

Psychodynamic Group Intervention With Parents of Children With Attention-Deficit/Hyperactivity Disorder: Outcomes for Parents and Their Children

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The study measured the impact of a psychodynamic group intervention on parents of children with attention-deficit/hyperactivity disorder. Outcomes of treatment for the 78 parents (perceived social support, parenting style, and self-efficacy) and their nontreated children ($n = 78$; self-efficacy and emotional/behavioral state) were compared with nontreatment parents at pre–post measurement. For treatment parents, a follow-up measurement was conducted. Treatment parents showed better outcomes than nontreatment parents on all measures. Children of treatment parents showed more favorable outcomes than children of nontreatment parents, further validating the impact of the intervention. The conclusion is that psychodynamic interventions that target broad characteristics of parenting are effective in bringing change to parents and children alike.

Keywords: parents, children, ADHD, group, outcomes

Attention-deficit/hyperactivity disorder (ADHD) is a developmental disorder with two major components: (a) attention deficit and (b) impulsivity and hyperactivity (American Psychiatric Association, 2013). Children diagnosed with ADHD often reveal comorbidity with other disorders (Barkley, 2006), including oppositional defiant disorder (ODD) and conduct disorder (CD; Connor, Steeber, & McBurnett, 2010). They demonstrate a variety of cognitive, emotional, social, and behavioral disorders (Ozdemir, 2010): lower learning skills, motivation, and academic achievements (McConaughy, Volpe, Antshel, Gordon, & Eiraldi, 2011); emotional difficulties, including frustration, guilt, anger, anxiety, and depression (Young & Amarasinghe, 2010); social difficulties, including antisocial and aggressive behavior (McConaughy et al., 2011); delinquency; and substance abuse (Molina et al., 2013). Overall, they experience difficulties in executive functioning,

planning, problem solving, and controlling their behavior, which are more visible in such children compared not only with normative peers, but also with children with similar problems but without ADHD (Barkley, 2006).

The most common disorder in child mental health (Bloom, Jones, & Freeman, 2013), ADHD affects the entire family (Pimentel, Vieira-Santos, Santos, & Vale, 2011). Parents are subject to emotional overload and stress (Theule, Wiener, Tannock, & Jenkins, 2013; Young & Amarasinghe, 2010); they experience difficulties in their parental role; and they often feel helplessness, fatigue, frustration, social isolation, and lack of support. These difficulties may lead to poor parental functioning, hostile and inconsistent parenting practices, and conflictive parent–child interactions (Cussen, Sciberras, Ukoumunne, & Efron, 2012; Deault, 2010; Jans et al., 2015). Considering the difficulties parents of children and adolescents with ADHD face, and the effect of parenting dysfunction on their children, there is a clear need to support these parents.

Indeed, the literature refers to perceived social support as a major resource for these parents. Effective parents are prepared to rely on family and friends, who may diminish their sense of loneliness. Parents who receive social

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support tend to have a higher sense of self-efficacy and well-being (Bandura, 1997; Sarason & Sarason, 2009; Weinblatt & Omer, 2008), which enables them to develop an authoritative style of parenting (Gross et al., 2003). They are more intimate, responsive and friendly with their children, and yet closely supervise them and provide guidance and support. In contrast, noneffective parents employ either an authoritarian parenting style, strictly controlling their children's behavior and using punishment to educate their children, or a permissive parenting style, showing warmth and love but avoiding supervision and control (Baumrind, 1967). These components of effective parenting are particularly critical when children with behavior difficulties are involved, such as children diagnosed with ADHD (Deault, 2010; Schei, Jozefiak, Nøvik, Lydersen, & Indredavik, 2016).

Interventions for parents of children with ADHD are mostly of a psychoeducational style and CBT orientation, focusing largely on guidance and skill training (Daley, Jones, Hutchings, & Thompson, 2009). The research literature usually indicates improved practice for the parents (Webster-Stratton, Reid, & Beauchaine, 2011), yet largely disregards the parental emotional state. We therefore suggest an alternative focus of treatment—on parents' emotional needs and growth rather than on guidance—using a psychodynamic approach.

Psychodynamic psychotherapy is characterized by a number of specific elements: a focus on affect and expression of emotions, including fears and fantasies; cognitive and emotional self-exploration; awareness of patterns of present behavior and past experiences that may affect the patients; and a focus on relationships, including the therapy relationship (Shedler, 2010). The goal of psychodynamic psychotherapy is to go beyond symptom reduction, fostering personal growth, increasing understanding of the self and others, and helping to face life's challenges with freedom and flexibility (Shedler, 2010). Studies support the efficacy of psychodynamic therapy for a range of difficulties, sometimes with better long-term outcomes than other treatments (Bateman & Fonagy, 2008). Moreover, change processes indicate that change is intrapsychic in psychodynamic psychotherapy, unlike in CBT (Levy et al., 2006). Psychodynamic psychotherapy in group

treatment therefore fits our goal of fostering parents' self-growth, enhancing their psychological capacities and resources, and improving relationships.

In process groups of a psychodynamic approach, we aim to help parents develop a better understanding of their parental role and how it affects their functioning. We expect self-growth through processes of self-exploration, insight, and change (Hill, 2005). The positive group climate encourages mutual sharing, and the exchange of feedback fosters interpersonal learning.

