Parenting in the age of Prozac: Parental decision-making in social context

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PARENTING IN THE AGE OF PROZAC:
PARENTAL DECISION-MAKING IN SOCIAL CONTEXT

BY

NENA F. STRACUZZI
BA, University of California at Irvine, 1994
MA, University of New Hampshire, 1998

DISSERTATION

Submitted to the University of New Hampshire
in Partial Fulfillment of
the Requirements of the Degree of

Doctor of Philosophy
in
Sociology

December, 2005
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DEDICATION

There is a saying: “Life is what happens while you are busy making other plans.” So too, life is what happens while obtaining a Ph.D., despite feeling as though you have been interminably placed “on hold.” In my time at UNH, there are a significant number of people who have ultimately contributed a great deal to my journey, though some were unable to see it through to the end. They will live in my heart forever and it is to their memories I would like to dedicate this dissertation.

To my dad who taught me how to laugh, the importance of being genuine and the fundamental value in remembering people’s names. To my sister-in-law Kathy who always had tremendous faith in abilities I never knew I had and taught me the power of loyalty and fierce determination. And finally, to my good friend Trish – who should currently be helping me to format this dissertation. In her unassuming way, never speaking an unkind word about anyone, she was the embodiment of grace, a quality I continually seek to cultivate.
ACKNOWLEDGEMENTS

A project such as this could not be undertaken, let alone completed, without the contributions of many. Indeed, numerous people have generously given time, money, emotional and instrumental support, good ideas, and tough criticisms above and beyond my hopes and expectations. This is where I get to formally thank some of those without whom it is highly probable that I would never have completed this journey.

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I am greatly appreciative of all parents who took the time to fill out my questionnaire and especially indebted to those who invited me into their homes and told me their stories. Without you, I would have no dissertation to celebrate. My gratitude is also extended to all school administrators who made it possible for this project to get off the ground in the first place.

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My love to you all.
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ABSTRACT

PARENTING IN THE AGE OF PROZAC:
PPARENTAL DECISION MAKING IN SOCIAL CONTEXT

by

Nena F. Stracuzzi

University of New Hampshire, December, 2005

Within recent years, prescriptions written for children's emotional and behavioral problems have increased significantly. Although this issue has garnered a great deal of public notice, it has received scant sociological attention. In this study, I investigate parents of children with problems, and those without, in an effort to gain insights into the social contexts that shape decisions around diagnoses and treatment. The bases of the theoretical underpinnings of this research are situated at the intersection of medicalization and mother-blame.

Survey data were collected from 235 parents in a single New Hampshire community. Respondents answered several open-ended questions on the questionnaire and fourteen additional in-depth interviews were conducted with parents whose children were at least suspected of having problems. Chi-Square Analyses and One-Way Analyses of Variance compared the ways in which parents conceptualize children's emotional and behavioral problems, as well as their attributions of origins, and their perceptions of blame and responsibility across four groups: 1) parents of children with no problems, 2) parents who suspect their children have problems; 3) parents whose children have diagnoses but are not
using medication, and 4) parents treating their children medically. Qualitative data were used for corroborative and illustrative purposes.

Key findings demonstrate that: 1) despite rising prescription rates, most respondents' attitudes towards children’s use of psychiatric medication are largely negative unless they have children for whom medication is prescribed; 2) most respondents of children without problems do not attribute children’s emotional and behavioral disorders to problems with brain function, blaming poor parenting practices instead; 3) parents’ decisions to medicate were most influenced by children’s behavior, possibly due to feeling stigmatized; and 4) there are a series of stages through which parents progress before accepting their children “need” psychiatric medication, beginning with similar negative attitudes towards medication held by parents of children with no problems.

It seems medication does not provide parents with the relief its critics imagine, but instead creates added burdens associated with parents’ need to continually monitor and change children’s treatment, indicating that contrary to popular belief, parents do not use medication as a “quick fix” for unruly children.
INTRODUCTION

STATEMENT OF THE PROBLEM

Medicating Childhood?

At present, approximately six million children in the United States are being prescribed psychiatric medication despite concerns over unknown long-term effects (Cohen et al. 2001). Ritalin use alone – which is used to treat attention deficit/hyperactivity disorders (AD/HD) – rose by 700 percent between 1991 and 1998 (Diller 2000). The use of Prozac and equivalent antidepressants has increased by 74 percent for children under 18, it has increased by 151 percent for children between the ages of seven and twelve, and for children six years old and under, it has increased by 580 percent (Diller 2000).

Diagnosis and treatment of AD/HD have long been controversial, but these new findings incited a blitz of media headlines and sparked a national debate. As Diller (2000) explains however, this dispute is just another version of the longstanding “nature versus nurture” debate, with one side arguing children’s problem behaviors are the result of their inherent brain chemistry, and the other side attributing children’s difficulties to their social environments. Because the debate is centered on children, who are dearly loved and unable to fend for themselves, the argument becomes intense (p. 10).

Indeed, legislation aimed at combating what critics see as prescription drug abuse was enacted after a study published in the Journal of American Medical Association (Zito et al. 2000) reported a dramatic increase in the number of two-to-four-year-olds on Prozac, Ritalin, and other psychotropic medications. Laws prohibiting school officials from recommending psychiatric drugs for any child have been passed in several states and are
currently being considered by many other state legislatures (American Academy of Child and Adolescent Psychiatry, Department of Government Affairs 2004).

Ironically, at the same time as laws are being passed to curb these prescribing trends, according to the National Institute of Mental Health (NIMH), one out of every ten children in the United States has an emotional, behavioral, and/or psychological disorder, yet less than one in five receives treatment. As a consequence, in many cases, children left untreated have adverse effects, which can endure into adulthood (2004).

Taken together, the preceding paragraphs give rise to a number of sociological questions. As C. Wright Mills noted, “What we experience in various and specific milieux . . . is often caused by structural changes. Accordingly, [in order] to understand the changes of personal milieux we are required to look beyond them” (1959:10). Obviously, health care decisions affecting such young children must be accomplished through their parents, but what drives parents to health professionals in the first place? The sociological attention paid to parents grappling with this problem is scant.

The amount of public attention these prescribing trends have received however suggests that America is in the midst of a mental health crisis with children either being over-diagnosed or under-diagnosed – or perhaps both. Whether or not children’s emotional, psychological and behavioral problems are attributed to ostensibly treatable medical conditions, is likely to have important implications for health care decisions. That is, the extent to which parents attribute children’s problems to medical disorders, such as hyperactivity, attention deficit, anxiety, or depression, rather than to environmental influences, is likely to influence their perceptions of responsibility, and ultimately, decisions about treatment and intervention.
Differences between parents’ attitudes who are dealing with their own children’s emotional and behavioral problems and parents whose attitudes are simply based on the observations of others need exploration in an effort to elucidate parents’ decision-making processes. It seems likely for example, that in parents’ attempts to respond to and cope with their own children’s problems they will adjust their attributions of cause, their perceptions of blame, their child-rearing behaviors and their feelings about parenting. It may also be the case that parents of children with psychological, emotional, and behavioral problems will be exposed to new circumstances, social interactions and associations within the health care system, schools and informal networks, not experienced by other parents. To the extent that parents faced with these challenges develop different behaviors, beliefs and attitudes than parents who are not directly confronted with these problems, we may gain insights into the social contexts that shape parents’ decision making. In so doing, we may begin to understand what is behind this trend in rising prescription rates.

**Public Acceptance**

McLeod et al. (2004) move towards understanding this trend through their investigation of the lay public’s attitudes towards the use of psychiatric medications for children with particular types of behavioral problems. Through their analyses of sample data obtained from the 1998 General Social Survey’s Pressing Issues in Health and Medical Care Module they found that more Americans (57%) are willing to use psychiatric medications for children who have expressed suicidal statements than for oppositional behaviors (34.2%), or for hyperactivity (29.5%). All told, their findings demonstrated that respondents were less willing to give Prozac than typical stimulant medications, such as Ritalin, which has long been used to treat children’s behavioral problems. They found that the most consistent correlates of willingness to give psychiatric medications to children were trust in personal

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physicians, general attitudes toward psychiatric medications, and respondents’ hypothetical willingness to take the same medications themselves.

Drawing on theories of medicalization, McLeod et al. (2004) attempt to reconcile increasing prescription rates with the fact that, except for cases in which a child has ever expressed thoughts of suicide, most Americans are generally opposed to the use of psychiatric medications for child behavior problems, and are particularly suspicious of Prozac. The authors point out that this uneasiness does not reside in “any particular sociodemographic group but rather extends to a broad cross section of the American public”, indicating from their perspective that “the medicalization of child behavior problems is not complete” (McLeod 2004:63). In other words, current prescription rates may not reflect the extent to which Americans attribute children’s emotional, psychological, and behavioral problems to medical disorders.

In fact, as a general rule, people’s attitudes and behaviors tend to be only weakly correlated (Schuman 1995 cited in McLeod et al. 2004) and may be even less so in the face of extreme circumstances such as parenting a particularly troubled or difficult child. In such cases, parents may be more amenable to medication than their expressed attitudes would suggest. It may be that, even though parents are opposed to psychiatric medications prescribed for children’s problem behaviors generally, in the case of their own child’s circumstances, they come to believe that medication is the only viable solution. This could be exacerbated if they feel pressured by medical practitioners, insurers, and/or the schools, many of whom have an interest in promoting medical solutions, given low costs and ease of administration relative to alternative therapies (McLeod et al. 2004).

The findings above help to illuminate Americans’ attitudes towards the use of psychiatric medications for children. To more fully understand the disparity between
Americans’ reluctance to give psychiatric medication to children and rising prescription rates, research should be specifically geared towards parents of school-aged children. If, as McLeod et al. suggest, differences in attitudes towards psychiatric medications for children are not the result of sociodemographic characteristics, their own experience with psychiatric treatment, or general attitudes towards medical care, this begs the question as to how people actually think about the children’s “disorders.” In other words, as McLeod et al. suggest, what is needed is “a focused exploration of how Americans conceptualize emotional and behavioral problems in children and adolescents, to what they attribute the causes, and who they feel is competent to address these issues” (2004:63).

This study is in response to this gap in the literature, though rather than a general focus on adults, I focused exclusively on parents who are confronted with these issues, whether dealing with their own children or through the observations of other children while engaged in school and/or extracurricular activities. In so doing we can see the extent to which the parental attitudes of children who have emotional, psychological, and behavioral problems differ from the attitudes of parents who do not have children with problems and, as noted previously, gain an understanding of the social contexts that ultimately shape parents’ decisions around their children’s mental health.

Mothers of Children with AD/HD

Claudia Malacrida’s research (2002) begins to fills this gap with her examination of 34 Canadian and British women’s experiences whose children were diagnosed with AD/HD. Malacrida was specifically interested in understanding the ways mothers experience the workings of medical, psychiatric, and educational professionals’ knowledge and power and how this may vary within different cultural contexts. At the time she began her study, the
most recent data available (1995) indicated that children in England, were being treated with psychostimulants at a rate of only .03%, and mothers there were struggling to obtain diagnoses, whereas, Canadian mothers were feeling pressure to accept diagnoses because 2.5% of Canada’s children were taking Ritalin (a four-fold increase since 1987).

Reflecting this disparity, Canadian and British discourses around AD/HD diagnoses and Ritalin were also very different. Much like the ongoing debate in the United States regarding psychiatric medications for children’s emotional, psychological, and behavioral issues, Canadians believed AD/HD was becoming an epidemic and that Ritalin was being used to compensate for other problems. By way of contrast, in England it was hard to find professionals who would prescribe Ritalin or who even believed that AD/HD was a legitimate diagnosis (Malacrida 2003).

Consequently, English mothers looking for something so that their children might live up to their potentials were perceived as pushing too hard for diagnoses, and were deemed by teachers, psychiatrists, and physicians, as overprotective, overachieving, or in denial of their child’s limits. In contrast, Canadian mothers were feeling pressured to accept diagnoses, often refusing to have their children subjected to yet another round of tests and resisting treatment. This branded them as negligent or in denial of their child’s difficulties. Ironically, despite mothers’ opposing strategies, Malacrida submits they actually had a great deal in common, in that all were engaged in efforts to cast themselves in the eyes of the professionals, as something other than inadequate mothers (2002).

Whereas McLeod et al. suggests that parents of children with emotional, psychological, and behavioral problems may feel pressured into medication by medical practitioners, insurers, and/or the schools given low costs and ease of administration (2004), Malacrida found that the pressure mothers experienced – whether seeking diagnoses or
feeling diagnoses were being thrust upon them – was tied to present-day notions of good mothering. Ultimately, regardless of what they decided, both British and Canadian mothers worried about being perceived as “less than good mothers” (2002:154). This is not to say Malacrida found no evidence of external pressures. Rather, these external pressures are interpreted through a lens of contemporary mothering ideals.

Similarly interested in mothers’ experiences, Singh (2004) looks at the problem of blame in relation to children’s AD/HD diagnoses and Ritalin use. She contends that the heart of the AD/HD–Ritalin debate is centered on the question of blame. Among the many targets are medical, educational, social, and genetic factors, but “parents occupy space in most positions within the web of blame” (2004:1194). She is quick to point out that in discourses around parenting however, the category “parents” is really a euphemism for “mothers” (2004:1194) as has been argued by a number of feminist scholars (e.g., Rich 1976). Indeed mothers have historically been blamed for a host of children’s problems that range from bedwetting to schizophrenia (Caplan and Hall-McCorquodale 1985).

From her analysis of 61 qualitative interviews with mothers and fathers of boys with AD/HD, Singh suggests that the medicalization of problematic behavior in young boys allows mothers to shift blame from their own parenting deficits to more biologically-based problems with their children’s brains, which provides mothers with a certain amount of relief. She argues however, that mothers’ turn to Ritalin is an “act of self-preservation” executed against a backdrop of cultural stereotypes that is more apt to place value on mothers’ acts of self-sacrifice (2004:1194). In the end, she claims that the “brain-blame narrative,” that is, the premise that children’s emotional and behavioral problems are a function of problems with their brains rather than their environments, merely serves to reinforce the good mother ideal, which she argues is oppressive (2004:1204). While mothers
may no longer be blamed for causing their son’s behavioral problems, ideals of good mothering demand they be vigilant in monitoring their problems and preventing them from getting worse (Singh 2004).

Drawing on existing research, my goal is to highlight the complexity of this discord between rising prescription rates for children despite American’s negative attitudes and to make evident, the need for further research. What is especially lacking is research that can help to shed light on the social context within which parents of children with emotional, psychological, and behavioral problems must make health care decisions. Despite the shortage of sociological research on this topic, the extent of public attention it has received illustrates that recognizing and responding to children’s mental health problems, both with and without medication, has become entrenched in American culture. Sociology must help to explain this phenomenon in an effort to resolve this conflict.

My study adds to the limited sociological research in this area and builds upon the work of Malacrida (2002), McLeod at al. (2004), and Singh (2004). Though Malacrida’s and Singh’s findings are specific to AD/HD, they also have broader implications for parents struggling with any emotional, behavioral, and/or psychological problems their children may be experiencing. Indeed, the dramatic increase in a host of psychiatric medications prescribed for children suggests a need for research more generally geared towards the ways parents think about their children’s emotional and behavioral problems. And, as pointed out by McLeod et al. this research should be focused on people’s conceptualization of emotional, psychological, and behavioral problems, their attributions concerning the origins of these problems, their ideas about the best ways to respond, and who they feel is competent to address these issues (2004).
Primary Aims of Dissertation Research

The present study investigates parents who are dealing with their own children’s psychological, emotional, and behavioral problems, as well as those who are not, in an effort to gain insights into the social contexts that may shape parents’ decision making. Sample data were collected from 235 parents in a single New Hampshire, predominantly white suburban community of 27,000 with children in attendance at each of the community’s three public elementary schools. Analyses were performed to assess the ways parents’ conceptualize children’s emotional, psychological, and behavioral problems, their attributions of the origins of these problems, and their perceptions of blame and responsibility. In an effort to examine the extent to which parents faced with these challenges develop different attitudes, behaviors and beliefs than parents not directly confronted with these problems, their child-rearing behaviors and their feelings about parenting were also examined. Finally, in order to assess parents’ ideas about how best to respond to these challenges and who they believe is best equipped to address these issues, their sources of parenting information were examined along with factors that may have been influential on their health care decisions.

Group comparisons on the above factors will be made to identify potential differences between parents of children with emotional, behavioral, or psychological problems and parents of children without problems. Moreover, I expect that significant variations may exist within the group of parents dealing with child problems. Parents whose children have received a medical diagnosis with respect to their child’s problems may differ from those who have children with problems but have not been diagnosed with medical problems. Further differences may be found for parents who are relying on medications to
deal with child symptoms. In other words, I hypothesize that parents who vary by their level of utilization or reliance on medical labels and treatments will differ on the dimensions assessed in this study. Four groups will be compared: a) parents of children with no emotional, psychological, or behavioral problems, b) parents of children who believe their children have problems though no formal diagnosis has been made; c) parents of children who have received a medical diagnosis but who are not using medication, and d) parents who are treating their children's problems with medication.

A comparison of the types and severity of children's problem behaviors with which these four groups of parents are confronted was also made. As explained in the next chapter, dimensions assessed were internalizing and externalizing behavior problems, consistent with a child-behavior checklist widely-used in clinical practice. Internalizing behaviors are those that tend to be more concealed, having to do with feelings of depression and anxiety, whereas externalizing behaviors are those that are more visible, such as hyperactivity, aggression and attentional problems. Academic performance problems were also assessed. I expect to see a difference in parents' reports of their children's challenging behaviors across the four groups, with parents' increasing utilization of medical labels and treatment in accordance with symptoms becoming more severe. In other words, it seems reasonable to expect that parents confronted with more problematic behaviors, will go to more extreme measures in their efforts to "correct" the problems.

That said, I also expect that group differences among parents will vary according to whether their children's behaviors are more internalized or externalized. I hypothesize that children's externalizing behaviors will be a better predictor of parents' increased reliance on medical labels and treatments than children's internalizing symptoms given that externalizing problems will likely be more conspicuous to others with whom children interact. As a
consequence of the types and severity of children's symptoms, some parents may feel more susceptible to judgment and blame, which may in turn persuade them to seek help more actively than other parents.

Finally, although this is a comparatively homogeneous sample, as outlined in the next chapter, I also examine possible sociodemographic variation across the four groups of parents.

The specific aims of the current study are:

1. To compare the four groups of parents on sociodemographic characteristics, including sex, education, employment, income, family structure, and family characteristics.

   The four groups are as follows: a) parents of children with no emotional, psychological, and behavioral problems (N = 137); b) parents of children who believe their children have problems though no formal diagnosis has been made (N = 40); c) parents of children who have received a medical diagnosis but who are not using medication (N = 35); and d) parents who are treating their children's problems with medication (N = 23).

2. To compare the four groups of parents on children's internalizing and externalizing behavior problems. In addition to behavior problems, academic performance problems were also assessed.
3. To gain an understanding of the social contexts within which parents' decisions around their children's emotional, psychological, and behavioral problems are made by comparing the four groups of parents on the following:

a. Child-rearing behaviors. Specifically I assess the extent to which parents monitor their children's time at the computer, their television viewing, and their homework, the extent to which they spend leisure time with their children, engage their children in discussions around their relationships with friends and classmates, their school performance, their educational goals, and outside interests, and the extent to which they are involved with their children's classrooms and their schools.

b. Feelings about parenting, including the extent to which parents take pleasure in parenting, feel burdened by parenting, feel that their parenting is important, and feel competent in their child-rearing skills or style.

c. Sources of parenting information, including advice literature found in print as well as the internet and television programs, family and friends, support groups, health practitioners, and school teachers and administrators. The extent to which parents are reliant on expert advice (all school and health practitioners) relative to that from non-experts (friends, family, and clergy), and advice literature is examined.

d. Respondents' reliance on experts' opinions of their parenting skills/style relative to non-experts.

e. General attitudes towards psychiatric medications used to treat children's emotional, psychological, and behavioral problems.
4. To gain an understanding of how parents differ around their conceptualization of children’s emotional, psychological, and behavioral problems by comparing the four groups of parents on:

   a. Attributions concerning the origins of children’s problems. In particular, I examine the extent to which parents view children’s problems as a result of genetic, neurological, and/or biological factors versus socialization influences.

   b. Perceptions of blame and responsibility for children’s problems. Specifically, I examine the extent to which parents blame their parenting skills/style for their children’s characteristics, and the extent to which they perceive that others hold their parenting skills/style responsible.

5. To gain a more in-depth understanding of how parents may differ around their conceptualization of children’s problems by comparing only those whose children have been diagnosed with emotional, psychological, and behavioral problems – both those who treat their children’s problems with medication and those who do not, on the following:

   a. Their ideas about the best ways to respond to children’s problems, indicated by the extent to which they: agree with children’s diagnoses; have difficulty making treatment decisions; treat with medication; use alternative treatments; feel treatments are effective; are satisfied with treatment; feel pressured into treatment; and refuse treatments.
b. Influential factors around treatment for children's problems, including children's academic performance, children's behavior, families' emotional well-being, availability and cost of services and children's request.

c. Ideas about who is competent to address children's problems, indicated by the extent to which respondents rely on recommendations from school personnel, general health practitioners, specialists in children's emotional, psychological, and behavioral problems, advice literature, or friends and family members is included as another measure of influential factors

In sum, the overarching goal of this research is to begin to understand what drives parents' decisions around psychiatric medication for their children in an effort to appreciate why their attitudes are seemingly different from those of most Americans.
CHAPTER ONE

BACKGROUND AND LITERATURE REVIEW

Ideals of Parenthood

Mothers

Sharon Hays (1996) traces the roots of contemporary child-rearing ideals in an effort to show both the variable nature of child-rearing ideas and their increasingly intensive qualities. She argues that the current cultural model of socially appropriate child-rearing is a historically constructed ideology and that in its present-day form it is an “ideology of intensive mothering” (p. x). By this she means it is a model advocating child-rearing methods that are “child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive [and] it is the individual mother who is ultimately held responsible for assuring that such methods are used (p.122). In other words mothers are expected to spend a great deal of time, energy, and money in raising their children and should be reliant upon the advice of experts. She questions the logic of such a model in a society that simultaneously emphasizes the “individualistic, calculating, competitive pursuit of personal gain” (p. 152) and in which over half of all mothers of small children are employed outside the home. These phenomena comprise what she calls the “cultural contradiction of contemporary motherhood” (p. x).

In Hays’ efforts to understand the bases of this contradiction, she draws on three types of data. She analyzes the history of ideas about child-rearing, she conducts in-depth interviews with 38 mothers of two- to four-year-old children, and she conducts a content analysis of the underlying themes in three popular contemporary child-rearing manuals all
written by top selling authors: Dr. Benjamin Spock, Dr. T. Barry Brazelton, and Penelope Leach (1996). Because of her combination of methods, she argues that there is reason to believe that the ideology of mothering she uncovered in her interviews was not limited to her small group of mothers. Rather, she claims that the ideology mothers espoused “turned out to be one that closely matched the ideology of mothering developed historically and elaborated in the best-selling child-rearing manuals” (p. xii). Central tenets of this ideology are that children’s needs should always be placed first, and mothers should demonstrate their deep emotional attachment to their children by centering all of their time and energy on their child’s needs and desires through each developmental stage (Hays 1996). Lending further weight to her analysis is the fact that her findings are in line with those of other researchers interested in motherhood.

Susan Walzer (1998) for example, alludes to what Hays calls the contradictions of motherhood in her assertion that “new mothers and fathers negotiate parenthood in a social context full of paradoxes” (p. 9). By this she means that, even when mothers and fathers in couples she interviewed were both employed and equal financial contributors, their divisions of emotional and physical labor insofar as they were connected to their family lives did not reflect that. Rather, the parents with whom she spoke felt that mothers were more tied to and responsible for the baby, while fathers felt more conscious of being wage-earners, regardless of which one actually worked longer hours, traveled more frequently, or earned more money. She discovered that regardless of what parents actually did in terms of caring for and spending time with their babies, they “carried particular images of what mothers’ and fathers’ . . . feelings and responsibilities were supposed to be – and they were accountable to those images” (p. 17).
Through interview data with fifty new mothers and fathers, Walzer (1998) examined the cultural imagery new parents associate with motherhood and fatherhood and the extent to which that imagery influences the ways they think about their new roles and negotiate their parenting arrangements. She labels these ways of thinking “parental consciousness,” by which she means parents’ thoughts and feelings about their babies – as well as their thoughts about their thoughts. “In other words,” as Walzer explains, “parents think about their babies, and they . . . judge these thoughts by how they think they should be thinking about their babies” (1998:16) relative to their interpretations of other families and images of their own idealized childhoods as well as media portrayals of family life. She asserts that the standards to which parents hold themselves accountable are their own images of good parenting, all of which, in her interview data, unfailingly reflected models of mothers as “ever-present nurturers and fathers as providers and part-time playmates” (1998:50).

The cultural imagery to which Walzer refers are the types of images to which Singh’s mothers responded when they were asked to choose pictures from a set of popular magazines in order to gauge their reactions to particular questions. Pictures chosen were selected by respondents to reflect what Singh stated was a “pervasive visual and narrative metaphor” throughout their interviews – that of the good mother (2004:1196). Pictures that illustrated the good mother were of happy children and smiling parents engaged in close activities like reading or watering flowers together. Respondents characterized the good mother with “qualities such as understanding, protection, closeness, wisdom, selflessness, and a lack of conflict” (p. 1196). These idealized images, which represent the bases of comparison from which parents tend to judge their own parenting, demonstrate the impossible standards to which parents hold themselves accountable, and help us to imagine that indeed parents of children with emotional, psychological, and behavioral problems may
feel relieved to discover that their child’s difficulties are genetic, biological or neurological in origin, rather than caused by them.

**Mother-Blame**

Both Hays (1996) and Walzer (1998) point out that one of the distinguishing features of mothers’ in their studies is their overwhelming sense of ultimate responsibility for their children and their accompanying sense that that is the way good mothers are supposed to feel. Taking primary responsibility for their children in terms of both actual time and emotional energy spent is what good mothers do. Given this, it is not surprising that “they understand themselves as largely responsible for the way their children turn out” (Hays 1996:120).

In actual fact, as the contemporary western nuclear family has become increasingly isolated in modern times, mothers have long-been blamed for children’s negative behaviors. As a sociological concept, “mother-blame” specifically refers to the far-reaching condemnation of mothers for a vast array of problems associated with individual children as well as larger societal issues. Phenomena for which mothers have been held responsible in individual children extend from children’s ill-mannered behaviors and poor school performance to schizophrenia and autism (Caplan and Hall-McCorquodale 1985). Societal issues, for which they have been held responsible, range from juvenile delinquency to national decay. Indeed, overly-indulgent mothers have been blamed for creating homosexuals deemed treasonous during the cold war as well as an entire generation of hippies (Terry 1998).

Paula Caplan, a clinical research psychologist, well known for her writings on mother-blame, maintains in her book, *The New Don’t Blame Mother*, that mother-blame persists in present-day practices and belief systems. She presents a typology of ten “perfect mother myths” developed out of her own extensive research and counseling of mothers and
daughters. Though these myths were first presented in her original 1989 *Don't Blame Mother*, according to Caplan, they endure. Among them, the most salient for the present study is the myth that “the measure of a good mother is a perfect [child]” (1989:74; 2000:70). As Caplan notes, obviously the frightening flip side of this myth is that a “bad” (or atypical) child indicates a “bad” mother (2000:71). Ironically, though the bad mother label certainly has significant negative impact, its meaning is continually changing and it is rarely agreed upon (Ladd-Taylor and Umansky 1998). In other words, that which constitutes bad mothering varies according to the social norms of the time and place. Consequently, mothers in our society tend to always be very concerned with notions of good parenting (Garey and Arendell 2001).

This becomes especially acute once parenting enters the public realm – frequently when children enter school. School is particularly salient because it is one of the points at which the private “practices of childcare become visible . . . outside the family”– and mothers begin to act in ways so as not be negatively evaluated by teachers and other school authorities (Prout 1988: 783-784). Prout discovered for example, through 35 in-depth interviews with mothers of elementary school-aged children, that mothers’ decisions to keep their children home sick from school always involved the impression management of their own maternal competence (1988). In other words, mothers felt pressured to act in ways approved of by the school, both in ensuring their children were healthy and attending school regularly, as well as knowing when to keep them home sick or potentially so. Prout asserts that mothers revealed they felt their “actions were under surveillance” and that they could be criticized as being either overly indulgent or neglectful depending on their “sickness absence practices” (1988:784-785).
Mothers are under public scrutiny long before their children enter school however. Consider dominant medical discourses that have pervaded the lay public in the past few decades, which extend good mothering to the moment of conception and even before, with publicly displayed messages and merchandise labels advising women not to smoke and drink alcohol while pregnant, or even while planning to become pregnant. Women who disregard such recommendations either because they are unwilling or unable, are portrayed as selfish, irresponsible, and uncaring – that is, as bad mothers (Lupton 1994).

Blum (1999) found that once the babies arrive, then it is the mothers who are unable or unwilling to comply with dominant ideals of infant care who are seen as selfish and uncaring. Contemporary ideals of infant care require breastfeeding, both for infants' health as well as a mechanism by which mothers bond with their infants. White middle-class mothers in Blum's study found breastfeeding to be an extremely rewarding experience, but white working-class mothers, often unable to breastfeed for health reasons or competing demands on their time and energies, reported feeling like failures. These mothers were so engaged with dominant ideals of good mothering, that they believed, regardless of whether they could comply, that breastfeeding was crucial to good mothering. Black-working class mothers, on the other hand, who were not as engaged with dominant ideals of exclusive mothering, felt no regrets if they were unable to breastfeed. And often, they simply rejected it altogether as for some it carried difficult reminders of relations between blacks and whites in the United States (Blum 1999).

"Less-Than-Perfect" Children

If, as noted above, even mothers' seemingly straightforward decisions regarding breastfeeding (Blum 1999) and whether to keep their children home sick from school must be made in the context of maintaining one's identity as a good mother (Prout 1998), this
suggests that mothers of “less-than-perfect” children must work especially hard to maintain that image. Recall Malacrida’s (2001) findings in which the efforts of mothers of children with AD/HD were to portray themselves in the eyes of the professionals as something other than inadequate mothers. And Singh (2004) demonstrated, in a similar vein, that mothers’ recourse to Ritalin was an act of self-preservation. That is, she found that if medication helped to increase children’s chances for success, so too, did it validate mothers’ feelings of competence (2004).

Other writings on mothering children with special needs make clear that the good mother ideal is a prevailing theme in these mothers’ lives, continually leading them to question their own competence and feel as if it is being questioned by others. Gail Landsman (1998) for example, who examines women’s experiences of mothering babies and toddlers with disabilities, found that all of the mothers in her study felt they had either done something wrong during pregnancy to bring about their child’s disability, or that they were being wrongfully judged by others. Whether they accepted responsibility or resisted it, the idea that society had placed the burden of responsibility on their shoulders escaped no one, and it was something to which they all felt they needed to respond (Landsman 1998).

