant felt the need for further discussion.

These considerations are based on the Helsinki Agreement (World Medical Association. Helsinki Declaration, 2008) on ethical guidelines for nursing research, based on volunteerism to withdraw from the project, potential risks or discomfort, anonymity, confidentiality and contacts for any information needed.

Phenomenological studies are always retrospective (Hedelin, 2001a). The mothers and teachers will tell their stories of adventures. To construct the stories seem to be a natural human process that assist individuals in understanding the experiences and themselves (Pennebaker, 2000). How can it be a health effect for informants to participate in the survey? There is a significant, positive, consistent and identifiable relationship between talking about emotional difficult experiences and health. To construct their own history is a type of knowledge that helps to organize the emotional effects of experience as well as experience in itself. Audio recording, for example, might be perceived as unpleasant for some people and therefore we are always asked for permission. Being able to tell their history can be

experienced as healing in itself. At the same time it might give some benefits for other parents and teachers in the same situation as a whole.

By telephone calls the mother of each child was informed to obtain consent to conduct the interview. We were very clear to explain to informants that their participation in the study be kept confidential and that the information that we have served will not be disclosed to anyone else and that the material will only be used in this study and that when the investigation is completed, the interview material will be destroyed and sound recordings erased. We also announced that the informants will be made anonymous in the presentation of the results.

The informants' identities were protected fully. No names or other information that may reveal informants' identities were reported. Our intention has been to maintain a moral researcher behavior, which means not just ethical knowledge but also includes our personality, sensitivity and commitment to moral issues and actions.

Chapter Four
Results

4. Results

The purpose of this study is to explore the experience of primary health care providers of Attention Deficit Hyperactivity Disorder children, which are mothers and teachers, and the management practices with behavioral disturbances of the children. The selected sample was 4 children (two males and two females) from different schools. We took into account the child diagnosed with ADHD according to the criteria provided by DSM-IV ADHD diagnosis. Children were between 8 and11 years of age and all children had been diagnosed with ADHD for more than 6 months. We conducted 16 interviews, four interviews with mothers, and 12 interviews with teachers (three teachers for each child).

The teachers selected were teachers who had taught the child for duration of at least 6 months and most of them had at least 3-4 classes every week with the child. We analyzed the teachers´ interviews and mothers´ interviews separately.

4.1. Mothers interviews results:

From the mothers´ interviews, three themes and nine sub-themes emerged: child care is a burden (academic track burden, activities of daily life burdensome, psychological and emotional burden); inadequate support (lack of support from the father, relatives, schools, and community); and disturbances in the child's behavior (hyper activity, impulsivity, inattention, and hostility). Themes and sub themes that emerged are presented in Table2.

Table 2. Themes and sub themes that emerged from mothers' interviews

Subthemes	Themes
1. Academic track burden 2. Activities of daily living burden 3. Psychological and emotional burden	I**. Burdens of caring**
1. Lack of support from father and relatives 2. Lack of support from schools 3. Lack of support from community	II. **Inadequate support**
1. Hyperactivity 2. Impulsivity 3. Inattention 4. hostility (physical &verbal)	III. **Features of ADHD**

I. Burdens of caring (The first theme)

Three types of burdens were experienced by mothers who are caring for ADHD children: academic track burden, activities of daily living burden, and psychological and emotional burden.

I.1 Academic track burden

Mothers face many difficulties in the child's academic track. In this study it was very clear that it is the difficulty for the child to concentrate, especially during the conduct of homework, that has been very stressful for mothers and it consumes a lot of mother´s time.

One of the mothers expressed this as follows:

"The time for studying is a hard time for me, it takes one to two hours to make her sit down and start homework without completing it" M2

The problem of inattention of the child makes the quality of studying time ineffective. So the problem of inattention affects the child's academic achievement, and increases the difficulty of taking care of the child. One of the mothers expressed this as follows:

"When I ask him to sit to do homework, he sits for a short period of time, whether he looks at something in the room, or plays with his hands, and I find that he did not understand what was said" M3

The mothers believe that despite the effort they make, and the time they spend with the child to study, the child's academic level is still very poor.

"The curriculum is getting harder and harder, and I faced many difficulties in finding appropriate ways to let him study. His academic level remains very poor "M4.

In summary, mothers face difficulties in making the child sit and study; it was clear in this study that the mother is the only one responsible to ensure the child studies, so for this reason, the child's study is a heavy burden for the mother.

It is difficult for mothers to make their children stay and complete school work, and difficult for them to cope with school work at home. They

face learning disabilities in their children, and they have no faith in the learning abilities of their children.

I.2 Activities of daily living burden

Daily activities are another problem faced by mothers. The child can not complete anything without help from the mother, who experiences a load on her.

"He cannot complete anything without my help, and this is an extra burden for me"M3.

"When she puts on her clothes, she doesn't arrange them, so I should help her"M4.

Sleeping problems like sleeping too late, playing at sleeping time and waking up too late create stress at home. It seems to be an annoyance for the family. One of the mothers expressed this as follows:

"She sleeps very late, at the time of the other´s sleeping. She makes noise. She wants to play and moves from one place to another. Her father becomes angry and sometimes hits her. The most stressful time for me is in the morning when she wakes up very late" M4.

One of the mothers experienced that the child has poor eating habits (refuses to sit at the table to eat, refuses to eat most types of food, eats unhealthy snacks like chips and chocolate), which puts an extra burden on her.

"Her diet is very poor, she eats chocolate and crisps or sandwiches so I force her to eat and drink good things like milk." M1

"She's hard to make eat; we use to give her some of food supplements" M3

In summary, mothers' burden refers to the difficulties in setting up a normal daily routine, and the fact that their children are very demanding.

I.3 Emotional and psychological burden

This burden includes the mother's experience of the child's behavior, including feelings of frustration and being shocked at the time of the child's diagnosis. Frustration and anger is felt because of the difficulty in organizing tasks and activities, as is powerless, desperation and worrying about the future of the child and that the child's condition will get worse with time. One of the mothers expressed this as follows:

"When the doctor told me that the child has indictor for behavioral disorder, it was very upsetting for me, because I thought it is normal for a child to be hyperactive"M1

The stress that mothers experience every day because of the child's behavior and inability to control this stress makes one mother angry and nervous, causing her to behave negatively to the child as she beats her and after that she feels guilty. Anger towards the child with ADHD is a common feeling among mothers.

“***Sometimes I feel very stressed and angry when I see that she cannot do anything properly, I hit her and after that I feel guilty."***

The poor improvement in the child's condition over time and to be the only person who can handle child's behavior makes the mothers worry about how the child’s future will continue to be. One of the mothers expressed this as follows:

"I cannot imagine what his life would be without me, he still cannot defend himself, he has nobody to support him "M3.

Another thing that makes mothers worry is the nature of the problem being chronic, so the child will never be a normal person in the future.

"The biggest thing that makes me worry is that her situation is the same as before, and this problem is chronic." M4

These realities of the child create a sense of powerlessness, and losing hope that surly affect the care that the mother gives to the child as reflected in the following:

"I feel less power to do something, and munch desperation and I do not expect that she will improve"M4

In summary, the emotional burden was the main topic discussed by mothers. It was clear that they are in need of much support and encouragement to assure a good future for their children. Emotional and

psychological burdens refer to the range of mothers' emotions experienced while caring for their ADHD children.

II. Inadequate support (The second theme)

II.1.Lack of support from the father and other relatives

The lack of support provided for the mothers in the child care from the fathers and relatives make the care of the child more difficult. This forces the mothers to be the only person responsible for child care. The fathers played a negative role in the management of child care, and do not pay enough attention to his child, which makes the mothers avoid asking for help from the fathers, as expressed by one mother in the following:

"Her father does not help* with *anything, and I do not like him to deal with her because he cannot tolerate her, he yells at her"M2

The lack of support from the fathers leads to conflict between spouses. The fathers do not seem to understand the child's needs and he expects the child to behave normally.

"My husband expects her to behave like her siblings, and it is impossible. He gets angry because he cannot be patient with her like me and he has no time to share with her care." M4

The mothers experience a lack of relatives' support as well. They think that the child is a bad boy and cannot tolerate the child's behavior. This makes the mothers feel outcast. The mothers experience that there is a

misunderstanding of the nature of the disease by the relatives. Two mothers expressed this as follows:

"Most people do not think he has a disorder, they think he is a bad boy and aggressive so that they do not understand his behavior" M2.

***"I avoid going to her grandparents, they do not tolerate her behavior, especially that she becomes more hyperactive outside the home"* M4**

In summary, most of the mothers experienced that their husbands took less responsibility than they did in taking care of the ADHD child.

II.2 Lack of school support

It was clear that there is a lack of coordination between mothers and children's schools, and the mothers experience that their children are neglected and ignored by teachers and the teachers are unsympathetic in their attitudes. One mother expressed this as follows:

"I feel so bad, I know that there is no care at school, I know that teachers get her out of the class most of the times, but I cannot transfer her to another location. They do not try to give her special materials; I think she just needs extra care that the school does not give to my child"M4.

The mothers feel very bad because the school does not provide their children with a good education and their children are even punished and beaten sometimes by teachers. One mother expressed this as follows:

"Most of the times, when I visit him at school, I find him out of the class, he told that they hit him,* so *I have no feeling that he is safe at school, they do not care about him"M2.

The mothers feel that there is no cooperation between the schools and mothers. Mothers stated that they do not trust the school because they feel that the teachers at school do not give any regard to the child's special needs. The teachers are ignorant, unprofessional and unsympathetic. One mother expressed this as follows:

"At some point when he makes a part of the homework, I expect the teachers to understand, but they beat him, and every time I go there they just start complaining. So from the beginning of this year I did not go to school".

II.3 Lack of community support

The mothers mentioned that there are no specialized centers to care for the children and there is a deficiency of experts in the field of ADHD. Added to this is misunderstanding of the child´s status by the society, which makes the mothers avoid even going out with the child. One mother expressed this as follows:

"People think she is mentally retarded, especially that she has abnormal movements, so I avoid taking her with me."M3

"Until now I have not found a specialized person to guide me as to how I should handle him." M1

Lack of community support refers to a lack of supportive resources for helping the mothers to accept and bring up a child with ADHD. The mothers complain that they don´t receive adequate support by health care providers. It was hard for them to understand the problem that their children have, what they should do, or where they should get assistance. One mother expressed this as follows:

"The ministry of health doesn't care for our children and doesn't provide any services for them" M1

III. Features of ADHD (The third theme)

The three symptoms of Attention Deficit Hyper Activity Disorder (hyperactivity, inattention and impulsivity) have been clearly demonstrated in this study in addition to other behaviors like disruptive behaviors. Behaviors of children with ADHD have a great effect on the mothers' lives and the relationship between mother and child. The behavioral problems of the child were a very important part of mothers' experience as they live the situation every day.