Two earlier studies using this treatment with parents of children with learning disabilities (LD) and ADHD showed positive results. In the first study (Shechtman & Gilat, 2005), mothers of children with LD treated in psychodynamic groups were compared with mothers treated in educational groups. Outcomes were more favorable for those in the psychodynamic groups: the mothers exhibited a reduction in stress in parent-child relationships, improved their perception of their child's difficulties, and gained in sense of control more than the mothers in the educational group. The second study (Danino & Shechtman, 2012), mainly involving parents of children with ADHD (over 70%, and under 30% were parents of children with LD), compared psychodynamic group treatment with individual coaching. Results indicated a greater reduction in stress in the psychodynamic intervention than in the coaching setting. There was also a greater reduction in negative responses and a greater increase in positive responses in parental practices. Furthermore, bonding predicted parents' outcomes (reduction of stress and of negative responses in parental practices) in the psychodynamic group, congruent with our theory.

The current study goes further, first by treating a sample of parents whose children were all formally diagnosed with ADHD. Second, we studied variables that have not been researched before and that are broad characteristics of effective parenting. Most important, we measured the impact of the parental intervention on the children, who were not involved in any treatment.

In light of the above, three research hypotheses were tested. First, we expected more favorable outcomes in terms of perceived social support, parenting style, and parent self-efficacy

among treatment parents than nontreatment parents. The psychodynamic group intervention is tailored to achieve such goals: parents feel free to explore their parental style; they learn to receive and provide support; and, supported by the group, they feel more efficacious, allowing them to choose a more flexible style of parenting. Second, we expected more favorable outcomes on self-efficacy and emotional/behavioral state for children of treatment parents than for children of nontreatment parents. Parents' sense of empowerment and confidence may be presented in the child's behavior. Finally, our third hypothesis suggests a relationship between parent outcomes and child outcomes: the more parents gain on sense of support, self-efficacy, and authoritative style, the more their children will gain in self efficacy and improved behavior.

Method

Participants

A total of 156 parents participated in the study. They were recruited by school counselors in different schools, based on the information that all had children diagnosed with ADHD by psychiatrist or neurologist, prior to treatment. These children displayed behavioral difficulties, such as acting out, aggression, social difficulties, and extremely withdrawn behavior. Sixty-three mothers and 15 couples (93 parents) of 78 children participated in the treatment condition. When a couple attended, only one of them completed the questionnaires; therefore, they are considered 78 parents for the purpose of the study. In addition, 78 parents of 78 children diagnosed with ADHD, who were recruited from other schools, participated in the no treatment condition. Children's ages ranged from 6 to 19, with an average of 11.58 years, $SD = 3.03$, with no group difference (intervention group: $M = 11.15$, $SD = 2.53$, vs. control: $M = 12.01$, $SD = 3.53$; $t(154) = 1.74$, $p = .084$). There were 107 boys (68.6%) and 49 girls (31.4%), with no group difference (56 boys and 22 girls in the intervention group, and 51 boys and 27 girls in the control group, $Z = 0.86$, $p = .389$). Most parents were of Jewish origin (88%); the rest were of Arab origin. Treatment groups were located in different geographical areas in Israel, representing a wide range of the

Israeli population. Each group was led by two trained and supervised school counselors ($n = 22$), all female, with an age range of 37–53 and with 9–17 years of experience.

Intervention

The intervention involved 12 weekly 2-hr sessions, lasting about 3 months, which took place in the child's school. The goal was to improve the child's functioning through the improvement of parenting. In terms of Kivlighan and Kivlighan's (2014) typology, these groups may be considered affective-insight groups due to the strong focus on emotions, emotional support, and self-awareness. In these groups parents were encouraged to explore their feelings regarding their children and their own parenting style; they were challenged to develop understanding of self and others; and they were encouraged to change their behavior, while being supported in achieving their goals. The therapeutic factors of catharsis, universality, altruism, group cohesion, and interpersonal learning were important in the group process.

Being a psychodynamic intervention, the process is by definition unstructured, employing a free flow of sharing experiences and emotions. At the same time, it was a short-term intervention, so that it required some structure to stay focused. We used various techniques (films, stories, cards, family pictures, role playing) to enhance parental involvement in the group. Such techniques, however, were only used as stimuli for self-exploration in a psychodynamic way.

The intervention progressed in stages. In the first few sessions the goals were to establish a climate of trust and develop norms of sharing and mutual support. For example, parents gave themselves awards for positive aspects of their parenting practices and were empowered by the group. The working stage—the heart of treatment—was devoted to self-exploration. Parents shared their difficulties, identified their own contribution to the child's difficulties, developed a commitment to change, and made attempts to achieve change. At this point, participants usually did not need much structure, but when necessary, therapeutic techniques were employed. For example, a story about an overly ambitious father was used to help parents understand the consequences of parental ex-

pressed dissatisfaction, unrealistic demands, and rejection of the child. Another example was a poem focusing on compliments, to convey the importance of reinforcement of the child. Still another technique was photo-therapy—sharing a photo of the child and discussing positive and negative feelings about him/her. In addition, parents wrote a letter to their child to deliver a personal message. A film presenting difficulties of a child with ADHD was used to increase understanding of the disorder. Finally, a focus on behavior change was practiced through role playing. At termination (last two sessions), parents summarized the lessons they learned and established goals for further learning. They also said good bye to each other, exchanging messages of support.

