



Parents psychopathology of children with Attention Deficit Hyperactivity Disorder

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ABSTRACT

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder with extremely complex etiology, not yet well defined but certainly multi-factorial. This study investigated the possible etiopathogenetic role of ADHD symptoms and psychopathology disorders in parents of children with ADHD. We present a case–control study of parents of 50 children affected by ADHD and of 45 healthy children, matched to age and gender. Parents of ADHD children reported higher levels of ADHD symptoms, depressive disorders and Depressive Personality Disorders than parents of healthy children. Mothers displayed greater presence of depression, while fathers showed problems concerning alcohol use. The occurrence of ADHD symptoms, psychopathology and personality disorders in parents highlights the importance to integrate the treatment programs in the ADHD children with the screening and treatment for psychopathological symptoms of the parents.

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1. Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is neurodevelopmental disorder with three core symptoms: inattention, hyperactivity and impulsivity. The ADHD etiology is multi-factorial whereby genetic factors are a predisposition to the disorder, but the activation of this susceptibility is modulated by acquired risk factors, both biological and environmental. Recent developments in the field of ADHD have led to a renewed interest in the link between parental psychopathology and child functioning. Indeed the family is an important aspect of the child's environment that has been linked to variability in comorbidity, academic performance and social difficulties for children with ADHD. In a review study, Johnston and Mash (2001) reported that the presence of ADHD in children is associated to varying degrees with disturbances in family and marital functioning, disrupted parent–child relationships, reduced parenting self-efficacy and increased levels of parenting stress and parental psychopathology, particularly when ADHD is comorbid with conduct problems. Children with ADHD often ignore parental requests, fight with siblings and peers and elicit negative reactions from teachers, in turn, the parents of children with ADHD tend to be more controlling, disapproving and rejecting of their children, they give more verbal direction, repeated commands, verbal reprimands and correction than parents of children without ADHD; they are also less rewarding and responsive than parents of children without ADHD (Johnston & Mash, 2001; Kim & Yoo, 2012; Mano & Uno, 2007). Thus, it is conceivable that parental psychopathology is likely to be linked to greater involvement in managing the problem. Parent diagnosed disorders and personality traits are rarely examined together but these might contribute differentially to child behavioral outcomes. Actually, parental mental illness influences directly and indirectly on the

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development of the child affected by ADHD (Bornoalova, Hicks, Iacono, & McGue, 2010; Loeber, Hipwell, Battista, Sembower, & Stouthamer-Loeber, 2009). Indeed, parents of children with ADHD are at risk of experiencing more mental disorders than parents of children with typical development (Humphreys, Mehta, & Lee, 2012; Johnston et al., 2001). For this reason, it is important to consider the relationship between parental psychopathology and parenting practices with respect to children's behavioral symptoms. A limited number of studies have reported that parent history of childhood ADHD is associated with child ADHD regardless of comorbid CD or ODD (Psychogiou, Daley, Thompson, & Sonuga-Barke, 2007). High levels of parental ADHD symptoms might also aggravate the negative parenting of children with ADHD and the arguing patterns of parent–child interactions (Ellis & Nigg, 2009; Harvey, Danforth, McKee, Ulaszek, & Friedman, 2003). Kashdan et al. showed that parental anxiety was also uniquely related to negative parenting practices with ADHD children. The authors suggested that parental anxiety might make parents particularly vulnerable to significant distress, with reciprocal interaction patterns between parents and children contributing to negative interpersonal styles (Kashdan et al., 2004). In a longitudinal study, Chronis et al. investigated the role of parent psychopathology and observed parent–child interactions, on the development of conduct problems in children with ADHD over early childhood. They detected that both maternal depression and parenting during early childhood (i.e. observed praise and positive affect) were unique predictors of the developmental course of conduct problems (Chronis, Gamble, Roberts, & Pelham, 2006; Chronis, Jones, & Raggi, 2006).

Although parent personality is thought to relate to the development of child psychopathology study of specific parent traits in relation to child ADHD and associated problems has been relatively neglected (Nigg & Hinshaw, 1998). We propose that parents' personalities might influence their parenting and children's developmental outcomes.

Moreover, greater severity of ADHD symptoms and the presence of comorbidity have been linked to the increase in family conflict, reduced family cohesion and in an authoritarian and punitive parenting style (Biederman et al., 2001; Buschgens et al., 2010). The relationship between parental psychopathology and ADHD symptoms in children is complex and appears to influence each other hence triggering a cycle of cause and effect that characterizes the entire family system. Hence further investigations are required into ADHD with a multidimensional approach that includes parental psychopathology and familial predisposition to ADHD into a dynamic system.

We hypothesized that parental psychopathology play a role in the development of ADHD. Thus, we investigated parental psychopathology in ADHD children to demonstrate a specific impairment in parental functioning and parenting practices. Moreover, we analyzed the differences between mother and father to detect specific psychopathological features in parents of ADHD children.

2. Methods

2.1. ADHD sample

We recruited the parents of 50 children (mean age = 8 years 4 months \pm 3 years 8 months) affected by ADHD (45 males and 5 females). ADHD children, referred to the Child Neuropsychiatry Unit, Department of Neuroscience and Sensory Organs, University of Bari "Aldo Moro", were diagnosed according to the criteria of *Diagnostic Statistical Manual of Mental Disorders IV Edition-Text Revised (DSM-IV-TR)*. The diagnosis of ADHD involved clinical observation and neuropsychological assessment including scales, structured and semi-structured interviews and questionnaires: Wechsler Intelligence Scale for Children (WISC-III) (Wechsler, 1991), Leiter International Performance Scale-Revised (Roid and Miller, 1997), Child Behavior Checklist (CBCL) (Achenbach, Howell, Quay, & Conners, 1991) for parents and Teacher Self Report (TSR) (Achenbach et al., 1990), Conners' Rating Scales-Revised (Conners et al., 1997), Clinical Global Impressions (CGI) (Guy, 2000); and Children's Global Assessment Scale (CGAS) (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000).

2.2. Control group

The control group involved volunteer parents of 45 healthy children matched to age ($t = 1.25$; $p = 0.21$) and gender ($t = 2.04$; $p = 0.15$), that were recruited from regular primary and secondary schools and were fully informed about the research. Exclusionary criteria included a history of a seizure disorder, mental retardation, progressive neurological problems, traumatic brain injury, or any other serious medical condition. Children with non biological parents were not included in the study.

The study was approved by the local ethical committee "Azienda Ospedaliero-Universitaria Consorziale Policlinico di Bari"; all the parents who were interviewed provided a written consent.

2.3. Assessment

The assessment of the parents included clinical standardized interviews and scales, such as the Brown Attention Deficit Disorder Scales (BADDs), the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II).

The Brown Attention-Deficit Disorder Scales for Adolescents and Adults (BADDs) (Brown, 2009) is used to assess Attention Deficit Disorder (ADD) symptoms in adults. These scales explore the executive cognitive functions associated with ADHD and consist of 40 items that assess five clusters of ADD-related executive function impairments: (1) organizing,

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