UNDERSTANDING PARENTAL ATTITUDES TOWARD THEIR CHILDREN’S BEHAVIOR MEDICATION

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Introduction

This report summarizes the perspectives of three parents whose children are prescribed medication to address behavior at school.

The current trend in education is toward inclusion of previously marginalized groups of students. One of the last groups to be included in regular classrooms is the child with behavior difficulties. Increasingly, medication is being used to alter and improve behavior, especially in children so that increasingly larger numbers of previously excluded children can now be accommodated within the classroom setting. “The ‘new’ medical model of special education posits that screening for psychiatric diagnosis and possible referral for psychopharmacologic treatment need to be added to existing behavioral interventions for a significant number of children with emotional or behavioral disorders” (Forness, Kavale, & Davanzo, 2002, p. 168). Of all the conditions for which medication is prescribed, a great deal of research affirms the efficacy of medication to address attention difficulties in the classroom (National Institute of Mental Health, 1999) and, more particularly, Attention Deficit Hyperactivity Disorder. Given its effectiveness and given the implication that not to offer medication is tantamount to negligence, I am interested in parents’ willingness or reluctance to use medication to address behavior in the classroom setting. “Individual differences in drug response may depend on the attitudes about drug treatment held by the child and his or her parents . . . failure to predict long term response to drug therapy may stem most directly from our failure to assess the sociocognitive contexts in which the drugs are given, taken and evaluated” (Whalen & Henker, 1976, p. 1122). Parental attitudes are clearly highly predictive of whether children will be diagnosed and treated with medication for disorders that affect behavior. Whalen and Henker discussed the constructs developed by the child to explain his or her perceived problems and their solutions. Parents too must have a construct or belief system. Many years later, Whalen (2001) wrote of increased parental satisfaction when treatment included a behavioral component along with medication. She queries whether the degree of parental satisfaction with the treatment outcome enhances the outcomes for children with ADHD because the effects of medication have enhanced parental perceptions of the value of adjunctive therapies.
Another issue is that of self medicating: it is often believed that, if ADHD is not adequately diagnosed and treated in childhood, adolescents with the disorder will often “self medicate” or relieve some of the negative effects of ADHD by using illicit drugs. If we know that the child is likely to be properly diagnosed and treated with the parents’ involvement, it makes sense to do this in as timely a fashion as possible. This research project seeks to better understand the perspective of parents who have made the decision to use medication to address their children’s behavior at school.

My expectation would be that parents who give their children medication for improved school behavior look to certain sources to reassure themselves that they have made the right decision. I also would have expected that parents would have had a strong support network that encouraged and supported them in using medication to improve behavior. I also expected that parents felt pressured by school personnel to place their children on medication and also to maintain the medication regime. In my own experience as a school psychologist, I see quite regularly how quickly schools are to recognize when a previously medicated child who is acting out might not be on medication and to contact parents with a reminder to give the next dose.

My prior assumptions were that, for parents to use medication, they would have a good relationship with their doctor and with the school because my own experience has been that the stigma of the disorder is equal to the stigma of using medication to alter behavior in children.

**Summary of Methodology**

The three parents of children in a suburban school division were interviewed between November 1 and December 8, 2004. Interviews were conducted either in the homes of the interviewee or at my school-based office. Prior to each interview, participants were provided with written documentation of the purpose and nature of my research project, and all provided written informed consent. The interviews were tape-recorded, the tapes transcribed into text, and the audiotapes erased after the transcription. The transcripts were then analyzed and coded for theme areas.

This study used purposive sampling wherein school psychologists in a suburban Winnipeg school division selected participants. These school psychologists were asked to identify parents who had children currently attending school who were prescribed medication to address their behavior at school. These parents were invited to be interviewed about their experiences, and all three who were approached agreed to be interviewed.

