Parenting Adolescents with Attention Deficit Hyperactivity Disorder: Analysis of the Literature for Social Work Practice

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Parenting an adolescent with ADHD presents a number of unique challenges and stressors. Social workers can play an important role in providing psychosocial therapies for clients with ADHD and their families. However, practice with this population has not been well-addressed in the social work literature. This article analyzes theories of parenting stress; stress, appraisal, and coping theory; and the research literature about parenting and ADHD, with a focus on relevance for social work practice.

Key words
adolescence
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literature review

Attention deficit hyperactivity disorder (ADHD) and disruptive behavior disorders are among the most common reasons for referrals of adolescents to mental health services (Kazdin, Siegel, & Bass, 1990). ADHD is associated with significant morbidity in terms of social functioning and adjustment of both adolescents and their parents (Anastopoulos, Guevremont, Shelton, & DuPaul, 1992; Biederman et al., 1996; Breen & Barkley, 1988; Faigel, Sznajderman, Tishby, Turel, & Pinus, 1995). Social workers serving adolescents in any setting are likely to encounter clients with ADHD and provide some form of psychosocial treatment for these adolescents and their families. However, practice with this population has not been well-addressed in the social work literature. The question addressed in this article is: How do theories and research on parenting stress inform social work practice with parents of adolescents with ADHD?

Background: ADHD

ADHD is one of the disruptive behavior disorders of childhood and adolescence listed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 1994). Adolescent prevalence is 3.4 percent among girls and 7.3 percent among boys (Szatmari, Offord, & Boyle, 1989b). Comorbidity, the co-occurrence of ADHD with learning disabilities or mental health problems, is common (Biederman et al., 1996; Szatmari, Offord, & Boyle, 1989a).

The essential features of ADHD are persistent, frequent, and severe inattention; hyperactivity; and impulsivity (APA, 1994). Children with ADHD are easily distracted by extraneous stimuli and have difficulty organizing their activities. They have difficulty sustaining attention in tasks and play activities such that tasks like schoolwork and homework, which require sustained mental effort, are unpleasant experiences for them. Teachers may comment that the child could do better in school if he or she would just try harder. If inattention is a more prominent...
feature than hyperactivity, the ADHD may not be identified until adolescence, when the disorder interferes with the increasingly demanding attention and organizational requirements for academic success (Faigel et al., 1995). Impulsivity in ADHD is characterized by impatience, difficulty delaying responses, and social intrusiveness. These problems interfere with social relationships. Impulsivity may result in accidents and the adolescent’s engaging in potentially dangerous activities without thinking about the consequences.

ADHD-associated impairments affect children at home, with friends, at school, and in the community. The disorder persists into adolescence for a majority of individuals. Although ADHD symptoms generally are resolved by adulthood, there are significant risks of psychosocial impairments, such as poor academic or occupational adjustment and antisocial behavior (Hechtman, 1996).

The goals of ADHD treatment are reduced morbidity, improved functioning, and prevention of negative sequelae. Treatments include psychopharmacologic treatment with stimulants or other medications; social skills and relationship training for the child or adolescent; individual counseling or cognitive therapy for the adolescent; family therapy; parent counseling and education; and modification of the school environment. It is generally acknowledged that no single treatment may be sufficient, and multimodal treatments are recommended (Barkley, 1990; Faigel et al., 1995).

Stress and Parenting

A number of theorists and researchers have postulated a relationship between parenting and the course and outcome of ADHD. Some have investigated parental psychopathology and dysfunctional parenting as risk factors for childhood ADHD and negative sequelae. Others have proposed more complex reciprocal and interactive relationships among parenting, expression of ADHD, and ADHD problem behaviors as sources of parenting stress. Three models guide research in the field of parenting stress (Abidin & Burke, cited in Abidin, 1990; Mash & Johnston, 1990; Webster-Stratton, 1990) and are compatible with ecological systems models of social work practice. They recognize that parenting is a highly complex task; that an interplay among parent, child, and environmental factors influences parent–child interactions and child outcomes (Abidin, 1990).

The earliest model of stress and parenting, proposed by Abidin and Burke (cited in Abidin, 1990), strongly influenced subsequent theorizing and research. According to this model, the degree of parenting stress is determined by parent factors such as health, depression, sense of competence, personality, and psychopathology; child factors including adaptability, acceptability, demandingness, mood, hyperactivity, and reinforcing the parent; and social–environmental factors such as parent role restrictions, spousal relationship, and social support. Parenting stress, in turn, results in dysfunctional parenting, which then influences child outcome (Abidin, 1990). This model is limited in its applicability to social work practice with parents of adolescents with ADHD, because parenting stress is not clearly defined, and examination of the relative importance of the child, parent, and environmental factors is not possible. Furthermore, it does not elucidate a process that might be influenced by therapeutic interventions.