Instruments

Parents' measures. Perceived social support was measured through the *Multidimensional Scale of Perceived Social Support* (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). In this 12-item scale, responses range from 1 to 7, with a higher score representing higher rates of social support. The instrument is comprised of three components: family (“My family really tries to help me”), friends (“I can speak openly with my friends about my problems”), and meaningful others (“There is a close person that I can rely on”). Reported internal consistency ranged from .85 to .91 for the subscales and was .88 for the total score. Test-retest reliability (3-month interval) ranged from .72 to .85. Validity was based on comparison with the Hopkins Symptoms Checklist ($r = .24$ and $r = .18$ with depression and anxiety, respectively). Because of high correlations among the three components, we used the total score ($\alpha = .95$).

Parenting style was measured through the *Parental Practice Questionnaire* (PPQ; Robinson, Mandlco, Olsen, & Hart, 1995). The scale consists of three components: authoritative style (“I praise my child when he/she behaves well”), authoritarian style (“I use physical punishment in my child’s education”), and permissive style (“I ignore my child’s negative behavior”). There are 32 items, with responses ranging from 1 to 5. Reported reliability was .81, .72, and .66 for authoritative, authoritarian, and permissive styles, respectively. Validity was based on cor-

relations with children’s problem behavior: $r = .17$ for authoritative style, $.27$ for authoritarian style, and $.29$ for permissive style. Internal consistency in the current study was .91, .84, and .59, for authoritative, authoritarian, and permissive styles, respectively.

Parental self-efficacy was measured through the *Parent Self-Efficacy* scale (Yishay, Cohen, Cohen-Shoev, & Pazi-Marton, 1995). The scale includes 15 items with a response range of 1–6, where a higher score indicates greater self-efficacy. For example: “How are you satisfied with the help you give your child?” Reported internal consistency in several studies ranged from .84 to .87. Validity was based on correlation with parental helplessness ($r = -.56$) and with authoritative parenting style ($r = .35$). Internal consistency in the current study was .87.

Children’s measures. Child self-efficacy was measured through *The Child Self-Efficacy* scale (Bandura, 1997), which assesses the child’s level of functioning in school, at home, and in social situations. The measure contains 10 items with a 1–4 response range, with a higher score indicating greater self-efficacy (e.g., “I can work well with a group of classmates”). Internal consistency in the current study was .81. Internal consistency for children younger than 12 years of age in the current study was .79.

Children’s emotional/behavioral state was measured by the Youth Outcome Questionnaire–30 (Y-OQ-30; Burlingame et al., 2004). Although the scale was developed for adolescents, in the interest of applying one measure to all children, we used it for the younger children as well. However, to ensure that the younger ones understood the items, internal consistency was measured for them separately (see below). This 30-item scale is comprised of a total score and five components (loneliness/depression, distraction/hyperactivity, behavior problems, aggression, and somatic problems). The response range is 0–4, and the scale was completed by both the child and the parent (“I often have headaches”; “My child often has headaches”). Scores range from 0 to 120, with a score of 29 serving as the criterion for a clinical population. Reported internal consistency was .96. Validity was based on correlations with the CBCL ($r = .76$). Test-retest reliability (4 weeks) was .83. Internal consistency in the cur-

rent study was .61–.86 and .93 for the child self-report; it was .77–.86 and .93 for the parent report. Internal consistency for children younger than 12 years of age in the current study was .64–.80 and .88 for the child self-report (except for somatic problems, where $\alpha = .44$).

All measures were completed pre and post in both conditions. Follow-up measures were completed in the treatment group only.

Procedure

A group of school counselors was trained for two years (120 hours) to conduct groups with parents of children with ADHD. In the second year of training, each pair of counselors conducted one group in the study and received supervision throughout the intervention by the two trainers. The two trainers were veterans in group work, with long experience of conducting groups with parents based on the method described above. Out of 104 treatment participants in 11 groups, 78 completed all pre- and post-instruments (75%), an average of 7 people per group. Parents received the instruments at the intake interview and turned them in before the first treatment session. At termination, parents completed the questionnaires after the session ended. Six months later, parents in the treatment condition returned for a follow-up meeting and again completed the same questionnaires. Only 42% of the parents completed the third measurement. No statistical difference was shown between these parents and the rest on any of the outcome variables.

Nontreatment parents, whose children attended schools not involved in the intervention, were asked to serve as a control group to test a treatment for children diagnosed with ADHD (no incentives were offered). These parents completed questionnaires where they were recruited, at the time of pre- and posttreatment. Because of difficulties in engaging them to complete the questionnaires, no follow-up measurement was possible.

Children completed the questionnaires in school, in a small group format, assisted by a teacher who was not involved in the study. To facilitate the children's task, she read each item of the instrument to them and they marked their answers. This procedure was used to help chil-

dren overcome reading comprehension or attention difficulties.

Permission to conduct the study was granted by the Chief Scientist of the Ministry of Education. All parents signed consent forms. To keep the data confidential, all questionnaires had a personal code rather than a name. All counselors were trained by the same therapists and followed the psychodynamic modality as presented by Shechtman (2007). Adherence was further secured in weekly group supervision meetings conducted by the two professionals who trained the counselors. No attempt was made to code the sessions to ensure adherence to the treatment protocol.