Jane Taylor McDonnell (1998), a professor of Women’s Studies and English, and the mother of a child with autism, wrote (among other things) an essay titled On Being the “Bad” Mother of an Autistic Child, which she derived from her own life experiences during her son’s pre- and middle school years. Although just one mother’s story, it is consistent with the literature on mother-blame. McDonnell presents her feelings of frustration at the constant criticism many teachers, doctors and school administrators levied against her. Though never confronted directly as being a bad mother, it was implicit in countless remarks, and caused her to feel, as she puts it, “that [her] deepest self was being attacked” (1998:222). Though
she resisted the notion that her son's difficulties were her fault, she said she still found herself filled with “niggling doubts” and “tiny pinpricks of anxiety” and wanting desperately to be recognized as a good mother (p. 222).

Landsman (1998) and Malacrida (2001) also describe their experiences as mothers of children with disabilities (developmental delay and AD/HD, respectively) and assert that it was from these experiences that their research projects sprang. Each one tells their own story about the anger they have felt in response to others’ judgments of them in regard to their child’s disabilities. Malacrida says she is chagrined that she was so quick over the years to comply with the school’s demands, and wonders the extent to which her “own sense of maternal worth [was] tied up in producing a good child and looking like a good mother and a good family that she was willing to sacrifice [their] quality of life just to appease the school” (2001:254).

Landsman whose daughter was just a toddler at the time of her writing, says that for her as well as the vast majority of her respondents, the idea of “real” motherhood is problematic with disabled infants, because “the cultural markers publicly acknowledging motherhood are sorely lacking” (p.85). In other words as she explains, once people become aware that something is wrong, the congratulations disappear, and suddenly it’s as if there is no baby. She suggests, that regardless of class, race, education, ethnicity, or religion, mothers of disabled children belong to what she refers to as a “community of shared experience” and a transformation occurs involving a shift of identity from one’s prior identity – seemingly created in another culture – to “mother of disabled child” (1998:76).

What she describes is much like Goffman’s (1963) “courtesy stigma” – by which is meant “a stigma of affiliation that applies to people who associate with stigmatized groups rather than through any quality of their own” – and the way it has been used in the small
body of research studying families of children with disabilities. One theme from this literature, concerns the issue of how parents experience and cope with stigma, in particular discreditable stigma, which refers to stigma that are not visible. This concept, considered in conjunction with the preceding evidence, helps to make sense of the notion that mothers of children with emotional and behavioral problems will likely be exposed to circumstances unlike those experienced by parents of children without problems. To be sure, they are not likely to be experiences for which most parents have been prepared given the dominant cultural imagery around norms of parenting to which most of us are exposed. It is likely that these alternative experiences may result in alternative attitudes, behaviors and beliefs stemming in large part from parents’ new communities of shared experience.

What About the Dads?

It seems likely that in the same ways mothers of children with disabilities may belong to a community of shared experience unlike that of other mothers, so too may fathers of children with disabilities have different experiences than other fathers, and consequently, similarly develop different attitudes, behaviors and beliefs. That fathers will feel as responsible for their children’s difficulties as mothers however seems unlikely, given that fathers in general tend not to be blamed for their children’s negative behaviors in our society in the same ways mothers are. That said, gender differences are not the focus of the present study; rather the focus of this research is to compare the experiences of parents – both mothers and fathers – of children with emotional, psychological, and behavioral problems. While attitudes of mothers and fathers may differ somewhat from each other, the existing research suggests that all parents faced with these challenges will develop different behaviors, beliefs and attitudes than parents not confronted with their own children’s emotional, psychological, and behavioral problems.

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Medicalization and Mother-Blame

Considerable sociological attention has focused on the extent to which a wide range of human experiences have become "medicalized." Specifically, the concept to which this term refers is a sociocultural process by which problems, previously considered nonmedical, come to be defined and "treated" as illnesses or disorders. In American society, medicalization has occurred for both natural human processes, like childbirth and menopause, as well as deviant behaviors, like hyperactivity, drug addiction, and alcoholism. The new medical categories that have emerged in recent decades for children, such as conduct, anxiety, and learning disorders, as well as AD/HD, provide good examples of this phenomenon (Conrad 1992).

"Medicalization" is a significant sociological concept, which emphasizes the fact that medicine is a social enterprise (Reissman1983). Although the term itself is typically used as a critique of overmedicalization, rather than as a benign description of something that has simply become medical, the onus is not solely on the medical profession. Instead, the medical profession is recognized as a part of a much larger and complex social process (Conrad 1975). Zola argues, "this 'medicalizing of society' is as much a result of medicine's potential as it is for society's wish to use that potential" (1972:500). This is especially important to consider when thinking about what is driving the escalating use of psychiatric drugs.

With the expansion of medical authority, a host of human and social problems have been reframed as individual, biological disorders. Deflection of responsibility is perhaps the greatest impact of medicalization. Once an individual is considered ill or found to have a disorder, s/he is no longer regarded as the problem, but rather it is the illness itself (Zola 1972). Despite deflecting responsibility for disorders away from the individual however, in many ways, blame has only been displaced. As illness and its treatment have taken center
stage, individuals are no longer condemned or stigmatized for being ill; fault can now be found in how they manage their illness. So while alcoholics for example are no longer held responsible for their alcoholism, as it is now considered a disease over which they have no control, they are expected to gain control in some socially approved way such as attending daily Alcoholics' Anonymous meetings. In other words they must seek treatment and cooperate in their course of treatment. Not doing so results in stigma ascribed back to the individual (Quam 1990).

At the intersection of medicalization and mother-blame, this issue becomes less clear. As the biomedical model has become more prevalent in the last decade, and American psychiatry has “shifted 180 degrees” from blaming mothers for their children’s problems to blaming chemicals and misfiring synapses in the brain (Diller 2000), ostensibly, finding fault with mothers should also have lessened. Singh (2004) argues however, that despite the promise of medical diagnoses, to “sweep a culture of mother-blame into ‘absurdity”’ it would be foolish to think that the medical-scientific enterprise around emotional, psychological, and behavioral problems does not depend in part on mothers feelings of maternal inadequacy (p. 1202).

It is specifically AD/HD to which Singh refers, but her meaning can be extrapolated to include other emotional, psychological, and behavioral problems with which children are diagnosed. As she explains it, while diagnoses and medication may help mothers, children and families feel and function better, at the same time the success of many of these diagnoses may actually be to some degree, driven by the good mother ideology. Mothers struggling to solve their children’s problems may be hard pressed to ignore the “absolution” promised through medical science (Singh 2004:1203), especially within the “culture of Prozac” that has pervaded popular discourse and underscored the use of psychiatric
medication to manage one's problems throughout the bulk of the last two decades (Diller 1996).

**Popular Discourse**

When Prozac, the first of the serotonin reuptake inhibitors known for their low side effect profile compared to earlier antidepressants, went on the market in 1988, it increased the range of people for whom psychotropics for depression might be successful (Diller 1996), and generated unparalleled media attention relative to earlier psychopharmaceuticals (Blum and Stracuzzi 2004). One example (among many) of Prozac's fame is psychiatrist Peter Kramer's best seller, *Listening to Prozac*, which attracted enormous publicity in 1993, and played a role in the now widely held belief that most emotional disorders are neurochemical in origin, best treated with medication (Diller 1998).

At the same time, a resurgence of public interest in Ritalin and AD/HD generated a flurry of cover stories, books, articles and news broadcasts, routinely referring to AD/HD as a neurological disorder that showed dramatic improvements with the use of Ritalin (Diller 1998). According to Diller (1996), “most experts agree that genetic-bio-chemical factors influence behavior to some degree, [but] the general public tends to transform this view into a biological determinism in which only heredity and brain chemistry determine behavior rather than interaction with the environment” (p. 16). As Diller points out, interpreting children's emotional, psychological, and behavioral problems in this way can only be reassuring to beleaguered parents feeling responsible for their children's problems and harried schoolteachers needing assistance with unruly children (1996). It seems likely that the dramatic increase of psychotropic medication for children during this same period of time provides at least partial evidence of the influence of popular discourse.
Nevertheless, despite rising prescription rates for children, as demonstrated previously, only one third of the general public claim they are willing to use psychopharmaceuticals for children except in extreme cases of suicide, and a sizeable minority are not even willing to do that (McLeod et al. 2004). Recall that McLeod et al. (2004) found that willingness to give psychiatric medications to children are not the result of sociodemographic characteristics, experience with psychiatric treatment, or general attitudes towards medical care. They argue that this calls into question the ways in which people perceive the nature of the “disorder” itself. Consequently, they suggest the need for an examination of how Americans conceptualize children’s emotional, psychological, and behavioral problems. Certainly this calls for a look at the other side of the debate. In what follows, I discuss alternative frameworks for children’s emotional and behavioral problems in which medication is not considered.

Alternative Frameworks. Concurrent with media stories and parental guidebooks that promote Ritalin and other stimulant medications for behavior management, there are a number of alternative frameworks for explaining and treating AD/HD. In fact there is a “burgeoning range of alternative therapies” to be found in professional and lay circles on the other side of this debate (Malacrida 2002:366). These frameworks tend to portray AD/HD as a condition with external influences, the most prominent of which are diet, television viewing, and playing video games (Rafalovich 2001), all of which, it is important to note, suggest that parents are blameworthy and responsible for managing their children’s problems, as they are ostensibly the ones in charge of the amount of time children spend in front of a television set and/or computer as well as providing food consumed in the household.
Regardless of the different ways AD/HD may be framed however, both etiologically and in terms of treatment, Rafalovich (2001) found, through his examination of popular parenting AD/HD guidebooks, that the AD/HD child is constructed as outside the realm of normal mental functioning and in need of some type of regulation. Whether in addition to medication or instead of, there are a number of parameters dictating appropriate conduct for parents of children with AD/HD outlined in these guidebooks that require special regulation of children's behaviors to aid them in living a "normal" life (Rafalovich 2001).

It would appear that the success of alternative therapies for children's emotional, psychological, and behavioral problems also relies in part on mothers' feelings of maternal inadequacy. Malacrida furthers this notion in her examination of texts presenting alternative frameworks for AD/HD (2002) as she attempts to determine whether any real challenges to traditional discourses of medicalized motherhood are offered.

Like Rafalovich (2002), what she unearths instead is that the factors suspected of causing AD/HD and the measures mothers are expected to take in these alternative texts actually increase the level of responsibility imposed on women. Indeed, she finds that mothers are just as likely to be represented as inadequate and blameworthy — sometimes even more so. She makes sure to point out that as a general rule, mothers are not addressed directly in these guidebooks, but that cultural norms holding mothers responsible for their children imply that mothers are the intended audience. And consistent with the ideology of intensive mothering presented by Hays (1996), Malacrida asserts that in most accounts "what constitutes good maternal care is seemingly boundless" (2002:375).

Vignettes in these texts frequently portray mothers who must take extreme measures to find alternative treatments for their children, most of which require professional expertise. While these alternative frameworks may challenge the use of Ritalin, Malacrida makes the
case that AD/HD is still treated as a legitimate diagnostic medical category, and these authorities are just as likely to claim that specialized intervention is the necessary response (2002). Apparently, according to both mainstream and alternative texts on AD/HD, whether parents are responsible for causing their children's behaviors or not, they are unquestionably responsible for managing them, if not with medication as suggested by dominant medical discourse, then with dietary changes and behavior modification techniques suggested by alternative texts. Either way, neither discourse relieves mothers of the oppressive weight of responsibility that is part of the good mother ideology, which seemingly makes it hard for them to resist following prescribed courses of action, whatever they may be.

As Singh (2004) found, being able to “do something” that is recommended as treatment for children with emotional, psychological, and behavioral problems, serves as “material authority” for the legitimacy of blaming the brain rather than the child, and subsequently the mother (p. 1201). Given the controversy that surrounds children’s emotional, psychological, and behavioral problems, it is little wonder that Malacrida’s (2001) results demonstrated that mothers find themselves stigmatized regardless of what they do. In actual fact, keeping with her findings, what we see is that mothers are blamed when they do not act in accordance with the normative expectations of the dominant childrearing culture in which they happen to find themselves.

In sum, an extensive body of research indicates that despite disparate frames of reference for AD/HD – and by extension other emotional, psychological, and behavioral problems – as well as their varying forms of treatment, there are two consistent overriding themes. Namely these are problems that require professional intervention, and that parents must be vigilant in their efforts towards treating their children’s problems, whichever
methods they may choose. There is also an implication, as I suggested previously, that the
different circumstances to which parents of children with emotional, psychological, and
behavioral problems will be exposed will consequently push them to develop different
childrearing behaviors, beliefs and feelings about parenting than parents of children not
faced with these difficulties. More than likely, they will also develop differing attitudes
regarding attributions of cause and the best ways to respond to children’s problems as well
as differing ideas about who is most competent to address these issues than parents not
faced with these difficulties. As suggested by McLeod et al. (2004), this may explain the
disparity between most Americans’ negative attitudes towards psychiatric treatments for
children’s behavioral problems and rising prescription rates.

Finally, studies suggest that the good mothering ideal will be influential on parents’
decisions, though it may manifest itself differently for mothers and fathers. It may be for
instance, that fathers of children with emotional, psychological, and behavioral problems are
influenced by mothers and share in their beliefs. Conversely, parents’ divergent beliefs may
create conflict between them, resulting in decisions with which at least one parent is not
comfortable. It is also likely that in the case of fathers who do the primary parenting – or
share parenting equally – and are as apt to be in contact with school and health practitioners
as mothers, that they too feel the weight of judgment and blame levied against them.

What is not clear is what factors might influence parents of children with emotional,
psychological, and behavioral problems to choose the medical route over alternative
therapies or vice versa. It may be that the types and severity of children’s emotional,
psychological, and behavioral problems and the extent to which they disrupt children’s
academics or family life are influential. Parents’ sources of parenting information and social
networks may also play a contributing role in their decision-making. Finally, the extent to
which parents had similar problems as children and feel they may have suffered
consequences as a result of their childhood problems may contribute to divergent points of
view.
CHAPTER 2

METHODS

Sample

Statistical analyses were based on data collected from a sample of 235 parents residing in a single New Hampshire community of 27,000. To contact parents I distributed questionnaires to approximately 1300 children in attendance at each of the community’s three public elementary schools (K – 4) during the 2003 – 04 academic year. This is not an accurate number of households that actually received surveys however as many parents have more than one child attending elementary school.

An exact number of households was unavailable, but children’s ages indicate that approximately one-third (80) of my respondents have more than one child in elementary school. Further, estimations given to me by administrative assistants at each school suggest that at least one-third, if not one-half of students, have siblings in school, implying that somewhere between 650 – 850 households were contacted. This information suggests a response rate of somewhere between 28% and 36%, which is typical of a mail questionnaire (Nachmias and Nachmias 1996).

Obviously results obtained from this group of parents cannot be claimed as representative of all parents and the extent to which they can be considered representative of parents within this population is unclear, given the low response rate. What I do know, according to 2000 census data however, is that my respondents have slightly higher incomes, on average, than families in the general community population (e.g., nine percent of...
respondents' incomes fall below $40,000 compared to 22% of families in the community; twenty-four percent of respondents' incomes are above $100,000 compared to 15% of families in the community), a higher percentage owns their own homes (81% compared to 51%), and there is a lower percentage of single mothers among respondents compared to families in the community (nine percent compared to 24%).

Respondents are largely female (81%) and married (85%; only 4% were never married), predominantly white (97%), and, as noted, highly educated (85% have attended college and over 60% have at least a Bachelor's degree). Most (92%) are between the ages of 30 and 50. Ninety-five percent claim they have usually been employed since having children and 74% are currently employed. Seventy-eight percent have more than one child. All have at least one child in elementary school.

Given the focus of my research, the sample's homogeneity is actually advantageous; it is as though I am controlling on a number of factors to determine whether differences among respondents can be explained by the extent to which they have children with emotional, psychological, and behavioral problems. Ultimately, my goal was to understand how parents' child-rearing values and beliefs may be elaborated and reshaped in the context of parenting challenging children. Consequently, the homogeneity of my sample was ideal.

Sample characteristics are shown in Table 1.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Mode</th>
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<td>Schools attended</td>
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<td>Grover</td>
<td>96</td>
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<td>Whitman</td>
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<td>44</td>
<td>18.28</td>
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Sample characteristics are shown in Table 1.
### Sample Characteristics

**N = 235**

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<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
<th>Mean</th>
<th>SD</th>
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<td>21 – 30</td>
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<td>31 – 40</td>
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<td>41 – 50</td>
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<td>over 50</td>
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<td>Earned graduate degree</td>
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<td>$100,000 and over</td>
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<td>Four</td>
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<tr>
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<td>Yes</td>
<td>173</td>
<td>73.62</td>
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</table>
Comparison Groups

For the purposes of some comparative analyses, the sample was divided into groups. There is a subset of 98 parents from the total sample who have concerns around their children's emotional, behavioral, learning, and/or psychological well-being. Of those parents, 58 have children who have actually been diagnosed with emotional, behavioral, learning, and/or psychological problems, and, of that subset of parents, 35 treated their children medically and 23 did not. See Table 2.

Table 2
Comparison Groups
N = 235

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>It has been suggested child may have an emotional, behavioral, learning, and/or psychological problem (N = 235)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98</td>
<td>41.70</td>
</tr>
<tr>
<td>No</td>
<td>137</td>
<td>58.30</td>
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<tr>
<td>Child has been diagnosed with an emotional, behavioral, learning, and/or psychological problem (N = 98)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>58</td>
<td>59.18</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>40.82</td>
</tr>
<tr>
<td>Child with an emotional, behavioral, learning, and/or psychological problem treated medically (N = 58)</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>39.66</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>60.34</td>
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Quantitative Measures

Socio-demographic variables. Sex is a dummy variable with males coded 0 and females coded 1. Age is a continuous variable with respondents' ranging from 21 to 70 years of age and respondents' spouses' ages ranging from 24 to 66 years. Schools attended by children consist of three categories: Whitman, Grover, and Harrison Elementary Schools.
Parents’ education was measured according to schooling completed. Originally comprised of ten categories, because of the homogeneity of the sample and small numbers in some categories, it was collapsed into four categories for analyses with “no college” coded 0, “some college” coded 1, “Bachelor’s degree earned or Bachelor’s degree plus some post graduate work” coded 2, and “graduate degree earned” coded 3. Income was measured by families’ total yearly income before taxes. Also comprised of more categories originally, because of homogeneity and small numbers in certain categories, eight categories were collapsed into four, with “income under $40,000” coded 1, “income between $40,000 and $74,999” coded 2, “income between $75,000 and $99,000” coded 3, and $100,000 and over” coded 4. Ethnicity is a categorical variable consisting of one open category in which respondents could write-in the ethnic or racial group with which they most closely identified or check one of four categories: White, African-American, Hispanic, and Asian American. Socio-economic status was determined by education and income.

Family Characteristics and Family Structure:

Family structure consists of three categories: parents in two-parent families with biological or adopted children were coded 0; parents in single-parent families were coded 1; parents in remarried two-parent blended or stepfamilies were coded 2. Family characteristics are comprised of the number of children living in the home, sex of target child, and age of target child.

Parents Perceptions of Challenging Childhood Behaviors:

Parents’ perceptions of challenging childhood behaviors were measured by Thomas Achenbach’s Child Behavior Check List (CBCL; Achenbach 1966), a behavior-problem
checklist that has been widely and reliably used in research and clinical practice with emotionally disturbed children. Forty-three out of 112 items were selected for brevity and combined to reflect challenges with which parents of children with emotional, behavioral, learning, and/or psychological problems may be confronted as found in the literature. Specific dimensions measured were (1) problems with depression/anxiety, (2) problems with hyperactivity, aggression, and attentional difficulties, and (3) academic performance problems. Response categories of this scale ranged from (1) “not true (as far as you know)” to (2) “somewhat or sometimes true” and (3) “very true or often true.”

Given the reduction in items, a factor analysis was conducted to ensure each of the dimensions remained consistent with the CBCL and alpha coefficients were obtained to ensure the reliability of the scale as a whole as well as that of the separate dimensions. Additionally, factor scores and alpha coefficients were obtained for Achenbach’s second-order factor dimensions, internalizing and externalizing, to ensure consistency and reliability. Internalizing items are those that reflect depression and anxiety and externalizing items reflect problems with hyperactivity, attentional problems, and aggression. Alpha coefficients are as follows: scale as a whole (.92); internalizing items (.87); externalizing items (.89). See separate dimensions below.

Sample items included:

1) Depression/Anxiety: You have a child who, “fears going to school,” “feels persecuted,” “cries a lot,” “worries a lot,” “feels worthless or inferior,” “feels s/he has to be perfect,” “is unhappy, sad, or depressed,” “feels unloved,” “is withdrawn,” “complains of loneliness,” “seems more stubborn than other children his/her age,” “seems more timid or shy than other children his/her age,” “won’t talk,” “seems to like being alone more than other children his/her age,” “gets teased a lot,” “is very self-conscious or easily
embarrassed," "is too fearful or anxious," and is especially clingy with you and other adults. The alpha coefficient for these items is .89.

2) **Hyperactivity and attentional problems**: You have a child who, "can't sit still," "is restless or hyperactive," "is impulsive, and acts without thinking," "is unable to concentrate or pay attention for long," "acts too young for his or her age," "talks too much," "is poorly coordinated or clumsy," "prefers playing with children younger than him or herself," and "daydreams or gets lost in his or her thoughts." The alpha coefficient for these items is .89.

3) **Aggression**: You have a child who, "demands a lot of attention," "is disobedient at home," "destroys his or her own things," "destroys things belonging to others," "throws temper tantrums," "is argumentative," "is disobedient at school," "is sullen, stubborn, or irritable," "bullies other children," "brags and/or shows off," "is disliked by others," and "is moody." The alpha coefficient for these items is .88.

4) **Academic problems**: "Compared to other children his or her age, how is your child's current school performance in the following areas: reading, english, math, writing, spelling, and other subjects – please specify? Response choices ranged from "failing," to "below average," to, "average," and, "above average." The alpha coefficient for these items is .88.

**Child-Rearing Behaviors:**

**Parental Involvement.** Parental involvement was evaluated according to a slightly modified fourteen-item-scale examining the extent to which various dimensions of parental involvement affect children's behavior and academic achievement (Ralph McNeal, Jr. 1999). In previous research, mean scores have been calculated on the scale as a whole or on one of three dimensions of involvement: 1) **monitoring**, or the extent to which parents limit their children's computer interaction, watching television, reading, or doing homework; 2)
**parent-child discussion**, or the degree to which parents and children engage in conversations and the extent to which they discuss education; and 3) **school-involvement**, or the extent to which parents are involved in parent-teacher organizations and are able to volunteer at school. For this study, a fourth dimension was added to evaluate **leisure time spent**, in an effort to reveal the extent of more leisurely time spent with children relative to time spent engaged in purposeful activities. Each dimension, or variable, has roughly the same number of questions. Response choices ranged from (1) “frequently” to (2) “regularly” to (3) “occasionally” to (4) “rarely” and (5) “never.”

An assessment of the additional variables’ contribution to an already modified scale showed an alpha coefficient of .49. In an effort towards increasing the reliability of the scale, I employed a factor analysis to determine whether there might be a more accurate way to group the variables. Results indicated that removing items representing **school involvement** from the index raised the alpha coefficient of the index to .78, while the alpha coefficient for those items representing **school involvement** was .76. Hence, for the purposes of analyses, parental involvement was evaluated according to summary scores on two dimensions: 1) **school involvement**, and 2) **home involvement**, or rather the combined items from **leisure time spent**, **monitoring**, and **parent-child discussion** (see sample items from each dimension below).

Sample items included:

1) **Monitoring**: “How often do you limit your children’s television viewing, i.e., time spent, programs watched,” “limit your children’s time at the computer, i.e., time spent, websites visited,” “supervise your children’s homework, i.e. spend time helping, make sure it’s done correctly,” and, “do you read to your children/read with your children?”

2) **Parent-child discussion**: “How often do you speak with your children about what they’re doing in school,” “speak with your children about their interests and outside
activities," "speak with your children about their education and future goals," and, speak
with your children about relationships with their friends and classmates?"

3) School-involvement: "How often do you volunteer in your children’s
school/classroom (e.g., chaperone field trips, assist with class work, organize classroom
activities, etc)," "attend parent-teacher organization meetings," "volunteer in your children’s
school (help organize school functions on a broad scale, e.g., plays, Halloween parties,
concerts, etc)?"

4) Leisure time spent: "How often do you take your children on outings," "spend time
playing with your child," and "eat family meals together?"

Feelings About Parenting:

Parental Satisfaction. Parental satisfaction was evaluated according to two variables:

1) general satisfaction with parenting and 2) feelings of parental competence. General
satisfaction was measured with a summary score of a fifteen-item scale modified from
Charles Halverson’s “Parent Attitude Questionnaire” (Department of Child and Family
Development, University of Georgia), which examines parents’ attitudes in their parenting
roles. For the sake of brevity I reduced the number of items from 30 to 15, though I
selected equal numbers of questions from each of three sub-categories: “pleasure of
parenting,” “burden of parenting,” and “importance of parenting.” A summary score of the
fifteen items provides a general satisfaction score, the internal reliability of which is .84.
Alpha coefficients for each of the sub-categories are as follows: pleasure of parenting (alpha
=.77); burden of parenting (alpha = .74); importance of parenting (alpha = .71). In each
case, lower summary scores means that parents feel that way most of the time.
Response options on this five-point scale ranged from (1) “strongly agree” to (5) “strongly disagree.” Sample items in the following categories included: A) pleasure of parenting: “Having children is worth all the sacrifices”; “I derive a great deal of fun and enjoyment from being a parent”; “In general, as a parent, I am happy most of the time”; “Surprisingly, child-rearing is not as rewarding as I thought it would be”; “Watching children grow and develop is especially satisfying.” B) burden of parenting: “The rewards for being a parent easily outweigh the effort and hard work”; “Having children to care for is a lot of fun”; “Children are a large burden for me”; “Being a parent has always been enjoyable”; “Being with my children is more boring than I thought it would be,” and C) importance of parenting: “You know, it’s hard being stuck home with children”; “Childrearing is one of the most stimulating things that I can think of”; “Being able to provide a good home for my children has been a source of great satisfaction for me”; “Compared to outside employment, childrearing is more satisfying”; “Being a parent is the best way of achieving self-fulfillment”; Parenthood is the most important aspect of life.”

2) Feelings of parental competence were measured by a six-item scale regarding parents’ feelings of competency about their child-rearing skills and/or style. Parents were asked to agree or disagree – according to a scale that ranged from (1) “strongly agree” to (5) “strongly disagree” – with the following statements: “You feel that you are good at resolving conflict with your children.” “You feel proud of the job you have done as a parent.” “You often feel unsure of yourself.” “You wish you could do a better job as a parent.” “You feel that your parenting is better than most.” “You wish you could do a better job as a parent.”

One final open-ended question was asked to determine what parents might change about their family life and child-rearing practices if they could arrange things just the way they
wanted. A summary score of the six items provides a score on parental competence, the internal reliability of which is .70. Lower scores equal lower feelings of parental competence.

**Sources of Parenting Information:**

The extent to which parents are reliant on what they may perceive as sources of "expert child-rearing advice" was determined by scores on two variables: 1) **Sources of Information** and advice had eighteen items reflecting possible sources of information and advice, either from friends and family members, practitioners, or advice literature. The question asked, "If you felt you needed advice about parenting, how likely is it that you would turn to the following people or sources?" Choices were as follows: 1) "spouse/partner," 2) "mother," 3) "father," 4) "another family member or relative," 5) "friends," 6) "childcare provider," 7) "family therapist," 8) "teacher," 9) "guidance counselor," 10) "school psychologist," 11) "other school personnel," 12) "pediatrician," 13) "other medical practitioners," 14) "members of the clergy," 15) "child-rearing advice literature," 16) "websites on child-rearing," 17) "parenting support groups (community or online)," and 18) "other." Response choices ranged from (1) "very likely," to (2) "somewhat likely," to (3) "not very likely," to (4) "not at all likely."

A factor analysis revealed that many of the items could be organized into a more conceptually precise group of variables, as expected. The first stage of the factor analysis separated items into eleven components, but only the first four had eigenvalues (for an explanation see Hamilton 1992) higher than one, and they explained more than 86 percent of the eighteen items' combined variance. Hence the remaining seven components were disregarded for subsequent analyses. Twelve of the eighteen items – numbers seven through eighteen – loaded on factors 1 and 2 (loadings = .43 and above) with several loading on both
(with the exception of item fourteen (clergy), which loaded on factors 1 and 3). In an effort to combine items so that variables would best represent differences between experts and others, reliability coefficients were calculated.

Reliance on Experts. Experts were represented with items seven through thirteen, which included all school and medical personnel (alpha = .85). Items fifteen through eighteen represent advice literature, which included parenting support groups, parenting websites, books and magazines, and an “other” category, which consisted largely of the same, such as newspaper articles, parenting lectures, classes, and workshops (alpha = .78). Most of the remaining items, with the exception of item one (spouse/partner) and item six (childcare provider) displayed loadings on factors 3 and 4 that were high enough to be considered (above .40). These items combined are representative of nonexperts, that is family, friends, and clergy (alpha = .60). Loadings on items one and six were too weak to be considered as good indicators of any dimensions (.30 or below) and were consequently disregarded in subsequent analyses.

Summary scores on experts and/or advice literature, relative to nonexperts, gave a sense of the extent to which parents are likely to trust what they may perceive as expert advice over that from friends or family.

2) Importance of others’ opinions had fifteen items reflecting possible sources of information and advice, either from friends and family members or practitioners. Response choices ranged from (1) “most important” to (5) “of no importance.” The question asked, “Whose opinions concerning your parenting skills or style would be important to you?” Again, summary scores on experts relative to nonexperts, gave a sense of the extent to which parents may have relied more on expert advice than that from friends or family members. As above, experts are represented by all school and medical personnel (alpha = .88) and
nonexperts are represented by mother, father, relatives, friends, clergy, and “other,” which in this case primarily included in-laws, and neighbors (alpha = .72). For the sake of consistency, childcare providers and spouses were again dropped from analyses.

Parents' Attitudes Towards Psychiatric Medications:

Parents' attitudes towards psychiatric medications were examined with three measures: parents' awareness of, and attitudes towards other children being treated for emotional, psychological, and behavioral problems; parents' sense of their own childhood emotional, psychological, and behavioral problems and whether they believe their lives might have been better if they had been treated; and, parents' general attitudes towards children's psychiatric medication. These general attitudes were measured with a five-item scale, with response choices that ranged from (1) "strongly agree" to (5) "strongly disagree." As noted previously, these items were selected from a set of nine statements modified from divergent statements made by experts in the field regarding the extent to which they believe attributions of childhood emotional, psychological and behavioral problems are biological or social-structural in origin and the extent to which these children are being medicated.

An equal number of statements reflecting both positive and negative attitudes towards medication in regard to children's emotional, psychological and behavioral problems were selected. The reliability coefficient for this scale is .83. Sample items included: “Thanks to new psychiatric medications, more children with emotional, psychological, and behavioral problems can be helped than ever before.” “Rather than promoting medication, we need to discover different ways for kids to be successful.” “Psychiatric drugs are just a quick fix for busy parents whose children demonstrate annoying but normal behavior.” “Taking medication for emotional, behavioral, learning, and/or psychological problems is no
different than taking insulin for diabetes.” “Medication can give children with emotional, psychological, and behavioral problems an equal chance to succeed along with their peers.” Scores on particular items were reversed so that all were entering in the same direction. Higher summary scores indicate parents’ attitudes are more positive towards psychiatric medication than lower summary scores.