Mash and Johnston (1990) proposed a four-component model of parent–child interactive stress that focuses on explaining parent–child conflict. Parent–child conflict is determined by characteristics of the child, the environment, and the parent. Each of the three determinants has a direct effect on interactive stress. In addition, parent characteristics mediate the effects of the child and the environment on interactive stress. Parent–child conflict has an impact on the child, the environment, and the parent. The differences between the concepts parenting stress, interactive stress, and parent–child conflict are not clear in this model, limiting its usefulness for practice.

Webster-Stratton’s (1990) model of stress and parenting in families with children with conduct problems is a process of parental coping with stressors. According to this model, three classes of stressors influence parenting (extrafamilial stressors, interpersonal stressors, and child stressors). The impact of these stressors on parenting is mediated by the parent’s psychological well-being, personal resources, and appraisal of the stressor. In theory, child conduct problems result from disrupted parenting.

The utility of these models for guiding social work interventions with parents of adolescents with ADHD is limited by their focus on explaining child outcomes and by their relative lack of attention to parent outcomes. It is difficult to distinguish between parenting and child behaviors as causes or consequences of one another. The models lack conceptual clarity with respect to both child and parent outcomes. For example, parental
depression is a stressor, a mediator, and an outcome of parental coping.

The focus on child outcome implies an assumption that interventions with parents would be valued if they had an effect on child outcome. However, the stress experienced by some parents of adolescents with ADHD is considerable. Relief of that stress would be worthwhile even if it did not have an appreciable immediate effect on adolescent behavior.

**Stress, Appraisal, and Coping Theory**

Lazarus and Folkman’s (1984) theory of stress, appraisal, and coping is a useful framework to guide practice with parents of adolescents with ADHD. It offers greater conceptual clarity than the parenting stress models. The theory is compatible with a goal of facilitating the process of client adaptation. It has been successfully applied to social work practice with clients in similar stressful circumstances, for example, families of adults with psychiatric illness (Hatfield & Lefley, 1987).

Lazarus and Folkman’s (1984) theory is a cognitive model of a process of coping with stress. Essential components of the model are psychological stress, appraisal of stress, coping, and the adaptation outcomes of coping (morale, social functioning, and somatic health). Psychological stress occurs when an individual judges his or her relationship with the environment as taxing, exceeding resources, or endangering personal well-being (Lazarus & Folkman). Potential stressors for parents of an adolescent with ADHD may stem from the adolescent’s problems sustaining attention (for example, difficulty attending to and following instructions, losing or forgetting homework assignments, difficulty sustaining attention to schoolwork); from the social effects of ADHD behaviors (for example, taunting by other children or problems with friendships); from impulsivity and related risks to the adolescent’s personal safety (for example, physical injuries or risky use of motor vehicles); or from the reactions of people outside the family (for example, frequent complaints from school). These stressors occur in the context of other stressors in parents’ lives, including the normal stresses in the parent–adolescent relationship as developmental tasks of autonomy and individuation are worked out.

Cognitive appraisal determines whether the person-in-environment relationship is judged as stressful or not (Lazarus & Folkman, 1984)—that is, adolescent ADHD behavior may or may not be stressful, depending on how the parent appraises the behavior. One parent may find adolescent impulsivity particularly stressful, whereas another parent may find phone calls from school principals or sibling conflict more stressful.

Theoretically, cognitive appraisal is influenced by personal characteristics such as commitments, values, and beliefs; situation characteristics such as novelty, predictability, event uncertainty, immience, duration, and temporal uncertainty of the stressor; and timing of stressful events in the life cycle and in relation to other events (Lazarus & Folkman, 1984). For example, parents who value education would find school problems stressful and focus their coping efforts on school problems; parents who believe they can control their adolescent’s behaviors would focus their coping efforts on attempts to change the behaviors. With respect to appraisal of situation characteristics, adolescent behaviors that are seen as “normal” would be less stressful. Thus, theoretically, parents’ understanding of ADHD and adolescent development influences their appraisal of the situation. Finally, parents’ simultaneous experiences of other stressors, such as household moves, family caregiving, or work-related stressors, influence their appraisal of their adolescent’s behaviors. For example, long-standing ADHD-related stressors might be reappraised as more or less stressful in the context of a new stressor, such as job stress.