Data Analysis

Data analysis was conducted with SPSS ver. 23. Due to the nested nature of the data, mixed hierarchical linear models were used for participants in the treatment condition only, to consider the dependency effects of the treatment groups. As participants in the control condition (who were not grouped) had measurement results at two time points, each such participant received a random variable.

Preliminary analyses included preintervention group differences for the study variables, differences by gender, and correlations with child's age. Analyses of the data were conducted with mixed models by time and group (2×2) to assess change in parent and child variables. These models included three levels: time within the individual, the individual level, and the group level. To predict change, gains in the outcome variables were defined as adjusted residual gains, controlling for the initial score. Mixed models were used to predict change in child behavior outcomes from parent predictors, controlling for children's gender and age.

As follow-up was applied only to the treatment participants, and because only about 40% of them completed the third time measurement, follow-up data were not applied to the general pre-post analyses, but rather were examined separately. This procedure inflates the alpha level, but it avoids estimating results with a majority of missing cases. Bonferroni correction for multiple comparisons was applied throughout the analyses, specifically per the number of analyses in each part of a table.

Results

Preliminary Results

We first examined prestudy differences by experimental condition and child's gender, as well correlations with child's age. No significant differences were found by treatment condition for parents' perceived social support, parenting style, parent self-efficacy, child self-efficacy, parent report on the Y-OQ-30, or child report on the Y-OQ-30 (see Table 1).

Several gender differences were found (see Table 2). Parents of boys reported higher scores on the Y-OQ-30 for the total score, distraction/hyperactivity, behavior problems, and aggression. Higher scores were also found for boys in the child self-report of Y-OQ-30: for behavior problems and aggression. No significant correlations were found between the study variables and the children's ages. Nonetheless, due to the wide range of ages in this study, analyses were conducted while controlling for children's age as well.

Intercorrelations among the parent variables at pretest ranged between $r = -.47$ and $r = .54$

($p < .001$), representing no collinearity. The correlation between the child self-efficacy score and the total Y-OQ-30 score was high, $r = -.70$, $p < .001$; however, as these two variables represent different concepts, they were retained and used separately in the analyses.

Assessing the ICC for each dependent parent variable at post treatment revealed that 8.9% of the explained variance was at the group level for the authoritative style, 34.4% for the authoritarian style, and 1.4% for the permissive style. In addition, 8.1% of the explained variance was at the group level for parent self-efficacy and less than 1% for perceived social support.

Assessing the ICC for each dependent child variable at post treatment revealed that less than 1% of the explained variance was at the group level for child self-efficacy. Regarding the parent report of Y-OQ-30, 4.5% of the explained variance was at the group level for the total score, 1.3% for loneliness/depression, 12.4% for distraction/hyperactivity, 6.1% for behavior problems, less than 1% for aggression, and 6.2% for somatic problems. With respect to the child report of Y-OQ-30, 7.3% of the explained

Table 1
Means, Standard Deviations, and *F* Values for Pretreatment Group Differences ($N = 156$)

| Report | Treatment <i>M</i> (<i>SD</i>) | No treatment <i>M</i> (<i>SD</i>) | <i>F</i> (η^2) |
|---------------------------|-------------------------------------|--|-----------------------------|
| Parent report | | | |
| Perceived social support | 5.48 (1.33) | 5.56 (1.42) | $F(1,27.25) = .13 (.002)$ |
| Parenting style | | | |
| Authoritative parenting | 4.15 (0.47) | 4.06 (0.75) | $F(1,33.95) = .18 (.002)$ |
| Authoritarian parenting | 2.43 (0.57) | 2.26 (0.74) | $F(1,9.38) = 1.51 (.012)$ |
| Permissive parenting | 3.03 (0.70) | 2.92 (0.72) | $F(1,21.66) = .85 (.009)$ |
| Parent self-efficacy | 4.51 (0.69) | 4.66 (0.72) | $F(1,27.15) = 1.27 (.010)$ |
| Parent report, Y-OQ-30 | | | |
| Total score | 1.12 (0.63) | 1.32 (0.73) | $F(1,18.36) = 2.72 (.020)$ |
| Loneliness/depression | 0.71 (0.66) | 0.99 (0.79) | $F(1,13.30) = 3.95 (.027)$ |
| Distraction/hyperactivity | 2.05 (0.85) | 2.30 (1.03) | $F(1,12.40) = 1.89 (.015)$ |
| Behavior problems | 0.97 (0.73) | 1.06 (0.82) | $F(1,25.16) = 0.53 (.006)$ |
| Aggression | 0.75 (0.79) | 0.82 (0.85) | $F(1,16.08) = 0.23 (.003)$ |
| Somatic problems | 0.80 (0.86) | 1.28 (1.12) | $F(1,11.20) = 4.48 (.035)$ |
| Child report | | | |
| Child self-efficacy | 2.91 (0.55) | 2.80 (0.54) | $F(1,26.58) = 1.16 (.009)$ |
| Child report, Y-OQ-30 | | | |
| Total score | 1.09 (0.55) | 1.25 (0.73) | $F(1,8.45) = 1.39 (.011)$ |
| Loneliness/depression | 0.78 (0.59) | 0.83 (0.78) | $F(1,9.12) = 0.21 (.003)$ |
| Distraction/hyperactivity | 1.84 (0.88) | 2.30 (1.06) | $F(1,19.07) = 3.77 (.026)$ |
| Behavior problems | 0.88 (0.73) | 0.96 (0.78) | $F(1,20.64) = 0.23 (.003)$ |
| Aggression | 0.72 (0.79) | 0.79 (0.81) | $F(1,15.61) = 0.29 (.004)$ |
| Somatic problems | 1.13 (0.79) | 1.33 (1.04) | $F(1,20.79) = 0.90 (0.008)$ |

Note. Y-OQ-30 = Youth Outcome Questionnaire-30.