Each of these parents was interviewed for one hour at their convenience. While I had prepared a series of questions, I found it was easier to start with some basic questions (e.g., condition for which their child was medicated, type of medication) and then probe and clarify
responses or comments made by the participants. I have referenced many of the themes or
direct quotes made by the participants in this report from the interview transcripts and,
following their name, there will be a page number from the unpublished transcript from which
the quote was taken.

A Portrait of the Participants

While both the mother and father of each couple were invited, only the mothers
responded to the invitation to participate, the significance of which will be discussed later. All
three of the children who took medication were boys from grades two through eight. Each of
the mother-and-son dyads was assigned pseudonyms and included Corinne and son, Adam;
Sandy and son, Scott; and Monica and son, Carl. All three children were taking medication to
address symptoms consistent with Attention Deficit Hyperactivity Disorder, although one of
the three boys did not officially have this diagnosis according to his mother. Therefore, all three
boys were taking methylphenidate (Ritalin), and one of the three was also prescribed Risperdal.
Two of these mothers were interviewed in their homes; the third requested that she be
interviewed at my school-based office because she was a stay at home mom who would prefer
to “go out” (it seemed almost a social event) to be interviewed. I believe this was significant
for a few reasons. For the two mothers who opted to be interviewed at home, it became
apparent during our conversations that they felt very disconnected from the schools their
children attended. It is not clear if these mothers perceived my role as part of the school and
whether they preferred an environment not connected to the school. Conversely, the one
mother who wished to be interviewed outside of her home was comparatively more active and
involved in her child’s progress at school. All three mothers willingly answered my questions
and, in fact, provided a great deal of unsolicited information. Despite my advising each of the
mothers that I was approaching our agreed-upon time limit for the interview, two of the
mothers spoke beyond this limit.

In terms of analysis procedures, the interviews were reviewed, coded, and similar themes
emerged that were then noted and synthesized.

Results

This research project illustrated a number of issues parents face when their child is on
medication that addresses his behavior. Each of the mothers was very able to delineate how the
medication helped her son. For Carl, it addressed his impulsivity (Monica, 43) and thinking
ahead (Monica, 41) to reduce risk-taking behaviors. Sandy noted improvement in Scott’s
Corinne spoke of her son’s reduced aggressive behaviors and improved ability to interact more appropriately with peers (Corinne, 23).

All these mothers recognized that adaptations by the school were necessary for their sons, though there was great variability in how they viewed this. Monica believed that behavioral expectations by the school were too high for children with ADHD (Monica, 27), in general, while their academic expectations of Carl were too low, “I don’t feel they’re (the school) pushing him hard enough” (Monica, 50). Sandy felt that the school was providing many important services to her son Scott including counseling (Sandy, 14) and arrangements for administration of his medication (Sandy, 15) but felt that they were not adequately addressing the teasing by peers. Corinne indicated that she was pleased with accommodations and modifications that Adam received (Corinne, 14) by the classroom teacher and the resource team at the school of which she was a part.

Side effects of the medication were numerous and quite individualized. All three mothers, however, spoke of the “rebound” effect their sons experienced when the effects of the Ritalin had worn off at the end of the school day.

Although each of the parents had unique issues they were dealing with using medication, there were three clear themes that frequently cut across all of the interviews with these mothers. First, all three mentioned pressure from the school to provide medication to their child, though from different perspectives. Also the relationship each parent had with the school personnel, due to or in spite of this pressure, was of note. Second, the lack of support and isolation they as parents felt was a consistent theme, not only about the fact that their child has ADHD but also about their decision to use medication to improve behavior. The third theme that emerged from the interviews was the legitimacy that each parent placed on the medical involvement they used. While there has to be medical legitimacy in order for there to be a prescription for medication, there seemed to emerge a particular meaning or explanation that each mother had created that helped her to understand her child’s behavior. It was during these explanations that the level of empathy these mothers felt for their sons became evident and seemed to be the vehicle through which these explanations derived.