Coping is an individual’s “constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). Coping is what parents do to manage stressors, determined by their resources and constraints on the use of resources. Coping efforts are modified on the basis of a continuous process of reappraisal of the stressful situation. Problem-focused coping efforts include reading about ADHD, adolescent development, and parent–adolescent relationships; restricting the adolescent’s activity; arguing with the adolescent; or working to change expectations at school. Emotion-focused coping efforts include removing one’s self from the stressful situation; venting frustrations; or reappraising a situation as less stressful (for example, cognitive reappraisals such as “it could be worse” or “my child is not doing this on purpose”).

Social support, self-efficacy, and attribution are theoretically and empirically linked with appraisal
(Lazarus & Folkman, 1984; Maddux, 1995). Social support may have positive or negative effects in the coping process (Lazarus & Folkman). Parents often report isolation from friends because of their children’s ADHD-related behavior. They may feel blamed for their children’s behavior by extended family members. Conflicting understandings of ADHD and its treatment may further isolate parents from their families, who might otherwise be a source of support (Alexander-Roberts, 1995).

Self-efficacy is the individual’s perception of ability to perform a specific behavior or task (Bandura, 1986). High conflict management self-efficacy is associated with likelihood of initiating, persisting, and cooperating with problem-solving strategies to manage family conflict (Doherty, 1981a). Thus, self-efficacy is a theoretical determinant of whether a parent engages in emotion-focused or problem-focused coping. For example, perceived competence as a negotiator would affect a parent’s willingness and ability to advocate on the child’s behalf in the school system; low sense of competence as a parent might result in help seeking.

Attribution theory concerns how people use information to make causal inferences. Attribution affects problem-solving abilities and plays a role in family conflict. In conflict, one attributes cause to oneself, the other person, or the external environment. Attributing negative intent to another results in blame (Doherty, 1981a). Such attributions of malicious intent are a major dimension of parent–adolescent conflict in ADHD (Robin, 1990). Theoretically, if parents view their adolescents’ behaviors as deliberate attempts to annoy or antagonize them, adaptive coping ability will diminish.

Adaptation is the outcome of coping efforts. It is multifaceted, including morale, general well-being, health, and social functioning (Lazarus & Folkman, 1984). Potential negative adaptation outcomes include parents’ depressed or anxious moods, physical illnesses, and impaired social functioning. Outcomes are not static. In this model of a process of appraisal and reappraisal, outcomes influence subsequent appraisal of the stressful person–environment relationship and coping efforts. The ongoing process inherent in Lazarus and Folkman’s theory is particularly useful when thinking about parenting stress in adolescent ADHD, where social functioning in the parent role influences adolescent behavior which, in turn, affects appraisal and subsequent outcome.

To summarize, according to stress, appraisal, and coping theory, adolescent ADHD-related behavior is a stressor that occurs in the context of other stressors in a parent’s life. Whether or not adolescent ADHD is stressful for a parent depends on cognitive appraisal, which is influenced by characteristics of the parent and by adolescent behavior. Parents who experience their adolescent’s ADHD as stressful engage in coping efforts. The outcome of coping is adaptation and includes parents’ role performance. Parents’ role performance, in turn, influences adolescent behavior. Compared with the models of parenting stress, Lazarus and Folkman’s (1984) theory provides greater conceptual clarity, elucidation of a process, and less potential for confounding of stressor and outcome.

Related theoretical constructs, including social support, self-efficacy, and attribution theory, can be incorporated for application to social work practice.

**Parents’ Stress, Appraisal, Coping, and Adaptation: Research Evidence**

The research on stress and parenting adolescents with ADHD has several methodological limitations. The predominance of cross-sectional, correlational, and case-control study designs limits our ability to make causal inferences. Few studies followed children and parents over time or tested the effects of changes in child behavior on parent stress. Most of the research has been conducted with parents of younger children and, therefore, some of the research findings may not apply to parents of adolescents. Research has tended to focus on mother–child relations. To the extent that fathers’ experiences differ from mothers’ experiences, the research findings may have limited relevance for work with fathers. Finally, most of the studies measured parenting stress using an overall summary score of the Parenting Stress Index (Abidin, 1986). This means it is impossible to untangle the relationships between stressor, appraisal, and outcome because they are confounded or combined in the summary score.

**Parents’ Experiences of Stressors**

The research literature indicates that severity of child behavioral disturbance is an important characteristic of the stressful situation. Parent stress is higher for the parents of children with ADHD than for the parents of other children, and parent stress is consistently associated with both
behavioral disturbance and severity of ADHD (Anastopoulos et al., 1992; Breen & Barkley, 1988; Mash & Johnston, 1983). Mothers’ perceptions of problem behavior were congruent with ratings of other observers, indicating that faulty perceptions of severity of behavior do not account for differences in parent stress (Mash & Johnston, 1990). Thus, regardless of their stress levels, mothers are good informants about their children’s behavior and about their stress.

