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RESEARCH ARTICLE

Effect of Clinic-Based Parental Guidance with ADHD Management on Parental Attitude and Behaviour in ADHD Children – A Practice-Based 5-Year Follow-Up

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Abstract

Introduction: The prevalence of ADHD in India is 8 to 10 % of school-going children. Yet most parents do not seek the advice of a Developmental Paediatrician /mental health professional due to stigmas present in society and lack of awareness. In many cases, it's difficult for the parents to exactly understand the progress.

Aims and Objectives

To track the progress of ADHD children and see if there is a difference in the parental outlook.

Materials & Methods

A Quantitative Study on ADHD patients by using a self-administered survey questionnaire.

Results

A total of 50 parents of ADHD children were asked to answer the survey questionnaire, out of which 35 were answered. The survey comprised of77.8% males and 22.2% females; 48.1 % of children were 16 to 20 years old, 29.6% were 7 to 10 and 14.8 % were 11 to 15 years of age. 40.7% visited the clinic at the age of 11 to 15 and 25.9% at the age of 7 to 10. The common reasons for consultation were low concentration (88.9%), inattention (77.8%), hyperactivity (74.1%), difficulty in handling daily activities at school (70.4%), difficulty in handling daily activities at home (44.6%), behavioural issues (55.6%) and aggressive behaviour (44.4%). 48.1% of

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children showed improvement with behaviour modification alone and an equal percentage responded to both (behaviour modification and medications).< 5% responded to medication alone 77.8% are still following treatment after coming to the clinic> 5 years.7.4%followedfor 12 months or more whereas the least time frame for following recommendations was < 2 months, and only 7.4% followed treatment for less than 2 months. At least, 44.4 % of parents were>50% satisfied with medication, whereas about 30% were>80% satisfied with medication. About 70% of patients were > 50% satisfied with behaviour modification.

The effectiveness of behaviour modification was the highest in positive reinforcement (92.6%), followed by short targets for studies (77.8%),1:1 attention 74.1 %, repeat instructions, following timetable, and stopped criticizing with equal percentage (70.4%), physical activity 63% and stopped scolding (67%).91.2 % gave a score of > 50% satisfaction with the overall treatment.

Conclusion

Even though parents face problems with their kids from an early age, they seek guidance after 11 years of age, thus showing parental resistance to accepting a problem. However, the fact that currently, nearly 50% of children are in the 16 to 20 age group means that once they seek guidance and see results, they stick to the advice. However, there is a lot of resistance to medication, although they follow behavioural modification.

Keywords

Attention Deficit Hyperactive Disorder (ADHD), Developmental Paediatrician /mental health, parental

Introduction

Attention Deficit Hyperactive Disorder (ADHD) has a prevalence ranging from 2.5-10% in various parts of India, which is similar to the prevalence arrived at by many studies done internationally [1,2,3,4]. Lack of awareness and social stigma associated with it prevents most parents from seeking help at appropriate times. ADHD is a neurodevelopmental disorder defined by impairing levels of inattention, disorganization, and hyperactivity-impulsivity.

Behaviour management interventions are widely utilized as non-pharmacological strategies for addressing ADHD and its associated challenges. Among school-aged children with ADHD, symptoms of inattention, hyperactivity, and impulsivity often result in significant academic and social difficulties at home, school, and in various settings. Rather than directly addressing ADHD symptoms, behaviour management interventions primarily focus on addressing functional impairments [5]. In a home setting, behaviour management treatment commonly targets issues such as noncompliance with daily tasks, homework difficulties, and conflicts with family members. Behavioural parent training aims to improve parenting practices, enhance child behaviours, strengthen family relationships, and reduce overall family conflict.

Similarly, in school environments, students with ADHD frequently struggle with inattention, disorganization, and disruptive behaviours, leading to incomplete work and peer-related difficulties. Behaviour management interventions in schools aim to address these behaviours comprehensively [6]. The importance of treating ADHD during the school-age years cannot be overstated. Short-term consequences of untreated ADHD symptoms include

academic underachievement and strained social relationships, including conflicts within families and challenges in forming friendships. The aim of treating ADHD is to better the core symptoms and mitigate behavioural issues, typically through drug therapy and non-drug interventions. Evidence-backed treatments involve stimulant medication and behavioural approaches, either independently or in combination, although professional consensus on their relative efficacy and timing of initiation varies. Concerns over stimulant side effects, such as impacts on growth, heightwith dosage and duration of use counteract its optimal use. Consequently, behavioural interventions, which may improve outcomes, reduce costs, and minimize side effects, are often the initial choice, especially for preschoolers, as recommended by the American Academy of Paediatrics, Indian Academy of pediatrics (IAP) , and National institute of Health and care excellence (NICE) guidelines (UK).