Medication was a last resort after trying other herbal alternatives for Sandy, while Corinne sought to understand within the medical model by questioning and demanding more specialized information and training in hopes of a clear diagnosis. Monica was satisfied with the current explanation given by her son’s doctor. All three parents wanted the specialty of psychiatry in dealing with ADHD: Two of the parents already using a psychiatrist, one was seeking to have her son seen by a psychiatrist as opposed to dealing with their general practitioner to manage medication. All three mothers spoke of using a medication “trial” when they decided to look at medication, a subtle distinction that seemed to imply a more cautious approach as compared to categorically placing your child on medication indefinitely. It should also be noted that Ritalin is notoriously fast acting; the benefit of this is that effects would be
seen quite quickly. The medication trial’s success could be gauged quite efficiently with this
drug in a short space of time and more independently of other variables that sometimes get in
the way when trying longer-acting medications. Sandy stated: “I did it on a trial basis because
I was scared of all the baddies [sic] attached to Ritalin. I didn’t want the stigmatism [sic] I’m
drugging my child to have them behave, but then I tried it, I went ‘wow’” (Sandy, 36). Corinne too was impressed with the speed with which an improvement was noted (Corinne, 23).

Pressure from the School

All three participants highlighted the “pressure” they felt from the school, though it was in
different contexts. Monica noted it when her son was returning to school after a summer off
medication. She talked of having to put her son on medication at the school’s insistence in years
previous: “The school was complaining for a long time . . . finally it came down to we had to
put him on medication” (Monica, 7) and how “they rely on medication too much in the school
system” (Monica, 15). Sandy claimed that her experience at the time of diagnosis was
particularly problematic and termed teachers as “drug pushers” (Sandy, 40), a practice she
stated “needs to stop” (p. 41). Corinne’s experience was somewhat different. She claimed that
she was surprised by the fact there was no pressure from the school when her son Adam was
experiencing the worst of his behavior. It was not until after he had been prescribed the
medication and had been on it that the school pressured her to ensure he kept taking it
consistently (Corinne, 46).

The connection each of these mothers’ had with the school—or the lack thereof—was
notable. Throughout their interviews, two of the mothers indicated difficulties connecting with
their sons’ schools. Monica talked about suspensions that her son had had but was unclear of
the circumstances around them (Monica, 19). Sandy indicated that she had not had contact
with the school this year (Sandy, 14). These incidentally were the two mothers who opted to
be interviewed in their homes rather than in a school building, my interpretation being that,
given the opportunity, they would rather not have to go to the school. The third mother, who
had a strong connection with her son’s school which she characterized it as “excellent”
(Corinne, 16), chose to be interviewed at my office in a divisional elementary school (though
not her son’s). She personified a strong, committed relationship with her son’s school and had
started this quite early by having a communication log about her son that had followed him
from nursery school to the end of grade 1. It seems her inclusion in a “game plan” that she was
a part of (Corinne, 16) meant she better tolerated the negative reporting of behavior that often
accompanies a communication book and telephone calls from the school, even though she used
the phrase being called “for every niggling thing” (Corinne, 17). The other two mothers
negatively categorized the contact they received from the school regarding behavior. Something
I did not explore with these two mothers was how disruptive these school contacts were and how that may have contributed to their negativity. Corinne was a homemaker so would have had the phone calls placed to her at home. The other two women were not asked if they worked outside of the home. While they both selected interview times during weekdays in their own homes, neither indicated if they were employed outside of the home.

The Stigma of Behavioral Challenges, Medication, and Levels of Support

The stigma of behavior disorders as well as medication was noted by two of the mothers. Monica talked of the prevalence of ADHD (Monica, 53) in society as a whole but could name only one other child she was aware of who had the condition. Corinne talked about being able to get past the stigma of using medication (Corinne, 59), and Sandy likened ADHD to a “handicap,” then pardoned herself for using the term, my interpretation being this prompted a sense of shame in her (Sandy, 38).