Parents’ Awareness Of Other Children’s Problems And Treatments. Parents’ awareness of other children’s problems and treatments was measured with four questions developed by the principal investigator to get a sense of parents’ awareness about children they know – besides their own – who were being treated for emotional, behavioral, learning, and/or psychological problems.

1) “Do you know of any children – besides your own – who have been diagnosed with emotional, behavioral, learning and/or psychological problems? Response choices were (1) “yes – one or two,” (2) “yes – a few,” (3) “yes – several,” and (4) “no.”

2) “If yes, who?” Response choices ranged from “your children’s friends,” to “your friends’ children,” to “neighbors” and “siblings” and “other relatives children,” and “children in your child’s classroom/s.”

3) “Are any of these children being treated? Response choices were (1) “yes,” (2) “no,” (3) unsure.”

4) “Do you think these children should be being treated?” Response choices were (1) “yes,” (2) “no,” (3) unsure.”

Parents’ Childhood Problems. Parents’ childhood problems were measured with two questions: 1) “As a child, were you ever diagnosed with, or do you suspect that you may have experienced an emotional, behavioral, learning and/or psychological problem? 2) “If
yes, do you feel your life might have had a more positive outcome if you had: (1) “been treated in some way,” (2) “had not been treated,” and (3) “other (please specify).”

Attributions Concerning Origins of Children’s Problems

The extent to which parents believe that the origins of their children’s emotional, psychological, and behavioral problems are the result of genetic, neurological, and/or biological factors versus socialization influences was assessed according to three measures: 1) innate characteristics, 2) parental influence, and 3) brain function. The first two measures were selected from six items, originally developed as a single scale meant to reflect parents’ belief that their children’s temperament and other characteristics are innate but an alpha coefficient of .47 suggested the items were reflecting more than one dimension. Consequently, I employed a factor analysis to determine the number of dimensions being measured. Factor loadings indicated that three of the six items had a high loading on factor 1: all were above .56. These items were subsequently combined to represent innate characteristics.

Innate Characteristics. This three-item scale included: 1) “Parenting is a job just like any other; evidence of a job done well or done poorly can be seen in the actions and characteristics of children”; 2) “there are no ‘bad’ children; badly behaved children are actually the result of bad parenting”; 3) “parents are primarily responsible for how their children turn out.” Response choices ranged from (1) “strongly agree” to (5) “strongly disagree.” Higher scores equal stronger agreement with the notion that children’s characteristics are innate. The alpha coefficient for this scale is .65.

Parental Influence. One other item loaded high enough on factor 2 to represent a separate factor (.43), but the remaining items were too weak (all below .30) to be considered
as good indicators of separate dimensions (Nachmias and Nachmias 1996). Hence, the two weakest items were discarded, and the single remaining item states, “no matter how parents may try they actually have very little influence over their children’s temperament, personality traits, and/or intelligence.” In this case, response choices ranged from (1) “strongly disagree” to (5) “strongly agree.” As above however, higher scores are indicative of the notion that inborn traits are more influential on children’s characteristics than parents.

**Brain Function.** The extent to which parents blame their children’s emotional, psychological, and behavioral problems on genetic, neurological and/or biological factors affecting brain function is measured by three separate items. These items were selected from a set of nine statements, modified from divergent statements made by experts in the field regarding the extent to which children are being medicated and the extent to which they believe attributions of childhood emotional, psychological and behavioral problems are biological or social-structural in origin. An equal number of statements reflecting both positive and negative attitudes were selected. Though they were originally conceived as a single scale, again, a factor analysis determined more than one dimension. Consequently, five items representing attitudes towards medication were combined (discussed in a later section) and three items reflecting attributions of cause were considered separately.

Individual items regarding attributions of cause are as follows: 1) *Cause of Misbehaviors.* “Many common childhood misbehaviors are actually signs of emotional, psychological, and behavioral problems.” 2) *Brain Blame.* “Most emotional, behavioral, learning, and/or psychological problems are a consequence of physical/biological or genetic problems with the brain.” For both items, response choices ranged from (1) “strongly disagree” to (5) “strongly agree. 3) *Proper Care.* “With proper nutrition, exercise, plenty of sleep, and discipline, most behavioral problems in children would disappear.” In the case of
this item, response choices are in the opposite direction, ranging from (1) “strongly agree” to (5) “strongly disagree.” In all cases however, higher scores indicate that parents more strongly agree that children’s emotional, psychological, and behavioral problems are a function of problems with their brains.

Perceptions of Responsibility and Blame

Parenting Skills/Style. Parents’ perceptions of blame and responsibility for their children’s emotional, psychological, and behavioral problems was assessed by three measures. The first is an eight-item summary scale developed to expressly determine the extent to which parents consider that their parenting skills or style are responsible for their children’s physical and behavioral characteristics. Response categories ranged from (1) “totally” to (2) “a lot” to (3) “a little” and (4) “not at all.” Sample items included, “to what degree do you feel that the following are the result of your parenting skills or style: “children’s academic performance,” “children’s behavior in school and other social settings,” “the degree to which others like your children,” “children’s physical health,” “children’s mental health,” “children’s physical appearance,” “children’s temperament,” and “children’s personalities.” Higher scores demonstrate that parents strongly disagree with the idea that parenting skills or style are responsible for their children’s characteristics, which suggests they believe more strongly that children’s characteristics are innate. The internal reliability of this scale is .81.

Other Blame. Another eight-item scale—nearly identical to the scale above—was developed to examine the extent to which parents may feel that they are judged by others who believe that their children’s characteristics are a consequence of their parenting skills or style. Items are exactly the same but, the question was as follows: “To what degree do you feel
"Others think the following are the result of your parenting skills or style?" "Others" was meant to include individuals with whom parents and their children interacted regularly. Both of these scales were developed out of the literature on mother-blame in an effort to examine how much parents blame themselves, relative to how much they perceive others may blame them. The alpha coefficient for this scale is .86. Lower scores indicate that parents feel strongly that their parenting skills and/or style are blamed by others.

**Ideas About the Best Ways to Respond to Children’s Problems:**

Parents were simply asked to answer “yes” or “no” to a number of questions pertaining to ways they may have responded to their children’s diagnoses. Questions asked were as follows: Do you agree with your child’s diagnosis? Did you have difficulty making decisions around treatment or services for your child? Parents who had officially obtained diagnoses for their child/ren were asked whether they agreed with the diagnosis and whether their children had tried any treatment/s or services. If any treatment/s or services had been tried, they were asked which ones (a list of treatments was provided) and whether they felt they had been effective. Further, they were asked whether they had ever refused particular treatment/s and services. Parents who felt treatment/s and/or services had been effective and those who had refused them were asked to specify which.

Finally in order to examine differences between mothers and fathers around diagnosis and treatment, they were asked if they had been in disagreement with their child/ren’s other parent, and if so about what specifically had they disagreed. Response options were as follows: 1) the severity of your child’s problems, 2) the necessity of obtaining a diagnosis, 3) the diagnosis itself, 4) the necessity of treatment and/or services, 5) the type/s of treatment and/or services, 6) you blame your spouse/partner (or parent with
whom you share responsibility for this child) for your child’s problems, 7) your spouse/partner (or parent with whom you share responsibility for this child) blames you for your child’s problems, and 8) other (please specify). For parents with children who had not obtained official diagnoses, they were skipped out of several subsequent sections comprised of parents’ decision-making processes around treatments and services as well as issues pertaining to understanding and support.

Influential Factors Around Treatment for Children’s Problems:

Influential factors were measured with a comprehensive list of nineteen items that were selected and modified from statements made by experts in the field pertaining to parental decision-making around treating hearing-impaired children (Steinberg and Bain 2001; Steinberg, Brainsky, Bain, Montoya, Indenbaum, Potsic 2000; Yuelin, Bain, Steiniberg 2003). Items were combined to represent several dimensions expected to influence parents’ decision-making processes around treatment and/or services for their children’s emotional, behavioral, learning, and/or psychological problems. Dimensions are listed below; all dimensions with more than one item include alpha coefficients.

The question asked was “to what extent have the following items been influential on your decision-making around treatments and/or special services for your child?” Response categories ranged from: (1) “very influential” to (4) “not at all influential.” Sample items included:

1) Academic performance. “Poor academic achievement was a serious/frequent concern.”

2) Behavior. “Behavioral issues at school were a frequent/serious concern,” “behavioral issues at home were a frequent/serious concern,” “behavioral issues at friends’
homes or other social settings were a frequent/serious concern,” “child having difficulty getting along with others/and or making friends were frequent/serious concerns.” The alpha coefficient is .86.

3) Family’s emotional well-being: “Well-being of family life (child’s behavior disrupted home and family life) was a frequent/serious concern,” “Child’s emotional well-being (child often felt sad, worried, or angry) was a frequent/serious concern,” “Parents’ emotional well-being (parent/s often felt frustrated, angry, worried, sad, embarrassed) was a frequent/serious concern,” “Siblings emotional well-being (other family members often felt frustrated, angry, worried, sad, embarrassed) was a frequent/serious concern.” The alpha coefficient is of this scale .87.

4) Child’s request: “Child requested treatment.”

5) Information/Recommendations from Specialists: “Information/recommendations found on an internet website, or from book/s, magazine/s, newspaper article/s, and/or television program/s,” “recommendations of a pediatric psychiatrist,” and “recommendations of a pediatric neurologist.” The alpha coefficient is .74.

6) Recommendations from School Personnel: “Recommendations of a teacher, school psychologist, guidance counselor, or other school personnel.”

7) Recommendations of a Pediatrician: “Recommendations of a pediatrician.”

8) Recommendations of a Friend or Family Member: “Recommendations of a friend or family member.”

9) Availability and cost of services: “Availability and cost of services.”
Qualitative Data-Gathering Methods

In addition to quantitative data-gathering methods I also conducted 14 in-depth face-to-face interviews and asked a number of open-ended questions within each mail questionnaire, most of which were answered by approximately 76% of respondents. By asking similar questions with different methods, findings were naturally being double-checked, which ultimately maximized the reliability and validity of research findings. More importantly however, while survey data provided me with a tremendous amount of information, qualitative methods and open-ended questions revealed the complexity that can get left behind with standardized questions. I was able to go beyond simple snapshots of "what" and "how many" to gain a deeper understanding of how and why things happen as they do.

Qualitative interviews for example generated data about how parents who decided to have psychiatric medication prescribed for their children arrived at their decisions. Further, they helped to demonstrate a series of fairly consistent stages through which parents progressed before ultimately deciding their children needed medication, which could only be suggested with quantitative data. Open-ended questions on the questionnaires also provided a tremendous amount of detailed information regarding the ways many parents of children with no problems tend to regard parents of children taking medication. Quantitative findings demonstrating the extent to which many parents are critical of parents whose children are on medication would not have been understood without answers to these questions. In short, qualitative data were used to corroborate quantitative findings, but in terms of their illustrative purposes, they were invaluable. As explained by Miles and Huberman (1994), "numbers and words are both needed if we are to understand the world" (p. 40).

In-Depth Interviews. Respondents for 14 in-depth interviews were those parents who returned questionnaires with their contact information and indicated that they were interested in
participating further. Interviews were conducted to add richness and nuance to parents' answers on their questionnaires – to capture why people feel and think the way they do. I employed a semi-structured interview format, asking people to elaborate and explain many of their responses to survey questions and provide detailed accounts of concrete incidents. While doing so, I also allowed respondents to let their stories unfold naturally. Hence rather than a standardized set of questions that had to be asked, respondents' answers to their survey questions were largely used as a point of departure for further discussion. Examples of topics covered that were not specifically included in the survey, were typically parents’ personal difficulties such as their own alcohol abuse, depression or anger issues and ways they affected their parenting, as well as issues they had with the schools their children were attending. Respondents also talked about problems they encountered with their spouses, ex-spouses, siblings, parents, friends and other family members as a consequence of the difficulties they had with their children. Parents were equally likely to discuss their children's triumphs as well as their failures, and most were very clear as to what (or whom) they attributed both.

**Interview Data Analysis.** Interviews were transcribed as soon as they were completed. Transcribed interviews were then loaded into NVivo (QSR Nud®ist Vivo Software for Qualitative Analysis) for analysis. For the purposes of this dissertation, inductive data analysis techniques in which themes are allowed to emerge naturally from the data and are typically used for qualitative data were not used. Rather I looked for themes specifically relating to those explored in quantitative data analysis. In presenting results of my analyses, I integrated qualitative narratives within the context of answering each research question, noting examples reflecting themes that are both consistent and inconsistent with quantitative findings.
Respondents. Interview respondents were chosen from a pool of volunteers on the basis of whether their children had been diagnosed with emotional, psychological, and behavioral problems. All volunteers reporting diagnoses were contacted and in the end, I was able to interview 15 parents, 14 of whom were mothers. I discount the one father's interview however as it turned out that his daughter actually did not have any problems, and he did not seem to really understand the questions. Consequently, his information is anomalous, and does not apply to any of my research questions. As I did not interview parents of children with no problems, all narratives from parents of children with no problems are a product of answers to the survey's open-ended questions.
CHAPTER 3

RESULTS OF ANALYSES

This chapter presents a series of analyses following the order outlined in the previous section. I begin with a comparison of sociodemographic characteristics between the four groups of parents (1] parents of children with no problems; 2] parents of children who suspect their children may have problems; 3] parents of children with diagnosed problems but no medication; and 4] parents of children taking psychiatric medication). This is followed by comparisons of behavioral and academic performance problems, child-rearing behaviors and feelings about parenting, sources of parenting information, parents’ general attitudes towards psychiatric medication, parents’ awareness of other children’s problems as well as their own childhood problems, causal attributions concerning the origins of children’s emotional and behavioral problems, and finally, influential factors around treatment.

This section offers descriptive statistics and presents findings from a series of Chi-Square Analyses and Analyses of Variance (ANOVA) designed to compare the four groups of parents on all variables of interest. Given the small sample sizes across the four groups of parents, I report differences in means and proportions as statistically significant if \( p < .05 \) and approaching significance if \( p < .10 \). Also, in addition to chi-square tests, Fisher’s exact tests were run when the data contain “thin cells.” Fisher’s exact calculates exact probabilities instead of relying on the chi-square approximation in the case of low expected frequencies as thin cells can disproportionately influence the outcome of chi-square tests (Hamilton 1998).
While I might have run only Fisher's exact tests, there is some disagreement as to what the rule of thumb should be around the minimum number of expected frequencies in order for chi-square test results to be trustworthy (Hamilton 1998). Consequently, I ran both tests for each variable and report on Fisher's exact only in the case of a contradiction between the two tests.

In ANOVA analyses, when there is evidence of low Bartlett's probability (which implies that ANOVA's equal variance assumption is implausible), Kruskal-Wallis tests were run. This test is a non-parametric alternative to a one-way ANOVA that works with ranks rather than measurements and makes no assumptions of equal variance; it is useful when ANOVA's assumptions of normality appear doubtful (Hamilton 1996). When overall group differences are statistically significant, Scheffe multiple-comparison tests were also run to determine where the main contrast actually lies among these four groups.

As noted previously, I present qualitative data by integrating respondents' narratives within the context of answering each research question, noting examples reflecting themes that are both consistent and inconsistent with quantitative findings. These data were used to corroborate and illustrate quantitative findings. Mothers' stories add richness to the survey data that would not have been possible with standardized questions alone.

The first set of analyses began with a series of Chi-Square tests in which the four groups of parents were compared on sociodemographic characteristics (with the exception of one ANOVA for children's ages). Findings are presented in Table 3.

**Sociodemographic Characteristics**

Differences approaching significance were found between the four groups of parents on respondents' sex ($p < .10$), respondents' education ($p < .10$), and the sex of the child on whom respondents were reporting ($p < .10$). The only statistically significant finding
between the four groups of parents was on the age of the child on whom respondents were reporting ($p < .001$). No statistically significant differences were found between the four groups of parents on spouses' education, respondents' employment, spouses' employment, family income, family structure, or number of children.

Table 3. Chi-Square Analyses: Demographic Characteristics by Four Groups of Parents

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<th>Characteristics</th>
<th>Total Sample N = 235</th>
<th>Kids w/no prob N = 137</th>
<th>Kids w/prob, but no diag N = 40</th>
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* Scheffe test results show that value is significantly different from value in column identified (a,b,c,d)
* * p < .05  ** p < .01  *** p < .001

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Table 3. Chi-Square Analyses: Demographic Characteristics by Four Groups of Parents (cont’d)

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<td>2.79</td>
<td>3.19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With respect to differences in the sex of the children on whom respondents are reporting, we can see that males are significantly overrepresented among parents whose children have been diagnosed, but are not treated with medication (65%) relative to their proportion in the overall sample (54%). This difference becomes even greater among those parents whose children are treated with medication, with males representing roughly 74% of the children in this group.

In terms of children’s ages, the mean age of children on whom parents are reporting is about eight-years-old for parents of children with no problems and parents of children with problems but no diagnoses. Children are slightly younger among parents whose children have been diagnosed but not treated (mean age equals 7.65), but in the group of parents whose children are taking medication, children are significantly older (mean age
equals 10.43). Significant pairwise differences are those found between the group of parents whose children are taking medication and each of the other groups: parents of children with no problems ($p < .001$); parents of children with problems but no diagnoses ($p < .01$); and parents of children with diagnoses who are not taking medication ($p < .001$). Findings from a Kruskall-Wallis test ($p < .001$) are consistent with ANOVA’s findings.

In sum, few significant associations were found among these four groups of parents on demographic characteristics, which was not unexpected, given previous research (McLeod et al. 2004) and the homogeneity of the sample. Two themes have emerged from these analyses however, regarding the children on whom parents are reporting. We see first that children with diagnoses, both those who are taking medication and those who are not, are largely male. Secondly, among the group of parents whose children are taking medication, children are significantly older than are those on whom parents are reporting in other groups.

It is interesting to note that, among the group of parents whose children have been diagnosed but are not taking medication, there are more mothers and fewer fathers than one might expect if parents’ groups and sex were independent of each other. More than likely however, this has occurred as a result of gender-related response bias.

Comparing Behavioral and Academic Performance Problems

The second series of analyses began with a set of ANOVAs conducted to compare means on internalizing and externalizing behavioral problems and academic performance problems across the four groups of parents. Results are presented in Table 4.

Mean values signify the extent to which children exhibit symptoms. Thus, higher values indicate that parents perceive their children are manifesting more severe problems. In the case of academic performance, lower mean values indicate lower scholastic abilities.
Each of the measures was found to be statistically significant across the four groups of parents ($p < .001$) with internalizing and externalizing behaviors increasing incrementally across the groups and academic performance decreasing incrementally. Externalizing behaviors are slightly more severe than internalizing behaviors in the extent to which they increase, with mean values progressing from 14.9 to 26.2 across the four groups of parents, as compared to internalizing behaviors with mean values that increase from 14.5 to 24.1 across the four groups. Results of a Kruskall-Wallis test, run on account of a low Bartlett’s probability ($p < .05$) in the case of both internalizing and externalizing behaviors, were in agreement with ANOVA’s conclusion that the overall models show significant differences between the four groups of parents.
Table 4. One-Way Analyses of Variance Comparing Means on Internalizing and Externalizing Behavioral Problems, and Academic Performance Problems Across Four Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/ no prob N = 137</th>
<th>Kids w/ prob, no diag N = 40</th>
<th>Kids w/ diag, no meds N = 35</th>
<th>Kids w/ meds N = 23</th>
<th>F</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internalizing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>Mean 14.46&lt;sup&gt;bcd&lt;/sup&gt;</td>
<td>17.93&lt;sup&gt;ad&lt;/sup&gt;</td>
<td>18.82&lt;sup&gt;ad&lt;/sup&gt;</td>
<td>24.09&lt;sup&gt;abc&lt;/sup&gt;</td>
<td>20.48***</td>
<td></td>
</tr>
<tr>
<td>SD 4.87</td>
<td></td>
<td>6.49</td>
<td>7.76</td>
<td>7.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Externalizing</strong></td>
<td>Mean 14.85&lt;sup&gt;bcd&lt;/sup&gt;</td>
<td>19.37&lt;sup&gt;ad&lt;/sup&gt;</td>
<td>20.23&lt;sup&gt;ad&lt;/sup&gt;</td>
<td>26.27&lt;sup&gt;abc&lt;/sup&gt;</td>
<td>24.52***</td>
<td></td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>SD 5.48</td>
<td>7.65</td>
<td>7.44</td>
<td>8.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Academic</strong></td>
<td>Mean 12.10&lt;sup&gt;c&lt;/sup&gt;</td>
<td>11.13</td>
<td>10.08&lt;sup&gt;*&lt;/sup&gt;</td>
<td>9.48&lt;sup&gt;*&lt;/sup&gt;</td>
<td>9.50***</td>
<td></td>
</tr>
<tr>
<td>Problems</td>
<td>SD 2.39</td>
<td>3.04</td>
<td>2.53</td>
<td>3.22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>abcd</sup> Scheffe test results show that value is significantly different from value in column identified (a,b,c,d)

* p < .10  ** p < .05  *** p < .01  **** p < .001

Only one pairwise difference is not significant – that between the groups of parents whose children have problems and no diagnoses and parents whose children have diagnoses but are not treated with medication. Significant differences are found between each of the other groups however. In terms of academic performance problems, the pairwise difference between children with no problems and children treated with medication is significant, as is the difference between children with no problems and children with diagnoses, not treated with medication.

Ultimately, results in Table 4 show that as children's problem behaviors increase and their academic performance decreases, parents' level of utilization or reliance on medical labels and treatments varies accordingly. In other words, according to parents' reports, children with no problems exhibit the least problem behaviors while children taking medication exhibit the most.
Comparing Child-Rearing Behaviors

ANOVA s were conducted to compare means on child-rearing behaviors across the four groups of parents. Both school involvement and home involvement were examined but results indicated that differences between the means are not statistically significant (results not shown).

Comparing Feelings About Parenting

Findings from the next series of ANOVAs, in which means on feelings about parenting were compared across the four groups of parents, are presented in Table 5. Regarding satisfaction with parenting, pleasure of parenting is first compared across the four groups and results indicate that differences between the means are approaching significance ($p < .10$). In this comparison, means signify the extent to which parents take pleasure in parenting. Higher mean values indicate that parents report feeling parenting pleasure most of the time. Findings show that for each group, means decrease incrementally from left to right, with parents of children with no emotional, psychological, and behavioral problems demonstrating the highest levels of parenting pleasure and parents whose children are treated with medication demonstrating the lowest. Neither burden of parenting nor importance of parenting showed significant differences across the four groups of parents.
Table 5. One-Way Analyses of Variance Comparing Means on Feelings about Parenting Across Four Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/no prob</th>
<th>Kids w/prob, but no diag</th>
<th>Kids w/diag, but no meds</th>
<th>Kids w/ meds</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 137</td>
<td>N = 40</td>
<td>N = 35</td>
<td>N = 23</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Parenting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasure of Parenting</td>
<td>Mean 23.11d</td>
<td>23.08</td>
<td>22.85</td>
<td>21.82a</td>
<td>2.23+</td>
</tr>
<tr>
<td></td>
<td>SD 2.22</td>
<td>1.89</td>
<td>2.36</td>
<td>2.36</td>
<td></td>
</tr>
<tr>
<td>Burden of Parenting</td>
<td>Mean 10.30</td>
<td>10.56</td>
<td>10.32</td>
<td>11.59</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td>SD 3.13</td>
<td>3.40</td>
<td>3.91</td>
<td>3.29</td>
<td></td>
</tr>
<tr>
<td>Importance of Parenting</td>
<td>Mean 10.17</td>
<td>9.95</td>
<td>9.97</td>
<td>9.86</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>SD 3.51</td>
<td>3.14</td>
<td>3.70</td>
<td>3.54</td>
<td></td>
</tr>
<tr>
<td>Parental Competence</td>
<td>Mean 22.77d</td>
<td>21.55</td>
<td>21.60</td>
<td>20.70a</td>
<td>4.56**</td>
</tr>
<tr>
<td></td>
<td>SD 2.95</td>
<td>3.46</td>
<td>3.16</td>
<td>2.87</td>
<td></td>
</tr>
</tbody>
</table>

* Scheffe test results show that value is significantly different from value in column identified (a,b,c,d)
+ p < .10  *p < .05  **p < .01  ***p < .001

With regard to feelings of parental competence, results show that overall group differences are statistically significant (p < .01) with means indicating the extent to which parents feel competent in their roles as parents. Higher mean values signify that parents feel more competent than lower mean values. In this case, as in previous examples, the trend remains largely the same. That is, parents of children with no emotional, psychological, and behavioral problems feel the most competent as parents and parents of children treated with medication feel the least competent. Unlike previous examples however, mean values for the two groups in the middle – parents of children with problems but no diagnoses and parents of children with diagnoses but no medication, are not appreciably different from one.

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another. The only statistically significant difference between pairs of means is that found between parents of children with no problems and parents of children treated with medication \( p < .05 \).

In summary, it was somewhat unexpected that there was no significant difference in burden of parenting across the groups, given that burden of parenting represents the “flip side” of parenting pleasure. It may be that parents had a hard time agreeing with statements such as “children are a large burden for me,” and “it’s hard being stuck home with children.” Regarding the importance of parenting however, that children’s problem behaviors had no impact on the value parents place on their parenting roles was not unanticipated. Neither was it surprising that parents whose children have no problems feel both more competent as parents than parents of children with problems and experience more pleasure. Given the greater challenges with which parents of children taking medication are confronted relative to other parents, it is understandable that they would feel the least competent as parents and experience the least pleasure.

To illustrate this finding, narratives presented from two mothers below, each of whom has a son on medication for fairly severe behavioral problems, describe their sons’ behaviors (without medication) as well as their feelings of competence, or rather lack thereof:

He didn’t have his medication yesterday. And even though, still technically, a little bit of it remains in their bloodstream, you really see how much of it really isn’t in their bloodstream. He drove me nuts yesterday. And I feel that I’m a person . . . I mean, I’ve had a daycare for ten years now, and . . . to be able to take care of infants and toddlers you have to have a certain [amount of] patience, obviously. And so, for him to get me to where we’re going head to head, it’s pretty extreme. And he was just bouncing off the walls. Wouldn’t listen. We went out to breakfast, and I was beside myself. And I just kept saying,” ughh . . . how could I have forgotten to give [his medication] to him?”

Karen

64
I think I went to a [support group] meeting once ... and I think about going back, because, quite honestly, we don't think we deal with this well. We think that we constantly yell. And we keep saying we're not going to do that. But we can't help it. [His behavior] drives you there, and you get there, and it's like there's this cliff, and you get to that point, and you've gone over the edge and you can't stop it. And we're at that point now where we're just like, you know what? Go to your room. And he doesn't know enough to stop. So you know you have to [tell him] "just go to your room. Go away, you know?" We've tried time outs, and we set the timer. It's hard. It's really hard. It's very stressful when you get to the point where [you just know] this is going to be awful ... And you say to yourself, alright. I'm going to handle this better [next] time. I'm not going to get so angry. I'm not going to get so emotional about it.

Melissa

Both of the above narratives describe children's behavior at times when they were not on their medication — which seem to be the times when mothers feel the least effective, especially when they react in anger. Given that psychiatric medication is prescribed in an effort to alleviate children's problem behaviors, it would be reasonable to consider that once children begin taking medication, parents might begin to feel more capable as their problem behaviors diminish. However, results suggest that although medication may improve behavior, it does not eliminate the challenges of parenting children with problems and may even create added burdens associated with the need to monitor and change treatments, which again helps us to make sense of the fact that parents of children on medication feel the least competent as parents. A lengthy narrative from Melissa explaining her son's history with medication helps us to see the extent of the challenges with which parents of children on medication can be faced.

Medication probably wouldn't have been my first option, but you know, I really don't think he could have functioned in school without it. So we started him on Ritalin. At first we tried the generic brand. And we found that he can't take generic. The psychologist thought that it was probably the dyes in it. So, that didn't work real well. So we went on Ritalin, and you know, it helped. It helped, but I guess he was also diagnosed, after that, with a learning disability. Non-verbal. So ... we've been working with a psychologist from that point on ... since he was five. But he's also got some other issues that got added on ... he's been diagnosed with mood disorder ... and he's also been diagnosed with anxiety disorder. So we've been working with
the school on that. And you never quite know what you're dealing with . . . whether the anxiety or the mood . . . [and] you never know whether the medication is having an affect or not, or whether it's the full moon . . . or school's out. So you sit there with the psychiatrist and he says, how is this working? And you say, I don't know. Like right now we're in the middle of a medication change. We went from Ritalin to Adderall. Because he was doing the Ritalin twice a day. . . and we found that he was getting a little aggressive, which can be a side effect.

So the Adderall lasts all day and that was pretty good for a while. And then he's also been on Wellbutrin, for anxiety . . . the problem with Ritalin and Adderall is that you can't sleep at night. So he was on a low dose of [something that] helped him to get to sleep at night. Which helped with the mood, and then we were finding that he started with tics . . . when he gets nervous he tics, he twitches his eye, or he sniffs his hand, or he's sniffing. Or it's always something. So I don't know if that's when they finally decided to add Tourette's syndrome to the mix. [I] feel like I've got this kid on so much medication, but each one does a different thing, and without it, it's such a marked difference, when he's not on it, or late afternoon, early evening comes on, and it's all gone. So now he's been on Concerta, which has been fairly good. [But] we're finding that it's . . . we think his body is just getting too big for it, so now we're [also] trying Strattera, which is the new non-stimulant. But it takes about a month to get into your system before it takes affect. So he's doing that and the Concerta, a lower dose of the Concerta. Quite honestly, I'm not seeing a big effect. He's jumpier than usual. He's somersaulting through the house right now. And I don't know whether that's just cause its winter and they can't get outside and burn off energy, or what. So we go to see the psychiatrist next week, so we'll have to ask him. Melissa

While the extent of these changes in medication sound fairly extreme, the above narratives demonstrate that even when children are "taking medication" there are frequently periods of time when the medication is out of their system, whether because they forgot to take it or they are in between doses, or they are in the midst of switching medication as a consequence of diminished efficacy or an adverse reaction. Recall, that it is at these times in particular when parents feel the least competent, and according to mothers' narratives, despite having children "on medication," they continue to experience their children on a daily basis when there is no medication in their system. Indeed, the scenario described above has been echoed by several mothers as seen in the comments below.

He was originally on Concerta, and the side effects were just . . . he was not able to sleep at night. Even though he was getting it in the morning . . . He's fighting to go
Karen

We’ve tried approximately twelve different drugs, like to help him with focus and stuff like that. And none of them worked, and one of them had a really bad reaction. But you know, I just tried them, and gave him the three weeks or whatever that they told me to keep him on them, and then when I saw no improvement or when I saw that he was actually getting worse, then I took him off them.