Biofeedback, a therapeutic method targeting brain function to address neurological or psychological symptoms, represents a well-established treatment for ADHD, boasting remission rates of 32-47% with sustained effects observed after 6-12 months. [7] Research into behavioural interventions for ADHD underscores the effectiveness of parental management training in reducing symptoms. Cognitive-behavioural therapy interventions have shown promise in ameliorating ADHD symptoms and associated anxiety [8]. Studies also highlight the efficacy of telephone-assisted self-help interventions for parents of children with ADHD, indicating improvements in child behaviour and parenting practices [9] Moreover, observational data suggests that behaviour therapy can lead to long-term improvements in ADHD symptoms, suggesting promising prognoses for affected children [10]. However, its impact on core ADHD symptoms varies and is relatively modest when only blinded assessments are considered. Recent research suggests that combining medication with Cognitive Behaviour Therapy [CBT] is more effective than using stimulant medication alone [11].

For children under the age of 6 diagnosed with ADHD, the most recommended evidence based initial intervention is parent behaviour training. The effectiveness of psychostimulants in this age group is not well supported, and their use is not approved by any international guidelines, including the IAP guidelines on ADHD [12,13, 14]. However, for children aged 6 and above, medication, primarily targeting core ADHD symptoms, should be considered. Nonetheless, since over half of children with ADHD have other psychiatric and developmental conditions, a comprehensive approach that includes non-pharmacological interventions,including psycho educating the parents and families, should be adopted to improve compliance, academic performance, and overall quality of life.[9]Parents' preferences for either medication or behavioral interventions for younger children are influenced by their beliefs, accessibility of interventions, and concerns regarding adverse effects and stigma. Those focusing on improving academic skills tend to lean toward medication, while those concerned about behaviour are more inclined toward behavioural therapy. Further, there's a growing concern about the overprescription of stimulants for non-ADHD-related disorders and the use of multiple medications for ADHD treatment [10].Consequently, the prescription rates for ADHD have risen substantially in

various countries. Regarding the effects of stimulant medication, while short-term trials have shown improvements in various domains such as decision-making and academic productivity, the long-term impact on core ADHD symptoms is uncertain. However, stimulants seem to enhance quality of life, and academic achievement, and reduce rates of comorbid anxiety and depression in young adulthood. Longitudinal studies suggest that persistent ADHD symptoms into adulthood may warrant continued stimulant treatment, as it is associated with better employment outcomes and reduced risks related to motor vehicle injuries. [11]

Considering the uniqueness of Indian scenario where the parents often take self-decisions, do irrational interventions and are often mislead to alternative interventions with dubious benefits, it becomes imperative to understand the role of psychoeducation of the parents of children with ADHD and understanding the dynamics behind informed decision making. Hence a study was proposed to compare the effectiveness of the stimulant medications with or without parental education for parents of children with ADHD.

Objectives

The primary objectives of the study were to understand the progress of the ADHD children undergoing ADHD interventions by behaviour modification and / or medication and to assess the effectiveness of parental training followed up by interval guidance in sustaining the interventions at clinic level.

The secondary objective was to study the parental outlook towards clinic based parental guidance in maintaining sustained interventions in children with ADHD.

Methods

Parents of children in the school going age group 6 years to 18 years, who gave written informed consent to participate in the study and undergo interventions as explained in the study brochure were enrolled into the study by consecutive sampling method. A validated self-administered questionnaire on ADHD was given to the parents to fill up their response. This quantitative study analysed the effect of the clinic based parental guidance on changing unhealthy attitudes of parents and its consequences on the behaviour of children. Questionnaire is given as Appendix: 1. Following recruitment, depending on their age, they were either offered medication with behaviour modification (CBT) or parental training on behaviour management alone. Counselling was done by Clinical psychologist, and medical interventions and needed assessments were done by Developmental paediatrician. Survey method was used for data collection to understand the attitude and changes there-in.

Statistical analysis

Descriptive analysis was done for the demographic characteristics. Mean with SD was calculated where ever parametric data was available and median with interquartile were calculated for nonparametric data.