All three mothers indicated that the behavior their sons exhibited was not only difficult to manage and viewed negatively but was also the use of medication to address this behavior. Sandy talked about the issue of her son Scott being teased for his use of medication at school by peers (Sandy, 15). Two of the mothers used the term “crutch” in reference to medication (Monica, 53; Sandy, 35) suggesting a negative reliance on it rather than learning to deal with it. It would seem that reducing negative behavior would heighten the support for medication use; however, all three indicated they were not supported in their decision to use medication and specifically, Ritalin. Monica, who was estranged from her son’s father, did not inform the father of the boy’s use of medication, and Carl did not take it when at his dad’s (Monica, 35). Sandy reported that both her husband and his family “doesn’t like Scott on medication” (Sandy, 33). In fact, all three reported few supports to manage her child or in the use of medication. Corinne’s family, who would not look after Adam when he was not on medication, was also not favorable toward the decision to place him on Ritalin (Corinne, 30). While they had few family or friends to understand and support them, all three indicated that their doctors (i.e., psychiatrists and a pediatrician) were helpful and supportive. Two of the three indicated that explanations about the disorder were very useful, and, while Corinne did not specifically mention it, by virtue of her seeking further specialized medical opinion, it would seem she wanted more definitive explanation to obtain a label and understanding of her son. Only Corinne mentioned accessing community-based support (Corinne, 44) which was in the context of providing some services to the rest of her family to cope with her son Adam’s behavior at home.

Interestingly, school was not necessarily named as supportive, only demanding that the child be on the medication. Sandy even remarked she didn’t know who the medication was for--her son or the school (Sandy, 42).
Role of Medical Practitioners and Understanding Behavior

Each mother constructed an explanation that drew from the field of medicine to explain her son’s behavioral difficulties. Monica saw her son’s difficulty on a spectrum that had reached a severity warranting medication. She worried about worsening behavior and how his impulsivity would make her son Carl make “bad choices” (Monica, 52, 67). Corinne reconciled the use of medication for her son Adam’s difficulties because it made him a more manageable child like he used to be (Corinne, 30) before he began talking. Sandy conceptualized her son’s ADHD on a spectrum because of her own experiences with the disorder, and also the fact she understood the genetic component and seemed to have accepted that there was a biological basis for it (Sandy, 19). She also believed medication was for younger children with this disorder and that the use of Ritalin would give her son a good foundation (Sandy, 25) that could be discontinued when he was an adolescent (Sandy, 12). All three women cited good relationships with their sons’ physicians, and these professionals seemed to be one of the only sources of support for use of medication that they had.

All three spoke of the isolation of having a child with behavior problems. Monica talked about knowing only one other child with ADHD (Monica, 36), while Sandy (27) indicated she knew no one else with the same experiences of a child with behavioral difficulties. Corinne talked about having no one, including family, to provide babysitting for her son (Corinne, 44) because of his behavior. This isolation may also reflect the shame involved in having a child with behavioral difficulties.

For Sandy and Monica, there was no support for medication use by a spouse. Corinne, however, had the support of her husband, and they made many decisions regarding Adam as a couple (Corinne, 54).

How was it then that these women were able to resist the stigma and use prescription medication to help their sons? One of the key components seems to have been the strong empathy all three expressed in regards to their sons. These mothers continually reflected upon how their sons’ experiences and views influenced their perceptions and decisions. Only one of the three mothers alluded to her own experiences with a disorder that made her more empathic to her son’s behavior. The other two mothers empathized and often returned—albeit with direct questioning—to how her child perceived his disorder, behavior, or the medication used to control it. They did not indicate they had their own experiences to compare their sons to. In her interview, Sandy sometimes assumed the actual dialogue she has with her son to help illustrate to me how she interacts with Scott to explain his behavior and her decisions (Sandy, 31). Corinne used her son’s actual pronunciation of the word “crazy” (Corinne, 24) to define how he felt without medication, but it also illustrated to me how connected to Adam she felt.
and how empathic she was in her understanding of him. Her level of empathy also helped her to see when he was being manipulative of others, as well, including physicians (Corinne, 41).