Sara

[My daughter] started her first medication when she was four and she started with Benadryl. That was for the Attention Deficit Disorder. It would knock her right out . . . and didn’t like that. That lasted a month, and I was like mmm mmm. I don’t like having such a noticeable side . . . affect . . . [so] then we went on Ritalin because I didn’t like the Benadryl. And the Ritalin worked for her. She was able to get control, but then she went through a growth spurt, and by second grade we needed to change her medication cause it wasn’t working. And that’s when she moved to Adderall. And she stayed on Adderall until she was . . . I think it was ten years old we entered her in a study down in Boston at Mass General for a new drug – Provigil – which was for Narcolepsy. They wanted kids with ADHD. So, she went into that study and it worked for her. It slowed her down. But then she went through another growing spurt and it stopped working. So then she went to Adderall-XR. And that’s what she’s been on, with the Zoloft. The Zoloft she started when she got diagnosed with Asperger’s and we were realizing that she had the social anxiety [disorder], so that was [when she was] eleven.

Bryce

Further evidence that changes in children’s medication are characteristic is provided by Melissa who, in addition to having a daughter about whom she is concerned, is an elementary school teacher. She comments on changes in two children’s medications in her classroom in this academic year alone, again demonstrating the normalcy of frequent changes in children’s psychiatric medication, as well as the continued challenges with which parents are faced in their efforts to find the “right” medication.

Actually I have two students who are already coded ADHD. I’ve got one who . . . has gone through a couple medications. I mean this little boy, he just can’t focus. But [right now] he’s on medication and he’s doing okay. I can control him. I have another child, who I’m beginning to have nightmares about. [His parents] put him on medication over the summer . . . and he ended up being very manageable, a nice boy, very bright – they all are . . . and then something happened and the medication started to wear off. I didn’t know . . . the parents, unfortunately, have not been good
about telling me, or even telling the school nurse who really needs to know when they take him off medication or change it. But they did change it around Thanksgiving, and he went through a couple of different things, and then finally right before Christmas, they put him on some type of anti-depressant. They were thinking he was bipolar... so anyway... nothing, it did not work at all. So he’s completely off medication now. And the poor child, he goes around, saying I’m a bad kid. I’m bad. I’m like, no, no, you’re not bad. I’m going to have to put him on a behavior program, [but] when I found out he was off medication, I’m thinking... like, oh, well, how can I, when he can’t regulate himself?

Melissa

Demonstrating the extent to which parents of children taking medication feel incompetent as parents, Melissa also had this to say about parents she has known whose children are taking medication:

I admire those parents, in my classroom, who do go through with [medication]. Of course their children are very different, and I know it’s not easy. And I’ll tell them that whenever I can, because I think they need to be reassured that what they’re doing, in most cases, I think, is really what needs to be done. And I find most time my parent conferences end up being therapy sessions for parents, especially if I have a lot of concerns about [their children] academically. I figure the best way to get at helping a child is to get to the parents. If you can get them feeling better about themselves, confident about themselves as a parent, it’s going to reflect back on the child.

Melissa

Given the time parents must spend monitoring children’s behavior to determine the medication’s effectiveness as children continue to grow and change, along with the fallout they experience contending with children’s problematic behaviors when the medications are not working, the above narratives both illustrate and help to explain why many parents of children taking medication may be experiencing the least pleasure and feeling the least capable.
Comparing Sources of Parenting Information

Table 6 presents findings from a series of ANOVAs comparing means on sources of parenting information across the four groups of parents. Concerning parents’ reliance on experts, mean values on experts, non-experts, and advice literature were compared across the groups, though results indicate that only the difference between mean values on experts was found to be statistically significant ($p < .05$). In this analysis, mean values signify the extent to which parents are reliant on experts' advice (which in this instance is comprised of school and medical personnel) as their source of child-rearing information. Higher mean values indicate the extent to which parents report reliance on expert advice as compared to advice from other sources. As before, findings show that for each group means increase incrementally, with parents of children with no emotional, psychological, and behavioral problems reporting the least reliance on expert-advice and parents whose children are treated with medication, reporting the highest. A closer look at these data (not shown) indicate that, of the expert advice upon which parents rely, family therapists may be the most important source among this group of parents ($p < .01$), followed by school psychologists ($p = .078$), school nurses ($p = .090$), and teachers ($p = .094$), all of which are approaching significance at the alpha < .10 level. Differences on mean values of pediatricians across the four groups were not significant.

In terms of non-experts and advice literature, neither showed significant differences across the four groups of parents, except for the variable support groups ($p < .05$), which by itself showed the same incremental differences across the four groups.
Table 6. One-Way Analyses of Variance Comparing Means on Sources of Parenting Information Across Four Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/no prob</th>
<th>Kids w/prob, but no diag</th>
<th>Kids w/diag, but no meds</th>
<th>Kids w/ meds</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 137</td>
<td>N = 40</td>
<td>N = 35</td>
<td>N = 23</td>
<td></td>
</tr>
<tr>
<td>Reliance on Experts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experts</td>
<td>Mean 11.92d</td>
<td>12.43</td>
<td>13.45</td>
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</tr>
<tr>
<td></td>
<td>SD 3.72</td>
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<tr>
<td>Non-Experts</td>
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<td>.39</td>
</tr>
<tr>
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<td>Importance of Others' Opinions</td>
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<td>Experts</td>
<td>Mean 11.75d</td>
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<td>4.08</td>
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<tr>
<td>Non-Experts</td>
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<tr>
<td></td>
<td>SD 3.42</td>
<td>3.09</td>
<td>2.85</td>
<td>3.26</td>
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</tr>
</tbody>
</table>

*a,b,c,d Scheffe test results show that value is significantly different from value in column identified (a,b,c,d)
+p < .10   **p < .05   ***p < .001

Regarding the importance of others’ opinions, experts and non-experts were compared across the four groups, but again, consistent with findings above, only the difference found between means on experts was statistically significant (p < .05). Higher mean values indicate the extent to which parents are concerned with experts’ and non-experts’ opinions of their parenting, adding further weight to their importance as sources of child-rearing information. In this case, as above, mean values increase from left to right with parents of children with no emotional, psychological, and behavioral problems reporting the least concern with experts’ opinions of their parenting and parents of children being treated with medication reporting the most concern.
A closer look at the analyses (not shown) demonstrates that findings are consistent with those above, with parents' concerned mostly with the opinions of family therapists ($p < .01$), followed by school psychologists ($p < .05$) and other medical practitioners, such as neurologists, child behavior specialists, and psychiatrists (approaching significance at $p = .069$). In this case, teachers are not included, and again, neither are pediatricians. The main contrast between pairs of means lies between parents of children with no emotional, psychological, and behavioral problems and parents of children treated with medication ($p < .05$).

All told, I was surprised that advice literature did not show significant differences across the groups, with the number of books and websites devoted to children's emotional, psychological, and behavioral problems. And in fact this finding is somewhat inconsistent with what many of the mothers with whom I spoke had to say in regard to seeking and finding information presented in advice literature. Several narratives are presented below:

Well we did One, Two, Three Magic. It works really well... with [my daughter]. [And] I just read The Explosive Child... it's awesome. I had a high frustration level and also lack of tolerance. So I read the book. A friend of mine... recommended this book for me. Took me three months, but I read it. So it was basket A, B and C. Basket A is safety. Basket B is compromise. C, who cares. Is it worth the meltdown. Well, [my son], sometimes, you know...not wanting to wear a jacket. Well, then you have a choice between [making him wear] his jacket... or [saying]" you're going to have to work [it]out." And he picked out [another] jacket. So it was a compromise, as I learned from that book.  

Meredith

This is a good book, The Explosive Child. There's a part in this where it talks about her problems... there are certain circumstances [where] you know there's going to be problems, like homework, starting homework, or doing math, which is something that's not popular. I know when I pick her up the first thing she's going to say is that she wants to go out to eat. She doesn't like anything in the house and she wants to go out to eat... so it's like, I'm trying... what did he call it, distractions, like go on to another subject. So I'm trying to think, "what's she going to be interested in me saying... that she's interested in, like her birthday party?"

Lauren
As far as . . . disciplining . . . when [my daughter] was . . . six or seven, I read that book, One, Two, Three, Magic. And watched the video . . . and it actually saved me, because I was at my wit’s end with behavior issues, you know. And I started spanking, which was something I didn’t want to do . . . but it was like, oh, you know, you just like (whack), “Get into your bedroom” Or, or the threats, and I didn’t like that, so the One, Two, Three Magic worked, and it still works today, with her . . . for both of them, you know . . . I mean there’s not even a consequence at the end. When they were younger I had something set up, you know, you go into your bedroom, or you won’t be playing with that, or whatever, but now, it’s just like it’s not even a consequence, they just start moving.

Bryce

I was flipping through [a parenting magazine] . . . and there was an article entitled, “The Boy who Doesn’t Have Any Friends.” And I thought, ooh, interesting. So I started reading it, and prior to this . . . this teacher kept talking about AD/HD. And the teacher just thought medicating him would be an answer, [which was] the first time any medicine was suggested to us. So I started reading about ADHD. And I would go onto the website, and bring the whole checklist up to my husband . . . and I’d read through it, and we’d both say, well, he’s got some of it, but he doesn’t have all of it. And, you know, maybe he’d have 50% of the list. We both said, it’s not this, but it’s similar. It’s just got to be something else. So the magazine article talked about this boy who is the middle child of three boys, and it just hit the nail on the head. They said he had Asperger’s. So, I had gone into the site for Asperger’s. And this was sort of after I had done all this [research] into ADHD. You know, my husband and I both sort of figured out it wasn’t that, but it was so close that it had to be related. And we didn’t know of anything else out there. Cause that’s what everyone just talked about. So when I heard about Asperger’s from this article, I went into their sites, and I read the descriptions. And he had clearly 80% of the stuff that they talked about.

Suzie

Perhaps no significant differences were found on advice literature across the groups because it is commonplace that most parents in this sample have read books and magazines on parenting, and when they do, they do not consider that they are actively seeking parenting information. Had the question been rephrased, perhaps regarding the type of information parents were seeking, significant differences may have been found across groups. As demonstrated by the mother in the narrative below, although she is currently confronted with behavioral issues, it seems she has always sought general parenting information through advice literature.
I had kids because I wanted to be a parent, and so I take that very serious, and I always have, and so I've always read about it, and if I don't know the answer, then I'm going to find out. Thank God we have the internet, because it makes it a lot easier now instead of going to the library and reading stuff, and you know, going and finding this book and that book, and chasing this reference, and that. So, that's what I've always done. I've always sought help to make sure that I am parenting right. To make sure that I am making the right decision, and to make sure that there's some kind of backing up.

In regard to parents' reliance on experts however, ANOVA findings confirmed my expectation that parents of children with emotional, psychological, and behavioral problems would be more reliant on experts as sources of child-rearing information than parents of children with no problems, with the main contrast appearing to be between parents of children with no problems and parents of children taking medication. I was very surprised however, that parents of children taking medication are not reliant upon teachers as sources of child-rearing advice as they are particularly likely to be in regular contact with school personnel.

The following example is demonstrative of the type of regular interaction with school personnel, parents of children taking medication are likely to have:

So, [at school] we have a lot of rewards. He has a chart when he's done something like worked independently for ten minutes, he gets a sticker. At the end of every day he gets a report card. He brings it home and we talk about it they try to help him with social issues, like in his IEP he has to talk about a topic that somebody else brings up, or write a paragraph about something other than his latest obsession, which is very difficult for him. So they're very helpful, and we have meetings like every other week. We have [lots of] meetings. And they all know me very well. And we've been fortunate. It's a really, really, good school, and he's had really good teachers.

Though parents seem not to be reliant on teachers for child-rearing advice, mothers' comments presented below demonstrate the importance of the role teachers can play in their lives. Many of the mothers with whom I spoke, explained that they did not realize their children had problems until a teacher brought it to their attention. It seems that with no
basis of comparison, while parents may be frustrated with their children's behavior, they
often have no idea that it is not within the realm of "normal" until it is pointed out by a
teacher who observes their child within the context of numerous children in the same age-
group. Lauren, whose daughter has a non-verbal learning disability, and Suzie, whose son
has Asperger's Syndrome relate their early school experiences.

We didn't have any comparison, really. We had my daughter, who is two and a half
years older. She never had a speech problem. [My son was hard to understand but
he] is very verbal and the words that he uses were always more mature than what his
peers use. So it was hard for us to tell. Is it the words he's using, or is it really his
language? And, for us, we knew that, in order to understand him, you had to know
the context to figure out what he was talking about; we had to think about his day,
and ask a lot of questions. [So] he was a late speaker. So, there were a lot of sort of
little indications, but nothing, until the preschool teacher said, you know, we think
maybe a speech specialist should check him out, but we didn't really even pursue that
cause we just thought, well, it's developmental, you know, he only started talking
when he was three, which was right before preschool. So in about March of
kindergarten year, his teachers were talking to me about possibly having him repeat
kindergarten. And that's what sort of started a lot more testing. Because I wanted to
know for sure holding him back would benefit him. I had a lot of confidence in the
teachers. I probably relied too much on them to tell me what's going on, and I didn't
really investigate myself until they started talking about retention, and I thought, wait
a minute. This . . . is like a major thing for him. So, kindergarten is what started a lot
of testing, to figure out, you know, would holding him back benefit him, socially and
academically?

Suzie

[Her disability] was not apparent from an early age, because I didn't have my kids
until I was older. I was 33 when I had [her] and not having had any other kids before
it was hard for me to pick up on things. I knew that she was really quiet. Like she
wasn't the type of toddler to explore things. She walked at an appropriate age. She
was about 12, 13 months old. But she wasn't the type that one day would start
walking and the next day would be buzzing around the house. You know . . . she did
everything very cautiously and very slowly. And her response time was slow and
when she was in daycare, I can remember, she didn't really interact that easily
verbally with the other kids. Whereas my son is like the total opposite. You get
instant feedback from him. [But I had him much later] so I didn't really have
anything to compare [her] to, so that's why I wish that I had known what I know
now, because at three years old I would have had intervention. So, how we got to
find these things out was when she was in kindergarten. And I knew she was having
problems . . . like the [way she] follows directions. The teacher says "go to your
cubbies and get your lunchboxes and bring them to the table so we can have lunch." And [she] would sit there and all the kids would go do what the teacher said. And it
wasn't that she was deliberately defying the teacher, but her processing time is so much slower than a normal kid, that it takes her a little bit longer to get what she has to do.

It appears that school personnel may play a sizeable role in identifying children's problems and influencing parents to pursue avenues of intervention. Parents are not always appreciative of the way children's issues are brought to their attention however, which we see both in the fact that they seem not be particularly important as sources of child-rearing advice, as well as the following complaints from Karen and Suzie that may help to explain why that may be the case.

I saw it happen to him at preschool. I taught him till a certain age, and then before he went into kindergarten, [I decided] he needed to be away from me, for tons of reasons. I thought I picked a good school . . . come to find out it was March, and they're like, oh, he's not ready for kindergarten. He needs to stay here another year. He doesn't even know how to hold a pencil. And I was like . . . you're telling me this now? And then I . . . saw [the classroom] on videotape, [and realized] that there were too many kids. And it didn't matter how many people were working in the room . . . children with behavioral or learning issues fall by the wayside, because the [preschool teachers], from an educational standpoint weren't equipped to deal with it. And I saw literally, the kids that were advanced, and could work independently, got all the praise and attention. And I went to the owner, and I was like, well, shit if he's going to kindergarten, I'll work with him all summer. This is a bunch of crap . . . and he was fine, he wasn't kept back. I mean, academically. I work with him every night. And he's gotten mostly As and Bs. So, I mean, there's no doubt in my mind that if I didn't pick up on and intervene, from early on [that he had a learning disability], yeah, maybe he would have behavioral [problems].

Karen

Stuff at home was starting to get [evened out] . . . before, he would have a rough day at school, and they would say, “what's happening at home?” And sometimes he'd have little blips at home. And I'd say, well, this or that. And they were kind of relying on what was happening at home to affect what was happening during his day at school. They weren't looking at like an internal, environmental problem. [I started getting angry when] I realized we had gotten our home environment calm, that there weren't any issues. And still they'll say something like, “is your husband traveling, because he's having an off day.” And my husband hasn't been traveling as much, and I'll say, “no, he's here.” And you can't keep looking at what's happening at home. You've got to focus on what's happening at school. And it could be little things. I keep trying to tell them now, “don't try to figure it out, just ask him what's going on.” He's very verbal. It might be that he forgot his library book at home and he

Karen
really wants to check out a new one. And he’s going to be annoyed and frustrated the whole day because he really just wanted to check out a book. The solution might be, okay, let’s ask the librarian if you can check out that book anyway and bring your other book in tomorrow. That should like solve his whole problem. But instead they’ll say, “oh, he’s having a really rough day. Is your husband traveling?” Suzie

Indeed teachers may not be well-equipped to handle all problems and at times may even be contributing factors. Be that as it may, given the extent of the behavioral problems with which parents of children taking medication have reported, mothers’ narratives help us to understand the extent to which parents may interact with teachers relative to parents of children with no problems.

The following sentiment expressed by Suzie when asked whether she had fears about problems with her son repeating the next school year, suggest that parents of children with problems probably start out being reliant on teachers to understand their children’s difficulties, until they become aware that their children’s teachers are often not educated about their children’s emotional and behavioral problems:

It could start all over, but we’re at a different starting point, and I always think, it’s not going to be as worse, it’s not going to be as bad as it was in first grade [when we didn’t know what was happening] and we were trying to figure it out. I didn’t know that his teacher really didn’t have a grasp. And I sort of relied on her to understand. Suzie

Suzie’s disappointment is apparent and demonstrative of the need for teachers to be better educated about children’s emotional and behavioral problems.

Interactions with therapists were not described in such vivid detail by the mothers with whom I spoke, though it was made very clear that in many cases, once teachers had drawn parents’ attention to their children’s problems, as they pursued diagnoses and initiated a course of treatment, therapists played an integral role in their lives. Indeed, of all of the mothers I interviewed, only two had not been to some type of family therapist, but of those
two, one had set an intent to do so in the near future. Ironically, therapists were typically mentioned in an offhand manner, as a routine occurrence, not requiring much of an explanation as demonstrated in the following narratives:

... it kind of got triggered in preschool that there were issues, attention issues, hyperactive issues. And [then] we started seeing a psychologist.  

Melissa

[In first grade his teacher recommended counseling and then in second grade] his father suggested that he go to counseling . . . he thought it was a good idea . . . I [had] tried to find counselors for him, but since I'm not a primary holder in his insurance . . . well, that's how it all got started, so in second grade [he started counseling].

Veronica

She's only told me once [about what she does in therapy] . . . the last [session] she said that they did timed tests. And that she beat the doctor's time. And that's the only thing she's ever told me about what they do . . . I go in for the first five or ten minutes and tell [the therapist] what's going on and what we've done this week.

Alissa

[Before the divorce, my husband and I] went to a counselor together, for a while, and then he lost interest and I just kept going, and started talking about some of the stuff that had been going on in our marriage the whole time, and started realizing [a lot about our marriage]. And then after he moved out . . . [my son] started having a really hard time [and] I immediately found a family counselor.

Janet

The ways in which mothers spoke about their family therapists were so casual, that they almost belied their importance. If not for the striking fact that the majority of them have a therapist to whom they casually refer, it may have gone unnoticed. This is consistent with quantitative analyses however, suggesting that when it came to sources of child-rearing advice and the importance of experts' opinions regarding parents' child-rearing techniques, family therapists were at the top of the list.

Comparing General Attitudes Towards Psychiatric Medication

Results from an ANOVA comparing means on parents' general attitudes towards psychiatric medication used to treat children's emotional, psychological, and behavioral

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problems are presented in Table 7. Higher mean values indicate more positive attitudes towards treating children's problems with psychiatric medication and lower mean values indicate more negative attitudes. The overall model shows that there are significant mean differences across the four groups of parents, as demonstrated by the F Ratio ($p < .001$). The significant difference is actually between parents of children being treated with psychiatric medication versus parents in each of the other groups ($p < .001$). In other words, parents of children being treated with psychiatric medication have significantly more positive feelings about treating children with medication than all other parents in the sample.

To sum up, it is interesting to note that, unlike the trend in most of the previous analyses, whereby means increase incrementally across the four groups, parents with the most negative attitudes towards treating children with psychiatric medication are those whose children have been diagnosed but are not using medication. It may be that parents of children who have received medical diagnoses but are not treating them have consciously decided against medical treatment (perhaps even if it was recommended), and therefore represent a relatively select group of parents with negative attitudes towards such treatment.

In contrast, parents of children with suspected problems but no formal diagnoses seem more favorable towards psychiatric medication than either the group of parents of children with no problems or the group of parents with diagnoses whose children are not treated medically. It is possible that parents of children with suspected problems feel hopeful, and therefore more positive about medication as a potential treatment than those parents for whom medication is not even a concern. Parents of children with no problems may more easily accept the negativity surrounding children's psychiatric medication than parents concerned that it may be an issue with which they are eventually faced. But again, only the differences between mean values of parents of children treated with medication and

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each of the other groups are significant, which suggests that it is equally likely that mean
differences between the other groups are simply due to chance.

Table 7. One-Way Analysis of Variance Comparing Means on Parents’ Attitudes Towards
Psychiatric Medication Across Four Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/ no prob</th>
<th>Kids w/ prob, no diag</th>
<th>Kids w/ diag, no meds</th>
<th>Kids w/ meds</th>
<th>F</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 137</td>
<td>N = 40</td>
<td>N = 35</td>
<td>N = 23</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Attitudes towards medication</td>
<td>Mean 13.87&lt;sup&gt;d&lt;/sup&gt;</td>
<td>14.76&lt;sup&gt;d&lt;/sup&gt;</td>
<td>13.49&lt;sup&gt;d&lt;/sup&gt;</td>
<td>19.22&lt;sup&gt;abc&lt;/sup&gt;</td>
<td>13.92***</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD 3.84</td>
<td>3.89</td>
<td>3.78</td>
<td>3.41</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

<sup>*p < .10  **p < .05  ***p < .001</sup>

To illustrate this finding, I present contrasting accounts of parents’ attitudes towards
medication below. Narratives from mothers whose children are taking medication are pulled
from in-depth interviews, while comments from parents of children with no problems, are
taken from written responses to the survey’s open-ended questions. To begin, Sara, Janet,
Bryce and Karen each describe how they felt upon beginning treatment. Despite completely
different diagnoses, all mothers recount similarly that while they initially did not want to put
their children on medication, once they found a treatment that worked, their feelings
changed.

It’s hard for me to believe now that it was so hard of a decision then. But I was in
tears all the time. I was having nightmares ... and I thought that I was going to turn
him into a zombie, that I was giving up, that it was my fault ... But ... he was awful.
He was hurting people, he was destroying the house, and, I couldn't do anything
about it. So, eventually, I said okay, I'll try [the medication]; I can always take him
off of it. ... And so, he went on it, and within 36 hours, he was a different person.
He was laughing, and he didn't try to hurt anybody. He didn't talk about how fat and
ugly and stupid he was. He was able to do art again, and he didn't try to destroy the
house. He didn't pinch me and laugh evilly. You know, he was just having fun again.
And then we had a really good two years on the Zyprexa.  

Sara

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I hated [the idea of putting him on medication], but he was suicidal. He was banging his head against the wall, he was biting his wrists when he was in bed at night, trying to make himself bleed. Um, he was telling me that he was going to try to run out in front of a car, or step out in front of a car while he was at the bus stop, which is down at the end of this busy street. That’s always been one of his suicidal plans. So anyway, he got put on Zoloft, and it seemed like his depression was lifting . . . [but] then . . . because [he] wasn’t able to sleep at all as a side effect, [we] started him on Remeron, which is an anti-depressant with sedating properties, and he, to this day, is on that. And that has been the one that has been a life saver for both of us.

Janet

I think the Zoloft works . . . I mean, I don’t like having to have my kid on medication, but as her first doctor, put it, if you have problems seeing, you go out and you get glasses and you fix it. You know, and it’s like, yeah, you would. And if the medication is working, [why not put her on it?] We tried the diet, [but] those things didn’t work with her . . . the medications worked and I hope that in her adult life she sticks with it, because it’s only going to help her. I think if she gets off medication . . . I’ve seen it with my brother. He chose not to take it, and he doesn’t make the best choices in his life, you know, and has a hard time, and I just hope she makes the right choice and stays with it. I mean, she’s so used to it . . . it’s a part of her life now, you know. But it’s tough, having to have your kid on medication. I wish I didn’t have to.

Bryce

I found a lot of different stories from people who were against [psychiatric medication for children] and feel that it just turned their child into a zombie . . . that they were overmedicated. And some who don’t know how their child would function without it. I think it’s hard. It’s definitely a personal decision. It was really hard for me. I sat at [my pediatrician’s office] crying my eyes out. It’s still hard for me even to get the words out today. He was originally on Concerta, [but] the side effects were that he was not able to sleep at night. But we did see improvements in school, and [with] the teachers. But [with the problem sleeping] he was miserable . . . So about a year ago . . . they came out with that somewhat newer medication, Strattera. And we switched him to that. And, I love it.

Karen

These mothers definitely give the impression that if not for the circumstances in which they found themselves with their children’s problems, they too might hold attitudes against psychiatric medication for children. Indeed, Sara and Janet each told me they were completely against medication of any kind prior to their experiences with their children. As Sara reports, her mom had Chrohn’s Disease and by the time she died, she was taking about
30 medications. Not only did Sara believe the drugs made her mother behave meanly towards her, she also believed the drugs caused her mother additional ailments.

And she would walk around the house with all of her pills in her hand for a long time and then she'd make sure she'd take them in front of me. And she'd take them and she'd just make awful faces, and she was mean. And, so, I [believed] a lot of her physical problems were because first she would have problems, and instead of looking at the base cause and saying, “hey, I'm really stressed out and it's making me sick. I've got to find a way to not be so angry all the time.” Instead of doing that, she would fix the symptoms with a new drug. And then the new drug would cause a problem, like her bones got brittle, and she started breaking her bones all the time. So . . . I won't even take aspirin, because I figure it's my body telling me there's a problem, you better fix something in your life. And so I'm really anti-drug . . . as far as taking drugs to solve your problems, I try not to because I figure, like if I have a fever, my body knows what it's doing. It wants to kill the virus, and my white blood cells can take [care of it]. And I also think I've got to go ahead and have this sickness and tiredness, because if I just fix it, then I'm not going to know [what caused it].

Sara

Neither did Janet believe in taking as much as an aspirin, albeit for completely different reasons.

I'm a nurse midwife professionally. I'm not practicing as a nurse midwife right now. I haven't been actually since my youngest was born. And of course, when I had my children, my goal in life was to do everything, from pregnancy and childbirth on naturally, holistically, without medication, without interventions. In midwifery school, so many of my classmates were very holistic. People were on macrobiotic diets, and they didn't have their kids immunized. And that's when I started realizing that those choices were out there, and considering what I wanted to do. And certainly, from the midwifery standpoint, for labor and birth, that's how we were trained. It's to not intervene. So anyway, that was when I developed that very, very strong philosophy . . . and, you know, I wanted our family to be vegetarian. I was cooking tofu . . . I thought we shouldn't have [our children] immunized . . . and you know, ironically, I've gone completely in the opposite direction from all of that.

Janet

Of all the mothers I interviewed in fact, given Janet's and Sara's fundamental positions on medication, it is ironic that their children had the most severe problems and had ultimately, taken the most extreme medications. At another point in our conversations they each expressed how their experiences with their children had completely transformed them — not only as parents, but as people, they felt they were less judgmental and less rigid; as Sara put
it, “a kinder, tireder person.” Lauren’s recounting below is in line with Sara’s comment above, and also typical of the ways mothers described feeling much less judgmental towards others now that they have children with emotional and behavioral problems.

Yeah . . . if you don’t have kids, and you go to the grocery store, and you see a big ordeal...I used to say to myself, boy, I would never allow . . . any kid of mine would never do that. But . . . the parent really doesn’t have a whole lot of control over what happens. Unless you want to either not bring them, or else be able to leave in a moment’s notice if something happens. And how could you do that? Lauren

Now that Lauren has a daughter with problem behaviors, she claims parents may not really have much control over their children’s behaviors. By way of contrast, the following comments, expressed by parents of children with no emotional, psychological, and behavioral problems, provide examples of the negative attitudes many of these parents have towards parents who use psychiatric medication for children.

As a parent and as a teacher, I have become frustrated with children being enabled through vague diagnoses and excuses. I have seen a number of parents cry “learning disability,” “anxiety disorder,” or “ADD” just to have their child coded and consequently not held accountable. Katie

Many parents I know use a diagnosis of some type of behavior disorder to avoid discipline – allowing the children to never experience the consequences of misbehavior. This doesn’t help the children in the long run. Holly

This belief that parents “use diagnoses” so that children are not held accountable or do not “experience the consequences of [their] misbehavior” was reiterated in a variety of ways by other parents of children with no emotional, psychological, and behavioral problems. Narratives below are from parents who disagreed with the statements “Many common childhood misbehaviors are actually signs of emotional, psychological, and behavioral problems” and “Most emotional, psychological, and behavioral problems are a consequence of physical/biological or genetic problems with the brain.” Moreover, these same parents
also agreed that, “Most psychiatric drugs are just a quick fix for busy parents whose children demonstrate normal but annoying behaviors.”

In general, I believe that we have become a very self-centered society and we are raising self-centered children . . . the family unit no longer seems to be a priority and it is broken way too easily. I believe children need a clean, loving, healthy, consistent, and structured environment.

Sarah

I see a general trend away from letting kids experience the consequences of their actions. In the well meaning intent of protecting them, I believe we are denying them the opportunity of learning and growing from their mistakes . . . I believe we have taken away a lot of our educators’ options for consequences so they become “toothless lions” at the head of the class. And parents need to be more supportive of any consequences the teachers do pass out. Even if the child was not directly at fault, they may have been at the wrong place at the wrong time, and a good life skill is recognizing those situations and avoiding them whenever possible.

Jean

Kids learn very quickly if you [make empty threats] that you are not likely to follow through and soon tune out parents who threaten consequences but never make those consequences happen. This is a factor of lazy parenting. It can be hard and/or inconvenient to enforce consequences for bad behavior, but if not done consistently, the behavior doesn't change.

Kristen

The above comments, coupled with findings from quantitative analyses, suggest a trend towards blaming parents for children’s challenging behaviors. In looking a little more closely at the data to explore this further, I found that indeed a number of parents do seem to consider that in many cases poor parenting is responsible for a number of children’s problematic behaviors. I closely examined all written comments from parents who believe parents use psychiatric drugs as a “quick fix” in an effort to find common themes among those who seem, not only to be generally against psychiatric medication for children, but also seem to feel that parents who rely on medication, may actually be doing so in order that they not be annoyed.

In total, 89 respondents agreed that parents use drugs as a “quick fix” to deal with their children’s normal, but annoying behaviors. Themes will be presented below, but first, I
will present a brief breakdown of where these 89 parents fit in terms of the four groups used for quantitative analyses. Sixty out of 89 parents (67%) reported their children had no emotional, psychological, and behavioral problems. Of the remaining twenty-nine parents who thought their children might have emotional, psychological, and behavioral problems, 16 (18%) had actually obtained diagnoses, and only one (1%) of those parents had ever tried medication. She had this to say:

My ten-year old was diagnosed in 1st grade with ADD. He was treated with Prozac and Zoloft for three years. He twitched (facially) constantly and this took over his attention span. With extra help at school, he’s been off meds since December. He’s doing much better. He is still below average in some of his subjects, but he is making friends and he is having fun. Barb

Interesting that only one out of 89 parents who feel that parents use drugs as a quick fix, had any experience with medication at all. And in their case (i.e., the above mother and son), apparently, whatever success they may have had was outweighed by negative side-effects. Five other parents who received diagnoses, flatly refused medication, three of whom had children diagnosed with AD/HD, one with a diagnosis of depression, and one with autism. These five parents are actually those about whom I speculated above who might represent a select group among parents who were against medication, that is parents for whom medication was recommended but refused it.