III.1 Hyperactivity of the child

The hyperactivity that increases the child's abnormal and disruptive movement as if he/she is driven by a motor could be dangerous for the

child and his/her or her siblings. This problem was mentioned as prevalent for the mothers at home, which creates a hardship and tension in the domestic atmosphere. Mothers expressed this as follows:

"She makes the home noisy, I cannot control her, she sometimes hurts herself by falling down during her movements all the time …she has broken many things in the home ..it is a very stressful every day situation" M4

"When he started playing and jumping, I did not control him or deal with him and his activities increased when other children were around".M1

"He cannot sit still and just wants to play all the time, I know it is involuntary, but he makes home noisy" M4

III.2. Inattention

Mothers feel that their children have difficulties maintaining and focusing their attention, which lead to poor academic performance and problems with staying on task and staying in their seats. As expressed by one of the mothers:

***"The first thing that appears clear is that she does not sit, if I force her to sit, she sits for a short period of time, she does not listen to me, I forced her to sit to study, and she did not complete anything"* M3**

III.3. Impulsivity:

Impulsivity refers to an inability to control emotions and movements, like not being able to monitor needs and getting angry very quickly. The physical and emotional impulsiveness that has been demonstrated in this study expose the child to accidents and trauma. Mothers worry all the time for the children's safety.

"She is unable to control her urges. When she wants something, she should have it" **M1**

During her motion she hits things in front of her, she also controls her anger by shouting, and breaking things when she gets upset "M2

III.4 hostility (verbal & physical)

Mothers complain of the hostile behavior of children with siblings and peers, an issue that creates conflict between the child and his/her siblings. This aggressive behavior creates also a poor relationship between the child and his/her peers, resulting in the likelihood of the child being excluded. It also appears that the child's inability to express his/her emotions in the correct way leads him/her to violence, and the child's inability to control jealous feelings make him/her beat siblings.

"He feels jealous when I talk with his brother, and when they start playing they make problems after a short time. He hits his brother, and I feel like no one likes him" M3

In many cases the violent behavior of the child allows the mother to isolate the child and prevent him/her from playing with other children, as expressed by one participant in the following:

"I prefer not to let him play with others because he creates problems. To avoid that I let him play alone "M3

We note from the results that the child sometimes use violence, especially verbal violence when he finds difficulty defending him/herself; one mother expressed it as follows:

"When he cannot defend himself, he says bad words. As a consequence of the child's bad behavior, the teachers hit him" M1

In addition, we have discussed in the interviews the management practices that are used by the mothers to handle the child's behavioral disturbances, which include: negative practices (punishment & beating), positive reinforcement (presents & speaking nicely) and neglect.

Mothers declared that the child's behaviors listed above cause anxiety and stress for both parents, especially the mothers, as shown in the results. Management practices have varied, one by negative reactions such as beating the child by parents and the other has provided a good result that was positive reinforcement, including giving the child a favorable object or giving a present when he/she behaves well.

“I bring a favorite object for her if she obeys me"M2

Another method used - to reward the child with kind words and pleasant speaking - appears to have relatively good effects.

"***I cannot manage his behavior any more. I try to give him things that he likes, and to speak nicely with him, it works sometimes, but for a short time*****." M4**

The parents have used negative practices that prevent the child from the favorite object and beating the child, but these strategies appear to increase the intensity of the child's bad behavior, and often his/her response is negative.

"***When I get nervous and prevent her from watching TV, she starts screaming and sometimes breaks things"***

Awareness of the mother that the behavior of the child is involuntary and the child cannot control it makes the mother feel guilty when punishing the child.

"Sometimes I feel very stressed and angry when I see that she cannot do anything properly, I hit her ... and I feel guilty" M2

Some of the mothers reported that they neglect certain behaviors and try not to react every time to the child's behavior.

"I cannot follow each movement so I let him some times to do what he wants" M3

Table 3: Management practices used by the mothers

Management practices used by the mothers	**I. Positive reinforcement** **II. Negative reinforcement** **III. Neglect**

Table.4: The analysis of mothers' interviews

Meanings Full units	**Condensation**	**Subthemes**	**Themes**
"it's difficult for me to make the child sit still and just wait to finish his / her home work, and he / she gets bored after a short time"	being unable to stick to tasks	**I.1 Academic track burden**	**1.Burdens of caring**
" The time of studying is a difficult time for me, it needs one to two hours to make her / him to sit down and start homework, and most times without finishing"	Difficulty in managing school homework		
"curriculum becomes more difficult, and I faced many difficulties in finding appropriate ways to get him to study"	learning difficulties		
"In the days of exams, I do not send her to school, because I know what the outcome will be."	Lack of trust in the ability of the child		
"I should prepare special food for her, she refuses to eat	Demanding	**I.2 Activities of daily living burden**	

most types of food"			
"she sleeps very late , and at the time of the other´s sleeping she makes noise, she wants to play and moves from one place to another. Her father becomes angry and sometimes hits her, it's the most stressful time for me, in the morning she wakes up very late"	Difficulties in setting up a normal daily routine like sleep disorders		
"When the doctor told me that the child has indicators for behavioral disorders, it was very upsetting for me, because I thought it´s normal for a child to be hyperactive"	Frustration	**I.3 Psychological and emotional burden**	
"When she starts to scream or she breaks something, I do not control my emotions and I feel so frustrated and hit her or get nervous."			
"It was the first time I heard about this disorder, I never expect this. I was shocked".	Shock		
"I was worried, the doctor said to me that we can deal with the situation, but I need someone to give me more information "	Acquire more information		
"I cannot imagine, what his life would be without me, he still cannot defend himself, and he does not have someone to support him"	Worry		

"Sometimes I feel very stressed and angry when I see that she cannot do anything properly, I hit her ... and I feel guilty."	Stress and anger		
“I feel powerless to do anything, and much despair. I do not expect that she could be improved"	Powerlessness, Despair		
"I live in this bad situation alone every day, no one understands my experience, not even her father. He does not share with me in anything relating to her care. He just wants her to be normal"	The mother is the only person responsible of child care	**II.1 Lack of father & relatives support**	**II. Lack of support**
"I avoid going to her grandparents, they do not tolerate her behavior, especially that she becomes more hyperactive outside the home "	Refusal		
"I avoid going to her grandparents, they do not tolerate her behavior, especially that she becomes more hyperactive outside the home "			
"At some point when he does a part of the homework, I expect the teachers to understand, but they beat him, and every time I go there they just start complaining. So from the beginning of this year I did not	unsympathetic	**II.2 Lack of school support**	

go to school.			
"I feel so bad, I know that there is no care at school, I know teachers send her out of the class most of the times, but I cannot transfer her to another location. They do not try to give her special materials; I think she just needs extra care that the school does not give to my child. "	Negligent & unprofessional		
"until now I have not found a specialized person to guide me in how I should deal with him "	Deficiency of experts in the field of ADHD	**II.3 Lack of Community support**	
"The ministry of health doesn't care for our children and doesn't provide any services for them "	Lack of services by health care professionals		
"She makes the home noisy, I cannot control her, she sometimes hurts herself by falling down during her movements all the time …she has broken many things in the home ..it is a very stressful every day situation"		**III.1.hyperactivity**	**III.Features of ADHD.**
"The first thing that appears clear is that she does not sit, if I force her to sit, she sits for a short period of time, she does not listen to me, I forced her to sit to study, and she did not complete anything"		**III.2. Inattention**	
"She is unable to control her urges. When she wants	Impatient	**III.3 Impulsivity**	

something, she should have it"			
"During her motion, she hits things in front of her, she also expresses her anger by shouting, and breaking things when she gets upset."	Temper outbursts		
"He feels jealous when I talk with his brother, and when they start playing they make problems after a short time. He hits his brother, and I feel like no one likes him."	Alienates existing relationships Poor relationship		
"She is aggressive and she is not integrated into the team when playing. I am used to keeping her away from her siblings and other children because she hurts them sometimes. At school, she is isolated from other students, and they keep her away."	Isolated		
"When he can`t defend himself, he says bad words, and this makes the teachers beat him."	Blurt out Inappropriate comments	**III.4 hostility**	
She often destroys her toys. When they call me at school, they are always complaining that she hits the students"	Inconsolable		

Table 5. Demographic data of the mothers of children with ADHD

	Age	**Education**	**Job**	**Child gender/age**
M1	49	Elementary school	House wife	Male / 9 years old
M2	32	University	House wife	Female / 10 years old
M3	32	University	Teacher	Male / 8 years old
M4	34	Secondary school	Hair dresser	Female / 9 years old

4.2. Results of the teachers' interviews

The teachers' interviews were conducted in four governmental schools in Nablus city; the selected sample was12 teachers. We choose three teachers for each student so that we could have extensive experience of teachers of ADHD children and their methods of management for the child's behavior. The author selects teachers of different courses. Five major themes and their subthemes emerged from the teachers' interviews.

Table .6: Themes and subthemes that emerged from the teachers interviews:

Themes	Sub themes
I. Lack of information	**1.1.Lack of information about the nature of the disease** **I.2.Lack of information on student health and follow-up** **I.3.Lack of information about the ideal method for dealing with the child**
II. Child's behavior is disruptive	**II.1 Inability to follow class rules** **II.2 Inattention & Impulsivity** **III.3 Obscene using verbal abuse & using physical abuse**
III. Lack of resources	**III.1 Lack of time** **III.2 Lack of materials and experts**
VI. Lack of support	**IV.1 Lack of Ministry of Education system support and school team.** **IV. 2 Lack of parental support**
V. Burden of having the child in the class	**V.1 Burden of managing the safety of the child** **V.2 Burden to calm the child & the other students** **V.3 Emotional burden**

I. Lack information (The first theme)

I. I Lack of information about the nature of the disease

The lack of information was not only about the child's health but also about ADHD as a disorder. Most of the teachers do not know what ADHD is; some of them had not heard about this problem before, and the others have disguised the fact that most of the children have hyperactivity. One of the teachers expressed this as follows:

"I do not know anything about this problem, actually I did not hear about it before"

Some of the teachers have misconceptions about the issues that show that it is mental retardation or children with ADHD are less than others his/her age (problems in mental development). One of the teachers expressed this as follows:

"What I know about hyperactivity disorder is that this problem is mental retardation"

"The children with ADHD are less than their actual age on their mental maturity and need special care"

I.2 Lack of information on student health and follow up

Teachers have a lack of information about the child's condition. Their information is mainly built on their own observations when they notice that the child has abnormal behaviors

"I begin to notice when I start to teach him that his behavior is not like his fellow students, but no one told me before about his situation"

The teachers have a lack of information on the treatment of the child. Most of the teachers have no idea if the child is using medication or not and what medication or what its effects could be. One teacher expressed this as follows:

"I have no idea if the child is taking any medication, or if he is followed up by medical doctors"

I.3 Lack of information about the method for dealing with child

Lack of information on diagnosis and on the children's health situation affects how teachers react to the child's behavior because most of the teachers reported that they have a lack of information on how to answer the child's needs. They understand that their practices to children are mostly unsuitable, but they do not have or know other options. One teacher expressed this as follows.

"None of us and not even a social worker is trained to deal with such cases"

"I feel that my response to her behavior is wrong, but I really do not have other options"

These two examples show that there is a lack of information for teachers and also for social workers in schools to deal with ADHD children.

II. Child's behavior is disruptive (The second theme)

II.1 Inability to follow class rules

Teachers complained that the children do not follow the rules and instructions of the school, and do what is forbidden to be done in the classroom. This creates problems in the class. The teachers said that the children eat during class session, and leave their seats and the classroom without permission. These behaviors cause stress for teachers.

"She makes me very stressed when she leaves her place and even leaves class without permission"

Inability of the ADHD student to concentrate on what is said in the class was one of the most obvious problems. The child either plays with paper and pencil, or sings while the teacher explains the session to all students.