Results

Out of 50 parents who enrolled in the study, only 35 parents of ADHD children completed the 5-year follow-up study and answered the survey questionnaire. Sex distribution was skewed towards males with 77.8% males and 22.2% females. At the time of analysis, 48.1 % of children were 16 to 20 years of age, 29.6% were 7 to 10 years, and 14.8 % were 11 to 15 years of age. (Figure:1)

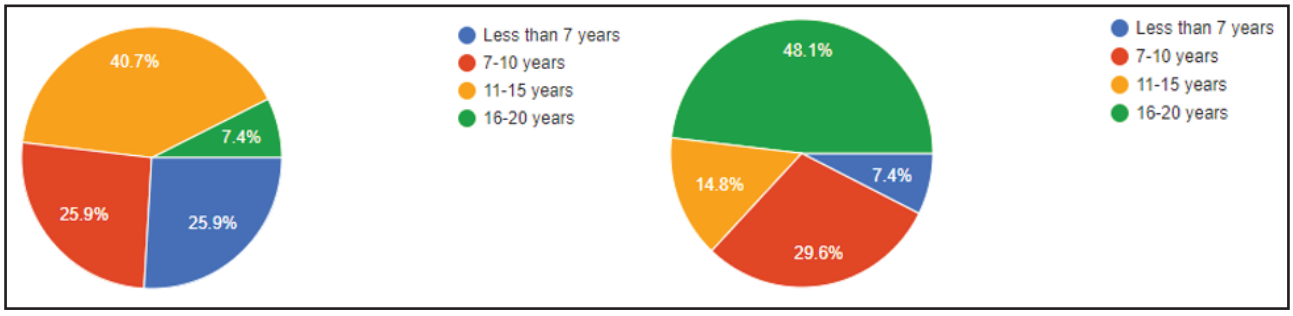


Figure 1: Distribution of age at enrolment and at follow-up.

Out of the study population, 40.7% came to the health care facility at 11 to 15 years, and 25.9 % came at 7 to 10 years. The common reasons for consultation were low concentration (88.9%), inattention (77.8%), and hyperactivity (74.1%), difficulty in handling daily activities at school (70.4%). Difficulty in handling daily activities at home (44.6%) behavioral issues (55.6%), aggressive behavior (44.4%).

Effect of Interventions:

48.1% of children showed improvement with behavior modification alone and an equal percentage responded to both (behavior modification and medications); < 5% responded to medication alone (Figure2).

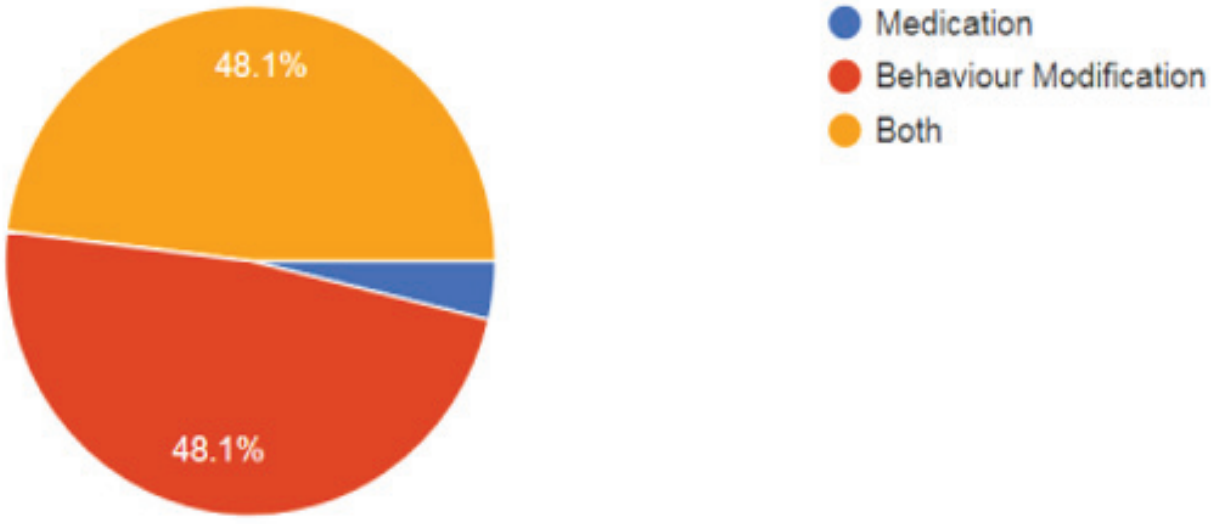
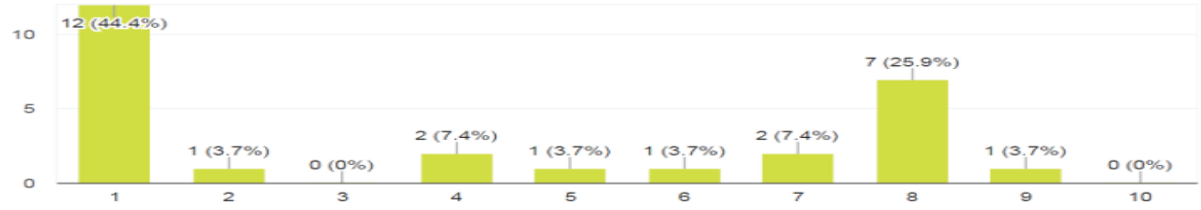