Of the 89 parents who feel parents use drugs as a quick fix, I found five recurring themes throughout 66 answers to open-ended questions at the end of the questionnaire, which asked what parenting values they dislike or disapprove of in other parents they know, as well as what practices they admire in other parents (the remaining 23 parents left this section blank). Forty-four percent of comments included talk about discipline, structure, consistency, and accountability. In other words, parents wrote that they either approve of parents who do, or disapprove of parents who do not, provide structure for their children,
are (in)consistent with their discipline (if they discipline at all), and do not teach their children that they are accountable for their behavior. Most comments are a combination of both, though I do not present them that way for the sake of brevity. Finally, themes are not mutually exclusive.

Twenty-six percent of comments alluded to parents who do not put their children first; that is before themselves, their careers, or their financial success. Fifteen percent of remarks criticize parents for being indulgent, whether giving into their children's every whim or buying too many things for them rather than spending any time with them. Sixteen percent of comments make reference to children who are rude, disrespectful, ill-mannered, or irresponsible because their parents have not taught them appropriately. And finally, 56% of parents' comments were disapproving of parents who yell at, shame, or belittle their children. One or two comments were made about cleanliness, church attendance, and alcohol problems and several parents remarked that they admire parents who get involved with coaching sports or leading scouts. Ultimately, it seems that in many cases, parents of children with no problems seem to believe that parents, who use medication, do so recklessly in an effort to take care of ill-mannered behaviors that came about because of their poor parenting style.

Comparing Parents' Awareness of Other Children's Problems and Parents' Childhood Problems

Findings from a series of chi-square analyses comparing parents' awareness of other children's problems and parents' childhood problems by the four groups are presented in Table 8. With respect to parents' awareness of other children's emotional, psychological, and behavioral problems, results show that differences approaching significance were found between the groups ($p < .10$). Among those parents whose children are being treated with
medication, over 95% reported they were aware of other children with emotional, psychological, and behavioral problems, which is considerably higher than the proportion of parents in the overall sample who report awareness of other children's problems (roughly 83%).

Upon looking more specifically at the particular children on whom parents report they know with problems, we see that parents' friends' children are significantly overrepresented relative to their proportion in the overall sample \((p < .05)\), as are parents' other relative's children \((p < .05)\), and children in parents' children's classrooms \((p < .05)\). Parents' siblings' children are also overrepresented, but this finding is just approaching significance at the \(p < .10\) level. In terms of parents' opinions as to whether these children should be medicated or not, no significant differences were found across the four groups.
Table 8. Chi-Square Analyses: Parents’ Awareness of Other Children’s Problems and Parents’ Childhood Problems by Four Groups

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>Kids w/no prob</th>
<th>Kids w/prob, but no diag</th>
<th>Kids w/diag, but no meds</th>
<th>Kids w/ meds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 235</td>
<td>N = 137</td>
<td>N = 40</td>
<td>N = 35</td>
<td>X²</td>
</tr>
<tr>
<td>Awareness other kids’ problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>82.98%</td>
<td>78.10%</td>
<td>87.50%</td>
<td>88.57%</td>
<td>95.65%</td>
</tr>
<tr>
<td>No</td>
<td>17.02%</td>
<td>21.90%</td>
<td>12.50%</td>
<td>11.43%</td>
<td>4.35%</td>
</tr>
<tr>
<td>What Kids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kids’ friends</td>
<td>37.63%</td>
<td>36.79%</td>
<td>44.12%</td>
<td>37.50%</td>
<td>31.82%</td>
</tr>
<tr>
<td>Friends’ kids</td>
<td>54.40%</td>
<td>53.77%</td>
<td>36.36%</td>
<td>59.38%</td>
<td>77.27%</td>
</tr>
<tr>
<td>Neighbor’s Kids</td>
<td>27.46%</td>
<td>29.25%</td>
<td>18.18%</td>
<td>28.12%</td>
<td>31.82%</td>
</tr>
<tr>
<td>Siblings’ kids</td>
<td>23.32%</td>
<td>17.92%</td>
<td>21.21%</td>
<td>37.50%</td>
<td>31.82%</td>
</tr>
<tr>
<td>Relative’s kids</td>
<td>20.73%</td>
<td>14.02%</td>
<td>25.00%</td>
<td>25.00%</td>
<td>40.91%</td>
</tr>
<tr>
<td>Kids in your Kids’ class</td>
<td>33.85%</td>
<td>26.42%</td>
<td>31.25%</td>
<td>46.88%</td>
<td>54.55%</td>
</tr>
<tr>
<td>Kids Treated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should kids be Treated?</td>
<td>34.72%</td>
<td>30.95%</td>
<td>36.84%</td>
<td>32.26%</td>
<td>57.14%</td>
</tr>
<tr>
<td>Parent’s Childhood Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed or suspected</td>
<td>19.23%</td>
<td>13.87%</td>
<td>20.00%</td>
<td>31.43%</td>
<td>31.82%</td>
</tr>
<tr>
<td>Life better if treated</td>
<td>82.50%</td>
<td>80.00%</td>
<td>100.00%</td>
<td>75.00%</td>
<td>77.80%</td>
</tr>
</tbody>
</table>

Regarding parents’ childhood problems, those parents who suspect they may have had emotional, psychological, and behavioral problems as children are significantly overrepresented among parents whose children have been diagnosed – both those treated with medication and those who are not – and significantly underrepresented among parents of children with no problems (p < .05). Concerning whether those parents who suspect
they may have had problems feel their lives might have had better outcomes had they been treated, there are no significant differences across the groups.

All told, despite no significant differences found between groups of parents on parents’ awareness of other children’s emotional, psychological, and behavioral problems, because significant differences were found between groups of parents and their awareness of particular children’s problems, specifically parent’s friends’ and relatives’ children and children in their children’s classroom, results suggest that some awareness of other children’s problems is a factor in parents decision-making around seeking diagnoses and treating their children with medication. This is strengthened by results indicating that there were no significant associations found between groups of parents and parents’ awareness of their children’s friends’ problems or their neighbor’s children’s problems. In other words, it seems likely that it is not simply that parents are aware of other children with problems, but rather it is the extent of that awareness, which is likely based on parents’ relationships with those children (and/or their parents) or the extent of their observations of the children in their children’s classrooms, that is likely to make a difference.

If parents are aware of other children whose emotional, psychological, and behavioral difficulties may have been helped with medication and/or some other form of treatment, and they are privy to that information because of their social interactions with these children and their parents, it seems reasonable to assume that they may be more likely to seek diagnoses and treatment themselves. Similarly, if parents’ believe that they had emotional, psychological, and behavioral problems as children, which caused them difficulties that they think may not have occurred otherwise, it seems reasonable to assume that they too, may be more likely to seek diagnoses and treatment for their children, than parents with no prior awareness.
Bryce, for example, whose daughter has been diagnosed with AD/HD, Asperger’s Syndrome, and Social Anxiety Disorder and has been on various medications since she was four, has long been aware of other children with emotional, psychological, and behavioral problems because she works in the school system, and both she and her brother had problems when they were little. She describes her experiences below.

Well, it’s funny. Working in the school system, you know, there are kids that I know [who] need medication, you know. Like, what’s wrong with their parents? And some parents don’t agree with that, so unfortunately, I think the kids suffer. Because they’re in school dinging off the walls, or becoming a behavior issue, when all they need is to take a little pill and they’re able to kind of slow it down and, you know, be at a level with everyone else. And, learn, because what happens is, they’re not learning. They’re becoming more of a discipline problem. Yeah. I think if I had gotten diagnosed early on, in life, I might have made different decisions. I mean, I look at my life now and it’s okay, but I didn’t go to college. I went for a little while, but I didn’t stick with it. I had two full scholarships. [I would have] become a special ed teacher through both of them, and I didn’t take them. And I look back and think, if I had, I don’t know, [my life might be different]. I had an abusive father growing up, so when they got a divorce, you know, I became a behavior issue. My brother, on the other hand, who’s eight years younger than me – when my parents got divorced, he was two. I was ten – and my mother had gotten him diagnosed. My father would never let anyone test me for anything. Because, that would be wrong . . . that would be bad on his part, or whatever. But, my brother got diagnosed and he did okay in school; I, however, was a behavior problem [and] ended up having to be in a self-contained classroom – a classroom with, like five other kids, [but] I was never put on medication.

Bryce’s familiarity with children’s emotional, psychological, and behavioral problems, exemplified by her thoughts about how her life might have been improved on medication, as well as her awareness of other children’s difficulties, is evident when she speaks about her own daughter’s problems with relative ease.

She was about two and half years old I put her into a little preschool. And, there, she showed signs of AD/HD . . . being very fast, and going at her own pace. By four years old I decided to get her tested, just by her activity level, and inability to focus on one thing . . . [Plus] I come from a family of people who have AD/HD. So I knew the signs, and she demonstrated a lot of those. But, as years went on she became more withdrawn and introverted, and in the fifth grade we started thinking that she might have Asperger’s Syndrome, [which] I [knew about because I] worked with autistic kids through the school system. And one of the children that I worked
with has Asperger’s. So I knew, and it was weird, because I would say to [her], sometimes you do that and it just makes me think that you’re autistic when you’re doing that, like . . . she makes vocal sounds, like Mmmrm, mrm, you know . . . whatever. And, the way that she withdraws. She doesn’t have any friends, she doesn’t communicate with peers her age, because she doesn’t know how to do that. And I don’t know if it’s anxiety or, just not knowing how to come up with conversations. When I decided to have her tested for this, I went back [and looked at] all [her] school records . . . starting right from preschool with teacher’s comments. You know, very introverted, plays by herself. Doesn’t interact with any of the kids . . . she will sit and read and not do anything else. And, that’s why I was, into the ADD, because thinking she’s not paying attention, she’s not doing the papers that they’re doing . . . but after figuring it out, after [seeing her] in middle school . . . you know, middle school kids, they interact with each other, and get friends, and go to the mall . . . and she wasn’t doing any of that. And that’s when it really clicked, you know. That there’s something else going on in there . . . so I think she has both [Asperger’s and AD/HD]. She has both the characteristics. Cause she’s [also] very, impulsive. Being like, you know, she’ll just come up and go “BEEP” in my ear, or something like that.

Bryce would prefer that her daughter did not need to be on medication however, as she demonstrated in her comments in a previous section, in which she said:

I mean, I don’t like having to have my kid on medication, but . . . the medications worked and I hope that in her adult life she sticks with it, because it’s only going to help her. I mean, she’s so used to it . . . it’s a part of her life now, you know. But it’s tough, having to have your kid on medication. I wish I didn’t have to. Bryce

It seems that Bryce’s experience with other children as well as the problems she and her brother had as children, may contribute to her professed comfort level, relative to some other parents who are far less experienced. Not all experiences with other children’s emotional, psychological, and behavioral problems have this same effect on parents however. As suggested above, it seems that depending on the particular circumstances, parents can be swayed in either direction. To illustrate how parents awareness of other children’s medication may have the opposite effect from that which Bryce experienced, Alissa, who worked in an after-school problem and has a great deal of experience with
children's behavioral problems shows her mixed feelings about medication in the narrative below:

I helped run the after-school YMCA program. Those children are not there because they can be trusted alone at home, or they have a friend or neighbor who would love to have them. They're there because no one stands them. So I had all the OCD, all the AD/HD . . . all of them, in one room. Hitting, touching, slapping, kicking, biting, calling names at each other. And you know, two boys in there needed to be medicated and were not. One boy was oppositionally defiant. They couldn't do anything with the child, so they just let him do whatever. And the kid was a hellion. Bit, kicked, he'd jab me with pencils. All kinds of stuff. He needed to be seriously medicated. [But] the father would have no [part of it, saying], I'm not medicating him! I'm not giving my kid drugs!

And another kid in the room, who [should have been medicated] — really smart kid, really smart. He was reading in first grade at a fourth grade level. [But] he was way below [his maturity] level. [I would say to myself], “what is wrong with this kid in class? I know him to be an extremely intelligent child.” They said that he had ADHD, he could never sit, he was always up and walking around. He'd go up and get a pencil, or sharpen his pencil, and be gone for ten minutes. Just gone, and out there; he needed to be medicated. So there’s two for instances. The thing is, that child was intelligent. ADHD kids mostly are intelligent. But not being on meds, he was not going to retain the edge that he had. He was going to lose. And as the other kids progressed to fourth grade, his IQ might have dropped because he wasn’t getting the [medication] that he needed.

Alissa

Clearly, Alissa was perturbed that the children she described above were not taking medication, but at another point in the interview, about her own daughter she said:

I didn’t want her to have a diagnostic. I didn’t want her on Ritalin, or Prozac, or you know. You don’t know what it’s going to do to children. It’s not meant for children to take. Not really. Really, that’s not what it was meant for.

Alissa

She claimed that, despite the fact that she was being pressured by the school to have her daughter tested for Oppositional Defiance Disorder (ODD), that she did not have behavioral problems, and remarked that “[her] daughter looks like a total angel next to [the kids in the after-school program].” At a later point during our conversation, she described
another girl with whom she worked who was taking medication, though Alissa believed she
should not have been.

Then, [there was] the mother that wanted to party all weekend, doping her kid up
with legitimate drugs, you know, that the doctor prescribed. [She] was a single
mother, an alcoholic, a known party girl, and she would dope her daughter up so she
could party all weekend. I don’t know what she was taking . . . Something so the kid
wouldn’t remember the weekend going by. So I’d see her on Monday, and say how
was your weekend, she’d be like I don’t know. What’s wrong with you? I don’t
know. I don’t remember much. She says I slept all weekend. My mom had a party. I
don’t remember. . . Yeah, she was a piece of work. So there are two ways of looking
at it.

Alissa’s remarks are seemingly inconsistent but she acknowledges this by pointing out that
there is more than one way of looking at the circumstances under which children are (or are
not) taking psychiatric medication. Taken together, narratives from Bryce and Alissa,
suggest that for parents who know other children taking psychiatric medication, the
influencing factor in terms as to how that may affect their own decisions regarding
medication, may be the extent to which they recognize their children’s problems in such
situations. Parents may also be influenced by their awareness of difficult circumstances with
children that are “successfully” managed. In other words, simply having a superficial
awareness of other children’s emotional and behavioral problems may not have an influence
on parents’ decisions around medication, but rather influence may arise out of particular
circumstances in which parents see evidence of “success.” The narrative below
demonstrates a positive exchange between parents of children with emotional and behavioral
problems that resulted in one of the parents changing her position on medication.

I know a lot of other parents, because, you know you start to talk. Obviously we
don’t hide this. Where a lot of people I think hide this and they pretend that there’s
nothing wrong, to the point where they say . . . [well for example] we have a
neighbor who was in denial for a long time about their son. Well, I have the BB
holes in my shed. And, you know, come on. Lie all you want. The kid’s got some
issues. Well, they finally got to the point where they’ve become open about it – it’s
like come out of the closet. And [now] we have a much better relationship. We've [also] got another neighbor that moved in a few years ago with three adopted kids. All from difficult situations, and the little boy was very evidently ADHD, and [had] a lot of issues.

And so she and I talked, and she finally made the decision to put him on medication, and they've seen a much better improvement. Cause, you know, he couldn't function in school. It was constant. You get a call about this, a call about that. And then we had another friend...my younger son, his best friend, we've always said...oh my God. This is like having Andrew here. And the more we interacted they would say, oh yeah, Andrew and he act so much alike. And so they've just started medication with him because they felt like they had to try it. And she's very anti-medication, so for them to try it...well, it was really affecting his ability at school. So, I don't know. I see both sides of it. If somebody could get away without medication, power to you. _Melissa_

Melissa's narrative, in which she discusses her relatively close relationships with two mothers whose children also have emotional, psychological, and behavioral problems, and who, seemingly as a result of Melissa's "successful" experience with medication for her son both decided to give medication a try, may help to explain why significant differences were found across the groups of parents on their awareness of particular kids' problems, namely, those of their friend's children, their relatives' children, and children in their children's classroom.

**Comparing Causal Attributions Concerning Origins of Children's Problems**

ANOVA results presented in Table 9 show the comparison between means on causal attributions concerning the origins of children's emotional, psychological, and behavioral problems across the four groups of parents. Measures of innate characteristics and parental influence were not found to be significantly different across the four groups of parents. With respect to responsibility and blame however, ANOVA results indicate that differences between the means on parenting skills and/or style are statistically significant ($p < .05$). Means in this case signify the extent to which parents believe that their parenting skills and/or style are responsible for their children's physical and behavioral characteristics. Higher mean values indicate parents' level of disagreement with the idea that their children's...
characteristics are a consequence of their parenting skills or style, which suggests they believe more strongly instead, that children's characteristics are innate. In this case, means increase incrementally across the groups, with parents of children with no emotional, psychological, and behavioral problems demonstrating the lowest levels of agreement with the notion that children's characteristics are innate and parents whose children are treated with medication demonstrating the highest.

Table 9. One-Way Analyses of Variance Comparing Means on Attributions Concerning Origins of, and Responsibility for, Children's Emotional, Psychological, and Behavioral Problems Across Four Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/no prob</th>
<th>Kids w/prob, but no diag</th>
<th>Kids w/diag, but no meds</th>
<th>Kids w/ meds</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innate Characteristics</td>
<td>Mean</td>
<td>7.68</td>
<td>8.00</td>
<td>7.71</td>
<td>8.35</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>2.24</td>
<td>2.49</td>
<td>2.33</td>
<td>3.01</td>
</tr>
<tr>
<td>Parental Influence</td>
<td>Mean</td>
<td>2.32</td>
<td>1.95</td>
<td>2.38</td>
<td>2.35</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.02</td>
<td>.86</td>
<td>1.07</td>
<td>1.27</td>
</tr>
<tr>
<td>Responsibility and Blame</td>
<td>Parenting Skills/Style</td>
<td>Mean</td>
<td>17.42</td>
<td>18.41</td>
<td>19.17</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>3.51</td>
<td>3.44</td>
<td>4.07</td>
<td>4.40</td>
</tr>
<tr>
<td></td>
<td>Other Blame</td>
<td>Mean</td>
<td>17.31</td>
<td>17.39</td>
<td>17.67</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>4.25</td>
<td>4.28</td>
<td>3.53</td>
<td>5.09</td>
</tr>
<tr>
<td>Brain Function</td>
<td>Cause of Misbehaviors</td>
<td>Mean</td>
<td>3.39</td>
<td>3.43</td>
<td>3.66</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.00</td>
<td>.90</td>
<td>.94</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>Brain Blame</td>
<td>Mean</td>
<td>2.76^d</td>
<td>2.95^c</td>
<td>3.34^bd</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>.76</td>
<td>.88</td>
<td>1.06</td>
<td>.97</td>
</tr>
<tr>
<td></td>
<td>Proper Care</td>
<td>Mean</td>
<td>2.74^d</td>
<td>2.85^d</td>
<td>3.00^d</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>.90</td>
<td>.86</td>
<td>.94</td>
<td>.89</td>
</tr>
</tbody>
</table>

* and Scheffe test results show that value is significantly different from value in column identified (a,b,c,d)
+ p < .10  *p < .05  **p < .01  ***p < .001

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Although the overall model demonstrates that there are significant differences in parenting style attributions between these four groups, Scheffe test results do not show that differences between any of the individual pairs of means are significant. It should be pointed out however, that these test results may be misleading throughout this entire series of analyses given the small numbers of parents in each group.

The extent to which parents perceive that others blame their parenting skills or style for their children's characteristics was not found to be significantly different across the four groups. In comparing brain function across the four groups of parents however, findings indicate that differences between the means on brain-blame \( (p < .001) \) as well as proper care \( (p < .001) \) are each statistically significant. In the case of brain-blame, mean values signify the extent to which parents agree that emotional, psychological, and behavioral problems are a consequence of physical/biological or genetic problems with the brain. Higher mean values indicate stronger agreement and lower mean values indicate weaker agreement.

In the case of proper care, means signify the extent to which parents believe that with proper nutrition, exercise, plenty of sleep, and discipline, most behavioral problems in children would disappear. Here, scores are entered in the opposite direction with lower means showing stronger agreement and higher means demonstrating weaker agreement. Therefore, in both cases, higher means demonstrate the extent to which parents believe that children's emotional, psychological, and behavioral problems are a function of problems with the brain. And again we see that means increase incrementally across the groups, with parents of children with no emotional, psychological, and behavioral problems demonstrating the lowest levels of agreement that these disorders are a function of problems with the brain and parents whose children are treated with medication demonstrating the highest.
Of the overall significant differences between the four groups of parents on brain-blame, significant pairwise differences are between: parents of children with no problems and parents of children treated with medication ($p < .001$), parents of children with no problems and parents of children with diagnoses but no medication ($p < .01$), and parents of children with problems but no diagnoses and parents of children treated with medication ($p < .05$). Results of a Kruskall-Wallis test, run on account of a low Bartlett's probability ($p < .05$), agree with ANOVA’s overall conclusion that there are significant differences between the four groups of parents on brain-blame.

In the case of proper care, the main contrasts lie between: parents of children being treated with medication versus parents of children with no problems ($p < .001$), parents of children being treated with medication versus parents of children with problems but no diagnoses ($p < .05$).

A clear pattern has emerged from analyses presented in Table 10: parents of children with no problems are significantly less likely to view children's emotional, psychological, and behavioral problems as a consequence of genetic, neurological, and/or biological factors than are parents of children with problems and, consistent with findings from previous analyses, this difference becomes greater as children's problems are formally diagnosed and then treated with medication. Examples of mothers' accounts of the bases of their children's disorders are presented below and help us to understand findings from quantitative analyses. Despite divergent diagnoses, comments from mothers whose children are taking medication are striking in their similarity regarding the origins of their children's problems.

My pediatrician ... said, "it has nothing to do with your parenting, or you as a mom, or any of that." It's the whole brain thing, and it can be hereditary. But it wasn’t until I did more research on it that I [realized] in my family, we had always made
reference to [my brother] who has full blown, full-blown, like big time – the
hyperactivity, the impulsiveness, everything. ADHD through the roof. And he
barely made it through school. My son doesn’t even have all of that.    Karen

When she first got diagnosed with Asperger’s I had to go around and explain to
everyone, you know, this is what’s going on and when you see these things they’re
just her. When we realized it was Asperger’s, it was like, whoa, this big awareness.
This big, light bulb went off, because before . . . you think it’s all behavior. It’s like,
come on, you can control this. Knock it off, behave. You know, or you try to figure
out ways to deal with the behavior. But dealing with Asperger’s, it’s not a behavior.
It’s more of a tic, or it’s something that they have no control over. None at all. We
had two zebra finches. She killed the first one because she squeezed it, you know. So
she can’t touch the [other] finch. And even with the dog. It’s funny, the dog knows
the difference between her and her sister. When her sister comes up the stairs, he’s
right there. But he stays away from her, because when she gets close, it’s like
Mmmrm.    Bryce

[My son] was always a little bit of a hyper kid. He was a hyper baby, and pretty active
toddler [but he] didn’t really start having major problems until after his sister was
born; he was six at that time. My [ex] husband, has a very strong family history of
mental illness, both his mother and his grandmother, were seriously mentally ill,
[though] they were never really diagnosed because it was so long ago. But they were
both in and out of the hospital all the time; they both had electric shock therapy. His
mother would become psychotically depressed. And then they would put her in the
hospital, and they would give her shock therapy, and then she’d be home for a little
while.

[My husband would] have meltdowns. He had meltdowns just like both my kids do
now. [I used to wonder if] their meltdowns were role modeling. Although, I am
more convinced that it’s not role modeling anymore, because he hasn’t been around
for 6 years, and [my daughter] was only 2 when he moved out. When [my son] was
diagnosed as being bipolar, that’s when all of a sudden it clicked with me that his
father’s bipolar, and that’s probably what was going on with his mother and his
grandmother too. And I see the patterns with both of them. Well, obviously [my
son] is diagnosed now, but even with my younger one, I see periods [in which she
seems manic]. She makes up stories, she does this creative play stuff, she’s like
Handel when he was writing the Messiah, you know? Da Vinci . . . all these people
that are supposedly bipolar.    Janet

What I find particularly interesting is how unambiguous these mothers’ sound in their
explanations of the bases of their children’s emotional, psychological, and behavioral
problems – now that they have had their children on medication for quite some time. When
juxtaposed against their recollections at an earlier point in the process or against mothers’
stories who are not “there yet,” we see a marked contrast, which is in line with ANOVA’s
findings. To explain further, according to quantitative results, we see that as parents become
more reliant upon the medical model — that is if they were to move through all stages of the
process, which not everyone does, they seem to move from no problem to suspicion of a
problem, to seeking a diagnosis, and finally treatment — they are less likely to blame
themselves for their children’s problems and more likely to consider a brain-blame narrative,
and ultimately, more accepting of psychiatric medication.

Qualitative data supports these findings in demonstrating the nuances of change as
parents progress through these stages. At earlier points in the process for instance, many
mothers’ narratives (including those of mothers above) suggest that they struggled,
wondering the extent to which their children’s problems might be their fault, whereas at later
points they are less likely to do so. And of course, there are many shades of gray between
stages. Sara recounts a particularly dramatic moment before she was finally convinced that
she should give medication a try. Like several parents from whom we heard previously, who
blame children’s emotional, psychological, and behavioral problems on other parents’ poor
parenting, Sara blamed herself.

I thought that it was my fault, and that if I could just, you know, be more patient. If
I could just give the behavior modification more time, if I divorced Dave, or if I only
could make the right atmosphere. If I was a neater person...because he gets
discombobulated by the mess, you know. If I could just keep the house always neat,
then he won’t go so crazy. I wasn’t really thinking very clearly. I was just feeling
like...I only had one real responsibility in the world, and I was totally failing. And
that if I put him on drugs it would be not because he needed them, but because I
failed. 

Sara

At a much later point however after trying and becoming more comfortable with
medication, Sara was saying things like:
Then [after medication] I was starting to tell everybody, like “Oh, if you’ve got problems, you’ve really got to try (this particular medication) . . . Now I can’t even believe I was living like that (i.e., pre-medication).”

Sara

Melissa’s account presented below is less dramatic than Sara’s, but we still see some concern that she feels she might be somewhat to blame. It is clear in the way she goes back and forth about possible causes, that while she does not feel completely responsible for the problems she perceives in her daughter, she is also far from confident. It is also clear that she is in an earlier stage of the process than many of the mothers above whose children are taking medication, but perhaps farther along than Sara was at the particular time to which she is referring in the previous narrative.

I know some of it might be my fault because I might be too critical, or whatever, but at the same time, it might just be her genetic personality, and then I really have no control over it. So if I had to [put her on medication], I would do it. The only reason I’m not doing it, is because I’m not sure if she’s still within the range of normal. And so I guess I’m waiting and seeing. She’s not totally unhappy. She threatens to run away. She actually packed her bag the other day . . . But I know it’s still normal. I was [also] thinking she was anxiety ridden. But she’s getting a little bit better, so it may just have been a phase. I mean, I wasn’t really going to medicate her unless [it got worse]. It’s one of those things where it’s a family trait. Because my husband’s family tends to be very depressed ridden. And both he and I are on anti-depressants. So I don’t know. It just may be a personality trait. [But it seems] that genetics does play an awful lot. Obviously not the end all/be all, but it plays a lot. I think people think that we have a lot more control over our children than we really do. That somehow they are just these lumps of clay and as a parent you form them into whatever, and if they turn out bad it’s your fault.

Melissa

Lauren’s narrative below demonstrates she is a farther along still than Melissa, in that her daughter has been tested at school and labeled with a non-verbal learning disability. She admits however that she’s “been thinking of having her tested privately [because] all [she has] to go on is the way the scores came out through the school testing.” This suggests Lauren feels she needs some confirmation of the school’s results, perhaps to go further with treatment. Indeed, Lauren explained that it is not something for which her daughter can be
treated medically and she said at another point during our interview that she would willingly go along with a “quick fix” in the form of a pill if she could. She describes the problem as neurological, but goes on to say that there is nothing “scientific” to suggest that it is hereditary. This seems to bother her, which she indicates by telling me twice that there were never any head injuries. Like Melissa, she seems to be feeling unsure of the origins of the problem, which is consistent with being in the earlier stages of this process.

It's a white matter problem in the brain, and it's really not supposed to be hereditary, it's neurological. But I don't know how really [she] got it, because we didn't have any kind of head injury problem. They said that they haven't scientifically connected it to be hereditary, but my sister and my father have the same sort of problem, so I think that it might be hereditary... and on the internet they talk about the same thing. Like somebody will write, I have this and my child has it, so I think that scientifically they haven't connected it to be hereditary like ADHD is, but I think that it is, because we haven't had any head injury problems. It's the right hemisphere of the brain. It's more neurological than anything.

Lauren

Much further into our conversation, Lauren also expressed relief that her son did not exhibit any of the same problems, which to her meant her daughter's problems were not a consequence of the way she may have treated or not treated her. It seemed apparent that it was something about which she had spent a lot of time worrying but, that she no longer believed this to be true demonstrates her progression through the stage of self-blame.

I think having another kid, and knowing that you didn't do a thing different between them, and [knowing] that [my son's] personality is totally different, that it isn't anything that I did that made her so withdrawn makes it easier for me to see that her personality is the way that it is because it's just the way she was born, with genetics, or whatever. That makes somebody either outgoing or not, you know? And I guess in some ways I feel better about that because I can remember when I first found out about this... [my son] was only like a year and a half old. And I knew she was not responsive. When you would ask her something, half the time she wouldn’t respond or you couldn’t hear a verbal response. And I would sometimes think that it was the way that I brought her up or I wasn’t engaging enough with her... but now [with my son I realize] I wasn’t really any different. In fact, I would have been more engaging with her because she was the oldest and I had all the time in the world. And
when I had him, it was a split so I wasn’t as engaging with him as I was with her. And he is so all over the place, you know. He’s very verbal as far as interacting with people. And so I do feel that it’s just the way that she is. You know, it doesn’t have anything to do with the way that I treated her or I did or didn’t do something.

Lauren

Narratives above typify various points at earlier stages of the process through which mothers of children taking medication have progressed before treating their children medically—from the time they first suspect their children have problems and are apt to blame themselves, until they are confronted with making decisions around seeking diagnoses and subsequent treatments. Karen’s and Bryce’s narratives below are suggestive of mothers in later stages who now seem to “really understand” their children’s problems and begin to take on roles as their children’s advocates:

I, for the most part, did not have many good experiences with the school. And had many frustrations with it, to the point where that’s one of the reasons why my youngest goes to another school. [It was] different things . . . how they deal with behaviors, and the bullies and the self-esteem . . . and all that other kind of stuff. And I just had really bad experiences. Like my older son’s elementary school . . . I [would] not put another child through . . . [given] the [lack of] support. I really, really . . . I had to ride their asses, quite frankly, big time, to not let him fall through the cracks. It was very frustrating to make sure that assessments got done. I mean, I was like, this is just not right. Why am I the one to say my child needs a 504? You know what I mean? You guys are supposed to do that stuff.