"***Most of the time whether she is playing with her pen and paper or singing in a low voice, she does not look at me when I speak"***

In other situations the child looks at the teachers when they teach but in reality his mind is completely absent, and he/she does not take in what the teachers say.

"He seems to see me, but in fact his mind is away"

"When I ask him about what I explained, he cannot answer"

The child cannot complete any work in class; teachers say that when they give the child some work to do in class, he/she needs a long time to start, and usually he/she does not complete it.

"I give him work to do it in class, when I return to him he has only written one or two words and then stopped"

II.2 Impulsivity & inattention

Impulsivity is one of the three main characteristics of ADHD. Teachers describe that the child falls down and hits the desk or table during movement. This problem is related to the inability of the child to coordinate his/her movements.

"Her movements are not organized, she hits the desk while running and falls down, she pays no attention to what is in front of her"

The teachers said that the child becomes angry and nervous about simple things and he/she cannot control his/her emotions. The child gets

upset if the teacher does not give him/her a full score. This anger makes most of the teachers obey what the student wants just to calm him down.

"He becomes angry and nervous very quickly, so I try to avoid the wrath of him"

II.3 Obscene use of verbal abuse & use of physical abuse

One of the most disturbing problems for the teachers is when the child hits the other students for no reason, and when he/she also says bad words. This creates problems between students. The child is not able to control his/her anger and he/she sometimes throws objects at other students. Some of teachers expressed this as follows:

"He is a troublemaker in the class; he hits the students and could seriously harm them"

"She throws objects at students"

III. Lack of resources (The third theme)

The lack of resources including either time, trained staff that can help or even material to facilitate childcare is another issue for teachers.

III.1 Lack of time

The teachers experienced that there is no time given for students with ADHD and the time of the class is not enough so it's impossible to give ADHD children extra time to do what they have to do.

"The time for the class is very limited, and he needs more than 5-10 minutes each time I enter the class"

III.2 Lack of materials and experts

There are no adequate facilities in schools to help teachers improve the academic achievement of the child. The lack of necessary materials in schools causes teachers to face many difficulties in childcare. One of the teachers expressed this as follows:

"There are no special materials or even special curriculum assigned to the student, we deal with him just like the rest of the other students and it's not fair for him"

The teachers expressed their needs for trained people to help them to cope with the child in the class. One of the teachers expressed this as follows:

"We really need a person who must be in the class all the time to address the child's behavior, so that we can follow up our session in the class as usual"

IV. Lack of support (the fourth theme)

IV.I Lack of support from the Ministry of Education and school team.

Lack of support from school principal, counselor, Ministry of Education, and parents were the major accusations of teachers.

The teachers said that the head of the school doesn’t help much in the child's follow-up, when they send the child to him/her, he/she usually sends the child back and asks the teachers to deal with the problem. This really upsets the teachers. One of teachers expressed this as follows:

"When I sent him to the school director, he sends him back to the class and says he cannot do anything"

The teachers experienced that even the counselor who would be the specialist person in the school do not help much. The teachers said that when they ask for help, he/she replies that he/she can´t do anything.

"counselor are not trained to handle these children, all he does is he takes the child to his office and lets him play, but he does not do any type of management"

It seems that the counselor can’t handle the child's behavior, and just finds ways for the child to pass time. This inability to help is based on the lack of training for social workers and teachers as well.

The Ministry of Education (M.O.E) does not provide any type of training for teachers to support them to address the ADHD children in school. The teachers expressed during interviews that the M.O.E does not follow up with the students with ADHD or monitor them:

"*The ministry of Education has never sent people to check the situation of these children, to see if they benefit from school*"

IV.2. Lack of parental support

The teachers experienced that the parents of the children do not make visits to the school to assess the conditions of their children, not even when the director asks them to come. Most of the time they complain that the teachers do not provide care for the child as it should be. Some of the teachers expressed this as follows:

"In the beginning, the mother came every day to school, but gradually her visits decreased and even when we call her she makes excuses"

"Her mother came to school to fight or blame us about her daughter's marks or as she said - our negligence"

<u>The fifth theme</u>

V.1 Burden of managing the safety of the child

It is very stressful for the teacher to take on the responsibilities of the child in school. Teachers felt that children with ADHD perform very dangerous acts and he/she may be harmful to him/herself and the other students, so teachers must keep an eye on the child all the time.

"His movements are very dangerous, so I should be alert all times, even in the garden"

V.2 Burden of calming the child and the other students in the class

Calming down the child was perceived by the teachers to be very difficult. The teachers felt that they had to calm the child in the class and to deal with the other students who react sometimes to the child's behavior. On the other hand, teachers have to complete the tutorial which they must give to students. The child with ADHD causes distraction to other students, but the teacher must guide everyone in the class. Teachers are worried about the other students. Teachers experience that other students are distracted because of the child's behavior and feel guilty because they cannot teach the curriculum that should be completed. This is expressed by some of the teachers in the following way:

'We suffer from his negative impact on other students. He distracts them by being loud, so I have a problem with their attention to me"

"Most of the students mimic her behavior. So we have also problems controlling them. It is very stressful"

V.3 Emotional burden

The emotional burden of teachers consists of nervousness, tension, and worry about the other students. The teachers are stressed because of the subordinate behavior of the child in the class. Some of the teachers expressed this as follows.

"I am always stressed because of her behavior and distraction"

"***While I am in the class, I feel anxious because I'm always thinking about how to keep him calm"***

"I feel worried about the other good students in the class, they can´t concentrate and hold their attention to me"

"I really feel guilty about the other students, their academic level gets worse, I cannot explain the curriculum which should be finished"

We discussed also during the interview the management practices that are conducted by the teachers when they react to the behavioral disturbances of the child.

Table.7: Management practices used by the teachers

Management practices used by teachers to deal with the child behavioral disorders	**I. Perform negative reinforcement** **II. Perform positive reinforcement**

1. Perform negative reinforcement

The teachers felt that they must use physical punishment in order to calm the child. So they hit the child, and some of them use the style of threats to calm the child.

“I feel that when I hit him he calms down and fears me, I know it's wrong but I cannot control his behavior"

"I threaten her that I will send her to the director; she feels scared and calms down for a while"

Other teachers said they try to keep the child occupied during the lesson because he does not take advantage of the class. They give him something to play with and they can continue the class with the least distraction.

"I give her a few stamps or paper to paint just to make her busy so I can get the attention of other students"

Some teachers prefer to ignore the behavior of the child and try to neglect him/her; they said there is no advantage to monitoring his/her behavior all the time.

"I let her to do what she wants if she does not disturb the other students, although she does not listen to anything I say, I do not care anymore"

2. Perform positive reinforcement

The positive reinforcement is another way used by teachers to encourage good behavior by the child. The teachers say good things to the child or promote the other students to clap for her, this makes her feel so happy and enhances the good behavior.

"***When she does something good in the class, I ask students to clap for her, she feels happy and I can see changes in her behavior throughout the day"***

Table.8: The analysis of the teacher's interviews:

Themes	Sub themes	Formulated meanings	Meaning full units
"What I know about hyper activity disorder is that this problem is mental retardation"	View problem as mental retardation	**1.1 Lack of information about the nature of the disorder.**	**I. Lack of information**
"The children with ADHD are less than their actual age on their mental maturity and need special care"	Consider the child as less than his age		
"It may be related to brain defect or brain trauma, I really was not sure what the problem is."	Not sure of the real cause		
"I do not know anything about this problem, actually I did not hear about it before"	Have no information about the problem		
"I began to notice when I started to teach him that his behavior is not like his classmates, but no one told me before about his situation"	Abnormal behaviors observed	**I.2 Lack of information on student health and follow up.**	
"I know she has a problem, but I do not know what kind of problems she had, the mother is often comes to the school, but she never talks about the child's condition "	Lack of information from parents		

"I have no idea if the child is taking any medication, or if he is followed by medical doctors"	Lack of information about the child's treatment		
"I feel sometimes that he is very lazy and not acting as usual, his mother said she was taking medication for concentration: she said no more"	The lack of information on adverse reactions to drugs		
None of us, and not even a social worker, are trained to deal with such cases "	Lack of training	**1.3 Lack of information about the ideal method for dealing with children**	
"I feel that my response to her behavior is wrong, but I really do not have other options"			
"She makes me very anxious when she leaves her place and even leaves class without permission"	Leaves seat and class without permission	**1I.1. Inability to follow class rules**	**II. Children's behaviors are disruptive**
"Suddenly, while I am speaking he goes out and buys chocolate or chips and starts eating in the class"	Eating in the class		
"Most of the time whether she is playing with her pen and paper or singing in a low voice, she does not look at me when I speak "	Play and sing during the lesson		
"He seems to see me, but in fact his mind is away " "When I ask him about what I explained, he cannot answer"	The mind goes blank		

"I give him work to do in the class, when I return to him he has only written one or two words and then stopped"	Inability to complete school work		
Her movements are not organized, she hits the desk while running and falls down, she gives no attention to what is in front of her "	Does not pay attention	**II.2 Impulsivity & inattention**	
“I must call her several times during the lesson to draw her attention to me.”	easily becomes nervous and angry		
“He became angry and nervous very quickly, so I try to avoid his wrath"			
"If he wants something he wants it immediately, otherwise he gets annoyed"	Inability to control impulses.		
"She says very bad words, even to the teachers "	Using bad languag	**II.3 Obscene using verbal abuse & using physical abuse**	
"He's a troublemaker in the class, he hits the students and could seriously harm them"	Hitting the students		
"She throws objects at students"	Throwing objects		
“The time for the class is very limited, and he needs more than 5-10 minutes each time I enter the class”	The need for additional time for the student	**III. 1 Lack of time**	**III. Lack of resources**

"There are no special materials or even special curriculum assigned to the student, we deal with him just like the rest of the other students and it's not fair for him"	There are no special materials to help teachers of special needs	**III.2 Lack of materials & experts**	
"We do not have people specialized and trained to handle these students or even guide us about how should we deal with them."	No additional trained people that help teachers to deal with the students		
"It may be beneficial and helpful if we have a trained person in the class to help us"	The need for an assistant in the class to handle the student		
"When I sent him to the school director, he sends him back to the class and says he cannot do anything."	Inability of the director of the school to offer any help	**IV.1 Lack of Ministry of Education (MOE) support and school team**	**IV. Lack of support**
"Counselors are not trained to handle these children, all he does is takes the child to his office and lets him play, but he does not do any type of management."	Inability of the counselor to provide some kind of plan		
"The ministry of Education (MOE) has never sent people to check the situation of these children, if they are benefiting from school "	Lack of monitoring from the Ministry of Education		

"Ministry of Education integrates these children into mainstream classes and it has never offered any training to teachers on ways of dealing with children's behavior"	Lack of training provided for teachers		
"In the beginning the mother came every day to school, but gradually her visits decreased and even when we call her she makes excuses."	Reduce mother visits to school		
"The role of father is completely absent. He did not visit his son or even call us by the phone to ask about his son. I feel as if he escapes from his responsibilities"	The absence of the father´s role	**IV.2 Lack of parental support**	
"Her mother came to school to fight or blame us about her daughter´s marks or as she said - our negligence "	Conflict between parents and teachers		
"His movements are very dangerous, so I should be alert all the time for him, even in the garden."	Being alert to the child's hazardous movements.	**V.1 Burden of managing the safety of the child**	**V. Burden to have the child in the class**
"More than once we find her out of school during the break, so we have a big responsibility to watch her"	Perform a great responsibility for child.		