Figure 2: Distribution of effect of interventions

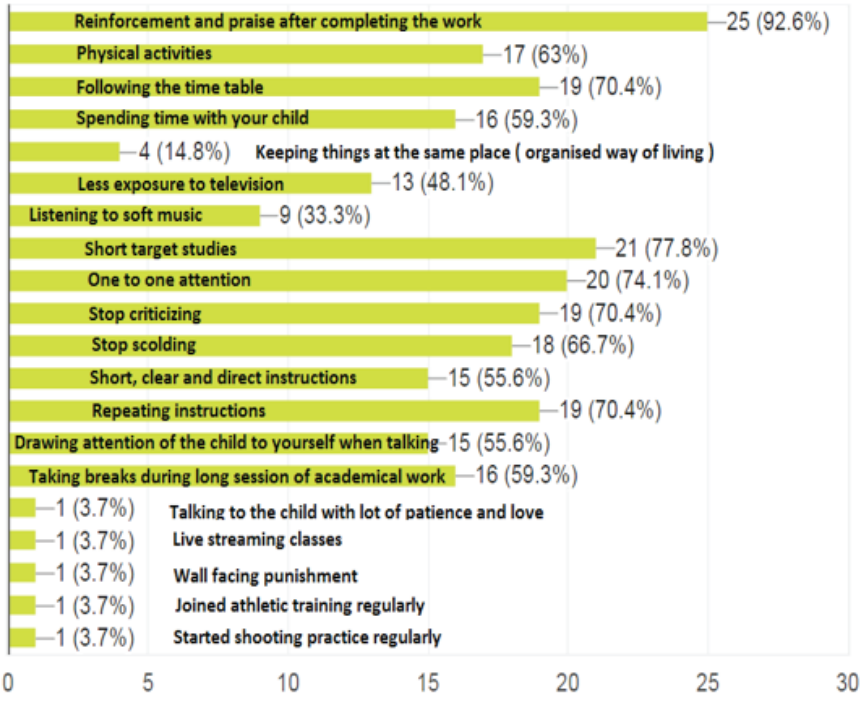
44.4 % were more than 50% satisfied with medication, whereas about 30% were more than80% satisfied with medication. About 70% of patients were more than 50% satisfied with behavior modification.44.4 % were more than 50% satisfied with medication, whereas about 30% were more than80% satisfied with medication. About 70% of patients were more than 50% satisfied with behavior modification. (Figure 3).



44.4% parents preferred not to give medication, which shows parental resistance to start medicine. Out of those ADHD kids who received medicine , about 70 % found it to be effective .

Figure 3: Figure 3: Effect of medications:

The most effective behavioural intervention was reinforcement and praising the child. In behavior modification positive reinforcement (92.6%), short targets for studies (77.8%),1:1 attention 74.1 %, following time table (70%), repeat instructions, and stopped criticizing (70 %,) physical activity 63%, Stopped Scolding (67 %).91.2 % gave a score of > 50% satisfaction in overall treatment. (Figure 4)



The most effective BM was found to be the 'positive reinforcement' given to the children followed by 'short target studies' and 'one to one attention'. The equal percent of effectiveness could be seen in 'not criticizing the child', 'repeating instructions' and 'following the time table.'