Karen

Um, well, when [she] was in sixth grade she had a teacher who, I don’t know, you know I gave her all the information on Asperger’s, and she never took the time to read it or even try. It was very frustrating that year. After that year I quit my job at the school, because I thought I’m going to end up home-schooling her because I wasn’t getting any support. And [feeling] very frustrated, you know, like I’d say [she] needs to use . . . Alpha Smart — [its like] — a keyboard . . . for two reasons. First of all, her writing words, you know, was not legible at all. And also it helped her to slow down. And it doesn’t correct anything or anything. [But], her teacher was against that because, you know, she wanted to see if she had grammar errors or whatever. And [I said], just print it up as it comes up on the computer and don’t let her change it. You know, it was like a constant struggle with this woman.

And then she’d grade her on her penmanship . . . and I’m like, you can’t do that. You can’t, because she can’t control that and slow down. If you let her use the Alpha

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Smart, she can slow down a little bit to where she’s thinking [about] the words and the spelling and... but, if you’re [making] her write it, forget it. You know, she’s going a hundred miles an hour. And [this teacher] would mention, like behavior things. You know, like [your daughter]’s going “Mmmrmmm” all the time, or you know, moaning. And I’m like “yeah, that’s [her].” You know, she has to do that. If you don’t like it, wear ear plugs. No, I didn’t say that. But, you know, it was like, really, you know, those are the things that are about [who she is].

Sentiments voiced by Karen and Bryce in which they are beginning to fight for their children, represent a stage of coming to terms with their children’s difficulties, not seen in mothers still at earlier points in the process. With findings from quantitative analyses alone, we would have been unable to get any sense of process over time, but with the addition of mothers’ stories, most of which are in line with results from quantitative analyses, we are able to see patterns that suggest fairly consistent stages through which parents under similar circumstances may progress.

Comparing Parents Ideas Regarding the Best Ways to Respond to Children’s Problems

To gain a more in-depth understanding of how parents may differ around their conceptualization of children’s emotional, psychological, and behavioral problems a series of chi-square analyses were performed comparing only parents whose children have been formally diagnosed — both those who treat their children’s problems with medication and those who do not — on their ideas regarding the best ways to respond to their own children’s problems. Findings are presented in Table 10. No significant differences between the two groups of parents were found in terms of general disagreement with the other parent around diagnoses and treatment. In asking respondents about what specifically they and their child’s other parent may have disagreed however, significant differences were found between the groups on the types of treatment ($p < .01$) and approaching significance on the diagnosis itself ($p < .10$). One hundred percent of respondents whose children have been diagnosed
but are not treated with medication reported being in disagreement with their child's other parent around the diagnosis itself compared to 57% of respondents whose children are treated with medication who reported any disagreement. In the case of disagreement between parents on types of treatment, 100% of respondents whose children are treated with medication, reported disagreement around types of treatment, compared with only 25% of parents whose children do not take medication.
Table 10. Chi-Square Analyses: Parents’ Ideas About the Best Ways to Respond to Children’s Emotional, Psychological, and Behavioral Problems by Two Groups

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/ diag, %</th>
<th>Kids w/ meds %</th>
<th>X²</th>
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<tr>
<td>Agree w/ Doctor re: Diagnoses</td>
<td>94.3</td>
<td>93.8</td>
<td>95.2</td>
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<td>28.6</td>
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<td>Regarding What Specifically:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Severity of Child’s Problems</td>
<td>64.3</td>
<td>71.4</td>
<td>57.1</td>
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<tr>
<td>Necessity of Diagnoses</td>
<td>63.6</td>
<td>80.0</td>
<td>50.0</td>
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<tr>
<td>Diagnosis Itself</td>
<td>75.0</td>
<td>100.0</td>
<td>57.1</td>
</tr>
<tr>
<td>Necessity of Treatment</td>
<td>54.6</td>
<td>25.0</td>
<td>71.43</td>
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<tr>
<td>Types of Treatment</td>
<td>72.7</td>
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<td>100.0</td>
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<tr>
<td>Blame Other Parent for Child’s Problems</td>
<td>37.5</td>
<td>66.7</td>
<td>20.0</td>
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<tr>
<td>Other Parent Blames You for Child’s Problems</td>
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<td>33.3</td>
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<tr>
<td>“Other”</td>
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<td>Very Difficult</td>
<td>16.1</td>
<td>8.8</td>
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<td>Somewhat Difficult</td>
<td>55.4</td>
<td>52.9</td>
<td>59.1</td>
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<tr>
<td>Not at all Difficult</td>
<td>28.6</td>
<td>38.2</td>
<td>13.6</td>
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<td>Alternative Treatments</td>
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<tr>
<td>Individual Therapy</td>
<td>83.3</td>
<td>78.3</td>
<td>89.5</td>
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<td>Family Therapy</td>
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<td>16.7</td>
<td>62.5</td>
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<td>Chiropractics</td>
<td>14.3</td>
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<td>9.1</td>
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<td>Special Diet and Exercise</td>
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<td>33.3</td>
<td>33.3</td>
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<td>Residential Treatment</td>
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<td>21.1</td>
<td>41.7</td>
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<tr>
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<td>87.9</td>
<td>87.0</td>
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<tr>
<td>No</td>
<td>5.4</td>
<td>3.0</td>
<td>8.7</td>
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<tr>
<td>Unsure</td>
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<td>9.1</td>
<td>4.2</td>
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<td>Felt Pressured into Treatment</td>
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<td>13.0</td>
</tr>
<tr>
<td>Refused Treatment</td>
<td>18.5</td>
<td>21.2</td>
<td>14.3</td>
</tr>
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*p < .10  **p < .05  ***p < .01  ****p < .001

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In the case of the question of difficulty around treatment decisions, 27% of respondents whose children are treated with medication reported the decision was very difficult relative to approximately nine percent of those respondents whose children are not treated with medication. Consistent with this finding, roughly 38% of respondents, whose children are not treated with medication found the decision to be not at all difficult, compared to about 17% of parents of children treated with medication. According to chi-square test results, these differences are statistically significant ($p < .05$).

Regarding treatments other than medication, parents were asked about a number of alternatives, but there was only one significant finding: family therapy ($p < .01$). Among parents who have not treated their children with medication, fewer than 17% have tried family therapy compared to almost 63% of parents whose children are treated with medication who have tried it. No significant differences were found between groups of parents on feeling treatments were effective, feeling pressured into treatments, or refusing treatments. As before, because of potentially thin cells, I also ran Fisher's exact tests for each variable. Only one contradiction was found between the two tests: the difference between the two groups of parents on disagreement around their children's diagnoses is not statistically significant according to Fisher's exact test results, which means we should discount chi-square's findings that there is a significant association.

To summarize, with regard to parents' ideas about the best ways to respond to their children's emotional, psychological, and behavioral problems, very few significant associations were found, but they are worthy of note. Despite results of a Fisher's exact test showing that the differences found on disagreement around the diagnosis itself and types of treatment between the two groups were not statistically significant, in asking respondents about what specifically they and their child's other parent may have disagreed there is a trend
showing significantly greater disagreement around the diagnosis itself among parents of children who have been diagnosed, who are not using medication, and greater disagreement around types of treatment among parents of children using medication.

Regarding the diagnosis itself, it may be that parents whose children are taking medication are much farther along in their process of acceptance and have largely settled any earlier disagreements around obtaining diagnoses, whereas parents of children who are not taking medication may still be in relatively early stages, having just received a diagnosis. Given the mean age of children on whom parents are reporting in this group, which is significantly younger than the mean ages of children on whom parents are reporting in all other groups (see table 3), it seems reasonable to assume that these parents may still be new to the idea of medical labels and possibly uncomfortable with them. Given previous findings, it seems likely that these same parents may also be confronted with considerable challenging problematic behaviors, which tends to increase parental stress and foster disagreements.

Significantly greater disagreement on types of treatment among parents whose children are taking medication is consistent with the finding that 86% of parents of children taking medication found the decision to be either very difficult or somewhat difficult, as well as the finding that there is a significant association between parents in this group and trying family therapy. All told, when considering these findings in the context of the challenging behaviors with which these parents are confronted suggests again, a stressful environment promoting parental disagreement around this issue.

Two different scenarios are presented below in which parents whose children are currently taking medication are still having some form of disagreement around both the diagnosis and the issue of medication.
I think some of this is just denial with him. He doesn’t want to think that his kids have any problems at all. And he’ll say to me, just because a kid doesn’t sit and play quietly, you think there’s something the matter with them. And for a long time he was talking about the fact that it was a result of my poor parenting skills. So I think, even though [he] is very traditionally medically oriented, that’s from a physical standpoint. I mean, if the kids had a broken leg, or appendicitis, or something like that, he’d be all for doing whatever, but this stuff was more mental health, which is a lot different, and you know, it really ends up by coming back to make him look at himself.

Janet

It was definitely a struggle between my husband and I. My husband definitely stayed in denial. [He’d say], “No, there’s nothing wrong with him, he’s this, he’s not that, you know.” That male ego. “He’s my son. He’s just a boy. He’s fine. This is how boys are.” And I kept saying no, I don’t think so. [And then, even after he finally agreed to the medication, my son was having some breathing problems during football practice] . . . And right away, my husband says it’s that damn medication, that’s it, he’s not taking it anymore. He doesn’t need it, he’s fine. Just like that. I’m like, what? But, I mean the first thing . . . my husband was convinced it was the medication . . . and I feel, I that I think it bugs him because I think it’s the slight egoman mental thing. That [he] feels [his] son’s not like whole.

Karen

Both Karen’s and Janet’s remarks are in line with past research, which suggests that fathers are less likely than mothers to consider their son’s behaviors as indicative of emotional, psychological, and behavioral problems (Singh 2004). Sara’s situation is somewhat different because she has recently remarried, so her husband was both new to the problems she is having with her son, and new to parenting generally, which only added to their potential for conflict. She recounts the early days when they were first married.

Yeah, so at first my husband was saying that I was spoiling him, and that I let him get away with anything. And he was on the side of corporal punishment. And he took it upon himself to start slapping Blair’s hand if he was sucking his thumb. And, Blair had a real strong need for that and it was soothing to him. So this was not the best beginning between two people. And Dave thought that I always took Blair’s side, I spoiled him, he was too dependent on me. And that I excused his behavior. And I think I was totally right and he was totally wrong. [But] when we got the diagnosis, and when he saw what the medication did, and he saw the way Blair is when he’s not in the throes of mental illness, he was like, “oh, maybe I do need to figure out how to parent a little bit.” So . . . after that then I think he did a little bit of research. We both read One, Two, Three, Magic, and had good luck with that, and he started having some alone time with Blair, so it’s been better, and now, [we found out that] Blair doesn’t process information well, so talk therapy is a waste of time, so
we're going to see a behaviorist. And so we're having one come, hopefully, this month. And we agreed to just say, "okay, we're both out of ideas, so you tell us what to do." So that's our plan now is to just give up and let somebody else tell us what to do — and do it.

Sara

It is easy to imagine that even with two parents in synch on parenting issues that parenting a child with emotional, psychological, and behavioral problems might create conflict, but Sara’s narrative provides us with a rich, concrete description of the kind of toll these circumstances could take on a new marriage.

Melissa’s recounting is of conflict around a hypothetical situation. Her daughter has not been diagnosed, but because Melissa is concerned about the possibility of depression and/or anxiety, she has brought up the possibility of medication with her husband and been met with resistance. She goes on to explain that in her experience as an elementary school teacher, this is a common disagreement among parents with whom she interacts whose children have emotional, psychological, and behavioral problems.

My husband would have some feelings on [medication if it became an issue]. Because when [my pediatrician] first mentioned it, and I mentioned it to him, he said no, I don’t want my child on medication. Now, as I’ve been [explaining things to him] he just sort of nods his head [indicating he would acquiesce if] she needs to be on medication, but I think he would have some anxiety too. As I would too, I mean it’s not something you do lightly. So yeah, his first impression was no. No way. Which I do find common in parents that I talk to. It’s usually one parent or another who puts their foot down and says no. And it’s not always the father, but I’m usually talking to the mothers. And they’re like oh...he just won’t let me.

Melissa

Less common according to both Melissa above and prior research is when the father is pushing for diagnoses and treatment but the mother is resisting, but as we see in Veronica’s lengthy narrative below, it happens.

He’s now taking Ritalin. I didn’t want him to take it. I think they’re too quick to judge kids, given, the hectic-ness of everything, they’re too quick to say, well, you know, he has this or she has that...let’s give him this. And I was dead set against it. But they say he has ADD, and this is helping him focus. I honestly don’t know if it’s
truly helping him at school — [since he just started it two days into third grade . . .
maybe he can just pay attention better this year.]

In first grade they noticed that he was reading way below first grade level, so they did
testing for dyslexia and learning disabilities, and the psychologists . . . or I don't know
what they're called, said that he has an inability, or hard time recalling short term
memories. Like you could tell him something and then five minutes later, he
wouldn't remember. Okay, but he wasn't diagnosed then, and then in second grade
. . . this is where it gets complicated. His father and I are no longer together. So his
father now lives with somebody who has a child a few months older than [my son]
who has ADHD. So his father keeps comparing the two together . . . and he's one
child, ours is another. They're two totally different households, two totally different
children, two totally different settings, everything. He keeps comparing them to each
other . . . and we're at odds with this medication because his doctor says he only
needs it for school. And he doesn't need it on the weekends unless there's something
that he really needs to be focused on. Well, his father says, he needs to be focused
on life everyday. So when I have him on the weekends, I don't give it to him. And
when he has him, he wants him to take it.

So . . . it's hard . . . and well, [my son seems to] think . . . and I think it's from listening
to his father, and the doctor that taking this pill helps [him] focus. Helps [him] pay
attention. So he doesn't mind taking it. He swallows it, and he goes about his
business, but, like I said, I don't give it to him when he's here with me. And he just
had two weeks off and he didn't take it the whole time he was here. Only when he
was with his dad. Cause I don't have problems with his behavior at home, or
anywhere else. I mean, he's a typical kid. I know at that age I didn't always pay
attention or always listen. But he's a generally good-hearted, good-natured, well-
behaved kid. I have no complaints at all. Yes, we have our yelling matches. But you
know, he's a typical kid.  

Veronica

While it may be unusual, that Veronica is the one arguing against medication, rather than her
ex-husband, their issues are very likely the same types of issues around which many parents
disagree — and certainly in line with findings from quantitative analyses. Indeed, the above
narratives provide vivid descriptions of the types of disagreements parents are likely to have
around diagnoses and treatment, in addition to possibly contextualizing why 63% of parents
of children on medication have tried family therapy.

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Comparing Means on Influential Factors Around Treatment for Children's Problems

In comparing means on influential factors around treatment for children's emotional, psychological, and behavioral problems, again, comparisons were made on the same two groups of parents. ANOVA results presented in Table 11 show that differences between the means are approaching significance in the case of two factors: children's academic performance ($p < .10$), and availability and cost of services ($p < .10$). Differences between the means are statistically significant on two factors as well: children's behavior ($p < .01$), and recommendations from specialists ($p < .05$). Higher means are a sign of the extent to which these items were influential in parents' decision-making around treatment or services for their children. We see that children's behavioral issues are the most influential factor, followed by recommendations from specialists, availability and cost of services, and children's academic performance. In all cases, means increase across the two groups of parents with parents of children treated with medication demonstrating the highest means, except for in the case of availability and cost of services, where we see that the mean is higher in the case of parents of children who are not treated with medication. It makes intuitive sense that problems with availability and cost of services would influence parents in the opposite direction. In other words, it stands to reason that the greater the influence of cost and availability of treatments on parents' decisions, the less likely they will be to utilize treatments.
Table 11. One-Way Analyses Of Variance Comparing Means on Influential Factors Around Treatment Across Two Groups of Parents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kids w/ diag, but no meds</th>
<th>Kids w/ meds</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 35</td>
<td>N = 23</td>
<td></td>
</tr>
<tr>
<td><strong>Influential Factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s Academic Performance</td>
<td>Mean</td>
<td>2.92</td>
<td>3.48</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.30</td>
<td>.93</td>
</tr>
<tr>
<td>Child’s Behavior</td>
<td>Mean</td>
<td>8.43</td>
<td>11.38</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>4.16</td>
<td>3.23</td>
</tr>
<tr>
<td>Family’s Emotional Well-Being</td>
<td>Mean</td>
<td>10.03</td>
<td>10.62</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>2.35</td>
<td>2.09</td>
</tr>
<tr>
<td>Availability and Cost of Services</td>
<td>Mean</td>
<td>2.15</td>
<td>1.62</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.18</td>
<td>.97</td>
</tr>
<tr>
<td>Child’s Request</td>
<td>Mean</td>
<td>1.61</td>
<td>2.10</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.00</td>
<td>1.17</td>
</tr>
<tr>
<td>Ideas re: whose competent to address children’s problems in terms of Recommendations from:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatricians</td>
<td>Mean</td>
<td>2.53</td>
<td>3.05</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.31</td>
<td>1.07</td>
</tr>
<tr>
<td>Specialists</td>
<td>Mean</td>
<td>6.97</td>
<td>9.44</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>3.33</td>
<td>3.54</td>
</tr>
<tr>
<td>School Personnel</td>
<td>Mean</td>
<td>2.88</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.12</td>
<td>1.14</td>
</tr>
<tr>
<td>Friends or Family Members</td>
<td>Mean</td>
<td>1.97</td>
<td>2.28</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>.90</td>
<td>1.19</td>
</tr>
</tbody>
</table>

+ p < .10  * p < .05  ** p < .01  *** p < .001

As above, recommendations from pediatricians and school personnel seem not to be influential in terms of treatment decisions for parents whose children are treated with medication. It seems likely that parents of children with emotional, psychological, and behavioral problems approach their pediatricians first, but when it comes down to making
decisions about medication, which as we have seen are frequently fraught with conflict, this group of parents sought out advice from specialists in the field.

As Melissa expressed in her explanation of a child’s medication change in her class, “they were thinking he was bipolar. But, it was just a pediatrician, which I thought, you know what, I would know more than just a regular pediatrician. [If it was my child] I would go right to the top of the food chain.” Of all the mothers I interviewed in fact, Melissa is one of a handful who has not taken her child to a specialist though she has made it very clear that in her opinion, only specialists are competent to respond to children’s emotional, psychological, and behavioral problems.

Apparently, the other mothers with whom I spoke agree with Melissa, as do 47% of mothers whose children were diagnosed with emotional, psychological, and/or behavioral problems, who took their children to specialists. Insofar as the type of specialists to whom the mothers I interviewed are taking their children, all but four were seeing a combination of child psychologists, pediatric neurologists, child psychiatrists, and behavior specialists at the time of our interview. Of the remaining four, Meredith was taking her son to a Communication Disorder Clinic, and Kaitlyn was looking for a child psychiatrist. Karen did not take her son to anyone other than her pediatrician, but her brother is a pharmacist and she consulted with him on all medication decisions. Lauren had thus far consulted only with the behavior specialists at her daughter’s school, which included the school psychologist. In addition, she regularly consults with her sister-in-law, who has worked as a behavior specialist in the public school system for over 30 years.

According to ANOVAs’ findings, as noted above, in addition to recommendations from specialists, children’s behavioral issues are the most influential factors around parents’ treatment decisions. These two factors are followed by children’s academic performance.
and availability and cost of services. Children’s academic performance was anticipated, but I was surprised that availability and cost of services was a significant influential factor, given the socioeconomic status of most respondents and the fact that no significant differences were found across groups of parents on income. Further, none of the mothers with whom I spoke mentioned cost of services, and only one mentioned availability.

Given the types of issues with which the mothers I interviewed have been confronted I was also somewhat surprised that family’s emotional well-being was not a significant factor as I expected both children’s behavior and family’s well-being to be equally influential. In thinking about it, however, after a careful analysis of in-depth interviews, and looking at how close the mean values are for both groups of parents on emotional well-being, I now see that it is understandable. Given that the means are pretty equal in both groups of parents demonstrates they are similarly concerned about their family’s emotional well-being. Both internalizing and externalizing behaviors were found to be significantly greater among parents of children taking medication than among parents not treating their children with medication (see table 4) however, which suggests that the tipping point for parents might be extreme behavioral issues.

Indeed, several extreme behavioral issues were seen in the dramatic narratives presented above in examining mothers’ attitudes towards psychiatric medication. Janet’s son was suicidal, banging his head against the wall and threatening to run in front of a car, while Sara’s son was destroying their house and hurting people. In a later section we discovered that Bryce’s daughter was becoming more withdrawn and introverted, not doing well academically or socially and regularly making inappropriate vocal sounds. Not quite as dramatic, but clearly extreme according to these mothers, the three narratives below recount
the points at which Karen, Melissa, and Shanna decided to put their children on AD/HD medication. Within the context of each narrative, academic performance is also included.

He was starting to go down hill in school. And I could just see that he could not sit down and focus on anything. I mean, he could not . . . and he still, to this day, I cannot give him a book and say you need to go read for ten minutes and send him to his room. ADD or ADHD . . . forget it, you're sending him to zone, and ignoring him – which I don't mind doing sometimes – but he just can't do that. You know, just for him to sit down, and anything complex, he can't. And it was affecting him. And it was really starting to affect his self-esteem and his grades. And because he was having such a struggle, he didn't know how to ask for help. So certain little behavioral things would start to come out in the classroom. He'd try to be like the class clown, to get that attention. And it doesn't matter, whether the attention was negative or positive, for him. And he finally, basically, came to like a breaking point. And he was like, "mom, I want to go to the doctor. I can't focus, I can't concentrate."

Karen

I wanted an active child. But he's always been very curious, very talkative, very, very . . . and his vocabulary skills are well beyond his age. He takes a lot of energy. When he comes in a room, the dynamic changes. And it focuses around Andrew. So, I guess we probably always knew, but it kind of got triggered in preschool that there were issues, attention issues, hyperactive issues. And we started seeing a psychologist when he was five. I think [my husband, myself, and the preschool teacher] all kind of came to the consensus at the same time. You know, it was never an "oh my God, you're kidding me." It's always just been known, that he's always been that way. And, that was just always Andrew. When Brian came along, [we could see he] was very different. Because we got pregnant after we adopted Andrew. So in the span of a year we had two kids. There's a two year difference between them. But there's always been that marked difference in personalities. So we pretty much had him diagnosed, formally diagnosed [with AD/HD] when he was in the first grade. And he went on medication then . . . which probably wouldn't have been my first option, but we knew that he needed it to function in school, or it was not going to go well.

Melissa

[My son's] medication situation actually came about as a very big surprise. It was kind of accidental for us to realize what was going on. Um, he was almost 8 years old, and was still wetting the bed. So I took him to see the doctor. We had already tried the mat. Tried waking him up in the middle of the night. It didn't matter what we tried. He was still wetting the bed. So we took him to the doctors, and the doctor decided to try [this] anti-depressant that helps with bedwetting. Yup. So we put him on that, and we kept him on it for about three months. And it just wasn't helping [with the bedwetting]. So we decided to stop the medication. When we stopped the medication, all of a sudden this child came back that was argumentative. He didn't
think before he spoke, he was constantly go go go go go. And his mouth was a mile a minute, and I hadn’t realized that while he’d been on this medication, he had been such a wonderful child. He was back to normal. And I hadn’t realized exactly how much of a handful he was. Until after he got off the medication. And uh, so I went back to talk to my doctor, and he found it very interesting as well and recommended that we go see a child psychologist, which we did, and the child psychologist looked me straight, point blank and he says, it looks like you know what the answer to your problem is. Because, while my son was on the medication, he was pleasant, his grades got better. It was very, very nice. So we put him back on the medication, and once again, my wonderful child came back. It was a drastic difference.  

Shanna

Qualitative data illustrate the extreme behaviors that tipped the scales for parents in favor of putting their children on medication. While all parents are ostensibly concerned with their family’s emotional well-being, it appears it is not until it is actually threatened by what they perceive as extreme behaviors, that they take equally extreme measures in an effort to control it. Again, qualitative findings are in line with findings from quantitative analyses and provide us with vibrant images, which help to illustrate and explain influential factors in mothers’ decision-making processes around treating their children with medication.

In sum, findings above demonstrate that decisions to medicate do not come easily to parents of children with emotional and behavioral problems, despite what people not exposed to these issues may believe, and parents are hardly provided with a “quick fix” in the form of a pill as indicated by the great lengths to which parents had to go to finally find a medication that “worked.” Academic performance and behavioral problems seem to be the most influential factors when it comes to deciding between various forms of treatment, especially when seen in the extreme.

In the following chapter I offer further interpretation and implications of these findings and provide directions for further research.
In this project, my goal was to examine how Americans conceptualize children’s emotional and behavioral problems in an effort to account for the disjunction between steadily rising psychotropic prescription rates for children in the United States and most Americans’ negative attitudes towards the use of such medication for children. Given that Americans’ opposing viewpoints seem to be driving both escalating prescribing trends for children as well as the ensuing legislation attempting to curb them, findings described in the present study have a number of implications. In the main, how the American public evaluates children’s emotional, psychological, and behavioral problems may have some direct bearing on its support for a range of possible societal responses.

A key finding from the present study is that the majority of respondents’ attitudes towards children’s use of psychiatric medication for emotional and behavioral problems are consistent with the attitudes of most Americans. That is, they are largely negative unless respondents themselves have children for whom medication has been prescribed – in which case they are much more accepting – but even then findings suggest that there are a series of stages through which these parents progress that begin with similarly negative attitudes before ultimately reaching acceptance.

Additionally, many parents who oppose psychiatric medication for children appear to be very critical of those parents of children for whom medication has been prescribed.
These critics seem to believe that the behaviors that purportedly warrant the use of such medication are largely normal behaviors by which parents are simply annoyed. To the extent that these behaviors are exaggerated in particular children, critics attribute their cause to poor parenting practices. Consequently, parents who do not believe in psychiatric medication for children believe that parents who rely on medication are looking for a quick and easy solution for a problem that they themselves created. Ironically, the medical intervention used for children's emotional and behavioral problems seems not to provide parents with nearly the relief that its critics seem to imagine. In fact, medication often creates added burdens associated with the need to continually monitor and frequently change treatment.

The finding above, when viewed in conjunction with the lay public's largely negative attitudes towards the use of psychiatric medication for children, support McLeod et al.'s (2004) assertion that, despite rising prescription rates concurrent with the changing knowledge base around mental health issues, the medicalization of children's emotional and behavior problems is not complete. Findings from the present study also support McLeod et al.'s (2004) assertion that existing prescription rates may not be a reflection of the extent to which Americans attribute children's emotional, psychological, and behavioral problems to medical disorders. In fact most of my respondents do not. When parents were specifically asked for example whether they believe most children's emotional and behavioral problems are a function of problems with the brain, 44% report feeling unsure and 30% disagree entirely, leaving only 26% who believe children' problems are a function of problems with the brain. Of this group, only 12 parents strongly agree that most children's emotional and behavioral problems are a function of problems with the brain, nine of whom have children with diagnoses and four of these children take medication. Of the remaining
48 parents, 22 have children with diagnoses, 12 of whom take medication. In other words, in the entire sample, there are only 29 parents (12%) who agree that most children's emotional and behavioral problems are a function of the brain – only three of whom strongly agree – whose children have not been diagnosed with any disorder. Given the number of children in the United States for whom psychiatric medication is currently being prescribed, this phenomenon is puzzling.

In what follows below, I offer a discussion of the ways in which parents in the present study think about children's emotional, psychological, and behavioral problems and how they believe children with problems should be treated.

Thinking about Children's Emotional, Psychological and Behavioral Problems

Culture of Shared Experience

Because the voices in this research represent individual parent’s experiences, I cannot make generalizations beyond this sample, but I can say that their voices are consistent with each other as well as the quantitative findings from this study, and a large body of literature located at the intersection of medicalization and mother-blame. So while I may have presented unique experiences, similar to Singh (2004) I have done so against an ideological backdrop comprised of participants' shared cultural knowledge. In other words “individual experiences resonate within this particular group of participants and are likely to be resonant with the experiences of other individuals from similar social and cultural backgrounds” (p. 1195).

The mothers with whom I spoke participate similarly in what Landsman (1998) refers to as a “community of shared experience.” By this she means, upon becoming mothers of disabled children, a transformation occurs involving a shift of identity from one's
prior identity – created in another culture – to “mother of disabled child” (p.76). Indeed, two of the mothers I interviewed explicitly expressed that their experiences with their children had completely transformed them, not only as parents, but as people. They found that they were less judgmental of others – especially of other parents – and more accepting of decisions that other people make with the realization that people are often thrust into circumstances they never previously imagined.

Correspondingly, narratives from mothers whose children were taking medication, described in painstakingly similar detail the trajectory of their experiences, which, ultimately transformed them, though they may not have expressed it as such. Their stories always began with their feelings of guilt as they initially blamed themselves for their children’s problems, the angst they suffered at the thought of giving their children psychiatric medication, their sense of defeat when they came to the realization that medication was the only viable option, the frustrations they felt as they tried numerous medications with varying degrees of success that needed to be weighed against negative side effects, and finally the relief they experienced when they found something that “worked.” And as Singh (2004) found for mothers who treated their sons with Ritalin, once mothers in my sample found effective medication for their children, they too felt they were finally empowered to “do something,” requiring careful “discussion, monitoring, and repeated dosing” (p.1201).

As Singh (2004) suggests, the ritual around medication as well as the medication itself, seems to serve as evidence of the legitimacy of their children’s problems, demonstrating they are caused by biological or genetic factors, for which no one can be faulted (2004). Finally, once mothers in my sample relinquished feelings of responsibility for their children’s behaviors, they too became advocates for them and began to educate others.
about their particular configuration of problems and ensuing medical needs, as they had educated themselves.

These mothers’ narratives suggest a process of acceptance with a series of similar stages through which each have progressed. As they recount their feelings at earlier stages, their stories are strikingly consistent with mothers’ stories whose children are not (yet) on medication. Combined with results from quantitative analyses, showing that parents who varied by their level of utilization or reliance on medical labels and treatments differed progressively “across the board” on all dimensions assessed, the notion of a common process is bolstered. In other words, clear patterns emerged from both quantitative and qualitative analyses suggesting fairly consistent stages of a process through which parents under similar circumstances may progress. In the following section, I present the stages through which parents in my study appear to have traversed.

Self-Blame. According to Singh (2004), mothers recounting of their early experiences with their sons prior to diagnoses included feelings of self-blame and inadequacy, all of which centered on the pervasive ideal of the good mother, against which no one felt they compared favorably. Two dominant themes elaborating the good mother ideal that emerged from mothers’ narratives in Singh’s analyses were their feelings of responsibility and anger. Responsibility was tied to mothers’ abilities to solve the problems their sons were having as they believed they would have been able if they were better mothers and the subsequent anger they experienced was what they often felt towards their sons’ behaviors. Any expression of their anger however, led them to feeling deeply ashamed and guilty given that they believed their inadequacies were keeping them from controlling their sons’ behaviors in the first place. In short, in expressing their anger, they confirmed to themselves that they were bad mothers (2004).
These feelings of anger and inadequacy were recurring themes in the narratives of many of the mothers with whom I spoke as well. In recounting their feelings about their children’s behaviors prior to diagnoses, mothers indicated that they frequently felt angered and embarrassed by their children’s behavior and at the same time guilty and inadequate.