"She takes 10 minutes sometimes to be quiet, then I can start the lesson, it is very upsetting."	Difficulties to draw the other students´ attention due to the child's distraction.	**V.2 Burden to calm the child**	
"I am always anxious because of her behavior"	Stress because of the child's behavior.	**V.3 Emotional burden**	
"While I am in the class, I feel tension because I'm always thinking about how to keep him calm."	Sense of tension to keep the child quiet.		
"I feel worried about the other good students in the class; they cannot concentrate and hold their attention on me."	Worry about the academic level of other students		
"I really feel guilty about the other students. Their academic level gets worse; I cannot explain the curriculum as it should be."	Guilty feeling		

Table .9 : Demographical data of the teachers:

Teachers	Name of the course	The number of sessions/ week	The period of teaching the student
T 1	**Arabic langue**	**7**	**1year**
T 2	**Islamic culture**	**4**	**6 months**
T 3	**Arabic language**	**7**	**1 year**
T 4	**English**	**6**	**1 year**
T 5	**Math**	**4**	**6 months**
T 6	**Art**	**2**	**1.5 years**
T 7	**Islamic culture**	**4**	**1 year**
T 8	**English**	**6**	**6 months**
T 9	**Arabic**	**7**	**1 year**
T 10	**Economic**	**3**	**2 years**
T 11	**History**	**4**	**6 months**
T 12	**Geography**	**3**	**1.5 years**

Chapter Five

Discussion of the Study Method and Findings

5. Discussion

5.1 Discussion of the study method

This study tried to focus on the experience of the mothers and teachers caring children with ADHD and how they try to manage and deal with the child. It was very important to understand the mother's experience with her child with ADHD, as this disorder causes disruption for all the family, especially for the mother who deals with the child on a daily basis.

In this study, to develop a clearer understanding of the steps that are essential for coping with raising children with a diagnosis of ADHD, we used a qualitative descriptive phenomenological approach to glean the specific life experiences of mothers and teachers of children with ADHD. Hallett (1995) claims that the phenomenological approach, which focuses on the subjective experience of the participants, is a natural and rational method for understanding human experience. Descriptive phenomenology is a useful approach because it analyses personal experience, thereby allowing researchers to explore the actual experiences of carers (Mu 2000; Huang et al. 2006). Phenomenological enquiry is the description of phenomena as experienced by an individual. It focuses on the participant's subjective perceptions and gives the researcher an opportunity to study phenomena in depth (Morse & Field 1996).

Our current research used the phenomenological descriptive design to understand the experience of primary care providers who interact daily with the ADHD children. This design allows exploring the participants lived experiences and formulating them into psychological understood language that is the essence of phenomenological design (Englander, 2007).

To obtain the goal of the study, face to face deep interviews with participants were conducted and the interviews were tape recorded to ensure not to miss any information. All interviews were transcribed verbatim in order to be prepared for analysis.

The analysis was based on Giorgi phenomenological psychological analysis that transforms the lived experience of ideas to words that can be easily understood (Giorgi, 1985). The role of the phenomenological analysis in this respect is to discern the psychological essence of the phenomenon (Giorgi, 1985, 1989).

The study analysis is divided into two sections, the mothers' interviews analysis and teachers' interviews analysis.

5. 2 Discussion of the study method and findings

Discussion of the experience of the mothers of Attention Deficit / Hyperactivity Disorder children, and their management practices for the behaviors of the child.

The themes that emerged from the mothers´ interviews were three major themes and ten sub themes:

- Burdens of caring:

One of the themes emerging from this study is the burden of caring. We found that mothers of children with ADHD experienced three basic types of burden: the academic track burden, activities of daily living, and psychological and emotional burden.

Our study finding was in line with the other scientists around the world that discuss the experience of mothers of ADHD children and found that mothers complain about the burden of care that includes the emotional burden of children's conditions. This agreement stems from the study which was conducted by Lin and Hung et al (2008) who described the burden of caring for ADHD children.

Mothers of children in our study experience burdens such as frustration, worry, anger, powerless, despair, and stress. According to Flick (1996), parents of children with ADHD often try the usual commands and discipline without success, thus causing frustration, anger and more strict demands and commands being placed on the child. Whatever resources parents use to help their children, they still worry that they are not doing a good enough job (Smith, 2002). Mothers of children with ADHD are worried about their children’s behaviour at school (Kottman et al. 1995; Lo, 2002). Several studies have also reported that caregivers of children

diagnosed with ADHD experience burdens such as worrying about the child's future, low levels of family support and high levels of children's demands (Gerdes et al. 2003; Cronin 2004; Bull & Whelan, 2006). Negative effects such as feelings of frustration (Hong, 2001; Lo, 2002; He, 2004; Kirby, 2005), exhaustion (Cronin, 2004; Simmons & York, 2006), depression (Thomas & Corcoran, 2003; Leslie et al, 2007), feelings of guilt or self-blame (Smith 2002; McInnes et al, 2003) and embarrassment (Myttas, 2001) can be experienced by the caregivers. Our study is in agreement with the above mentioned studies.

The mothers need more information about the nature of disease and strategies for dealing with the child. They also need psychological support and a center to help the child in behavior and academic aspects, since the majority of mothers complain that they have problems with the child's academic follow-up. The realization of the mothers that the children's disorder is chronic increases their emotional despair and loss of hope for the future of the children.

In a study that included 100 parents (87 mothers and 13 fathers) who took care of and raised children with ADHD in Taiwan, it was found that the two most influential factors causing parental stress were children's behavioural problems, lack of self-confidence and different emotional problems, which is in accordance with our study. The idea of offering more help to the major caregivers to manage children with ADHD effectively is an important outcome of the study. Approximately 88% of

mothers of children with clinically diagnosed ADHD worry about their children's behaviour at school, their self-esteem, social skills and ability to adapt to life in the future (Kottman et al, 1995). It was also found that 41% of carers of children with ADHD suffered from depression (Leslie et al, 2007).

Emotional burdens were often experienced by the mothers who took part in this study. Our research found several common emotions experienced by caregivers: frustration, helplessness, anger and worry. Previous studies have reported similar findings (Hong, 2001; Lo, 2002; Kirby, 2005; Leslie et al, 2007). It has been pointed out that children with ADHD often create an unhappy family and life environment and this makes caregivers feel frustrated with their lack of self-perceived parenting skills (He, 2004; Kirby, 2005). Our study is also in agreement with the study of Lin & Haung (2008) who described the burden of child care for the mother including the parenting, emotional and family conflict. Many other researchers described this burden to be a heavy emotional burden which the parent has difficulty handling, like feeling frustration, anger, guilt, fear, and helplessness (Cynthia, 2010). We conclude that it is important to decrease the level of emotional burdens experienced by primary caregivers.

Regarding the activities of daily living, the mothers in our study experience morning, afternoons and bedtime as the most difficult times when raising a child with ADHD, which is in accordance with the study of Firmin & Philip (2009), which declared that the morning routine seems to

exert pressure for school-going children in terms of managing the time before leaving home and making it in time for school.

After school homework time has also been listed as challenging to mothers in our study which is in line with Firmin & Philip (2009), who stated that the children are likely to be tired and more distracted, whilst bedtime was another difficult time where mothers´ fatigue contributed to less patience in dealing with a child especially when trying to calm them down.

Firmin & Philip (2009) show that most parents of ADHD children agree that routine and structure are the most helpful in dealing with their children with ADHD. These routines have to be reinforced over and over again as there is no such thing as habits when dealing with ADHD, but constant routines.

- Inadequate support

Lack of sufficient support is another theme that emerged from this study. The lack of support from spouses, relatives, schools and the community affected the experience of raising children with ADHD. Our research found that the mothers expressed the view that if they could receive family support and if their husbands could be better enabled to recognise and accept the fact that their children had ADHD, then the degree of family conflict would be diminished. Thus, family support is of the utmost significance in developing support networks (Liu, 2004; Su, 2004).

Common complaints expressed by mothers of children with ADHD include the lack of adequate family support, and the necessity of coping with excessive child-related demands and worries that their child will not meet social standards (Lin et al, 2009). Gau (2007) states that most mothers of ADHD children perceive themselves to be receiving low family support. Children function within a family system and therefore their behaviour has an effect on how parents view themselves as parents, especially mothers who are often blamed for their child´s inappropriate behaviour (Neophytou & Webber, 2005). Many of these mothers also have little confidence in their abilities to raise their children with ADHD successfully (Cronin 2004).

Our study shows that the mothers did ask support from their spouses, schools and communities to overcome the burdens associated with raising school-aged children with ADHD. This strategy was also reported in a previous study (Huang et al, 2008). Sayal et al. (2006) examined 232 parents of children with ADHD in the UK to investigate whether they understood the importance of the help-seeking process. The results showed that most parents (80%) admitted that their child had a problem, although some (35%) understood it in terms of hyperactivity. Most parents had been in contact with well-educated professionals, but few had consulted primary care physicians or sought help from relevant specialist health services. When parents recognise the problem, they usually realise that getting help from professionals can be very useful which is not the case in our study.

Bull and Whelan (2006) have defined eight common parental schemata in children with ADHD upbringing. They are: a sense that the child is different, expectations of overcoming the abnormality, the importance of medication, the limitations of management techniques, the rejection of parental authority, the subordinate position of fathers, the high self-expectations of participants and the limitations of community support.

Several studies have indicated that the most important steps that should be taken to help children with ADHD are solving behavioural and educational problems and improving communication skills (Lo, 2002; Huang et al, 2003; Bussing et al, 2006; Chang et al, 2007). The importance of giving parents complete information about the exact diagnosis, possible ways of treatment and available resources have been mentioned by many researchers (DeMarle et al, 2003; Hardy et al, 2004; Simmons & York, 2006).

To handle a child with ADHD was a heavy responsibility for the mothers and the lack of support from the surrounding people, including the community was the second theme that emerged from the study and was found in most of the past researches discussing ADHD. The lack of adequate support makes child care more difficult. The findings in the current study were similar to the study conducted by Cynthia 2010 that found that in the mother's experience with the ADHD child, the support provided by professionals for the mothers was not satisfactory for them.

The difficulty to find support from mental health professionals, especially during crisis, was also found in the qualitative research that was done by Oruche et al (2011). The mothers of ADHD children in the study often felt that health care professionals did not support them in their request for knowledge and how to provide the required care for their children with mental health needs. This, Dean (2005) believes, makes parents feel that the professionals do not care, as they go back to their normal lives whilst it is parents with children who have ADHD that have to struggle on their own. This was also mentioned by the mothers in our study.

The lack of support by the schools, an issue that appears in our study, was also a conclusion of this study, as the mothers said that their children were often kicked out of the class.

We also found from the analysis that the mothers feel stigmatized and ashamed because of their children's condition and behavior, so they are socially isolated and try not to take children out of the home because even the close relatives do not accept children's behaviors. Our result is in accordance with Dean (2005), who declared that socialization is also an extremely difficult time for parents since a family day out seems to cause children with ADHD excitement resulting in hyperactivity, which is often embarrassing to parents and leaves them worn out physically.