All three mothers also made references to understanding, from the school perspective, how the medication improved the behavior of their sons at school, gauged from fewer phone calls and discipline issues. Sandy believed teachers were “overworked” and had difficulty coping (Sandy, 36) and Scott might “drive his teacher off a bridge” (37).

The stress on the household was acknowledged by all of these mothers. Monica termed it “stir(ing) everything up around here” (Monica, 43) when Carl was not on medication. Corinne talked about “the more hyper (Adam) gets the more tense we all get” (Corinne, 26), and Sandy referred to the situation at home as “living on the edge of a knife” (Sandy, 29).

All three mothers were able to give examples and talk about how they believed their children viewed the medication. Monica stated Carl knows medication helps him and the reasons for taking it (Monica, 45), while Corinne indicated her son Adam saw medication as something that set him apart from his siblings (though this may be more of an issue of the nature of his disorder that makes him have obsessions about snacks) (Corinne, 37).

Despite the empathy, however, all three grappled with the guilt of turning to medication: Sandy often talked about the many things that parents should do saying “caring parents adapt” (Sandy, 45), while Corinne talked about getting over the guilt to the point that she even gives medication to Adam when not at school (Corinne, 59) so that her family might benefit. Monica stated her belief that tolerating her son’s behavioral difficulties at home and on weekends was her responsibility (Monica, 44, 64) and seemed to be the way in which she dealt with the guilt of using medication to conform his behavior at school. This coincided with some of the references to shame that behavior disorders invoke.

**Discussion**

These themes illustrated some of the core issues that impact the decision to consider medication as a treatment for ADHD and behavior problems in general. Pressure from the school, the stigma of medication and behavioral difficulties, support available, the role of the prescribing physician, and the amount of stress in the home were all variables in the meaning that these mothers gave to their sons’ behavior and how they chose to deal with it. Their strong empathy was the driving force that seemed to help them construct their meaning of their sons’ behavior.

One of the issues that this research project highlighted is the school system’s struggle to maintain a relationship between parents and school, especially when the child concerned is exhibiting behavioral difficulties. The nature of behavioral challenges aside, the strain of contact between school and home when the former is constantly informing the latter of what they are
doing wrong means relationships frequently erode. The reality is that the most effective interventions to understanding and ameliorating negative behavior within the school context are ones that include the involvement of parent and school working together in the interests of the child. This becomes harder to do the longer the child has behavioral difficulties.

Manitoba’s soon-to-be legislated Bill 13 will ensure “appropriate educational programming” for all students. This will have very specific meaning for students with diagnosed disorders that impact their behavior or educational needs. This would mean, for example, that Monica’s concern and request for in-school suspension as an alternative to out-of-school suspension would be a legitimate request that the school would be hard pressed not to accommodate. At present, this type of consequence is at the discretion of the individual school principal and its parent school division. However, Bill 13 will also emphasize the need for parents and schools to work together in planning and implementing program strategies, such as when Corinne spoke of wanting to try reducing Adam’s medication and to rely solely on the support of an educational assistant in the classroom. She was aware the school was not in agreement with this (Corinne, 48), but new legislation will make it more likely the school will be required to show consideration of, and respond to, this request. This will force school teams and parents to share their program planning ideas and, hopefully, to connect and remain connected.

There are a number of things we can take from the experiences of the three women interviewed and from their perceptions of their sons’ experiences. From the school perspective, there are many areas that could use improvement in working with parents, perhaps the most obvious being communication. Monica implied that she was not heard (Monica, 29) by the school and that efforts at communication such as communication books/logs had broken down.