Recall Melissa who had this to say about feeling angry:

We think that we constantly yell. And we keep saying we’re not going to do that. But we can’t help it. [His behavior] drives you there, and it’s like there’s this cliff, and you get to that point, and you’ve gone over the edge and you can’t stop it... It’s very stressful when you get to the point where [you just know] this is going to be awful... And you say to yourself, alright. I’m going to handle this better [next] time. I’m not going to get so angry. I’m not going to get so emotional about it.

And about feeling embarrassed, Melissa went on to say:

We used to get really embarrassed. You know?... part of it is you feel like everybody looks at you. For the longest time at school, he’d get in trouble about something. And I’d feel mortified that all these other mothers... think that I’m not raising this child properly. They think it’s me. It’s a reflection on me.

Melissa’s narrative is both characteristic of the feelings experienced by many mothers in my project and representative of the same type of self-blame in which Singh’s (2004) mothers engage. And as demonstrated earlier, findings from quantitative analyses also suggest that parents, typically mothers, are more likely to engage in self-blame, during pre-diagnoses, rather than latter stages. This is evidenced by the incremental differences found in the extent to which each of the four groups of parents (1] parents of children with no emotional, psychological, or behavioral problems; 2] parents of children who believe their children might have problems though no formal diagnoses have been made; 3] parents of children who have received medical diagnoses but who are not using medication; and 4] parents who are treating their children's problems with medication) attributes the origins of children’s emotional and behavioral problems to parenting skills and style as opposed to genetic or neurological problems with the brain.
Statistically significant differences were found on three key variables having to do with attribution of cause: 1) the extent to which parents explicitly attribute children’s problem behaviors to parenting skills or style; 2) the extent to which parents explicitly attribute children’s problem behaviors to genetic or neurological problems with the brain; and 3) the extent to which parents implicitly attribute children’s problematic behaviors to parenting skills or style insofar as they believe children’s problem behaviors would disappear with proper nutrition, exercise, plenty of sleep, and discipline. In all cases, findings consistently suggest that the degree to which parents relied on medication or medical labels was similarly correlated with the degree to which they felt their parenting skills or style were directly responsible for their children’s behaviors. That is, parents who claimed their children had no problems whatsoever were the most likely to attribute children’s problematic behaviors to parenting issues rather than problems with brain function relative to other parents. In turn, parents who suspected their children may have emotional, psychological, and behavioral problems were less likely to attribute children’s problematic behaviors to parenting issues rather than problems of brain function than parents whose children had diagnosed problems but were not on medication. And finally, parents whose children were on medication were the most likely to attribute children’s emotional, psychological, and behavioral problems to problems with brain function rather than parenting skills or style.

In line with findings from the current study as well as Singh’s (2003) results, Malacrida’s (2003) chapter titled *Mothers Talk about the Early Years*, provides an analysis of mothers’ narratives describing the period before their children were considered by professionals to have AD/HD, in which evidence of self-blame is equally apparent. In this chapter, she explains that she “turns her attention towards the narratives of mothers’ experiences of stigma, confusion, and isolation in their encounters in the community . . . .”
Though she and Singh (2004) choose different language to describe themes that emerged from mothers’ pre-diagnoses’ narratives, the qualitative aspects of what they describe are comparable. Indeed, Malacrida refers to numerous situations that angered and humiliated her respondents in which they felt they were continually running after their children, pleading with them to settle down, stopping them from doing things they were not supposed to be doing, taking things away from them they were not supposed to have, apologizing for things that had been broken or other children who had been hurt, sorting out arguments, attempting to calm temper tantrums, and trying to avert situations that were safety hazards.

In reference to these daily frustrations, she claims, “in the end, there were tremendous costs, not only for children but for mothers themselves” (p. 114). By this, she was referring to the anger and aggression that mothers often felt despite understanding that they were not necessarily effective. She acknowledges too that there were mothers who felt their anger pushed them towards violence — or leaving their children unattended in an effort to avoid violence — as a result of antagonistic exchanges. And finally, like mothers in Singh’s study (2004) as well as my own, mothers’ feelings of anger brought about tremendous feelings of guilt and shame and feelings of inadequacy after an emotional display. In fact, the sense of isolation to which Malacrida referred, experienced by many of her respondents, is a self-imposed isolation into which mothers entered after public situations in which they either lost control or felt as if they might. Ironically, even if they did not feel altogether out of control, they felt that their lack of feeling that way meant that they were somehow viewed by others as poor parents. Some claimed they went so far as to scold or strike their children publicly in an effort to demonstrate to disapproving strangers that they did make an effort to exert parental control over their children (2003).
As I discuss in the next section, mothers' self-blame may be in large part, a response to the blame they feel coming from others, which seems rooted in the all-pervading ideology of good mothers.

Other-Blame. According to my findings as well as those from past research, there is no shortage of outside sources of reinforcement that mothers are to blame. Whether from friends and family, school and medical personnel, or strangers in other community settings, others are only too willing to blame parents for the problem behaviors demonstrated by children. Mothers especially, as pointed out in the introductory chapter of this dissertation, have a long history of being blamed for their children's negative behaviors.

Professionals. Malacrida's (2004) focus is in large part, on mothers' interactions with professionals – nurses, teachers, school administrators, psychiatric and psychological professionals, and medical practitioners – and the extent to which these professionals call mothers' maternal practices into question. While she claims that some of the blame that some mothers experienced came from the community and the extended family, the most burdensome experienced by all mothers were criticisms that came from "helping professionals" (p. 244). She asserts, "Repeatedly, regardless of the specifics of the mother's life: whether she lived in Canada or England, whether she was married or single, whether her family was large or small, rich or poor, professional or working class, foreign or native, each mother described similar experiences of censure and distrust, particularly at the hands of helping professionals. . . . Professionals' attitudes towards mothers were judgmental, discrediting of maternal opinions and claims, and assumed some measure of maternal culpability" (p. 219).
I too found evidence that mothers' interactions with helping professionals – teachers in particular – could be problematic, though this was not necessarily an overarching theme that emerged from analyses of my qualitative data. In fact, findings were mixed, with some mothers reporting positive interactions with teachers and several describing what they considered to be irritating exchanges; mothers frequently felt teachers were not supportive and typically ready to locate the child's difficulties in problems they were having at home, rather than at school. In terms of the types of negative exchanges however, it is important to note that those reported by mothers in my study were not as overtly reproachful as those in Malacrida's (2003) study.

Nevertheless, results from quantitative analyses demonstrate teachers are not the professionals from whom parents are likely to seek counsel when it comes to childrearing advice, nor are parents concerned with teachers' opinions of their childrearing strategies, suggesting that parents' interactions with teachers regarding children's difficulties may be less than positive.

Regardless of the types of interaction parents had with teachers, it became very clear that for mothers whose children were taking medication, often their first awareness of their children's problems were brought to their attention by an early teacher. And it was from that point of initial awareness, that they sought counsel elsewhere. Elsewhere, as I discovered, was primarily with family therapists. While it is not surprising that family therapists would be included among the group of experts on which parents rely, it is perhaps surprising that family therapists would preclude teachers and other school personnel as well as pediatricians, and other medical practitioners. My expectation was that the popularity of psychopharmaceuticals would have rendered "talk therapy" as somewhat outdated, or at the least, unnecessary in the event of medications that "worked." This would seem especially
likely given the current trend in treatment coverage, in which insurers are far more willing to pay for medication than therapy (Diller 1998). I discovered however, as will be discussed in more detail in a following section, given that parents of children on medication experience the least pleasure in parenting and feel the most impotent (contrary to what many believe), it is perhaps understandable that family therapists would be so important to them. Indeed, among the range of possible treatment and service choices that parents may have tried, parents of children on medication were significantly more likely than other groups of parents to use family therapy. This was the only significant difference in service across the groups. The ways in which parents are often made to feel in public encounters, as described below, makes it clear why this may be the case.

*Community Settings.* When the mothers I interviewed described their experiences around blame coming from others, it was typically in reference to community settings, especially those that involved other mothers. This is consistent with findings from both Malacrida (2003) and Singh (2004), who report on mothers’ everyday encounters in public settings in which they felt public censure stemming from what they perceived as the belief that they could not control their children’s behavior. To be sure, mothers I interviewed described feeling that other’s attitudes towards them were judgmental and assumed culpability far more often in public settings than in settings in which they dealt with helping professionals.

These findings are also in line with other writings on parents of children with difficulties other than AD/HD, who report that parents are frequently concerned with judgments they perceive to be coming from others – especially other parents – in community settings. David Gray (2002) for example, Professor of Social Science at the University of England, New South Wales, Australia, writes about the experiences of parents
of children with high-functioning autism (characterized by impaired social relations, obsessions, uneven levels of intellectual and cognitive functioning, and peculiarities in language acquisition and functioning). According to Gray, “high functioning autism, despite being a potentially serious disability . . . does not necessarily prevent those with it from engaging in a wide range of regular social activities.” In fact, given the high level of functioning of children with this disability, parents, in an effort to work on their children’s social skills, tend to promote their children’s involvement in such activities as sports and clubs (p. 742). Consequently, like children with emotional, psychological, and behavioral problems whose disabilities are not evident to outsiders, when they behave in socially inappropriate ways onlookers frequently have negative reactions. Parents reported experiencing hostile staring and rude comments from others as well as outright social rejection in their public interactions. Gray reported that one woman said of her experiences:

I can walk through shopping center after shopping center and no one knows my child’s autistic or he’s got a problem. So, if he sees a drink machine and he wants a drink and I haven’t got the right change and he stands there . . . and screams . . . it runs through my mind, “What must some people be thinking? . . . Do you say to them, the reason he’s carrying on like this is because he’s autistic? . . . Actually, there were times when I thought, God, I wish he were Down’s Syndrome, because people would leave me alone.

This mother’s sentiment is much like the feelings of mothers with whom I spoke, as well as those interviewed by Landsman (1998), Malacrida (2003), and Singh (2004). Gray (2002) found that parents often felt embarrassed and consequently angry towards others when they were in public settings and their children were behaving in ways that might be considered as socially inappropriate. In light of this, it is understandable that parents in my study reported that their children’s behavioral problems turned out to be the most influential factor in their decision-making around treatment or services for their children. Given the ideology of good
mothers in which most westerners are immersed (see for example, Caplan 1989; Hays 1996; Malacrida 2003; Singh 2004; and Walzer 1998), mothers tend to experience public disapproval far more frequently than fathers and are sometimes even the recipients of fathers’ criticisms themselves.

**Fathers.** According to Gray (2002), although he is writing about parents of both sexes, mothers are much more likely to feel negatively judged in these situations than are fathers. First, mothers are most often dealing with their children in public encounters. Second, mothers tend to both feel more responsible and be attributed more responsibility for their children’s behaviors than fathers. Gray asserts that mothers’ negative public encounters caused greater distress and compounded the considerable burdens with which they were already confronted as parents of children with disabilities (2002).

Equally striking are Singh’s (2004) findings in which fathers themselves sometimes blame mothers for their children’s problem behaviors. A number of fathers with whom she spoke indicated that, not only did they not believe their son’s behaviors warranted medical intervention, but went so far as to suggest that they believed their wives may be perpetuating their sons’ negative behaviors through “overly indulgent mothering” (1200). While Malacrida (2003) gives only the briefest mention of fathers, she describes a similar story of a mother who felt her partner believed it was her inability to discipline their son properly, which led to his problematic behaviors. According to Singh, by and large, fathers have noticeably different attitudes towards their son’s “symptomatic” behaviors than do mothers and in fact tend not to participate in their clinical evaluations at all. Over two-thirds of the fathers she interviewed reported that they had not participated in their son’s initial evaluations and in the approximately 70 clinical case files she included in her study, she claims that only one father had contributed to parents’ written evaluation of their sons’
behaviors prior to clinical evaluation (2004). This suggests that fathers may not be nearly as invested in obtaining a medical diagnosis — and subsequent treatment — for their children as are mothers.

Diller (1998) too writes about absent fathers at clinical evaluations for children with AD/HD, in his reference to the research of Psychologist Stephen Hinshaw who runs an AD/HD treatment program at the University of California at Berkeley. At the time of Diller’s writing, Hinshaw was one of the principal researchers evaluating different treatment modalities for AD/HD. Within this program, Hinshaw set up a summer camp for kids both with and without AD/HD in an effort to observe real-time interactions with AD/HD children and their peers. Early within the program, parents were asked to fill out questionnaires describing their style of parenting, and participate in sessions in which they and their children would be videotaped—all for clinical purposes. According to Diller however, Hinshaw and his colleagues had thus far only assessed the attitudes of children’s mothers at the camp as they had been unable to “assemble a statistically significant cohort of fathers because . . . the fathers weren’t available to participate” (p. 191). And in Diller’s own clinical practice he claims he also found that fathers frequently did not “buy the concept of [AD/HD] at all” . . . preferring to think it was a disciplinary rather than a mental health problem, typically the fault of a child’s mother who was “too ‘soft’ with [them]” (p. 6).

Evidence from past research regarding father absences and fathers’ blaming mothers are consistent with my findings. Regarding father absences, fathers only comprised 18% of my total respondents and of the parents with whom I was able to speak directly, all were female. Of the 53 parents whose children had been diagnosed with emotional or behavioral disorders, only five were fathers ($p < .05$). As noted previously, the purpose of my project
was not to make gender comparisons on this issue. But had I decided to do so, with so few fathers, it would have been impossible.

In terms of fathers blaming mothers, according to my analyses, parents’ engaged in frequent conflicts around issues of diagnoses and treatment for their children’s problematic behaviors, which suggests these are issues fraught with tension. Results demonstrated that 100 percent of parents whose children had been diagnosed had argued over the necessity of obtaining a diagnosis as well as the necessity of seeking treatment. Further, according to mothers with whom I spoke who claimed they had disagreed with their husbands over issues of diagnoses and treatment, it was typically because fathers felt they were overreacting to what were normal childlike behaviors and concocting medical problems where none existed. Surely, this too would contribute to mothers’ feelings of parental inadequacy and diminished parenting pleasure relative to parents of children with no problems.

The variety and frequency of negative attitudes directed towards parents by others in numerous settings – including spouses – combined with mothers’ tendency to blame themselves, makes obvious the extent to which a sense of relief would be expressed by all mothers upon their “discovery” that what was wrong with their children’s behavior was actually a “brain problem” rather than willfully bad behavior brought about or somehow perpetuated by their own inadequacies.

**Brain-Blame.** Diller (1998) points out the extent to which parents of children with AD/HD have welcomed the notion that brain chemistry is to blame. For many years, according to Diller, psychotherapists had implied to parents – especially mothers – that it was their fault their children were having problems. “Thanks to the biological explanation,
now it’s nobody’s fault . . .” (p. 103). How could this be experienced as anything but a sense of relief?

Mothers in Singh’s study also claimed they felt relieved to discover a biological and/or genetic basis to their son’s problems. As a result, they no longer had to feel the burden of guilt and shame associated with their former beliefs that they had somehow caused their son’s problematic behaviors. Without a doubt, Singh reports that most mothers with whom she spoke said that they felt happier and less anxious once their sons had been diagnosed and were taking medication. Their family lives and school relations had improved, their sons began to progress academically, and they felt less restricted in their pursuit of social activities in the community with their sons (2004).

A similar sense of relief was expressed by mothers I interviewed as well, once they realized that what was wrong with their children was not the result of their parenting (in)actions, but rather problems with brain functioning. Yet, feelings of relief seem limited to that one particular notion, that mothers are not responsible for causing their children’s problems. Responsibility for the management of children’s problems is certainly not lessened in any way however. Lauren’s narrative below – repeated from the previous chapter – is typical of the relief mothers experienced in the realization that they did not cause their children’s problems, while demonstrating at the same time, that there is no real sense of liberation:

So you know . . . it’s hard . . . talking to other friends of mine who have kids that don’t have any of these problems, [I realize] they would be mortified if they saw the way that she acts, or the way that she speaks to us. Or particularly to me . . . You know . . . in the beginning I might have thought she was [the way she is because of me] . . . [but knowing] that it isn’t anything that I did that made her so withdrawn . . . makes it easier for me to see that her personality is the way that it is because it’s just the way she was born, with genetics, or whatever. And . . . I feel better about that because I can remember when I first found out about this . . . I knew she was not
responsive. . . . And I would sometimes think that it was the way that I brought her up or I wasn’t engaging enough with her. . . . but now [I realize] . . . that it’s just the way that she is. You know, it doesn’t have anything to do with the way that I treated her or [if] I did or didn’t do something. 

Lauren

Lauren’s narrative reads nothing like the emotional response we see captured in recent magazine advertisements for AD/HD medication, with broadly smiling pictures of moms shown embracing gleeful children. Rather, there is a sense that just a portion of a particularly heavy burden has been lifted from her shoulders. Like Singh (2004), I would argue that regardless of the relief mothers may feel at realizing their children’s behaviors are not their fault, the fact remains, their children still have emotional and behavioral problems that require careful monitoring.

As demonstrated previously, while results suggest that medication may improve behaviors, it does not eliminate the difficulties of parenting children with problems and may even create added burdens associated with the need to continually monitor and change treatments. Indeed, all of the mothers with whom I spoke whose children were taking medication, were continually monitoring the effects of the medicine on their children. Not one was successful with the first medication they tried, due to unpleasant side effects or inefficacy, and most had tried three or more medications, which in itself was difficult. Even when parents found a medication that worked, changes were routinely required as children grew older and their bodies changed, and of course there are always periods of time when children are not on medication, which means “symptoms” of emotional and behavior problems are frequently evident.

Beyond the problems with monitoring the medication however, there are other difficulties as well. In particular, Singh found that while mothers’ narratives may have been
centered on the lack of assignable blame for their sons’ problems, diagnoses and drug treatment pushed them to “reconfigure their [parenting] in line with a biological narrative of behavioral causation and to judge [parental] fitness against their ability to embed this narrative in their [parenting] behaviors” (2004: 1202). In other words, in addition to all that is required in terms of monitoring treatments, parents must continually monitor their children’s behaviors to determine which behaviors should be categorized as “no-fault” and which behaviors should be categorized as “fault.” They then must make decisions about how to react to those behaviors in line with this classification. As there is no clear clinical delineation of how children’s behaviors should be classified, this leaves parents with a great deal of ambiguity, and consequently adds even greater burdens to an already overloaded situation. Melissa’s uncertainty about her son’s behaviors and to what they should be attributed below is demonstrative of this:

He’s a complicated little kid. And you never quite know which one you’re dealing with. As far as the anxiety or the mood . . . so you just kind of jumble . . . them all together in this little package. . . . So, we played a lot of medication experimentation. I don’t know how else to put it . . . you never know whether the medication is having an affect or not, or whether it’s the full moon, or school is out or it’s holiday time. So you sit there with the psychiatrist and he says, well, what do you think? And . . . you say, I don’t know . . . you feel like you’ve got this kid on so much medication, but each one does a different thing, and without it, it’s such a marked difference . . . [like in the] late afternoon, early evening . . . and it’s all gone . . . and now . . . we’re finding that . . . his body is just getting too big for [his current medication] . . . so we’re trying . . . a new non-stimulant. . . . Quite honestly, I’m not seeing a big effect. . . . he’s . . . jumper than usual . . . somersaulting through the house . . . I don’t know whether that’s just cause it’s winter and he can’t get outside and burn off energy, or what. We go to see the psychiatrist next week, so we’ll have to ask him.

Melissa

As described previously, Melissa, like many other mothers went on to describe her frustration with her son’s behavior. As Singh (2004) proposed, Melissa’s frustrations with her son’s behavior were subsequently compounded by her frustrations with her inability to control her own reactions. She said she felt like she constantly yelled and was constantly picking...
on him. Despite her best efforts to stop however, she claimed that his behavior simply drove her there, which made her feel guilty on top of everything else. Upon hearing her recount her story it became apparent why she had decided in favor of medication. Although she claimed it was not her first option, at the same time she felt he needed it to function; it may be that she needed him to take it so that she could function as well.

**Decision to Medicate.** Not surprisingly, given the controversy around psychiatric medication for children, findings in regard to whether parents' struggled with their decisions around medicating their children were mixed, with some claiming the decision was not at all difficult while others claimed it was heartbreaking. Parents who decided in favor of putting their children on medication struggled with this decision far more than those who decided against it however. According to Singh (2004), medical diagnoses and the ritual around medication validate mothers' experiences in that they demonstrate the legitimacy of their children's problems while simultaneously showing that no one is at fault. I found evidence of this as well, but my findings suggest that feeling okay about psychiatric medication for your children may not be until treatment has been well-established. We see that mothers with whom I spoke had a great deal of difficulty with their decision to medicate, and then, once decided, went through a tremendous amount of emotional turmoil trying to find the "right" medication. All evolved into their current stage of acceptance, with most claiming to have been completely against psychiatric medication before being confronted with their own children's emotional and behavioral problems - not unlike many parents of children with no problems. Findings from quantitative analyses reinforce this notion, in demonstrating a clear progression of parents' attitudes towards psychiatric medication for children. The consistency of incremental scores showing increasing acceptance of psychiatric medication
as utilization of the medical model increases suggests that parents’ acceptance develops over time as parents and children adjust.

According to quantitative data analyses, parents’ decisions to medicate were most influenced by their children’s behavior, but this finding does not begin to adequately explain parents’ feelings about their children’s problem behaviors until illuminated with mothers’ narratives. Without being contextualized, notions of children’s behavior that may warrant medication brings to mind the very scenes that parents who are against psychiatric medication describe – the parody of the spoiled brat raised by overly-indulgent parents, who throws a temper tantrum whenever s/he does not get exactly what s/he wants. In other words, criticisms tend to be centered on the idea that parents who rely on medication are ostensibly doing so in order to avoid taking responsibility for raising such ill-mannered children in the first place. In actual fact, the most striking finding in this study is the extent to which that notion is an absurdity. While there may be overly-indulgent parents and children who throw temper tantrums to be sure, there is no evidence in this study to support the idea that parents whose children are on medication are benefiting from a “quick-fix” in the form of a pill. Indeed, what has been demonstrated is the extent of the damaging effects of the good mother ideology on parents who are already heavily burdened by the difficulties from which their children are suffering.

Summary

In sum, in an effort to understand the disjunction between steadily rising psychotropic prescription rates for children in the United States and most Americans’ negative attitudes towards the use of such medication for children this study has examined differences between attitudes of parents dealing with their own children’s emotional,
behavioral, and psychological problems and those whose attitudes are based on the observations of others. As predicted, parents' attempts to respond to and cope with their own children's problems involve adjusting their attributions of cause as well as their perceptions of blame. Their child-rearing behaviors are reconfigured in line with a biological narrative of behavioral causation and as a consequence they tend to experience less pleasure than other parents and feel less competent. It has been demonstrated that parents in this study have been exposed to circumstances and social interactions not experienced by other parents as a consequence of their children's difficulties and they have frequently felt that their parenting is judged and censured by the attitudes of others. Given the attitudes of many parents in this study whose children have no problems, we see that the feelings of blame parents of children with problems feel levied against them are very real and may contribute to their decision-making around treatment for their children – though it is not what ultimately drives their decisions. It seems fair to say that for the parents in this study, medication was used as a last resort when they believed they had no other viable options.

**Implications**

As pointed out by McLeod et al. (2004), this debate about the use of psychiatric medication for children requires careful and "continued monitoring from social scientists as the medical care system and scientific knowledge about children's emotional and behavioral problems evolve" (p.64). It is hoped that what has been learned from this study about parents' attitudes towards children and psychiatric medication in particular will generate interest for continued research in this area. Zola (1972) argued more than thirty years ago that "medicine is the battleground of what will become of society – where physical and functional well-being [will] compete with civil liberty and moral integrity – future trends in lay public attitudes towards psychiatric medication use for children serve as an important
indicator of which side holds the advantage” (cited in McLeod et al. 2004). Trends thus far, despite Americans’ reticence, seem to suggest that medicine is currently holding the advantage.

A recent article in the New York Times suggests that this increase in psychiatric prescription rates for children has broadened to include other pharmaceuticals such as sleeping pills. According to Gardiner Harris (October 2005), who wrote the article, the use of sleeping pills in children and very young adults (under age 20) has increased by 85% from 2000 to 2004. In his commentary, Harris suggests this is yet another indicator demonstrating that parents and doctors are increasingly turning to prescription medications to resolve their children’s health and behavioral problems. He quotes “several experts” who claim expensive marketing campaigns by makers of sleeping pills are behind this increase. Executives for the makers of one of the newer sleeping pills, Lunesta, strengthen this claim in their boast that their advertising spending could rival that of McDonald’s. Given the extent to which prescription rates for children (and adults) continue to increase; it would appear that unless we actively resist this push by large pharmaceutical companies, we may find ourselves in the midst of a brave new world.

In another recent New York Times Article, Amy Harmon (November 2005) quotes a current report in The New England Journal of Medicine, claiming that antidepressants are now prescribed to as many as half of the college students seen at student health centers, and increasing numbers of students fake the symptoms of depression or attention disorder to get prescriptions that they believe will give them an edge. Findings from a different study quoted in the article, published recently in The Journal of American College Health, reported that 14 percent of students at a Midwestern liberal arts college reported borrowing or buying prescription stimulants from each other, and that 44 percent knew of someone who had.
This borrowing or buying of other's prescription drugs may be an emerging cultural norm. According to Harmon's report, a sizable group of people in their 20's and 30's, are now deciding on their own what drugs to take and have taken to relying on their own research and each other's experience in treating their problems with prescription medications such as stimulants, antidepressants and other psychiatric medications either purchased on line or traded with friends. Problems like Social Anxiety Disorder, Depression, Obsessive Compulsive Disorder, and AD/HD along with their respective treatments such as Prozac and other antidepressants, and Ritalin and other psychostimulants, are common household words. If Americans are so willing to medicate themselves, why the reluctance when it comes to children? And if Americans are so reluctant to medicate children, why the dramatic increase in psychiatric drugs for this age group?

I believe it is because the ideology of mother blame is so deeply entrenched in society that this contradictory phenomenon persists. To the extent that parents are blamed for their children's negative behaviors - which as we have established largely means mothers are blamed - what could possibly be the justification for children's problems to be "alleviated" with medication, especially when the long-term effects of many of these medications on children are unknown? This study has demonstrated the extent to which parents hold other parents responsible for their children's problematic behavior. It has also demonstrated the extent to which most parents do not believe children's emotional and behavioral problems are a function of problems with the brain, unless they have children who have been diagnosed with a disorder. This, combined with the fact that most Americans are against psychiatric drugs for children except in the case of very extreme circumstances, strongly suggests that it is the beliefs around the origins of children's problems which poses the dilemma. How can this be reconciled?
Beginning at the Community Level

Evidence suggests that parents of children with emotional and behavioral problems are primarily seeking help from family therapists and feeling that other members of the community may be judging them unfairly. Further, based on quantitative findings as well as expressed attitudes of several of parents of children without problems, parents of children with emotional and behavioral problems are not wrong in feeling like they are being negatively evaluated by others as indeed, they are – especially at school functions and other community settings that tend to bring together parents and children. Given mounting evidence suggesting the extent to which parents of children with problems are feeling publicly censured as well as the extent to which public awareness regarding children’s emotional and behavioral problems has increased, it seems that educational programs created within the school system, geared towards all parents in an effort to end recrimination and foster understanding instead, would go a long way towards strengthening troubled families.

In addition, what is needed if our efforts are to be geared towards helping families of children at risk is more of a seamless network of support within the community. While only a few irritating exchanges with school personnel were actually reported, the fact that parents do not seek out teachers or other school personnel for parenting advice, nor are teachers and other school personnel influential in parents’ decision-making, speaks volumes. The implicit message is that parents do not feel they can count on help and support from school personnel, despite the fact, that very often, teachers are the ones who draw parents’ attention to children’s problems in the first place. Teachers in fact, as findings demonstrate, are in a unique place to identify problems frequently not recognized by parents, and as such, they should have more support as well as more education. Recall the sentiment expressed by
Judy when asked whether she had fears about the same problems with her son repeating the next school year, which suggest the importance of teachers being better educated:

It could start all over, but we’re at a different starting point, and I always think, it’s not going to be as worse, it’s not going to be as bad as it was in first grade [when we didn’t know what was happening] and we were trying to figure it out. I didn’t know that his teacher really didn’t have a grasp. And I sort of relied on her to understand.  

Suzie

At the point at which a number of parents discover their children are having difficulties in school, they may have be relying on their children’s teachers to understand, but may also be unfortunately disappointed. Rather than remanding teachers for their efforts, for example in supporting initiatives geared towards what teachers cannot and/or should not be doing in terms of recommending medication (in reference to legislation currently being passed in a number of states), perhaps more attention should be placed on educating the very people who are in the best position to provide assistance.

Limitations and Directions for Future Research

While this study has a number of noteworthy findings, they must be viewed with caution as there are certain limitations to the research that must be considered. First, because this study is limited to one school district in southern New Hampshire, reported findings reflect only the population of one specific county in one specific corner of the United States. As noted previously however, for the purposes of this study, the homogeneity of the population was not considered to be a disadvantage because it works as a statistical control on a number of factors in order to determine whether differences among respondents can be explained by the extent to which they have children with emotional, psychological, and behavioral problems. Moreover, to the extent that findings are consistent with findings from past research as well as the ideological backdrop against which they are presented, there are reasons to believe that findings are not necessarily limited to this small
group, but rather may be extended to the experiences of other individuals from similar social and cultural backgrounds. Regardless, until additional studies are conducted to help inform the findings from the present study, results must be viewed with the understanding that they are not representative of a larger population.

Second, because this study was cross-sectional in design, it suffers from problems inherent in this type of research design. That is, my efforts towards gaining a better understanding of causal processes that occur over time, are somewhat thwarted by the fact that I am able to draw conclusions based on observations at only one time. That said, this problem is somewhat lessened by the fact that qualitative findings suggest a process consistent with findings from quantitative analyses. In other words, the regularity of the stages through which mothers' with whom I spoke have progressed regarding their experiences with putting their children on medication, combined with similar patterns found through quantitative analyses, suggest that some provisional conclusions about causal processes over time can be drawn.

Third, as often happens with dissertation research, limited resources placed constraints on my data collection, one consequence of which was the small sample size of completed surveys – especially given that the sample was divided into groups in order to make comparisons, some of which were very small. As noted previously, given the small numbers of parents in each group, some test results may be misleading throughout the entire series of analyses. Further the relatively low response rate introduces a second problem of non-response bias, which suggests that parents who took part in the survey may be qualitatively different from parents who did not. Although, the resulting homogeneity created a desired effect, I should point out that the rate of children with emotional and behavioral problems in this sample of parents (approximately 25%) is much higher than the
rate of children with emotional and behavioral problems across the United States (about 5%), suggesting that parents of children with emotional and behavioral problems were especially interested in participating in this survey relative to other parents, though as a caveat, I should also note that the survey was not presented to attract parents of children with emotional and behavioral problems, but rather, parents in general.