Furthermore, relatives tend to blame mothers for not doing enough, not being disciplined enough and can be intolerant of a child who is

hyperactive and has low frustration tolerance or explodes at each hurdle (Smith, 2002).

- **Disturbances of the child's behavior (hyperactivity, impulsivity, inattention)**

The three main symptoms of ADHD (hyperactivity, impulsivity, and inattention) that mothers experienced were very disturbing and difficulties were handled by mothers. These three symptoms affected family life and interfered with all aspects of the life of the child, and made mothers anxious when it comes to the child. ADHD is a neurological disorder with three core symptoms - inattention, hyperactivity and impulsivity. It affects both cognitive and behavioral functioning in academic, social and family contexts (American Psychiatric Association 2000). Our study shows that these symptoms are the major source of stress for mothers. In a review of family factors associated with ADHD, Johnston and Mash (2001) emphasized increased parenting stress as a common co-occurring factor. According to Burke et al (2008), child disruptive symptoms often influence parental behaviors. Parents of hyperactive children tend to give in to their children´s misbehavior (Keown & Woodward, 2002). The parent´s ability to effectively manage their children behavior is usually strained.

Yousefia & Soltani (2011) show that the type of ADHD symptoms children have leads to more parenting challenges for mothers of these children than mothers of normal children, and the severity of ADHD symptoms increases parenting stress. It means that the more hyperactive

traits in a child, the more parenting stress mothers will have. Johnston and Mash (2001) argue that raising an ADHD child is considered one of the most important factors for the development and conduct endurance in children. Much of the research on the relationship between stress and child behavior problems is based on maternal report. Fischer (1990) pointed out that mothers who are more stressed experience their child's behavior as more negative, and the mothers of more difficult children experience more stress.

Added to the nature of the main symptoms of ADHD is much distress. Mothers of ADHD children have a really difficult experience with the child's behavior and they need support and understanding that was absent in their care for the child.

5. 3 Discussion of management practices of mothers for the behaviors of the child.

In our interviews with mothers, we asked about the management methods used by mothers to control child behavior disorders. The results showed that the mothers tend to use both positive and negative reinforcement.

Research shows that ADHD symptoms cause stress in mothers of children with ADHD and also force the mothers to use methods of punishment to control children's behavioral disorders. The review of stress resulting from child domain shows that testable scores of the mothers of the

ADHD children are in a higher level than the mothers of normal children. This was clear in the results of a Yousefia & Soltania (2011) study which investigated parenting stress and parenting styles of ADHD mothers. This study is in agreement with our study, as the mothers expressed the negative emotions they have due to the child's situation and how they react negatively to the child's behavior, which increases the intensity of the behaviors. Our results are consistent also with Deault's (2009) study which showed that the parents of ADHD children perform less positive parenting, including a lack of warmth and positive parental involvement, as well as reports of more negative discipline strategies and parental intrusiveness.

Families of children with ADHD may be dealing with challenges that go beyond the symptoms of ADHD alone. The struggles that parents are experiencing are important to consider with respect to intervention, as parents typically play a major role in working to change children's behavioural symptoms (e.g. through parent training and behaviour therapy programs), therefore understanding different family contexts and their impact on developmental trajectories for children with ADHD is crucial to the success of these interventions (American Psychiatric Association 2000).

It is worth asking how the mother copes with the children alone, and what are the facilities and resources for her to help in child care? Is the information provided to mothers enough to make them able to provide the best care for the children?

The results of this study showed that mothers are not supported even by the spouses in the management of children and that there is also a lack of the community and schools resources. All these problems create heavy emotional upset and stress, which makes the mother use the negative way of dealing with the child. This result is in accordance with the study of Shakilah (2011) who showed that mothers of ADHD children have higher stress levels and use different methods to punish the child. This stress and depression of mothers may worsen the child's condition and increase the tendency of bad behavior. Children with disruptive behaviors affect the parents' mental health with most parents suffering from stress, depression and fatigue (Kashadan et al, 2004).

In our research some of mothers mentioned that they use the positive management practices like giving verbal reinforcement or providing a favorable object for the child which appears to have more child compliance with the mothers as it was reported in another study conducted by Firmin & Philips (2009) who showed similar results to ours. They state that the mothers of ADHD children who choose to adjust their lives to the child's symptoms and use positive practices with the child are more able to deal with the child and make the child feel safer and make the home more relaxed.

Our result is also in accordance with Smith (2002), who decaled that nurturing a child´s gifts and interest and constant approval of positive behavior helps the children feel safe.

Podolski & Nigg (2010) examined parent role distress and coping in relation to childhood Attention Deficit Hyperactivity Disorder (ADHD) in mothers and fathers of 66 children ages 7 to 11 (42 boys, 24 girls). Parents of children with ADHD expressed more role dissatisfaction than parents of control children. For fathers, parenting role distress was associated with child oppositional or aggressive behaviors but not with ADHD symptom severity. Parent coping by more use of positive reframing (thinking about problems as challenges that might be overcome) was associated with higher role satisfaction for both mothers and fathers. Community supports were associated with higher distress for mothers only.

Children who suffer from hyperactivity disorder are often misunderstood (Barkley, 2000a; Smith, 2002). In such cases, children with ADHD are often criticised or punished when they exhibit worsening symptoms, or even are isolated and baited by their classmates (Guo, 2004; Simmons & York, 2006). Several researchers have found that parenting training can improve parents' understanding of children with ADHD behaviour, motivate parents' use of behavioural management techniques and, more importantly, help parents accept the fact that their children have ADHD (Barkley et al, 2001; Myttas, 2001; Thomas & Corcoran, 2003; Bussing et al, 2006). In an experiment, 10 mothers went through a five week training course. At the end of the course, all 10 participants showed improved parental satisfaction and parental sense of competence (Odom, 1996).

Parent training in behaviour therapy has successfully changed the behaviour of children with ADHD. Parent training typically begins with 8 to 12 weekly group sessions with a trained therapist. The focus is on the child's behaviour problems and difficulties in family relationships. A typical program aims to improve the parents' or caregivers' understanding of the child's behaviour and teaching them skills to deal with the behavioural difficulties posed by ADHD. Programs offer specific techniques for giving commands, reinforcing adaptive and positive social behaviour, and decreasing or eliminating inappropriate behaviour (Pelham, 1992).

Systematic rewards and consequences, including point systems or use of token economy, are included to increase appropriate behaviour and eliminate inappropriate behaviour. A periodic (often daily) report card can record the child's progress or performance with regard to goals and communicate the child's progress to the parents, who then provide re-enforcers or consequences based on that day's performance (American Academy of Paediatrics, 2010).

5. 4 Discussion of the experience of the teachers of Attention Deficit / Hyperactivity Disorder child, and their management practices for the behaviors of the child

In order to explore teachers' experience of the ADHD student, semi-structured interviews conducted with teachers of four children with ADHD

following an interview guide that contains questions about the child's situation in schools and how teachers perceive the behavior disorder of children and their reaction to these behaviors. The interviews were tape recorded in the school of each child and analyzed using the Giorgi method. There were five themes and thirteen subthemes that emerged from the analysis.

- Lack of information:

The deficit of knowledge about the disease and about the students' conditions was one of the most recurring experiences of the teachers. This lack of knowledge was the result of a gap in communication and interaction between the school and the family of the child, and it led to negative effects on how the teacher responded to students´ behavior so that training of teachers by the terms of the child's condition could raise the quality of care. However, this does not resemble what Sayal et al (2009) found in their study that aimed to investigate the effects of early school intervention to provide training on child ADHD status to teachers on the degree of hyperactivity, and impairment of learning. They concluded that none of the interventions were associated with improved outcomes.

Another study, conducted by Miranda et al (2002), focused on the teachers who do not have information about ADHD. They conducted educational sessions for the teachers on symptoms of ADHD and class behaviors for four months, the study concluded that increasing teachers'

information of the problem showed positive results on teacher knowledge and improvement in the child's academic performance.

- Child's behavior is disruptive

In this study, the results of teachers' experience in dealing with the child did not differ from other studies. The teachers mentioned the difficulties they face daily with the child in connection with his/her behavioral problems, which include hyperactivity, impulsivity, inattention, and breaking of the class rules. Lahy et al (1998) in their study on the validity of the DSM-IV diagnosis attention deficit hyperactivity disorder showed that the three presentation features of ADHD which are hyperactivity, impulsivity and inattention increase with school-aged children that increase the demand to make the child focus in the class. Other studies focused on the outcome of the ADHD condition in the school such as poor academic achievement and social problems (Weiss & Hechtman, 1993). This study is consistent with our study that showed the problem of poor academic level and relationship with peers also shared between ADHD children.

- Lack of resources and support

The lack of time and other resources necessary to improve the services provided to ADHD children in the class is one of the main barriers to providing a good quality of care. The teachers mentioned that it is difficult to know whether the focus should be on the class as a whole or on children

with ADHD who are in need of special support. The fact that there is not enough time in the current situation is a familiar phenomenon in the educational activity. Our study agrees with Gillberg (1996) who stated that students with ADHD need time in small groups and need more alone time with teachers.

Juul (2005) reported that students with ADHD need space for breaks and shorter sessions in class. But the question we set to ourselves is: Is it possible that students with ADHD have their own breaks during the school day? We ask ourselves if this would create a kind of segregation. A break does not necessarily mean that the candidate who has ADHD go out alone on the playground, but it may mean that the child will do anything else for a few minutes before returning to the original entry.

Kadesjö (2001) declared that it is important to stay ahead of the rule to restructure education and instruction based on students' needs. In our study teachers declared that they want more resources to respond to students in the best possible way. The research shows that students with ADHD have great difficulty with academic subjects, but we could ask whether teachers really see the problems from their own perspective and not from the student perspective. What we wonder is whether individualized instruction is best suited for students with ADHD. Duvner (1998) stated that students with ADHD need clear instructions and that organizational deficiencies and teachers in their pedagogy in the teaching environment are the problems.

From the analysis of the results there were many aspects that are considered important for improving the care of children with ADHD. One of them is that regular class with many students and limited time of the teachers is not suitable for children with ADHD.

According to the teachers' daily experiences, it was very difficult for them to focus their attention on the children or to give them extra time to perform their work. In addition, they do not have the knowledge or enough information about the disease and the child, so they were not sure how they could help the child. All these facts make the teachers wonder how much the children with ADHD will benefit either academically or behaviorally in a class with 35 other students who have other needs from the teacher. If there is any other solution, how can we integrate them into mainstream schools without hurting the other students, or creating problems for teachers in classrooms? The results of the research showed that school performance of children with ADHD were very poor even though all the teachers said that the mental abilities of these children are very good and some of them are clever and unique, so it is worth it to create the solution for those students.

- Burden of having the child in the class

The difficulties that teachers face in childcare make the existence of ADHD children in the class a burden on teachers. The nature of ADHD symptoms requires that the child received more attention to avoid harm to

himself. Posner et al (2007) stated that children with ADHD engage in dangerous behaviors such as falling off the furniture after climbing, unbuckling restraints and standing up in cars and strollers, drinking poison, and falling or jumping out of windows. Such security risks require a high level of supervision from parents and likely contribute to increased parental and teacher stress. The burden of ADHD children in the class and the inability of teachers to make the child concentrate affect the teachers will to have the child in the class and attempt to exclude the child.