Table 2
Means, Standard Deviations, and *F* Values for Pretreatment Gender Differences (*N* = 156)

| Report | Boys (<i>n</i> = 107) <i>M</i> (<i>SD</i>) | Girls (<i>n</i> = 49) <i>M</i> (<i>SD</i>) | <i>F</i> (η^2) |
|---------------------------|--|--|---------------------------------------|
| Parent report | | | |
| Perceived social support | 5.39 (1.44) | 5.80 (1.17) | <i>F</i> (1,153.78) = 3.09 (.019) |
| Parenting style | | | |
| Authoritative parenting | 4.06 (0.64) | 4.20 (0.60) | <i>F</i> (1,123.39) = .61 (.009) |
| Authoritarian parenting | 2.42 (.67) | 2.17 (0.62) | <i>F</i> (1,144.67) = 5.72 (.032) |
| Permissive parenting | 2.98 (0.72) | 2.97 (0.70) | <i>F</i> (1,134.03) = .01 (.001) |
| Parent self-efficacy | 4.52 (0.69) | 4.74 (0.73) | <i>F</i> (1,149.47) = 1.55 (.012) |
| Parent report, Y-OQ-30 | | | |
| Total score | 1.35 (0.69) | 0.95 (0.60) | <i>F</i> (1,153.42) = 12.16*** (.069) |
| Loneliness/depression | 0.95 (0.73) | 0.62 (0.71) | <i>F</i> (1,148.32) = 6.62 (.041) |
| Distraction/hyperactivity | 2.31 (0.95) | 1.88 (0.88) | <i>F</i> (1,152.45) = 6.84** (.039) |
| Behavior problems | 1.18 (0.80) | 0.66 (0.57) | <i>F</i> (1,154.00) = 17.09*** (.099) |
| Aggression | 0.97 (0.81) | 0.39 (0.68) | <i>F</i> (1,150.05) = 18.46*** (.112) |
| Somatic problems | 0.98 (1.02) | 1.13 (1.04) | <i>F</i> (1,142.04) = .61 (.004) |
| Child report | | | |
| Child self-efficacy | 2.79 (0.53) | 2.98 (0.55) | <i>F</i> (1,146.50) = 4.64 (.026) |
| Child report, Y-OQ-30 | | | |
| Total score | 1.25 (0.67) | 1.02 (0.58) | <i>F</i> (1,131.39) = 4.10 (.027) |
| Loneliness/depression | 0.89 (0.71) | 0.65 (0.65) | <i>F</i> (1,142.40) = 4.42 (.026) |
| Distraction/hyperactivity | 2.14 (1.01) | 1.96 (0.98) | <i>F</i> (1,133.45) = .66 (.007) |
| Behavior problems | 1.05 (0.78) | 0.65 (0.61) | <i>F</i> (1,146.95) = 9.05** (.060) |
| Aggression | 0.90 (0.83) | 0.46 (0.66) | <i>F</i> (1,136.73) = 10.36** (.062) |
| Somatic problems | 1.12 (0.85) | 1.47 (1.05) | <i>F</i> (1,129.90) = 3.51 (.030) |

Note. Bonferroni correction for multiple comparisons was applied. Y-OQ-30 = Youth Outcome Questionnaire-30.
** *p* < .01. *** *p* < .001.

variance was at the group level for the total score, less than 1% for loneliness/depression, 25.8% for distraction/hyperactivity, 9.5% for behavior problems, 7.4% for aggression, and 15.6% for somatic problems.

Main Results

The first hypothesis suggested that parents in the experimental condition would show more favorable outcomes than parents in the control condition. Mixed models revealed a significant time-by-group difference on most variables: perceived social support, parenting style, and parent self-efficacy. Parents in the intervention showed an increase in perceived social support, authoritative parenting style, and self-efficacy and a decrease in authoritarian parenting style, compared with no significant change in the control group (see Table 3). It should be noted that most effect sizes are small, except for authoritative parenting style, where it is moderate. That is, there was a difference mostly regarding parenting style. The first hypothesis was thus supported.

The second hypothesis suggested more favorable outcomes for children whose parents were treated in groups than children whose parents were in the no-treatment condition. Mixed models revealed a time-by-group difference on several study variables: child self-efficacy, parent report of behavior problems on the Y-OQ-30 and most of the child report Y-OQ-30 measures. Again, most effect sizes are small, but on the children's report on the Y-OQ-30 the effects were in the moderate range, for the total score, loneliness/depression, and distraction/hyperactivity, in the intervention group. These differences point to a significant positive change for children whose parents were in the treatment condition and no change for children of parents in the control condition (see Table 4). Thus, the second hypothesis was supported.