Investigations of parent–child interactions in ADHD indicate that child behavior is a stressor that influences parent behavior in the parent–child interaction. When interactions between children with ADHD and their parents were observed, situations requiring the child to accomplish a task resulted in greater parent–child conflict. Child compliance and maternal responsiveness were lower, and mothers were more negative and reprimanding (Barkley, 1990). When child behavior was modified by stimulant medication, maternal responses normalized (Barkley, 1989). In a trial of stimulant medication for childhood ADHD, response to medication was associated with increased maternal warmth, decreased maternal criticism, and greater frequency of contact (Schachar, Taylor, Wieselberg, Thorley, & Rutter, 1987). Thus, it will be insufficient to focus solely on changing parental coping.

An investigation of parent–adolescent interactions in ADHD indicated a pattern similar to parent–child interactions (Barkley, Fischer, Edelbrock, & Smallish, 1990). Adolescents with ADHD and comorbid oppositional defiant disorder (ODD) were more likely than normal controls to use commands and put-downs and to be less communicative with their mothers during conflict discussions. Mothers, in turn, used more commands and put-downs, talked less, and were more defensive. However, the interactions did not differ when the normal controls were compared with adolescents with ADHD but not ODD, suggesting that the presence of ODD increases parent–adolescent conflict.

The impact of characteristics of the stressor, other than child behavior, on parent stress and coping has not been well investigated. Younger age of the child is associated with higher maternal depression and self-blame (Mash & Johnston, 1983). Where it was tested, there was no relationship between child gender and parent stress (Breen & Barkley, 1988). Evidence that comorbidity is associated with increased parent–adolescent conflict (Barkley et al., 1990) indicates that there may be a greater effect when there are more sources of stress.

**Parent Characteristics and Stress Appraisal**

There are a limited number of empirical investigations of theoretical relationships between parenting stress related to adolescent ADHD and parent characteristics such as kin relationship, culture, or attitudes and beliefs about adolescent development. Mash and Johnston (1983) found that fathers’ appraisals of their children’s behavior were less severe than mothers’ appraisals. This finding indicates that fathers may experience ADHD differently than mothers. It highlights the need to consider that each parent’s experiences and needs will likely be different.

**Self-Efficacy**

Clinical observation indicates that some parents reach a state of “parenting learned helplessness” as a result of a long series of failed attempts to manage their children’s behavior (Barkley, 1990). Some parents of adolescents with ADHD attending a mental health center reported feeling as if they were “complete failures as parents” (McCleary & Ridley, 1999). Empirical evidence about parenting self-efficacy and coping efforts is scant. Two studies found that, compared with controls, parents of children with ADHD had lower sense of competence, lower perceived adequacy of parenting skills and knowledge, and less comfort in the role of parent (Breen & Barkley, 1988; Mash & Johnston, 1983). Thus, diminished parenting self-efficacy should be anticipated. When diminished parenting self-efficacy and repeated failures occur despite professional assistance, parents may be less likely to seek help.

**Attribution**

Only one study of parental attributions of ADHD behaviors has been conducted. Mothers of adolescents with conduct disorders were more likely to view problem adolescent behaviors as intentional than were the mothers of control group adolescents. Attribution of intent was correlated with severity of the behavior problem (Baden & Howe, 1992). These findings may not apply to parents of adolescents with ADHD, where behavior problems would be less severe. Anecdotal evidence from evaluation of parent education groups indicates that an important outcome for parents is the
realization that their adolescent’s behavior is not malicious (McCleary & Ridley, 1999).

**Information**

Experts in the field of ADHD advocate providing information as part of treatment for families of children and adolescents to correct misperceptions about ADHD and to diminish negative feelings that may accompany misperceptions (Barkley, 1990; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992). Research indicates conflicting findings about the relationship between knowledge about ADHD and willingness to pursue treatments for ADHD (Liu, Robin, Brenner, & Eastman, 1991; Rostain, Power, & Atkins, 1993). A moderate negative correlation between mothers’ knowledge of ADHD and perceived parenting competence (Rostain et al.) suggests that providing information about ADHD may improve mothers’ confidence. Limited evaluations of family therapies for child and adolescent ADHD, which include providing information, indicate positive effects on parent–child conflict, child behavior and adjustment, family functioning, and parent mood (Barkley, 1990; Barkley et al., 1992).