5. 5 Discussion of the teachers´ management practices for the behaviors of the child with ADHD.

The teachers in this study explain how they react to the affected child's behavior. Most of the teachers react with distraction by treating the child with negative methods, for example, to kick the child out of class or hit him. Other teachers tried to reinforce positive behaviors in the child by encouraging him by patting him or saying good words about him, which has a powerful effect on the affected child. Positive reinforcement has been supported by research. Behavioral therapy has been used for children, which covers a wide range of specific actions that have a common goal of modifying the physical and social environment to alter or change behavior. The behavioral therapy in the classroom were discussed in the guideline published by the American Academy of Pediatrics, 2010, which shows the effect of behavior management in the classroom as a reward and other

positive reinforcement by giving rewards or privileges contingent on the child's accomplishments.

Behaviour therapy represents a broad set of specific interventions that have a common goal of modifying the physical and social environment to alter or change behaviour. Along with behaviour therapy, most clinicians, parents, and schools address a variety of changes in the child's home and school environment, including more structure, closer attention, and limitations of distractions. Behaviour therapy usually is implemented by training parents and teachers in specific techniques of improving behaviour. Behaviour therapy then involves providing rewards for demonstrating the desired behaviour (e.g., positive reinforcement) or consequences for failure to meet the goals (e.g., punishment). Repetitive application of the rewards and consequences gradually shapes behaviour. Although behaviour therapy shares a set of principles, it includes different techniques with many of the strategies often combined into a comprehensive program.

Behaviour therapy should be directed to the child and designed to change the child's emotional status (e.g., play therapy) or thought patterns (e.g., cognitive therapy or cognitive-behaviour therapy) (Barkley 1998).

Classroom management also focuses on the child's behaviour and may be integrated into classroom routines for all students or targeted for a selected child in the classroom. Classroom management often begins with

increasing the structure of activities. Classroom behaviour management also may improve a child's functioning but may not bring the child's behaviour into the normal range on teacher behaviour rating scales (Pelham 1992).

Schools may provide behaviour therapy with teachers in the context of a Rehabilitation Act plan or an individual education plan. Where ADHD has a significant impact on a child's educational abilities, schools may be required to make classroom adaptations to help children with ADHD function in that setting. Adaptations may include preferential seating, decreased assignment and homework load, and behaviour therapy implemented by the teacher (American Academy of Paediatrics, 2001).

Chapter Six

Conclusion and Recommendations

6.1Conclusion:

The study concludes that the primary care givers of ADHD children experience burden and a lack of sufficient support and resources in the child's care. This negatively affects the quality of care provided for the child.

The findings show that caring for a child with ADHD is stressful emotionally for the care givers (the mothers and the teachers), so there is a need for support and education/training programs.

Based on the research findings, we make several recommendations and identify directions for conducting future research. The most important recommendations are: that improving professional services in family care should become a major concern of all healthcare professionals; that sufficient services should be provided by professionals, teachers and service users; and that more psychologists, social workers, occupational therapists and nurses who can help children diagnosed with ADHD are needed. Environmental and behavioural interventions will require ongoing efforts by parents, teachers, and the child.

6.2 Recommendations

The results of this thesis highlight many points that should be used for clinical nursing implications.

6.2.1- Recommendation for teaching and training:

It was clear from the results of the study that there is lack of knowledge and understanding about ADHD either from the family of the ADHD child, the community the child lives in, or the school team (the directors of the schools, the teachers, the social workers) as well as the other students in the class of the child. This lack of knowledge is reflected by the way they deal with the child.

There is a need for comprehensive psycho education programs, which should include the parents and the school team to increase the awareness about the disorder and the use of the best management practices.

According to the National Collaborative Centre for Mental Health, 2008, parent training/education programs should be founded to provide simple ways helping them to manage the child's behavior and enhance a good parent–child relationship.

6.2.2-Recommendations for policies:

The Ministry of Education should integrate the children with ADHD in its policies; there should be special resources and facilities for these children such as:

-special classes with trained persons to deal with the ADHD student on both the academic and behavioral level, with a smaller number of students and more time facilitated for the child to perform the tasks. This should be collaborative work between the Ministry of Health and the Ministry of Education.

- Considering the impulsivity and hyperactivity of the child, the Ministry of Education should provide special precaution in the gardens and classes, like designing the class to contain fewer hazards, providing more spaces for the child to play safely.

- The school should be responsible for safe transportation for the child, bringing and returning him to the home.

- Enhancing the process of screening and diagnosis of ADHD cases in health centers and ensuring regular contacts with the specialists to monitor the child's situation, response to medication, and parents' education.

- Medical Health records should be performed in the MoH to monitor patients and for the purpose of research.

-Primary care clinicians cannot work alone in the treatment of school-aged children with ADHD. Ongoing communication with parents, teachers, and other school-based professionals is necessary to monitor the progress and effectiveness of specific interventions. Parents are key partners in the management plan as sources of information and as the child's primary

caregiver. Integration of services with psychologists, child psychiatrists, neurologists, educational specialists, developmental-behavioural paediatricians, and other mental health professionals may be appropriate for children with ADHD who have coexisting conditions and may continue to have problems in functioning despite treatment. Attention to the child's social development in community settings other than school requires clinical knowledge of a variety of activities and services in the community.

6.2.3- Recommendations for family support:

- Psychotherapy sessions should be performed for the mothers to share their experience.
- Centers for counseling and support to help the parents deal with the child's behavior and daily problems they meet. These centers should be concerned with the impact of the disorder on the child's life and the family concerns, and assess the personal, mental, and social needs.

6.2.4- Recommendations for future researchers:

Improving the research in the childhood behavioral disorders generally and Attention Deficit Hyperactivity Disorder particularly is needed. Future research should focus on the child perception about their attention deficit hyperactivity disorder (their experience with the disorder), Future studies on large samples include interviews with fathers of children with ADHD

It will be worth it to focus future research on the alternative ways for treating ADHD (herbal medication, behavioral, art, music, play) and other types of therapies such as alternatives for medication.

6.2.5- Recommendations for Parents:

Positive parent/child relationship. This involves having realistic age-appropriate expectations, conveying these expectations in a direct clear manner, spelling out positive and negative consequences for compliance and non-compliance, and having these consequences be relevant, immediate and proportional. Specific parent training programs may be indicated that teach and monitor specific parenting skills. Parents may need support to build a positive relationship with the child after years of challenging behaviour.

Consistent daily routine. This may take weeks to establish, but encourage parents to persevere. Routine should include morning and bedtime regimes. It might be necessary to write these down for the child.

Timing of medication. For some children the early morning period is extremely difficult. In such cases it may be helpful to administer the stimulant to the child while he/she is still in bed, and then get him/her up for school after the stimulant has taken effect.

Homework monitoring. Establishing a regular time and place for the child to do his/her homework may improve results. Homework is best done in

the early part of the evening, leaving time for relaxation before bedtime. Homework should not be done in front of the TV or on the bed. Siblings and telephone are other major distracters that should be removed from the homework setting. A homework tutor or facilitator can be very helpful. Ask the school to help keep parents informed about requirements of assignments or special projects so the parent can plan with the child when and how these will be done. Write these plans on the calendar. It can be useful to suggest that homework be done for a reasonable period of time every day, independent of whether or not there is work to do to avoid children either saying they have no homework, or to avoid children becoming avoidant because homework takes hours. TV and electronic games should be removed until after homework is complete.

Keep regular appointments. ADHD is a chronic disorder where an ongoing supportive relationship with the child and family is valuable. It is necessary to have regular appointments, optimally once a month, and minimally every three months (Barkley 2003).

6- Recommendation for the Community :

Families of children and young people affected by ADHD are subject to considerable pressures associated with the disorder on a day to day basis. Clinical experience suggests that families have differing capacity to cope with this and that this fluctuates over time. The provision of support other than what may be available from extended family and friends may be an

important part of a multimodal intervention package. The need for social support must be considered for individual families (Scottish Intercollegiate Guidelines, 2001).

7-Recommendation for a greater awareness of early detection of cases: Establish companion 'to increase parents' awareness of the early risk of ADHD symptoms and contact health centers for screening and early lead. This should also include schools. In this area there must be co-operation between the Ministry of Health and Ministry of Education and to utilize the facilities and assistance as the government health centers. Raising awareness is also about the importance of regular contact and follow up with the medical team to evaluate and monitor the child situation, progress should be one of the major issues to focus on. Families may not accept their child's mental health problems and their need for treatment for fear of labelling and stigmatization. It is important to fight stigma and increase awareness of children's mental health and ADHD in particular. Parents' support groups are recommended for children with ADHD. The parent group’s support is to strengthen parents and allow them to help themselves and their children

6.3- The limitation of the study:

The difficulty to find the diagnosed cases of ADHD was one of the major limitations of this study, despite the fact that the cases of ADHD were 11.9% of males and 8.5% of females according to the research that

was done by Miller et al (1999) in Palestine. There is a lack of registration of cases in the medical health record. The cases of ADHD were integrated in the childhood disorders as mental retardation and weren't found easily, so we had to find cases in schools. The other limitation was that the study was conducted with the mothers and teachers but didn’t include the fathers who are also considered care givers.

6.4- Acknowledgment:

This project was supported by An-Najah National University, and the Ministry of Health which allowed us to use the patients´ files during searching for cases of ADHD. The authors would also like to thank the Ministry of Education for facilitating the research in the school. We would also like to appreciate the directors of the schools and the teachers´ cooperation with us, special thanks to mothers of the ADHD children for their willingness to share their experience with us.

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Appendices

Annex 1

Participant's information sheet

Information for the mother

Title of the study

The experience of the mothers and teachers of Attention Deficit / Hyperactivity Disorder children, and their management practices for the behaviors of the child

Introduction:

My name is Lobna Faroq Harazni, a student of the community mental health nursing masters program at An-Najah National University in the fourth term. My supervisor is Dr. Aidah Abu Elsoud Alkaissi.

-What is this study

This study is a university requirement for my masters degree. My purpose is to perform a research on Attention Deficit Hyperactivity Disorder (ADHD). ADHD is the most common disease of childhood and affects all aspects of a child and guardian´s life, so it requires special attention. For this reason I will study the experience of primary caregivers (mothers and teachers of children) and their management methods to manage the child.

The purpose of this study:

The aim of this study is to investigate and describe the experience of the adults that have the most interaction on a daily basis with school-aged children with Attention Deficit Hyperactivity Disorder, which are mothers and teachers. This study aims also to understand management practices that are used by mothers and teachers to deal with the most prominent signs of ADHD which are hyperactivity, impulsivity, and inattention in order to formulate a care plan.

What you are expected to do:

You as the mother of the child have a major role in the interaction with the child. For this reason you have been chosen for the study and your participation means that I will conduct interviews with you if you are willing to attend the interview, which will be recorded and it is expected to last 45 - 60 minutes and it will be implemented in your home at an appropriate time with you.

Privacy:

All data is recorded will be used only for the study purpose, and will remain stored in a locked cabinet during the study and destroyed after the study is complete. No real names will be mentioned in the study and you will be identified by codes.

Refusal to participate/withdraw from the study:

There is no obligation for you to participate in the study. You can refuse to participate or withdraw from the study at any time, even without giving reasons and this will not have negative effects on you or your child.