We also examined clinical change on the Y-OQ-30. Based on parent reports, 93 children (61.6%) were classified in the clinical range at pretest with no significant group difference. At posttest, 37 children (50.7%) from the intervention condition were classified as such, compared

Table 3
Means, Standard Deviations, and F Values for Parents' Perceived Social Support, Parenting Style, and Parent Self-Efficacy, by Group and Time (N = 156)

| Outcome variables | Treatment | | | No treatment | | | Difference | | | Interaction | | |
|--------------------------|-------------|-------------|-------------|--------------|-------------------------------|--------------------------|-------------------------------|-------------------------------|---------------------------|-------------|--|--|
| | Pre M (SD) | Post M (SD) | Pre M (SD) | Post M (SD) | Time F (η²) | Group F (η²) | Time × Group F (η²) | Intervention F (η²) | Control F (η²) | | | |
| Perceived social support | 5.48 (1.33) | 5.87 (1.12) | 5.56 (1.42) | 5.55 (1.40) | F(1,150.03) = 16.04*** (.099) | F(1,19.79) = .24 (.001) | F(1,150.03) = 16.57*** (.101) | F(1,150.56) = 31.62*** (.177) | F(1,149.46) = .01 (.001) | | | |
| Authoritative parenting | 4.15 (0.47) | 4.40 (0.42) | 4.06 (0.75) | 4.02 (0.72) | F(1,150.27) = 19.78*** (.113) | F(1,42.41) = 1.06 (.010) | F(1,150.27) = 35.02*** (.185) | F(1,151.22) = 52.17*** (.252) | F(1,149.27) = 1.11 (.007) | | | |
| Authoritarian parenting | 2.43 (0.57) | 2.29 (0.63) | 2.26 (0.74) | 2.27 (0.70) | F(1,148.78) = 4.87 (.032) | F(1,15.60) = .48 (.006) | F(1,148.78) = 7.49** (.049) | F(1,149.52) = 11.86*** (.075) | F(1,147.99) = .15 (.001) | | | |
| Permissive parenting | 3.03 (0.70) | 2.97 (0.71) | 2.92 (0.72) | 2.97 (0.64) | F(1,149.06) = .02 (.001) | F(1,24.43) = .43 (.002) | F(1,149.06) = 1.66 (.011) | F(1,151.32) = 17.90*** (.104) | F(1,149.34) = .98 (.007) | | | |
| Parent self-efficacy | 4.51 (0.69) | 4.73 (0.66) | 4.66 (0.72) | 4.61 (0.71) | F(1,150.36) = 5.50 (.035) | F(1,21.71) = .10 (.001) | F(1,150.36) = 13.87*** (.083) | | | | | |

Note. Bonferroni correction for multiple comparisons was applied. Calculating differences only for families with one participating parent yielded the same results. Difference = F values and effect sizes for main effects and the interaction; Interaction = post hoc analyses within each group (intervention and control).
 ** $p < .01$. *** $p < .001$.

with 53 children (67.9%) from the control group, a significant difference, $\chi^2(1) = 4.67$, $p = .031$. Similarly, based on child reports, 86 children (58.9%) were classified in the clinical range at pretest with no significant group difference. At posttest, 24 children (35.3%) from the intervention condition were classified as such, compared with 50 children (64.1%) in the control condition, a significant difference, $\chi^2(1) = 12.06$, $p < .001$. Thus, both mean scores and clinical classification support the second hypothesis.

The third hypothesis suggested that parents' change would be related to children's outcomes. Mixed models were used to predict change in the children's variables from change in the parents' variables in the intervention group. All changes were defined as adjusted gain scores. All predictors were centered. Given that a large number of statistical tests was conducted, Type I error was high and thus Bonferroni correction was applied. With its application, no significant results were detected.

Follow-Up Measurement

Follow-up measurement was available only for the intervention group. It involved 33 parents (42.3%) and 33 children. As mentioned earlier, due to the scarcity of the follow-up data, they were not used with the general pre-post analyses, but rather were analyzed separately to avoid estimating results with a majority of missing cases, even though this procedure inflates the alpha level. No significant differences were found in any of the pre- and postintervention measures between parents and children with and without follow-up data. Change between the postintervention measurement and the follow-up measurement was detected only regarding the authoritarian parenting style, which decreased from $M = 2.23$ ($SD = 0.48$) to $M = 2.11$ ($SD = 0.52$), $F(1, 29) = 4.93$, $p = .034$, $\chi^2(1) = .145$. Stability was noted on all other variables.

Discussion

The purpose of the study was to assess outcomes of parents of children with ADHD, who were treated in psychodynamic group therapy, and outcomes of their children, who were not treated. In comparison with nontreatment par-