**Social Support**

A longitudinal study found higher rates of separation and divorce associated with parenting a child with ADHD (Barkley et al., 1990), indicating that an important source of support for these parents was lost. Mothers of children with ADHD report greater social isolation than mothers of normal control children, and social isolation is positively correlated with severity of hyperactivity (Breen & Barkley, 1988; Mash & Johnston, 1983). Interventions aimed at increasing social support may overcome some of the isolation.

**Coping Skills**

Problem solving and social skills are among the personal resources available for coping (Lazarus & Folkman, 1984). To engage in problem-focused coping, for example, negotiating curfews or homework, or resolving parent–adolescent conflict, the parent must possess the appropriate skills. Research about the effects of parent training provides some evidence about the relationship between parenting skills and parents’ stress and coping. Family training in problem solving and communication effectively reduces parent–adolescent conflict and family problems in a variety of client groups (Robin, 1990). Family education and family therapy in adolescent ADHD may be effective (Barkley et al., 1992; McCleary & Ridley, 1999). Skills training seems to be an important addition to providing information. As of yet, we do not know which format for providing information and parenting skills training is most beneficial, nor can we predict which parents will benefit.

**Implications for Practice**

Stress, appraisal, and coping theory and the findings of empirical research summarized here have a number of implications for assessment and for the provision of psychosocial treatments. First, it is expected that parents will uniquely appraise what may objectively appear to be similar stressors. Accurate assessment of parents’ perceived stress and differential appraisal of stressors are essential for planning and evaluating work with parents. Low self-efficacy should be anticipated and care taken not to reinforce parents’ feelings of self-blame or failure.

The evidence that severity of behavioral disturbance is an important determinant of parenting stress suggests that reducing problem behaviors will reduce parents’ stress. Medications such as stimulants for the treatment of ADHD may play an important role in reducing problem behaviors and parents’ stress. To balance the positive effects of stimulants on concentration and attention against side effects such as interference with sleep, stimulants are frequently prescribed only for school hours. Thus, ADHD-related behaviors are often worse at home in the evening and on weekends and the impact of medication on parenting stress may be limited. Medication may not be as effective for some patients, or a choice may be made to not use medication. In these instances stress may be higher, magnifying the importance of providing psychosocial treatments. Parents and adolescents should be given information about the potential benefits and risks of medication and have access to a range of psychosocial therapies, for example, adolescent social skills training or parenting skills training. A narrow focus on ADHD symptom management will likely be insufficient.

Parent education in this client group may improve parents’ abilities to make treatment decisions and obtain treatments. Potential benefits include improved confidence, correcting misperceptions about ADHD, changing negative attributions about adolescent behavior, and helping parents to reframe their experiences as manageable. Education may be provided directly by social workers. In
addition to providing information, training in problem solving and communication may be necessary to change and improve coping skills. Education and skills training can be efficiently provided to groups of parents. Parents can obtain information about ADHD, adolescent development, and parent–adolescent conflict from a variety of sources, including videotapes, pamphlets, books written by parents (for example, Alexander-Roberts, 1995) or for parents (for example, Wender, 1987), and various Web sites.

Self-efficacy theory suggests that interventions to improve knowledge and coping skills will be insufficient. It is important not only to help parents improve their coping skills and competence, for example, by teaching conflict resolution skills, but also to support parents to view themselves as competent. Participation in education or support groups for parents of adolescents with ADHD may improve parenting self-efficacy.

Given the potential for the isolating effects of ADHD problems, it is important that social support networks be assessed and considered as a potential locus of intervention. For example, providing services to extended family members may reduce conflict with the extended family about the adolescent’s behavior and ADHD treatment, thus reducing an additional source of parent stress. It may also help parents access extended family as a source of support. Some parents find support from other parents helpful. Children (and Adults) with Attention Deficit Disorder, a lay organization, provides support and information meetings for members and the public.

**Conclusion**

In summary, the literature indicates that a number of therapeutic interventions with parents may be effective, including comprehensive assessment of sources of stress; providing information about adolescent development, ADHD, and the range of ADHD treatments; including education for the extended family; and parenting skills training. Much of the limited information about parenting and ADHD is in the psychology literature. Social workers are among those developing and providing psychosocial treatments for parents of adolescents with ADHD. However, description of such treatments is lacking in the social work literature and in the multidisciplinary literature. Furthermore, the effectiveness of such interventions is, for the most part, untested. The challenge facing those working with adolescents with ADHD and their parents is to evaluate their interventions and to disseminate the results of the evaluations. Pressing questions include which components of psychosocial interventions are essential, what are the outcomes, and who is most likely to benefit.

**References**


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