Harm:

No harm will come to you from participating, and your name will never be mentioned to anyone.
We appreciate your participation.
If after the interview still has something to convey, we are ready for more clarifications. You should not hesitate contact us at the following telephone numbers:

Dr. Aidah Alkaisss: 0597395520
Lobna Faroq Harazni: 0599228214

معلومات حول الدراسة للمشتركين (للأمهات)

عنوان الدراسة:

دراسة حول الأطفال الذين يعانون من اضطراب النشاط الزائد وعدم التركيز ،وصف لتجارب الأهالي والمدرسين وطرق تعاملهم مع الاضطرابات السلوكية للطفل.

مقدمة :

إنا الطالبة لبنى حرا زنة، طالبة ماجستير تمريض الصحة النفسية المجتمعية في جامعة النجاح الوطنية، أقوم بالتحضير لرسالة الماجستير حول موضوع الأطفال الذين يعانون من اضطراب النشاط الزائد وقلة التركيز بإشراف الدكتورة عايدة القيسي.

يعد إضراب فرط الحركة وقلة التركيز حسب الدراسات العالمية من أكثر المشاكل السلوكية شيوعا بين الأطفال والذي يؤثر على جميع مناحي حياة الطفل والقائمين على رعايته (الأم والمدرسين)، لهذا السبب أود القيام بدراسة تجارب هؤلاء القائمين على رعاية الطفل والطرق التي يستخدمونها للتعامل مع الاضطرابات السلوكية للطفل.

هدف الدراسة:

الهدف من الدراسة هو محاولة اكتشاف التجارب المختلفة والطرق المختلفة للتعامل مع الطفل الذي يعاني من هذا الاضطراب السلوكي، والذي سوف يساعد للوصول إلى خطة مناسبة للتعامل مع هذه الفئة من الأطفال ورعايتهم.

دورك في الدراسة :

الأهل(الأم والأب) أكثر من يتعامل مع الطفل ويتعايشون يوميا مع الطفل وسلوكياته المختلفة لذلك فأن تجربتكم مع الطفل تستحق الدراسة لذلك وبعد موافقتكم سأقوم بعمل مقابلة معكم لمدة

45–60 دقيقة وسيتم تسجيل المقابلة على كاسيت لتسهيل عملية جمع المعلومات وسيتم التركيز على عدة نقاط حول سلوكيات الطفل، وسيتم ترتيب الوقت بما يتناسب مع وقتك.

سرية المعلومات:

سوف تكون جميع المعلومات لاستخدام الدراسة فقط، وجميع المستندات والتسجيلات سوف تحفظ في مكان آمن ومحكم الإغلاق ،وجميع التسجيلات سوف تتلف بعد الدراسة ،ولن يتم ذكر الأسماء الحقيقة للمشاركين.

حق الرفض بالمشاركة في الدراسة أو الانسحاب :

مشاركتك في الدراسة هي مشاركة طوعية، لك الحق في رفض المشاركة أو الانسحاب من الدراسة في أي وقت من غير تقديم أسباب ولن يكون هناك أي ضرر عليك.

الأضرار المتوقعة من الدراسة:

ليس هناك أي أضرار يمكن أن يسببها اشتراكك في الدراسة.

Annex II

Participants' information sheet

Information to theTeacher

Title of the study

The experience of the mothers and teachers of Attention Deficit / Hyperactivity Disorder children, and their management practices for the behaviors of the child

Introduction:

My name is Lobna Faroq Harazni, a student of the community mental health nursing masters program at An-Najah National University in the fourth term. My supervisor is Dr. Aidah Abu Elsoud Alkaissi.

What is this study

This study is a university requirement for my masters degree. My purpose is to perform a research on Attention Deficit Hyperactivity Disorder (ADHD). ADHD is the most common disease of childhood and affects all aspects of a child and guardian´s life, so it requires special attention. For this reason I will study the experience of primary caregivers (mothers and teachers of children) and their management methods to manage the child.

The purpose of this study:

The aim of this study is to investigate and describe the experience of the adults that have the most interaction on a daily basis with school-aged children with Attention Deficit Hyperactivity Disorder, which are mothers and teachers. This study aims also to understand management practices that are used by mothers and teachers to deal with the most prominent signs of ADHD which are hyperactivity, impulsivity, and inattention in order to formulate a care plan.

Privacy:

All data is recorded will be used only for the study purpose, and will remain stored in a locked cabinet during the study and destroyed after the study is complete. No real names will be mentioned in the study and you will be identified by codes.

Harm:

No harm will come to you from participating, and your name will never be mentioned to anyone.
We appreciate your participation.
If after the interview still has something to convey, we are ready for more clarifications. You should not hesitate contact us at the following telephone numbers:

Dr. Aidah Alkaisss: 0597395520
Lobna Faroq Harazni: 0599228214

معلومات حول الدراسة للمشتركين (للمدرسين)

عنوان الدراسة:

دراسة حول الأطفال الذين يعانون من اضطراب النشاط الزائد وعدم التركيز ،وصف لتجارب الأهالي والمدرسين وطرق تعاملهم مع الاضطرابات السلوكية للطفل.

مقدمة :

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هدف الدراسة:

الهدف من الدراسة هو محاولة اكتشاف التجارب المختلفة والطرق المختلفة للتعامل مع الطفل الذي يعاني من هذا الاضطراب السلوكي، والذي سوف يساعد للوصول إلى خطة مناسبة للتعامل مع هذه الفئة من الأطفال ورعايتهم.

دورك في الدراسة :

كونك مدرس\اة الطفل وتتعامل\اين معه بشكل يومي فان تجربتك وتفاعلك مع الطفل يشكل خبرة جيدة ومفيدة للدراسة، لذلك وبعد موافقتك سأقوم بعمل مقابلة معك لمدة 45-60 دقيقة وسيتم تجيل المقابلة على كاسيت لتسهيل عملية جمع المعلومات وسيتم التركيز على عدة نقاط حول سلوكيات الطفل، وسيتم ترتيب الوقت بما يتناسب مع وقتك.

سرية المعلومات:

سوف تكون جميع المعلومات لاستخدام الدراسة فقط، وجميع المستندات والتسجيلات سوف تحفظ في مكان آمن ومحكم الإغلاق ،وجميع التسجيلات سوف تتلف بعد الدراسة ،ولن يتم ذكر الأسماء الحقيقة للمشاركين.

حق الرفض بالمشاركة في الدراسة أو الانسحاب :

مشاركتك في الدراسة هي مشاركة طوعية، لك الحق في رفض المشاركة أو الانسحاب من الدراسة في أي وقت من غير تقديم أسباب ولن يكون هناك أي ضرر عليك.

الأضرار المتوقعة من الدراسة:

ليس هناك أي أضرار يمكن أن يسببها اشتراكك في الدراسة

Annex III

Consent Form

The undersigned, ... (name), born on... ... ...

confirm to have read / been explained requests to participate in research project on "The experience of the care giver of the Attention Deficit / Hyperactivity Disorder children (the parents and the teachers), and their management practices for the behaviors of the child"

I have been given a copy of your request / project orientation and am willing to participate in the project. I have received both verbal and written information about the study, and I'm aware that my participation is voluntary. I am informed that at any time, without having to explain I might withdraw from the study if I wish. If needed, I can be contacted for a new interview or clarification of ambiguous relationships.

... ...

(Date) **(Signature of informant)**

The undersigned confirms that she provided information about the project and has handed over the above a copy of the request / project orientation and consent to participation.

... ...

(Date) **(Signature of project leader)**

نموذج موافقة على المشاركة في الدراسة :

الاسم:.....

لقد تلقيت المعلومات المكتوبة والكلامية حول الدراسة التي ستكون حول الأطفال الذين يعانون من اضطراب فرط النشاط وقلة التركيز وتجارب القائمين على رعايتهم، وأوافق على المشاركة بالدراسة بشكل طوعي ، وقد تم أخباري انه بإمكاني الانسحاب من الدراسة في أي وقت دون إعطاء أي أسباب .

التوقيع: التاريخ

Annex IV

Interview Guide for the teacher

Open questions:

- What do you know about Attention Deficit Hyperactivity Disorder?
- When you teach S1, do you know what his /her problem is?
- Do you have any idea of what medicine S1 uses? What do you know about this product?
- What are the most symptoms and behaviours that S1 complains often about? Give some examples of this behaviour.
- How do you deal with each of these behaviours?
- When does S1move from his seat suddenly? When can he not follow the class?
- Do you think it is helpful for the child to be in the regular class? If not, what do you suggest?
- Do you provide S1 special care? If yes, what is this special care?
- What resources (if found) are devices that help you in teaching S1?
- Performance in the school setting, including details of academic achievement
- Social functioning in relation to other children and staff, and the ways and behavior the teacher uses to address the inattention, impulsivity and aggression.
- The resources available in class to help the teacher to meet the needs of the child.
- Pedagogical methods, resources, and support
- Social relationships and routines in relation to the students in question.
- If the teacher makes use of some special methods / approaches, special materials or other resources to work with these students,
- What methods / approaches does the teacher use to include students with ADHD in a regular class?
- What aid in the form of materials, methods and resources are needed for students to develop their learning?
- What do you think can improve the quality of care given to S1?

.بعض الأسئلة الإرشادية للمقابلة مع مدرسة الطفل:
(S1هو الرمز الذي سيستخدم بدل أسم الطالب)

ماذا تعرف عن اضطراب نقص الانتباه وفرط النشاط؟

منذ متى بدأت بتدريس S1 وهل تعرف ما مشكلته؟

هل لديك فكرة حول ما يستخدمه S1؟ ماذا تعرف عن هذا الدواء؟

ما هي الأعراض ومعظم السلوكيات التي يشكو منها S1؟

مع إعطاء بعض الأمثلة عن هذه التصرفات؟

كيف تتعامل مع كل واحد منهم؟

(على سبيل المثال عندما ينهض S1من مقعده فجأة ، عندما لا يمكن تتبع الحصة الدراسية....)

هل تعتقد أن من المفيد لها للطفل ليكون في الصف الدراسي العادي ؟ إذا كان الجواب لا ماذا تقترح؟

هل يوجد تواصل بينك وبين أهل الطفل لمتابعة تطور حالته؟

هل توفر لS1 عناية خاصة؟ إذا كان الجواب نعم ، فما هي هذه الرعاية الخاصة؟

ما هي الموارد (إن وجدت) والإمكانيات التي تساعدك في تدريس S1؟

ما هي اقتراحاتك لتحسين الرعاية المقدمة للطالب S1 ؟

Annex V

Interview Guide for the mother

-Open questions: - Specific information on: The history of the child's current problems

-Disease - Diagnosis - Nature of the problem - the nature of the symptoms (frequency, duration, situational variation), sleep disorder

-Reasons (if there is a family history of head injury, prenatal conditions the symptoms and behavioural disturbances of child? -
- The medical treatment the child receives, social care by the child (doctor or other specialist units)

- How the mother assess infant growth, school performance, forecast of the state

- Styles to manage the child's behavior

-How mothers manage symptoms and behavioural problems
Each behaviour and symptoms will focus on the details

-The experiences of the mother's condition, its impact, handling (coping of parenthood / life)

-The child’s interaction and relationship with her, his/her siblings and friends.
- Are there resources or support to help the family and provide support? (Associations, centres ...)

- What is the interplay between family and school? And how does this interaction help the child?
- What do you suggest to help the child improve?