Table 4
Means, Standard Deviations, and F Values for Children's Self-Efficacy and Emotional/Behavioral State, by Group and Time (N = 156)

| Outcome variables | Intervention | | | Control | | | Difference | | | Interaction | |
|---------------------------|--------------|-------------|-------------|-------------|-------------------------------|---------------------------|-------------------------------|-------------------------------|---------------------------|-------------|--|
| | Pre M (SD) | Post M (SD) | Pre M (SD) | Post M (SD) | Time F (η²) | Group F (η²) | Time × Group F (η²) | Intervention F (η²) | Control F (η²) | | |
| Child self-efficacy | 2.91 (.55) | 3.06 (.48) | 2.80 (.54) | 2.75 (.54) | F(1,144.24) = 3.31 (.021) | F(1,24.91) = 6.06 (.047) | F(1,144.24) = 14.92*** (.092) | F(1,144.97) = 15.15*** (.092) | F(1,143.41) = 2.23 (.015) | | |
| Parent report, Y-OQ-30 | | | | | | | | | | | |
| Total score | 1.12 (0.63) | 1.02 (0.54) | 1.32 (0.74) | 1.34 (0.71) | F(1,146.25) = 1.70 (.011) | F(1,23.39) = 5.69 (.036) | F(1,146.25) = 4.85 (.032) | F(1,147.99) = 6.74** (.041) | F(1,147.53) = .58 (.004) | | |
| Loneliness/depression | 0.71 (0.66) | 0.69 (0.64) | 0.99 (0.79) | 1.00 (0.79) | F(1,149.14) = .01 (.001) | F(1,12.67) = 5.25 (.035) | F(1,149.14) = .05 (.001) | F(1,147.99) = 4.01 (.027) | | | |
| Distraction/hyperactivity | 2.06 (0.85) | 1.95 (0.81) | 2.27 (1.01) | 2.31 (0.96) | F(1,147.09) = 1.10 (.007) | F(1,10.04) = 3.36 (.022) | F(1,147.09) = 4.01 (.027) | | | | |
| Behavior problems | 0.97 (0.73) | 0.83 (0.62) | 1.06 (0.82) | 1.09 (0.78) | F(1,147.99) = 2.37 (.020) | F(1,34.51) = 2.09 (.014) | F(1,147.99) = 6.74** (.041) | | | | |
| Aggression | 0.75 (0.79) | 0.68 (0.77) | 0.82 (0.85) | 0.81 (0.81) | F(1,149.44) = 2.02 (.014) | F(1,18.25) = 1.09 (.008) | F(1,149.44) = 1.47 (.010) | | | | |
| Somatic problems | 0.78 (0.86) | 0.83 (0.83) | 1.28 (1.12) | 1.27 (1.07) | F(1,149.36) = .11 (.001) | F(1,10.20) = 4.39 (.030) | F(1,149.36) = .16 (.001) | | | | |
| Child report, Y-OQ-30 | | | | | | | | | | | |
| Total score | 1.09 (0.55) | 0.84 (0.50) | 1.25 (0.73) | 1.29 (0.71) | F(1,144.48) = 14.52*** (.092) | F(1,24.19) = 3.43 (.023) | F(1,144.48) = 27.14*** (.157) | F(1,145.38) = 38.20*** (.207) | F(1,143.46) = 1.05 (.007) | | |
| Loneliness/depression | 0.78 (0.59) | 0.47 (0.53) | 0.83 (0.78) | 0.86 (0.77) | F(1,146.05) = 13.61*** (.090) | F(1,40.55) = 1.67 (.013) | F(1,146.05) = 18.61*** (.121) | F(1,147.80) = 30.20*** (.182) | F(1,144.07) = .21 (.001) | | |
| Distraction/hyperactivity | 1.84 (0.88) | 1.54 (0.79) | 2.30 (1.06) | 2.38 (1.02) | F(1,145.57) = 6.99** (.046) | F(1,31.08) = 6.00* (.040) | F(1,145.57) = 20.16*** (.122) | F(1,146.61) = 23.92*** (.141) | F(1,144.39) = 1.82 (.012) | | |
| Behavior problems | 0.88 (0.73) | 0.70 (0.61) | 0.96 (0.78) | 0.99 (0.76) | F(1,143.65) = 3.90 (.025) | F(1,19.77) = 2.65 (.015) | F(1,143.65) = 9.67** (.060) | F(1,144.39) = 12.12*** (.076) | | | |
| Aggression | 0.72 (0.79) | 0.56 (0.83) | 0.79 (0.81) | 0.82 (0.80) | F(1,144.14) = 2.63 (.019) | F(1,31.99) = 2.45 (.016) | F(1,144.14) = 5.84 (.039) | | | | |
| Somatic problems | 1.13 (0.79) | 0.95 (0.72) | 1.33 (1.04) | 1.33 (0.99) | F(1,146.16) = 4.81 (.033) | F(1,30.45) = 1.40 (.010) | F(1,146.16) = 4.81 (.033) | | | | |

Note. Bonferroni correction for multiple comparisons was applied. Calculating differences only for families with one participating parent yielded the same results. Difference = F values and effect sizes for main effects and the interaction; Interaction = post hoc analyses within each group (intervention and control); Y-OQ-30 = Youth Outcome Questionnaire-30.
*** p < .01. ** p < .001.

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ents, results indicated more favorable outcomes on most variables for treatment parents and their children. Parents in the intervention group showed modest gains in perceived social support and self-efficacy, and they increased their authoritative parenting style. Children of treatment parents showed positive outcomes on child self-efficacy and emotional/behavioral state as reported by parents and children alike. No change was detected for nontreatment parents or their children. Moreover, outcomes sustained after 6 months. No significant relationship between child and parent outcomes was found.