A firm commitment to working with parents in planning programs is needed, but even more so is timely referral to other professionals who work with behavior disorders. At the very least, there needs to be some support to schools in how to begin the discussion with parents about emerging and escalating behavior problems. There must be clear boundaries and roles when it comes to introducing the topic of a medical disorder to explain behavior in an educational context. Clearly, the mothers in this study indicated they were comfortable dealing with the professionals who had this specialized, medical knowledge and felt it was displaced when a school began making demands of them. Beyond the rules and guidelines for how to ensure children take prescribed medication once it has been determined they could benefit from it, there seems to be a delicate period when communicating difficulties to the parent becomes the primary function that can tip the scales either for or against medication depending on how the parent perceives its purpose. Certainly there is no role for teachers to suggest medication. Trials of medication are best offered by physicians as a treatment choice, not in response to demands made by the school.
School personnel also need to be aware that they are not only recipients of the negative behavior; clearly the stress on parents and families is an issue, and it is a struggle for parents to decide on medication. They are in a double bind, trying to decide between the stigma about the behavior and its being seen as a “disciplinary problem” (Corinne, 29) and giving medication to a child to manage behavior. Whether this is generalized to all medication or just to Ritalin specifically warrants further study.

From the parent perspective, this study illustrates the importance of providing not only current relevant information about the disorder and options for treatment and medication but also the interplay of how the disorder impacts life in the classroom for affected students. If empathy is such a prevalent theme for mothers who have already made the decision to use medication, perhaps it is the missing piece for students who continue to struggle without medication. Who works at illustrating this picture for the parent becomes the issue. It appears parents are wary of school personnel who take this on and have a more hidden agenda of using pressure to get the child to be prescribed and maintained on medication.

One of the advantages in doing this project from within a qualitative research framework was the connection it allowed me to have with these mothers. Over the course of the hour interview, rapport was easily established, and it was difficult to turn the tape recorder off when so much relevant information was still coming. A particularly poignant gem that came from Monica was to ask me why wasn’t I interviewing her son and his teacher? Ethics review committees and course timelines aside, that certainly would provide a missing piece. Success in medication use is not just to ascertain if the child is on medication for the diagnosed disorder, but there also must be some documented benefit. Ideally it should be more positive school performance. While interviewing these mothers helped me to understand perspectives, my original intention of studying the link between the impact of medication on school performance and parental attitudes seems incomplete without the perspective of the student and the teacher. It might also be helpful to utilize a more traditional pre- and posttest research design to review performance on and off medication to gauge its effectiveness.

Perhaps one of the biggest surprises in this research was how little support each of these parents had in their decision to use medication. It was, in fact, really only the physician who validated their decision and the school, from a negative perspective, by not hounding the parent. There was little use of any community-based supports or extended family to assist these families.

Another issue that surfaced during the analysis of the interviews was the question of birth order and a mother’s empathy to her child in relation to her other children. At least one of the boys in this project was the eldest child in the family, a factor that I believe was relevant in that the mother of this child did not have any other sibling to compare behavior to, especially in the years prior to elementary school. Corinne noted that while her son Adam was the third in the family, she was able to recognize how different Adam’s behavior was from her
other children. It made me wonder whether this might be a supportive piece of information to parents in helping them define how different and problematic behavior can be in a child and that it is not simply a disciplinary or parenting issue when it has an organic basis.

Parents often feel bad about their children’s negative behavior at school, but even when the decision is made to use medication as a treatment, and it is effective at helping to ameliorate the behavior, they do not necessarily feel positive about medication use.
Interview Questions

What is your child’s diagnosis?

What medication is your child currently taking?

Why is that medication prescribed?

What is your understanding of how the medication works?

How does the medication affect your child’s behavior at school? At home?

Who prescribes your children’s medication?

How is the relationship with this Dr.?

What do you know about the diagnosis?

Where have you gotten information about the diagnosis?

Do you feel you need more information about the diagnosis?

Do you know any other children with this diagnosis?

Do you talk to other parents’ about this diagnosis?

What does your child’s teacher do in the classroom for your child’s diagnosis?

How do you feel about your child taking medication for this diagnosis?

Have you discussed with your Dr. how long your son will take this medication?

Does or has anyone in your family have this diagnosis? Do they take medication for this?
References