- Perceptions of social support in everyday life and family patterns.

أسئلة إرشادية للمقابل مع الأم:

-معلومات أساسية حول التاريخ المرضي للطفل:

منذ متى بدأ الطفل يعاني من الاضطراب ؟وكيف تم تشخيصه؟

هل هناك أسباب معينة للمشكلة (وراثة،حادث معين تعرض له الطفل،أسباب أثناء الحمل أو الولادة،)

أكثر الاضطرابات السلوكية التي يعاني منها الطفل، وكيف تطورت الإعراض منذ التشخيص وحتى الآن؟

كيف تتعامل الأم مع الطفل للتحكم بهذه الاضطرابات السلوكية (سيتم التركيز على كل اضطراب بالتفصيل)

كيف تقيم الأم وضع الطفل من حيث(نموه الجسدي وتحصيله الدراسي)،

ما هي العناية الطبية التي يتلقاها الطفل (الأدوية التي يستخدمها الطفل،المتابعة من قبل طبيب مختص أو مركز)

كيف تنظر الأم لتفاعل الطفل معها ومع العائلة ومع أصدقائه.

ما هي الموارد والجهات التي تقدم المشورة والعون للعائلة في رعاية الطفل (ان وجدت).

ما هي طبيعة التفاعل بين المدرسة والأم (إن وجد).

اقتراحات الأم لتحسين الرعاية المقدمة للطفل.

Annex VI

An-Najah
National University
Faculty of Medicine

بسم الله الرحمن الرحيم

جامعة
النجاح الوطنية
كلية الطب

IRB Approval letter

Study title:
The experience of the care giver of the Attention Deficit / Hyperactivity Disorder child (the mothers and the teachers) , and their management practices for the behaviors of the child A descriptive phenomenological study .

Submitted by:
Dr .Aidah Al -Qaisy

Date Reviewed:
Feb 20, 2011

Date approved:
Feb 20, 2011

Your study titled" The experience of the care giver of the Attention Deficit / Hyperactivity Disorder child (the mothers and the teachers), and their management practices for the behaviors of the child A descriptive phenomenological study. "Was reviewed by An-Najah National University IRB committee & approved on Jan 31, 2011

IRB

IRB Committee Chairman,
An-Najah National University
Samar Musmar,MD, FAAFP

نابلس - ص.ب ٧٠٧,٧ هاتف: ٢٣٤٢٩٠٢/٤/٧/٨/١٤ (٠٩)(٩٧٢)، فاكسميل ٢٣٤٩٧٣٩ (٠٩)(٩٧٢)
Nablus - P.O.Box 7,707 - Tel. (972)(09)2342902/4/7/8/14 - Facximile (972)(09)2349739
Web Site:www.najah.edu

Palestinian National Authority
Ministry of Education and Higher Education
Directorate of Education – Nablus

السلطة الوطنية الفلسطينية
وزارة التربية والتعليم العالي
مديرية التربية والتعليم – نابلس

الرقم: م.ن/ ٢٠/٢١/٢٤٤٢
التاريخ: ٢٤/٤/2011م
الموافق: ٢٤/٥/1432هـ

حضرة مدير/ ة مدرسة _____ المحترم/ ة

تحية طيبة وبعد،

الموضوع: الدراسة الميدانية

لا مانع من السماح للباحثة (لبنى حرازنه) بتطبيق استبانتها بعنوان (تجربة مقدمي الرعاية للطفل المصاب باضراب فرط النشاط وقلة التركيز) في مدرستكم.

مع الاحترام،،،

مديرة التربية والتعليم/

أ. سحر عكوب

السلطة الوطنية الفلسطينية * وزارة التربية والتعليم العالي * مديرية التربية والتعليم نابلس

- نسخة النائبان المحترمان.
- نسخة / الملف.

ع.ن / د.م

E:\ملفات ديانا 2009\جميع ملفات سطح المكتب التعليم العام 2009 نزار\الدراسة الميدانية - 2009.doc.

هاتف Tel. (+970-9-2380034) فاكس Fax (+970-9-2389495) نابلس ص.ب.Nablus P.O. Box (11)
.Email:edunab@hotmail.comwww.nablus.edu.ps

السلطة الوطنية الفلسطينية
وزارة الصحة- نابلس

الإدارة العامة للتعليم الصحي

Palestinian National Authority
Ministry of Health - Nablus
General Directorate of Higher &
Continuing Education

وزارة التربية والتعليم العالي
مديرية التربية والتعليم نابلس
27-04-2011
قسم الوارد
رقم الوارد ١٣

الرقم: ٢٠١١/٣٧١/١٦٢
التاريخ: ٢٠١١/٤/٢٠

Ref.:
Date:

الأخت مدير التربية والتعليم المحترمة/ محافظة نابلس،،،

تحية واحترام،،،

الموضوع: تسهيل مهمة طلاب.

تماشياً مع سياسة وزارة الصحة المتعلقة بتعزيز التعاون مع الجامعات والمؤسسات الأكاديمية بإتاحة فرص التدريب أمام الطلبة والخريجين والباحثين في المؤسسات الوطنية وإسهاماً في تنمية قدراتهم.

يرجى تسهيل مهمة الطالبة لبنى حرازنه/ ماجستير تمريض الصحة النفسية- جامعة النجاح الوطنية من اجل زيارة مدرسة (ياسر عرفات و مدرسة أخرى ترونها مناسبة) من اجل القيام بدراسة لرسالة الماجستير الخاصة بها والتي بعنوان "تجربة مقدمي الرعاية للطفل المصاب باضطراب فرط النشاط وقلة التركيز"

- شريطة: تزويدنا بنسخة من الدراسة.

مع الاحترام،،،

الدكتور سعيد الهموز
مدير عام التعليم الصحي

/ نسخة نائب الرئيس للشؤون الاكاديمية المحترم- جامعة النجاح الوطنية.

P.O .Box: 14
Tel.:09-2384771 -6 Fax: 09-2384777
E-mail: pnamoh@palnet.com
ص.ب. 14
تلفون: 6-09-2384771 فاكس: 09-2384777

جامعة النجاح الوطنية

كلية الدراسات العليا

تجربة مقدمي الرعاية للطفل المصاب باضطراب فرط النشاط وعدم التركيز (الأمهات والمدرسين) والأساليب التي يستخدمونها للتعامل مع سلوكيات الطفل.

دراسية نوعية ، الأسلوب الوصفي

إعداد

لبنى حرا زنة

أشراف

د. عائدة القيسي

قدمت هذه الأطروحة أستكمالاً لمتطلبات درجة الماجستير لتخصص تمريض الصحة النفسية المجتمعية بكلية التمريض في جامعة النجاح الوطنية في نابلس –فلسطين.

2012

تجربة مقدمي الرعاية للطفل المصاب باضطراب فرط النشاط وعدم التركيز(الأمهات والمدرسين) والأساليب التي يستخدمونها للتعامل مع سلوكيات الطفل.

دراسية نوعية ، الأسلوب الوصفي

إعداد

لبنى حرا زنة

أشراف

د. عائدة القيسي

الملخص

اضطراب نقص الانتباه وفرط النشاط اضطراب سلوكي يصيب الأطفال في جميع أنحاء العالم ويشكل عبئا ثقيلا على الطفل والأسرة، ومقدمي الرعاية حول الطفل.

تهدف هذه الدراسة إلى استكشاف تجربة مقدمي الرعاية الأولية الذين يتعاملون يوميا مع الطفل (الأمهات والمعلمين)، وفهم الممارسات التي يستخدمونها للتعامل مع سلوكيات الطفل، والنتائج والحقائق سوف تساعد على فهم احتياجات مقدمي الرعاية الأولية للأطفال من أجل تقديم رعاية أفضل.

استخدمت الدراسة المنهج الوصفي النوعي لاستكشاف خبرات مقدمي الرعاية الأولية للطفل المصاب بفرط النشاط وعدم التركيز، تم أجراء مقابلات عميقة وجها لوجه مع مقدمي الرعاية للطفل المصاب(الأمهات والمدرسين)،

العينة كانت هادفة لتحقيق أهداف الدراسة تم اختيار أربعة أطفال مشخصين اضطراب فرط النشاط وعدم التركيز وأجريت مقابلات مع أمهات، ومدرسين الأطفال، وعينة الأمهات كانت 4 و12 مدرس (3 مدرسين لكل طفل)، وتم أجراء المقابلات في منازل الأطفال ومدارسهم.

الطريقة التي تم استخدامها في التحليل هي طريقة جورجي (Giorgi method) وهي طريقة تستخدم لتحليل الأسلوب النوعي الوصفي للظواهر(phenomenological qualitative descriptive design)

نتائج الدراسة أبرزت ثلاثة موضوعات رئيسية وعشرة موضوعات فرعية في مقابلات الأمهات وهي عبء الرعاية (عبء تتبع المسار الأكاديمي، عبء أنشطة الحياة اليومية والعبء النفسي والعاطفي)، والدعم غير الكافي (غياب الدعم من الأب والأقارب، عدم وجود الدعم في المدارس، وغياب الدعم من المجتمع)، اضطرابات في سلوك الطفل (فرط النشاط، عدم الانتباه، الاندفاعية، العدوانية).

وكانت المواضيع والمواضيع الفرعية التي انبثقت عن مقابلات المعلمين: نقص المعرفة (نظرة المدرسين للتشخيص ، ونقص المعلومات المعطاة للمعلم حول الحالة الصحية للطالب، ونقص المعلومات حول معاملة الطفل ، عدم وجود المعلومات والمعارف حول الاستجابة الصحيحة للطفل.)، والاضطرابات السلوكية التي ذكرها المعلمين (عدم القدرة على إتباع قواعد الصف، التشتت، وعدم القدرة على استكمال المهام والاندفاع في الحركة والاندفاع في العاطفة، والشتم والإيذاء الجسدي)، وعدم وجود الموارد (ضيق الوقت، عدم وجود أدوات إضافية للتعليم وعدم وجود ألأشخاص المتخصصة والمدربة)، والافتقار إلى الدعم (عدم وجود مساعدة وتفهم من المدير، وقلة دعم الباحث الاجتماعي في المدرسة، وقلة الدعم والمراقبة من وزارة التربية والتعليم، عدم وجود متابعة من الوالدين)، ويقع عبء الطفل داخل الصف (سلامة الطفل، وعبء تهدئة الطفل في الصف، عبء إدارة الطلاب الآخرين).

الخلاصة: من المهم جدا فهم تجربة الأمهات والمدرسين للطفل المصاب باضطراب فرط النشاط وعدم التركيز لأنه يعكس الصعوبات والمشاكل خلال التعامل مع الطفل ، أظهرت النتائج إن هناك خلل واضح في المعرفة والفهم وكذلك الخدمات المقدمة للأطفال المصابين بقرط النشاط وعدم التركيز، وهذه الأمور تحتاج إلى تدخل من الأشخاص المعنيين لتحسين الرعاية المقدمة للأطفال المصابين باضطراب فرط النشاط وعدم التركيز.

هناك أيضا حاجة لتقديم الدعم النفسي والمعرفة لأهالي ومدرسي الأطفال المصابين باضطراب فرط النشاط وعدم التركيز لمساعدتهم على التعامل مع العبء العاطفي الذي يسببه وضع الطفل وهذا الدعم يمكن إن يشمل التعليم النفسي .