Figure 4: Effectiveness of interventions

77.8% were still following treatment after coming to clinic;14.8%followed for 12 months or more whereas only 7.4% followed treatment for less than 2 months. The fact that about 50% of children are 16 to 20 years old and still seeking guidance, means good compliance once they come to the centre. (Figure 5)

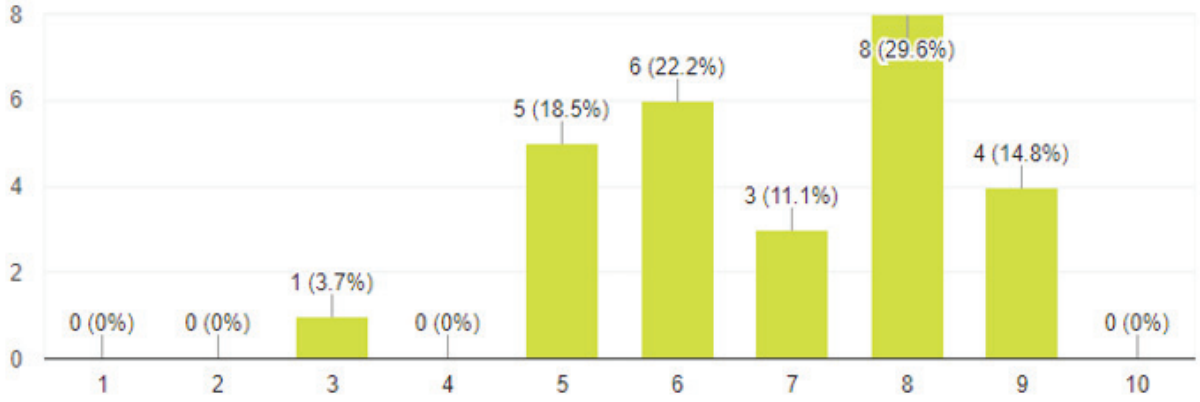


Figure 5: Better Overall satisfaction ensuring follow-up compliance

Most parents seek guidance after 11 years of age, although they face problems from an early age, thus showing parental resistance to accepting that there is a problem. However, the fact that currently, nearly 50% of children are in the 16 to 20 years age group, means once they seek guidance and see results, then they stick to the advice. However, there is still a lot of resistance to medication, although they follow behavioural modification.

Discussion

Despite its limitations, the current research has yielded insights into potential themes associated with ADHD behaviors in India [15,16]. Behavioral disorders in India are often viewed as specific to school environments and are not typically taken seriously until they impact academic performance as seen in the present study. This is inline with other studies also where the inattention and its effects are neglected till it affects the scholastic performance [17, 18].

In the present study, too most of the parents (74%) sought guidance after they got complaints from the school, that's why they approached our centre mostly when the child started showing poor scholastic performance. Parents of children diagnosed with ADHD often have doubts about behaviour interventions and medication. The acceptability of treatment depends on various factors such as positive outcomes, time, effort, and effectiveness. Parents who perceive their child's behaviours as severe, such as oppositional, disruptive, or aggressive, are more inclined to seek counselling rather than medication as a treatment option.

In Indian culture, child-rearing is primarily the responsibility of mothers, who are expected to prioritize homemaking and child-rearing over professional careers [19,20]. These expectations are deeply ingrained and reinforced by family and societal norms. Fathers typically become involved only when their child's behaviours become significantly problematic in a school setting [15; 16]

The present study found that ADHD children were perceived as difficult to handle at school and disruptive as is the case with Children with ADHD in many parts of India wherein they are often perceived as disruptive and hyperactive, leading to potential stigma for their mothers [21; 22; 23]. In the present study **the common reasons for consultation were low concentration in 45 children (88.9%), inattention in 39children (77.8%), hyperactivity in 37 children (74.1%),**

difficulty in handling daily activities at school in 35 children (70.4%). Difficulty in handling daily activities at home in 22 children (44.6%) behavioral issues in 28 children (55.6%), aggressive behavior in 22 children (44.4%).

The child's behaviors are commonly seen as a reflection of the mother's parenting style, regardless of whether the child is diagnosed with a mental illness [21]. Additionally, mothers may fear stigma themselves if they seek psychological services. Efforts to destigmatize mental illness are underway through initiatives like the National Mental Health Program in India.

The primary treatment for ADHD involves pharmacotherapy and behavioral management. Accurate diagnosis is crucial before initiating treatment, and parents should be counselled that while treatment may improve their child's behaviour, it might not eliminate core symptoms. Stimulant medications are typically the first line of treatment, with non-stimulant alternatives considered if there's no improvement after 6 to 8 weeks. Behavioral interventions from trained professionals are also beneficial in managing difficult behaviors.