The positive outcomes of group psychotherapy for parents facing challenges are not new. Group therapy is considered an effective mode of intervention for a variety of difficulties (Burlingame, Whitcomb, & Woodland, 2013), including those encountered by parents (Daley et al., 2009; Webster-Stratton et al., 2011). However, most group interventions with parents are cognitive-behavioral, focusing on guidance and training. In contrast, the current intervention takes a psychodynamic approach and focuses on the parent rather than the child, aiming at parental growth through processes of self-understanding and empowerment. The premise of this approach is that self-understanding will lead parents to find their way to their child with difficulties. Therefore, rather than training parents in specific practices or measuring specific skills, we focused on global parent characteristics, such as self-efficacy, authoritative parenting style, and perceived social support, assuming that growth in these areas would be beneficial for the child.

Indeed, gains were detected on all these measures. Parents gained in perceived social support, meaning that they felt less lonely (Sarason & Sarason, 2009). They became more authoritative and less rigid and controlling (Baumrind, 1967; Tancred & Greeff, 2015). They also felt more empowered and capable of coping with their child. Although parents' gains were modest, they should not be overlooked, particularly because no change was shown for parents in no treatment. These results are supported by earlier research employing a psychodynamic group intervention with parents (Danino & Shechtman, 2012; Shechtman & Gilat, 2005). The current study strengthens these earlier studies in two ways. First, it is the first to involve only parents

of children diagnosed with ADHD. Second, it adds the importance of parents' self-efficacy, perceived social support, and authoritative style to children's functioning. Because of the disruptive behavior of children with ADHD, parents tend to look for advice and guidance, and therapists are tempted to provide them to be responsive to these immediate needs. The results of the current study show that focusing on a more global parenting style, while encouraging self-expressiveness and insight in a supportive climate, may also help parents of children with ADHD.

More interesting and more salient are the outcomes for the children. Even though they themselves were not given treatment, children of treatment parents felt more efficacious and showed a reduction in emotional/behavioral difficulties based on both parent and child reports. Furthermore, they demonstrated a significant change from clinical to nonclinical classification at posttest. Many studies of children in group therapy have shown effective outcomes, including on the Y-OQ-30 (Shechtman & Sarig, 2016), but this is the first to yield such results following parent treatment alone. The impact of parental dysfunction on children's behavior is known (Johnston & Mash, 2001). Children with ADHD, in particular, need a parent who is confident, and who can guide the child with understanding, wisdom, and support. The emotional growth of parents is therefore expected to have a positive impact on the child.

The expected statistical relationship between gains of parents and gains of children was not found after applying the Bonferroni adjustment. However, further exploration of such a relationship is worthwhile. We also do not know what processes led to children's gains, another area worthy of further exploration. Nevertheless, the clear difference between the children of treatment parents and nontreatment parents at posttest suggests that the outcomes may be attributed to the treatment.

Limitations

Several limitations of the current study should be noted. First, the generalization of results is restricted because the study was conducted in one specific country. Second, outcomes were compared with no treatment; a comparison with another type of treatment

would be a stronger methodology. Third, parents were not randomly assigned to the experimental conditions. Although no initial difference between the two study populations was found on any of the variables, random assignment would be a more salient methodology. Fourth, the number of participants that could be followed up after termination was relatively small. Although the analysis did not indicate differences between those parents who were followed up and those who were not, caution should be taken regarding the sustainability of results. Fifth, internal consistency for the permissive parenting style was low, thus a priori limiting the likelihood of significant results with this variable. Related to this is the fact that children younger than 12 completed the Y-OQ-30. Although internal consistency of the instrument for this population was not different than for older children, and no difficulties were detected during completion of the questionnaire, this result should be interpreted with caution. Sixth, although the two authors were not directly involved in training, supervision, or data collection, those professionals who served as trainers did apply the method elaborated by one author. Hence, there is a possible risk of some research allegiance. Seven, no attempt was made to code sessions to ensure adherence to the treatment protocol. Eight, because the treatment was multifaceted there is no way to know which components were effective. Finally, absence of a structured and consistent ADHD assessment is another limitation of the study.

The initial gender differences found in children's behavior, call for further investigation. Because most of the sample was comprised of boys and the current sample was too small to compare the two genders, we controlled for gender differences but we did not measure differential impact of the treatment on boys and girls. This is an important question, which has implications for treatment, owing to the high percentage of male children diagnosed with ADHD. Past research on a different population of children (Shechtman & Vurembrand, 1996) showed that both boys and girls improved in self-disclosure following treatment, but boys gained more. It would be interesting to investigate the different outcomes for boys and girls following the treatment of their parents.

The Contribution of the Study

The current research differs from other studies of interventions with parents of children with ADHD, mainly in taking a psychodynamic approach. Because psychodynamic interventions are underrepresented (Shedler, 2010), it is extremely important to show that they can be applied successfully with parents of children with ADHD. This is the first study to test this unique intervention with parents of children who were all formally diagnosed with ADHD (earlier research employed a mixture of children with LD and ADHD). The results of the current study suggest that parents show a modest improvement in their parental practices and their children show improved behavior. Further research is needed to explore the treatment components that assist parents in their growth process.

It is also important to note that the intervention was conducted in the school by school counselors. This is not trivial, as school counselors usually do not carry out such tasks. This study provides a model for working with parents of children with ADHD that counselors can implement in their schools and thus strengthen the necessary family school cooperation, for the sake of all—children, parents and the school.

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