Knowledge of Parents toward Children with Attention Deficit Hyperactivity Disorder in Baghdad City

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Abstract

Attention deficit/hyperactivity disorder (ADHD) is one of the most common psychiatric disorders in child and teenage psychiatry. ADHD children are at risk for a school organization constrains a multimodal treatment database[1]. This study surveys parent's knowledge and attitudes towards attention deficit hyperactivity disorder. The study aimed to assess the level of the knowledge and perspective for Parents who have children with Attention Deficit Hyperactive Disorder. A non-probability, purposive sample of 75 child and 75 parents (40 mothers and 35 fathers), who had children with ADHD between the ages of (4 and 12) were selected. A descriptive study was conducted at the Child Psychiatric Unit at Ibn Rushed Psychiatric Teaching Hospital and Central Child Hospital Teaching in Baghdad City, from September8st to October 30th, 2017. A questionnaire format used for data collection and constructed by the researcher to achieve the objectives of the study. Reliability of questionnaires was estimated through a pilot study which was carried out for the period from December 10th 2017 to December 30th 2017. Data were analyzed through the application of descriptive statistical analysis and the application of inferential statistic. The results of the study indicate that the ADHD parents are no significant association between father knowledge and ' socio-demographic except income ,child age, gender and received medication which was correlated significantly at p-value 0.01 respectively. The researcher recommended that future researches should be directed toward teaching parents and teacher to increase their knowledge about the ADHD and provide many strategies to help them to reduce parents burden and coping .

Key words: *knowledge, Attention deficit hyperactivity disorder,Parents*

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a commonly diagnosed behavioral disorder of childhood that is characterized by symptoms of inattention, hyperactivity and impulsivity. There has been a dramatic increase in diagnoses of ADHD in recent years [1] · The primary features of the disorder are inattention, hyperactivity, and impulsivity, which combine in various ways to create three different subtypes of ADHD. Predominately Inattentive, Predominantly Hyperactive-Impulsive, and a Combined type [2] · Prevalence rates for ADHD for example in New Zealand are around 5% of school-aged children with rates for boys 3 times higher than those for girls [3] Similar prevalence rates are found in the U.S. and internationally [4] . A prevalence of 3–5% in the general population is the name of a group of attention-related symptoms that are often found together, especially in children and young adults. Prevalence rates among school-age children in the United States range from roughly 4% to 12 more, the percentage of children treated for ADHD in the United States increased dramatically from the 1980s to the 1990s [5] ·Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common reasons behind children referral to mental health clinics with estimated prevalence rates of 5% of school aged children [6] As noted ADHD is a chronic condition characterized by impairments in impulse control, sustained attention, and the regulation of behavior in response to situational demands [7] .Educational programs which increase parents and community awareness toward ADHD should be encouraged through the media.Establishing special school or institute for ADHD children to provide special services to decrease parents' psychological distress. Constructing a special program for children performing

at home and in the school in cooperation with the parents. This will depends on positive reinforcement for satisfactory behavior management.Monitoring ADHD children by their teacher using special questionnaires and standards of their behavior, to measure the type and degree of the child's behavior al distress.Establishing supportive groups allow for a personal touch where parents with similar problem and stressors might be more willing to share one to one.

Methodology

A descriptive-analytic study was carried out at the Child Psychiatric Units at Ibn Rushed psychiatric Teaching Hospital and Central Child Teaching Hospital in Baghdad.A purposive sample (75 children) was selected for the present study (The total number of children who had diagnosis with ADHD is 338). Seventy five parents of children with a primary diagnosis of pure ADHD were selected. The subject pool for this phase included 40 mothers and 35 fathers between the ages of 30 and 55 who had children between the ages of 4 and 12years. Questionnaire is constructed for the purpose of the study through a review of relevant literature and consultation from a panel of experts. The questionnaire includes three parts which are distributed as follows: Part I is a covering letter to obtain the agreement of patients and their family members to participate in the present study. Part II Parents demographic characteristic that included age, level of education, level of family income and marital status.Part 3 Attention-Deficit/Hyperactivity Disorder Knowledge Survey (AKOS-R). Onto their next visit to the clinic, participants were randomly assigned to parents after received an educational lecture about ADHD. All participants again completed and the AKOS-R.

The validity of questionnaire was determined by exposing it to (10) expert of different fields. Reliability was determined through a pilot study that was carried out on (15) parents who had ADHD child and were visiting in the Child Psychiatric Units.The internal consistency of the instrument was determined through the computation of Spelt-half. The results of the reliability werer=0.88.