In the present study too parents accepted behaviour modification very well and were satisfied with the results of behaviour modification by a trained psychologist. CBT was given to kids who were more than 10 years old in the present study. About 70%parents were more than 50% satisfied with behaviour modification whereas only 44.4% parents were more than 50% satisfied with medication in the present study.

Psychoeducation for parents and extended family members is essential for symptom improvement, along with involvement from schools to ensure appropriate behavioral management.

It showed beneficial results in the present study too.

Medication for ADHD should only be prescribed by healthcare professionals with expertise in ADHD diagnosis and management. Parent training programs are recommended as the initial treatment for children under 5 years old with ADHD. Medication for this age group should only be considered after consultation with a specialist. For children over 5 years old, education about ADHD causes and impacts, parenting advice, and collaboration with educational institutions are advised. Medication should only be considered for children and young people over 5 years old if symptoms persistently impair daily functioning after environmental modifications have been attempted and evaluated. These guidelines were followed in the present study.

Conclusion

The problems faced by the kids from an early age are often neglected and guidance is usually sought latesince behavioural problems in India are often viewed as typical to the school environment and not typically taken seriously until it affects scholastic performance. Further inattention and its ill effects are often neglected till it affects academic performance.

Kids with ADHD responded better to combined treatment with behaviour modification and medication than medication alone.However, there is a lot of resistance to medication, although they follow behavioural modification.The counselling of parents and behaviour modification sessions of the child in the clinic contribute significantly to improving the outcome. Medication has a very important role to play in a kid with ADHD, since it improves concentration, improves behaviour and makes the child less oppositional. Thus the

child is more available for learning. Behavioural interventions, improve outcomes, reduce costs, and minimize side effects of medication due to reduction in the dose requirement. Thus the parents should be counselled that behaviour modification in association with medication reduces the dose of medication required to improve the symptoms and thus their concerns about side effects and cost will be reduced.

Further, once they seek guidance and see results, they stick to the advice.

What this study Adds :

1. Most parents seek guidance for ADHD after 11 years of age, although they face problems from an early age, thus showing parental resistance to accepting that there is a problem.
2. Parents of children with ADHD have lots of resistance to medication, although they follow behavioral modification. But once they see results especially in a very difficult behaviour of the child or very poor academic achievement, they follow the advise.

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Conflicts of interest:

There are no conflicts of interest

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Appendix 1

Self-administered Survey Questionnaire:

ADHD Treatment Survey (Palak Child Development Centre - Dr. Lata Bhat)

"Your responses will contribute to our analysis and will give us a chance to improve things and reach to you and other ADHD parents and children in a better way. Through this survey, we will be able to authenticate our treatment with the evidence-based practices used worldwide to treat ADHD. Please fill the questionnaire as per your experience. We thank you for giving us your precious time and we ensure that the information provided by you will be kept confidential.

* Indicates required question

1. Name of the child*

2. Gender of the child*
   Male Female

3. Age of the child*
   Less than 7 years 7-10 years
   11-15 years 16-20 years

4. Approximate age of the child when first consulted to the Centre*
   Less than 7 years 7-10 years
   11-15 years 16-20 years

5. What was the issue/reason of consultation. You can mark more than one response.*
   Inattention Hyperactivity
   Low Concentration Low Confidence
   Low Motivation Behavioural Issues
   Aggression Difficult peer relations
   Difficulty in handling daily activities at home
   Difficulty in handling daily activities at school
   Other:

6. In your opinion, which of the following was more effective in the treatment of your child?*
   Medication Behaviour Modification
   Both

7. For how long did you follow the treatment/recommendations given?*
   Less than 2 months 6 months
   12 months 12 months or more
   Still following

8. On a scale of 1-10; how much effective was the Medication? (10 being the most effective)*
   1 2 3 4 5 6 7 8 9 10

9. On a scale of 1-10; how much effective was the Behaviour Modification? (10 being the most effective)*
   1 2 3 4 5 6 7 8 9 10

10. Which of the following recommendations of Behaviour Modification was more effective? You can mark more than one response.*
    Reinforcement and praise after completing the work
    Physical activities
    Following the time table
    Spending time with your child
    Keeping things at the same place
    (organised way of living)
    Less exposure to television
    Listening to soft music
    Short target studies
    One to one attention
    Stop criticizing
    Stop scolding
    Short, clear and direct instructions
    Repeating instructions
    Drawing attention of the child to yourself when talking
    Taking breaks during long session of academical work
    Other:

11. On a scale of 1-10; how much were you satisfied with the overall treatment? (10 being highly satisfied)*