Result and Discussion

Table (1) show that the mother age range group were fallen within the age 30-39 years old (48%). However the majority of percentage of father's age group were not fallen only within the age of 30-39 years (37.3 %) but also within the range of 40-50 years old and shows that the most mothers were secondary school and university graduated (42.7%), (41.3%), respectively that the majority of parent's educational score were fallen among fathers group 3 (37.3% and group four (42.7 %) whose score levels were within higher educational groups (secondary and Colleges.Table shows that the majority of Children with ADHD (58.7%) were receiving medication up to three years, the majority of ADHD Children were among urban regions (71%) while only 9.3% of children with ADHD were from rural area. that the majority of children with ADHD were male (81.3%),this table shows that the majority of Children with ADHD (58.7%) were receiving medication up to three years.Knowledge about ADHD was comparatively low, 86% of parents agreed that children with ADHD are usually brighter than those without AHD. 58% of the parents considered the most effective treatment of school-aged children are stimulant medication ,behavior modification ,or a combination of the two . The attitude score towards ADHD children was also low. 76% agree that medication often reduces child's tendency to be aggressive with others at school. 72% believe that almost all children with ADHD meet national and state standers for learning disabilities.69.3% of parents believes that children who are hyperactivity at the age of 3 almost always become identifies as having ADHD by the age of 7. 74.7% of parents unsure that in most cases, medication will help a child achieve better grades in school, also about 64% of them considered most children with ADHD, psychology treatment are not as effective as medication in improving attention and reducing disruptive behavior

Table 1. Correlation between fathers knowledge and 'child ADHD Variables (N= 75)

Correlation	Knowledge	Father age	Education father	Employment	income	city	Child age	medication
Knowledge	1.00							
Father age	.008	1.00						
Education father	.026	.055	1.00					
Employment father	-.201	.133	-.181	1.00				
Child age	.087	.314**	-.123	.081				
Gender	.059	-237*	.075	.061	-150			
city	.130	-.131	-.056	.088	.-101	.082		
Medication	.099	.320	-.155	.063	344**	-275	-108	1.00
income	.043	.071	-.484**	.205	.161	.093	.148	-018

**. Correlation is significant at the 0.01 level (2-tailed

*Correlation is significant at the 0.05 level (2-tailed)

The findings indicate that there is no significant association between father knowledge and ' socio-demographic except income, child age, gender and received medication which was correlated significantly at p-value 0.01 respectively.

Table 2. Correlation between mothers knowledge and 'child ADHD Variables (N= 75)

Correlation	Knowledge	Father age	Education father	Employment	income	city	Child age	Medication
Knowledge	1.00							
Mother age	.007	1.00						
Education mother	-118	.000	1.00					
Employment mother	.053	.340**	.467**					
Child age	.087	.435**	-283*	.067				
gender	.059	-259*	-001	-.014	-150			
city	.130	-226	.029	.124	-101	.082		
Medication	.099	.384**	.038	-183	344**	-275*	-108	
income	.043	-.097	-520**	.268*	-.093	.148	.018	1.00

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

This table shows that there is significant association between the parents knowledge and the socio demographic at p-value 0.05..

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Conflict of Interest: None to declare.

Ethical Clearance: All experimental protocols were approved and all experiments were carried out in accordance with approved guidelines.

References

1. Biederman J, Mick E, Faraone S, Braaten E, Doyle A, Spencer T, Wilens T, Frazier E, Johnson M A.: Influence of gender on attention deficit hyperactivity disorder in children referred to a psychiatric clinic. Am J Psychiatry; 2002;159: 36–42.
2. Nelson RA. Behavior disorders of childhood, New Jersey: Prentice Hall, 5thed, 2003
3. Ministry of Health (MOH): New Zealand Guidelines for the Assessment and Treatment of Attention Deficit/Hyperactivity Disorder, Wellington: Ministry of Health, 2001.
4. Barkley R . Attention-Deficit Hyperactivity Disorder: AHandbook for diagnosis and treatment (3rd ed.). New York: Guilford Press. 1999
5. Olson M, Gameroff M. Marcus SC, Jensen PS: National trends in the treatment of attention deficit hyperactivity disorder. Am J Psychiatry, 2003;160:1071-1077.Oxford
6. Barkley RA: History, in Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. New York, Guilford,1998; 3–55
7. American Psychiatric Association (APA).: Diagnostic and Statistical, Manual of Mental Disorders, 4thed, 1994.
8. Goldberg DP, Hillier VFA scaled version of the General Health Questionnaire. Psychological Medicine, 1979;9: 139- 45.
9. Bibou-Nakou I, Dikaiou M, Bairactaris C. Psychosocial dimensions of family burden among two groups of carers looking after psychiatric patients. Soc Psychiatry Psychiatr Epidemiol 1999; 32: 104-108.
10. Brannan A. Hefflinger, C. Distinguishing caregiver strain from psychological distress, Modeling the relationship between child, family, & caregiver variables, Journal Child & Family Studies, 2001;10: 405- 1
11. Podolski C , Nigg J.: Parent stress coping in relation to child ADHD Severity and associated child disruptive behavior problem, Journal of clinical psychology, 2011;4: 503- 13.
12. Bagwell C, Molina B, Pelham W , Hoza B: Attention- Deficit Hyperactivity Disorder (ADHD) and Problems in Peer Relations, predictions from childhood to adolescence. J Am Acad Child Adolesc Psychiatry, 2009; 40: 1285-1292.
13. Smith BH , Pelham WE , Gnagy E , Yudell R S.: Equivalent effects of stimulant treatment for Attention-deficit Hyperactivity Disorder during childhood and adolescence, Journal of the American Academy of Child and Adolescent Psychiatry, 1913;37: 314- 21.