Finally, given that this was a pilot study, in conducting my analyses, I realize there are a number of questions I would have liked to have asked but did not as well as several that were asked that turned out to be superfluous. Consequently, in repeating this study, I would add several questions and remove others. My overarching goal would be to shorten the questionnaire as I believe that is one reason for a lower response rate than I would have liked. In so doing I would keep it more focused and not try to cover the breadth of material I endeavored to cover beyond this first go round. In repeating this study, I would refine questions around mother-blame as well as other-blame in particular, and refine the organization of the entire questionnaire in an effort to save time in terms of both data entry and analyses. I believe I might also include field research in which I was able to actually observe parents and children in school and community settings.

Given the opportunity, I would conduct more face-to-face interviews, as the depth and nuance they brought to the study was well worth the extra time taken in terms of both conducting the interviews as well as the analyses. In addition to interviewing parents of children with emotional and behavioral problems, I would also like to interview parents of children without. Given the finding of the stages of acceptance through which most parents seem to progress, a brief follow-up interview three to six months after completing data collection may strengthen results demonstrating stages of a process which are so difficult to demonstrate with only cross-sectional data. This would be relatively easy to do via email,
once a database of parents has been created, and I believe the return would far outweigh any efforts put forth.

Finally, a larger sample size is ultimately desirable, though I believe this might be the natural outcome of a more streamlined questionnaire, especially given the number of parents who took the time to fill it out, despite its current length.
REFERENCES


APPENDIX A

Informed Consent Document for Face-to-Face Interviews

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT:
To Medicate or Not to Medicate: Parenting Practices in the Culture of Prozac

I am a Ph.D. Candidate in the Department of Sociology at the University of New Hampshire who researches and writes about families, gender issues, and the social implications of new medical technology. In this current project I am studying parents in an effort to learn how they make decisions whether to medicate their children who may have emotional, behavioral, and/or psychological problems. I am also interested in changes in parenting practices more generally in this new Age of Prozac.

As a participant, it is very important that you read, understand, and agree to the following:

1). You understand that your participation is strictly voluntary;

2). You understand that you may withdraw your participation at any time—either during or after the interview;

3). You understand that participation involves an informal interview, of approximately one to two hours, which will be tape recorded. The investigator, Nena Stracuzzi, seeks to maintain the confidentiality of all participants in the project. Names will not be recorded on the tapes or any notes or typed transcripts, but will be kept only on a list in the sole possession of Nena Stracuzzi. Tapes and transcripts will be retained only for research purposes and will be destroyed at the end of the study. Names and revealing details will be changed in any report or publication based on this research.

4). You understand that, with this confidentiality, this research involves no known risks or discomforts. You can refuse however, to answer any questions you don’t want to.

5) You understand that there are certain circumstances requiring breaches of confidentiality by the investigator, most notably, New Hampshire’s mandatory child abuse and/or neglect reporting requirement.

Signed: ____________________________ Date ____________________________

I am very appreciative of your help with this research project and welcome any questions you may have.

I can be reached by telephone: 603-740-9161; or email: nfs@cisunix.unh.edu

Nena F. Stracuzzi, Ph.D. Candidate

If you have any questions about your rights as a research subject, you may contact Julie Simpson in the UNH Office of Sponsored Research to discuss them: 603-862-2003.
APPENDIX B

Survey Instrument

The following 16 pages present the survey instrument. It was actually in booklet form, sized 8 ½ by 4 ½, when distributed but is presented here in sequential order, two booklet pages per page.
LETTER TO PARENTS

Dear Elementary School Parent,

I am a Ph.D. candidate in the Department of Sociology at the University of New Hampshire. For my dissertation research, I am conducting a survey of contemporary parents' child-rearing practices along with their child-rearing attitudes, values, and beliefs. In so doing, I hope to gain a better understanding of the issues and challenges that today's parents currently confront.

Please take the time to fill out this questionnaire. For most parents it should take approximately twenty-to-thirty minutes; I hope you will find it interesting and thoughtful. Confidentiality is assured. No personal identifying information will be linked to any of your answers or to any publications that may result from this study. As a token of my appreciation for parents' participation, a $100.00 donation will be made to your school's scholarship fund.

IMPORTANT NOTE: Each of these surveys is designated for either a mother or a father. Therefore, I would like to have only the designated parent (indicated on the survey cover) fill out this questionnaire. If this is not possible, due to time or availability constraints, then the other parent may instead complete the questionnaire. It is important, however, that any participating parent complete the survey by him/herself rather than mothers and fathers filling it out together.

I welcome questions anyone might have about this study. Call 603-740-9161 or email nfs@cisunix.unh.edu. Thank-you so much for your cooperation with this research project. I look forward to your response.

To return questionnaire, tape closed and drop it in the mail—my mailing address is printed on the back, and postage is pre-paid. Mailings tabs are provided (see inside back cover). Please return by June 27, 2003.

Sincerely,

Nena Stracuzzi, Principal Investigator

QUESTIONNAIRE

As you answer questions, try not to spend too much time thinking about any one item. Please answer each question as honestly as you can, remembering that there are no right or wrong answers. Circle numbers where appropriate in answer choices, write answers in the spaces provided, or check [X] the appropriate boxes. If you should have any reservations about questions you have answered, space is provided at the back of the questionnaire for your comments.

A. THESE FIRST QUESTIONS ARE ABOUT YOU AND PEOPLE IN YOUR HOUSEHOLD.

1. What is your age?_____

2. What is your sex?
   □ male
   □ female

3. What was the highest grade you completed in school? [CHECK HIGHEST GRADE.]
   □ Grade school or lower
   □ Earned Associate's Degree
   □ Junior high (middle) school only
   □ Some high school; no diploma
   □ High school graduate or GED
   □ Some college; no degree earned
   □ Bachelor's Degree
   □ Master's Degree
   □ Doctoral Degree [PhD, MD, JD]
   □ Some post-graduate education but no additional degree earned
   □ Technical/Vocational training

4. Are you currently employed?
   □ yes
   □ no [IF NO, SKIP TO # 6]

5. On average, about how many hours per week do you work for pay?____
6. Since having children, have you usually been employed?
   □ yes
   □ no

7. Are you currently married (or do you have a partner with whom you live and share responsibilities)?
   □ yes [IF YES, SKIP TO # 9]
   □ no

8. Have you ever been married?
   □ yes [IF YES, SKIP TO # 16]
   □ no [IF NO, SKIP TO # 16]

9. How many years have you been married to/living with your current spouse/partner? _______

10. Is this your first marriage/partnership?
    □ yes
    □ no

11. How old is your current spouse/partner? _______

12. What was the highest grade s/he completed in school? [CHECK HIGHEST GRADE.]
   □ Grade school or lower
   □ Earned Associate's Degree
   □ Junior high (middle) school only
   □ Some high school; no diploma
   □ High school graduate or GED
   □ Technical/Vocational training
   □ Some college; no degree earned
   □ Bachelor's Degree
   □ Master's Degree
   □ Doctoral Degree [PhD, MD, JD]
   □ Some post-graduate education but no additional degree earned

13. Is your spouse/partner currently employed?
    □ yes [IF NO, SKIP to # 16]
    □ no

14. On average, about how many hours per week does s/he work for pay? _______

15. Since having children, has your spouse/partner usually been employed?
    □ yes
    □ no

16. In total, how many biological, adopted, or step children, under the age of 18 are currently living with you? [PLEASE INDICATE EACH CHILD'S AGE AND SEX, AND CHECK THE SPACE PROVIDED FOR BIOLOGICAL, ADOPTED, OR STEP CHILD.]
   A. ___age ___ sex (M/F) □ biological □ stepchild □ adopted
   B. ___age ___ sex (M/F) □ biological □ stepchild □ adopted
   C. ___age ___ sex (M/F) □ biological □ stepchild □ adopted
   D. ___age ___ sex (M/F) □ biological □ stepchild □ adopted
   E. ___age ___ sex (M/F) □ biological □ stepchild □ adopted

17. Other than your spouse/partner, and your children under 18 years old, do any other people live in your household?
    □ yes [IF NO, SKIP TO # 19]
    □ no

18. Please indicate the age and relation of the other people in your household.
   A. age: _____ relation to you: __________________
   B. age: _____ relation to you: __________________
   C. age: _____ relation to you: __________________
   D. age: _____ relation to you: __________________

19. What best describes the type of residence in which you live?
   □ single-family home
   □ apartment
   □ condominium
   □ duplex
   □ communal multi-family home
   □ other (please specify) ____________________________
20. Is this residence owned or rented by you?
- [ ] owned
- [ ] rented
- [ ] other (please specify)

21. IDEAS ABOUT PARENTING: To what extent do you agree or disagree with the following statements? [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

<table>
<thead>
<tr>
<th>Number</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Generally speaking, I believe that . . .

A. . . . the basis of children’s disposition, intelligence, and personality traits, are there from birth.

B. . . . parenting is a job just like any other. Evidence of a job done well or done poorly can be seen in the actions and characteristics of children.

C. . . . parenting “style” does not make much difference as long as children are loved.

D. . . . there are no “bad” children; badly behaved children are actually the result of bad parenting.

E. . . . parents are primarily responsible for how their children turn out.

F. . . . no matter how parents may try they actually have very little influence over their children’s temperament, personality traits, and/or intelligence.

G. . . . mothers are held more responsible for how their children turn out than fathers.

H. . . . fathers are held more responsible for how their children turn out than mothers.

22. FEELINGS ABOUT PARENTING: Most parents have felt many of the ways covered by the following statements at one time or another. [PLEASE CIRCLE THE NUMBER THAT BEST INDICATES HOW OFTEN YOU HAVE THESE FEELINGS AS A PARENT.]

You feel this way:

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 = Most of the Time</th>
<th>2 = A Lot of the Time</th>
<th>3 = Some of the Time</th>
<th>4 = On Occasion</th>
<th>5 = Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Having children is worth all the sacrifices.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. I derive a great deal of fun and enjoyment from being a parent.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Surprisingly, child-rearing is not as rewarding as I thought it would be.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Watching children grow and develop is especially satisfying</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. In general, as a parent, I am happy most of the time.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Children are a large burden for me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Being a parent has always been enjoyable.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Having children to care for is a lot of fun.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. The rewards for being a parent easily outweigh the effort and hard work.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. You know, its hard being stuck home with children.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Childrearing is one of the most stimulating things that I can think of.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Being able to provide a good home for my children has been a source of great satisfaction for me.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
You feel this way:

<table>
<thead>
<tr>
<th></th>
<th>1 = most of the time</th>
<th>2 = a lot of the time</th>
<th>3 = some of the time</th>
<th>4 = on occasion</th>
<th>5 = never</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.</td>
<td>Compared to outside employment, childrearing is more satisfying.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N.</td>
<td>Being a parent is the best way of achieving self-fulfillment.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O.</td>
<td>Being with my children is more boring than I thought it would be.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P.</td>
<td>Parenthood is the most important aspect of life.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. FAMILY LIFE AND CHILD-REARING PRACTICES: How often do you engage in the following? [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

<table>
<thead>
<tr>
<th></th>
<th>1 = Frequently</th>
<th>2 = Regularly</th>
<th>3 = Occasionally</th>
<th>4 = Rarely</th>
<th>5 = Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>volunteer in your child's classroom (e.g., chaperone field trips, assist with classwork, organize classroom activities, etc)?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>attend parent-teacher organization meetings?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>take your children on outings?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>eat family meals together?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>spend time playing with your child?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>limit your children's television viewing, i.e., time spent, programs watched?</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. If you could arrange things just the way you wanted, what might you change about your family life and child-rearing practices? (Write your answer below.)
25. SOURCES OF INFORMATION AND ADVICE IN REGARD TO CHILD-REARING: To whom do you turn? [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

1 = very likely  
2 = somewhat likely  
3 = not very likely  
4 = not at all likely

If you felt you needed advice about parenting, how likely is it you would turn to the following people or sources?

A. Spouse/partner 1 2 3 4
B. Mother 1 2 3 4
C. Father 1 2 3 4
D. Another family member or relative 1 2 3 4
E. Friend/s 1 2 3 4
F. Childcare Provider 1 2 3 4
G. Family Therapist 1 2 3 4
H. Teacher 1 2 3 4
I. Guidance Counselor 1 2 3 4
E. School psychologist 1 2 3 4
F. Other school personnel (please specify) 1 2 3 4
G. Pediatrician 1 2 3 4
H. Other medical practitioners (please specify) 1 2 3 4
I. Member/s of the clergy 1 2 3 4
J. Child-rearing advice literature, i.e., books, magazines 1 2 3 4
K. Websites on child-rearing 1 2 3 4
L. Parenting support groups (community or online) 1 2 3 4
M. Other (please specify) 1 2 3 4

26. FEELINGS ABOUT PARENTING: To what extent do you agree or disagree with the following? PLEASE CIRCLE THE APPROPRIATE NUMBER.]

1 = strongly agree  
2 = agree  
3 = unsure  
4 = disagree  
5 = strongly disagree

A. You feel that you are good at resolving conflict with your child/ren. 1 2 3 4 5
B. You feel that you are a positive role model for your child/ren. 1 2 3 4 5
C. You wish you could do a better job as a parent. 1 2 3 4 5
D. You feel that your parenting is better than most. 1 2 3 4 5
E. You feel proud of the job you have done as a parent. 1 2 3 4 5
F. You often feel unsure of yourself. 1 2 3 4 5
27. CHALLENGES OFTEN CONFRONTED BY PARENTS: Below is a list of items that describe children. If you have more than one child under the age of 18, pick the child about whom you are **most** often concerned. Think of this **one child** when responding to the following statements. 

**[PLEASE CIRCLE THE APPROPRIATE NUMBER.]**

<table>
<thead>
<tr>
<th></th>
<th>1 = not true</th>
<th>2 = rarely true</th>
<th>3 = sometimes true</th>
<th>4 = frequently true</th>
<th>5 = always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>seems more anxious, worried, or fearful</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>seems more self-conscious and more likely to go out of his or her way to avoid situations in which she fears being embarrassed.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>seems more nervous, tense, irritable, stressed, or “on edge.”</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>seems more timid, shy, afraid to be alone, or separated from significant adults.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>is unable to sit still for long and seems more restless, fidgety, and hyperactive.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>more frequently acts without thinking and seems to be more hasty, impulsive, and disruptive.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>is less able to concentrate or pay attention for long, and is more easily distracted.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>seems to talk a lot, and is more likely to interrupt others.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>has more difficulty following directions, or seems less likely to follow through on tasks.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>seems more unhappy, sad, or depressed.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**When compared to other children his or her age, your child:**

<table>
<thead>
<tr>
<th></th>
<th>1 = not true</th>
<th>2 = rarely true</th>
<th>3 = sometimes true</th>
<th>4 = frequently true</th>
<th>5 = always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>seems to feel worthless, inferior, or hopeless more often.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>seems more negative, less capable of relaxing or having fun, or has little sense of humor.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>seems more withdrawn or likes to be alone more often.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>is more likely to bully others, brag and show off, or start fights.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>is more disobedient, destructive, argumentative, or angry.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>seems more dishonest or less likely to follow rules.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>seems destructive or less able to control his or her temper.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>seems less liked by other children or has more difficulty making friends.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

S. Please write in any problems your child has that were not listed above:

- 
- 
- 
- 
- 

1 2 3 4 5
T. Compared to other children his or her age, how is this child's current school performance in the following areas:

- **reading**
  - failing □ below average □ average □ above average
- **english**
  - failing □ below average □ average □ above average
- **math**
  - failing □ below average □ average □ above average
- **writing**
  - failing □ below average □ average □ above average
- **spelling**
  - failing □ below average □ average □ above average
- **other subjects (please specify)**
  - 1) ____________________
  - failing □ below average □ average □ above average
  - 2) ____________________
  - failing □ below average □ average □ above average
  - 3) ____________________
  - failing □ below average □ average □ above average

U. Please indicate the age and sex of the child to whom you were referring in the above questions (numbers 27 “A” through “T”) and check the space provided for a biological, adopted, or step child.

    ___ age: ___ sex (M or F): □ biological □ stepchild □ adopted

E. THESE NEXT QUESTIONS ARE ABOUT PERCEPTIONS OF YOUR PARENTING STYLE.

28. **YOUR PERCEPTIONS:** To what degree do you feel that the following are the result of your parenting skills or style? [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

<table>
<thead>
<tr>
<th></th>
<th>1 = totally</th>
<th>2 = a lot</th>
<th>3 = a little</th>
<th>4 = not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Your child/ren’s behavior in school or other social settings</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Your child/ren’s academic performance</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. The degree to which others like your child/ren</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Your child/ren’s physical health</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Your child/ren’s mental health</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Your child/ren’s temperament.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Your child/ren’s physical appearance.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Your child/ren’s personality</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. **OTHER’S PERCEPTIONS:** To what degree do you feel others think the following are the result of your parenting skills or style? By others, we mean individuals with whom you or your children interact regularly. [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

<table>
<thead>
<tr>
<th></th>
<th>1 = totally</th>
<th>2 = a lot</th>
<th>3 = a little</th>
<th>4 = not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Your child/ren’s behavior in school or other social settings</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Your child/ren’s academic performance</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. The degree to which others like your child/ren</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Perceptions of Parenting

#### Others' Perceptions (cont'd)

<table>
<thead>
<tr>
<th>Category</th>
<th>1 = totally</th>
<th>2 = a lot</th>
<th>3 = a little</th>
<th>4 = not at all likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child/ren's physical health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child/ren's mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child/ren's temperament</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child/ren's physical appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your child/ren's personality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Whose Opinions Regarding Your Parenting Skills or Style Are Important to You?

**Please circle the appropriate number.**

<table>
<thead>
<tr>
<th>Category</th>
<th>1 = very important</th>
<th>2 = important</th>
<th>3 = somewhat important</th>
<th>4 = not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another family member or relative</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend/s</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childcare provider</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapist</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher/s</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guidance counselor</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Childhood Problems

#### To What Extent Do You Agree or Disagree with the Following Statements? (Please circle the appropriate number.)

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 = strongly agree</th>
<th>2 = agree</th>
<th>3 = unsure</th>
<th>4 = disagree</th>
<th>5 = strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many common childhood misbehaviors are actually signs of emotional, behavioral, learning, and/or psychological problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thanks to new psychiatric medications, more children with emotional, behavioral, learning, and/or psychological problems can be helped than ever before.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. Parents are often pressured into giving medication to their children for emotional, behavioral, learning, and/or psychological problems.

D. Rather than promoting medication, we need to discover different ways for kids to be successful.

E. Psychiatric drugs are just a quick fix for busy parents whose children demonstrate annoying but normal behavior.

F. Most emotional, behavioral, learning, and/or psychological problems are a consequence of physical/biological or genetic problems with the brain.

G. With proper nutrition, exercise, plenty of sleep, and discipline, most behavioral problems in children would disappear.

H. Taking medication for emotional, behavioral, learning, and/or psychological problems is no different than taking insulin for diabetes.

I. Medication can give children with emotional, behavioral, learning, and/or psychological problems an equal chance to succeed along with their peers.

G. THE FOLLOWING QUESTIONS ARE ABOUT PROBLEMS A CHILD OF YOURS MAY HAVE EXPERIENCED.

32. Have you, or anyone else, ever suggested or implied that a child of yours may have an emotional, behavioral, learning, and/or psychological problem? [CHECK AS MANY AS APPLY]

33. Who suggested or implied that a child of yours may have an emotional, behavioral, learning, and/or psychological problem? [CHECK AS MANY AS APPLY]

34. Have you, or anyone else, ever suggested or implied that a child of yours may benefit from therapy, psychiatric medication/s or other treatment/s? [CHECK AS MANY AS APPLY]

35. Who suggested or implied that a child of yours may benefit from therapy, psychiatric medication/s or other treatment/s? [CHECK AS MANY AS APPLY]

36. Has a child of yours received a diagnosis for an emotional, behavioral, learning, and/or psychological problem/s? [CHECK AS MANY AS APPLY]
37. What diagnosis has your child received? [CHECK AS MANY AS APPLY AND INDICATE AGE S.HE FIRST RECEIVED THIS DIAGNOSIS]

☐ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) __ yrs old

☐ Learning Disorders (DYSLEXIA, MATH OR OTHER LEARNING PROBLEM—ADD OR ADHD SHOULD GO ABOVE) __ yrs old

☐ Social Anxiety Disorder __ yrs old

☐ Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) __ yrs old

☐ Autism, Pervasive Developmental Disorder (PDD) or Aspergers __ yrs old

☐ Developmental Delay or Retardation __ yrs old

☐ Depression __ yrs old

☐ Obsessive Compulsive Disorder (OCD) __ yrs old

☐ Another disorder (please specify): ____________________ __ yrs old

38. Do you agree with this diagnosis?

☐ yes

☐ no

39. What have you tried regarding treatment/s/services for your child/ren? [CHECK ALL THAT APPLY.]

☐ none [IF NONE, SKIP TO # 42]

☐ individual therapy

☐ special diet and exercise regimen

☐ psychiatric medication

☐ special curriculum within regular classroom

☐ chiropractics

☐ special classes in public school

☐ family therapy

☐ special placement/s in an alternative school or setting

☐ behavior modification

☐ hospitalization/residential treatment

☐ other (please specify)

40. Do you feel that any of the above treatments have been effective?

☐ yes

☐ no [IF NO, SKIP TO # 42]

☐ unsure [IF YOU ARE UNSURE, SKIP TO # 42]

41. Which treatments have been effective?

1. ____________________________

2. ____________________________

3. ____________________________

42. Did you have any difficulties making a decision about treatment/s or services for your child? This would also include decisions against treatment.

☐ decision very difficult

☐ decision somewhat difficult

☐ decision not at all difficult

43. Did you ever feel pressured or forced into making a treatment decision about which you were unsure?

☐ yes

☐ no [IF NO, SKIP TO # 45]

44. Which treatment decision did you feel pressured into? ____________________________

45. Have you explicitly refused treatments?

☐ yes (please specify) ____________________________

☐ no [IF NO, SKIP TO # 47]
46. Who suggested treatments or services that you have refused?

☐ spouse/partner
☐ your mother
☐ your father
☐ teacher/s
☐ other family member or relative
☐ other school personnel (please specify)
☐ childcare provider
☐ friend/s
☐ guidance counselor
☐ member/s of the clergy
☐ school psychologist
☐ family therapist
☐ pediatrician
☐ other medical practitioners
☐ other (please specify)

47. Have you and your spouse or partner (or the parent with whom you share responsibility for this child) ever been in disagreement around diagnoses and treatment?

☐ yes
☐ no [IF NO, SKIP TO #49]

48. About what have you specifically disagreed? [CHECK ALL THAT APPLY.]

☐ the severity of your child’s problem/s
☐ the necessity of obtaining a diagnosis
☐ the diagnosis itself
☐ the necessity of treatment or services
☐ the types of treatment or services
☐ you blame your spouse/partner (or the parent w/whom you share responsibility for this child) for your child’s problems
☐ your spouse/partner (or parent w/whom you share responsibility for this child) blames you for your child’s problems
☐ other (please specify) ___________________________

49. Influential issues around decision-making: [IF YOU DECIDED AGAINST TREATMENT OR SERVICES, SKIP TO #54.] How would you rate the following concerns in terms of their influence on your decision to provide treatment and/or special services for your child? [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

<table>
<thead>
<tr>
<th>Concern</th>
<th>1 = very influential</th>
<th>2 = somewhat influential</th>
<th>3 = a little influential</th>
<th>4 = not at all influential</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Poor academic achievement was a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Behavioral issues at school were a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Behavioral issues at home were a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Behavioral issues at friends’ homes or other social settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Having difficulty getting along with others and/or making friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Well-being of family life (child’s behavior disrupted home and family life) was a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Child’s emotional well-being (child often felt sad, worried, or angry) was a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Parents’ emotional well-being (parent/s often felt frustrated, angry, worried, sad, embarrassed) was a frequent/serious concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1 = very influential  
2 = somewhat influential  
3 = a little influential  
4 = not at all influential

I. Siblings emotional well-being (other children often felt frustrated, angry, worried, sad, embarrassed) was a frequent/serious concern

J. Child requested treatment

**HOW INFLUENTIAL WERE THE FOLLOWING SOURCES?**

K. Information/recommendations from a website/s found on the internet

L. Information/recommendations from book/s, magazine/s, newspaper article/s, or television program/s

M. Recommendations of a teacher, school psychologist, guidance counselor, or other school personnel.

N. Recommendations of a pediatrician

O. Recommendations of a pediatric psychiatrist

P. Recommendations of a pediatric neurologist

Q. Recommendations of other medical practitioners (please specify) ____________________________________________

R. Recommendations of a friend or family member

S. Availability and cost of services

50. Is your child still being treated and/or receiving services?  

- [ ] yes  
- [ ] no

51. If **no**, for how long was your child treated/receiving services?  

_____ years _____ months

52. If **yes**, for how long has your child been treated/receiving services?  

_____ years _____ months

53. Overall, to what extent have you been satisfied with treatment and/or services you have received?  

- [ ] very satisfied  
- [ ] somewhat satisfied  
- [ ] somewhat unsatisfied  
- [ ] very unsatisfied

54. UNDERSTANDING AND SUPPORT: [PLEASE CIRCLE THE APPROPRIATE NUMBER.]

To what extent do you feel the following people are understanding of your child's experiences or problems and have offered you their support?  

<table>
<thead>
<tr>
<th>1 = Extremely supportive</th>
<th>2 = Somewhat supportive</th>
<th>3 = Not at all supportive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Spouse/Partner</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>B. Mother</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>C. Father</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>D. Another family member or relative</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>E. Friend/s</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>F. Childcare provider</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>G. Family Therapist</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>H. Teacher/s</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>
To what extent do you feel the following people are understanding of your child's experiences or problems and have offered you their support?

<table>
<thead>
<tr>
<th>People</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Guidance counselor</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>J. School psychologist</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>K. Other school personnel (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>L. Pediatrician</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>M. Other medical practitioners (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>N. Member/s of the clergy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>O. Other (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

55. Is there someone who you feel should have been understanding about your child's experiences or problems but was not? [CHECK ALL THAT APPLY]
- spouse/partner
- your mother
- your father
- other family member or relative
- teacher/s
- other school personnel (please specify)
- childcare provider
- friend/s
- guidance counselor
- member/s of the clergy
- school psychologist
- family therapist
- pediatrician
- other medical practitioners (please specify)
- other (please specify)

56. Have problems that have arisen as a consequence of your child's emotional, behavioral, learning and/or psychological problems ever affected your employment and family finances?
1. yes
2. no [IF NO, SKIP TO # 58]

57. Because of my child's problems, I have . . . [CHECK ALL THAT APPLY]:
- cut back hours at work
- turned down a promotion
- turned down a job offer
- quit or was fired from a job
- had expenses that created financial problems
- sought government assistance:
  - Medicaid
  - TANF
  - Social Security
  - Food Stamps
- Other

58. Do you know of any children—besides your own—who have been diagnosed with emotional, behavioral, learning, and/or psychological problems?
1. yes—one or two
2. yes—a few
3. yes—several
4. no [SKIP to # 61]

59. If yes, who? [CHECK ALL THAT APPLY.]
- your children's friend/s
- your friends' children
- neighbors' children
- siblings' children
- other relative/s' children
- children in your children's classroom
- other

60. Are any of these children being given medication for their problems?
1. yes
2. no
3. unsure
61. Whether or not they are taking medication, do you think that these children should be being given medication for their emotional, behavioral, learning, and/or psychological problems?

□ yes
□ no
□ unsure

62. As a child, were you ever diagnosed with, or do you suspect that you may have experienced, an emotional, behavioral, learning, and/or psychological problem?

□ yes, diagnosed
□ yes, suspected
□ neither [IF NEITHER, SKIP TO # 64]

63. Do you feel that your life might have had a more positive outcome if you:

□ had been treated in some way
□ had not been treated
□ other____________________________________

I. THE FOLLOWING QUESTIONS ARE ABOUT MONEY AND FINANCIAL MATTERS.

64. FINANCIAL MATTERS: To what extent are the following statements true? [PLEASE CIRCLE THE APPROPRIATE NUMBER AND INDICATE HOW LONG THIS HAS BEEN TRUE.]

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 = not at all true</th>
<th>2 = somewhat true</th>
<th>3 = very true</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. You are too much in debt.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Your rent or mortgage is too high.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. You don’t have enough money to pay your regular bills.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>E. You don’t have enough money to buy a reliable car.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. You don’t have enough money to cover medical or dental care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. You don’t have enough money for quality childcare/after-school care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. You want to move to a better house or apartment but don’t have enough money.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

J. IF NOT CURRENTLY EMPLOYED SKIP TO # 70. [CHECK THE APPROPRIATE BOX AND SPECIFY WHERE ASKED.]

65. Do you have flexibility in your work arrangements in order to meet family needs?

□ yes
□ no

66. What are your childcare or after-school arrangements? [CHECK ALL THAT APPLY.]

□ a parent is home with children
□ older sibling is sitter
□ in-home sitter
□ children go to a friends’ home
□ children take care of themselves
□ neighbor helps out
□ after-school program
□ child-care center
□ other (please specify)____________________________________

67. How satisfied are you with your current childcare arrangements?

□ very satisfied
□ somewhat satisfied
□ somewhat unsatisfied
□ very unsatisfied
68. If you could arrange things just the way you wanted, which would you prefer to be doing now?
- [ ] exactly what I'm doing
- [ ] working fewer hours at my current job
- [ ] greater flexibility with my schedule at my current job
- [ ] a different job
- [ ] staying at home
- [ ] other (specify) ______________________________

69. How do you think your working outside the home has affected your parenting abilities?
- [ ] positively
- [ ] negatively
- [ ] don't think it matters

K. THE FOLLOWING QUESTIONS CONCERN YOUR GENERAL BACKGROUND. [PLEASE CHECK THE APPROPRIATE BOX AND SPECIFY WHERE ASKED.]

70. What is your religious preference? Do you consider yourself Protestant, Catholic, another type of Christian, Jewish, some other religion, or do you have no religion?
- [ ] Protestant
- [ ] Catholic
- [ ] Another type of Christian (please specify) __________________________
- [ ] Jewish
- [ ] Some other religion (please specify) __________________________
- [ ] No religion [IF NO, SKIP TO # 72]

71. How often do you attend services?
- [ ] daily
- [ ] every few weeks
- [ ] only on holidays
- [ ] weekly
- [ ] every few months
- [ ] never

72. With which of the following racial or ethnic groups do you most closely identify?
- [ ] White
- [ ] African-American
- [ ] Hispanic
- [ ] Asian-American
- [ ] other (please specify) __________________________

73. With which of the following racial and ethnic groups do your children seem to most closely identify?
- [ ] White
- [ ] African-American
- [ ] Hispanic
- [ ] Asian-American
- [ ] other (please specify) __________________________

74. What was your total family income before taxes in 2002. Include all family income, including wages, salaries, dividends, child support, and government assistance.
- [ ] under $10,000
- [ ] $10,000 to $19,999
- [ ] $20,000 to $29,999
- [ ] $30,000 to $39,999
- [ ] $40,000 to $49,999
- [ ] $50,000 to $74,999
- [ ] $75,000 to $99,999
- [ ] $100,000 and over

75. What parenting values and/or practices do you dislike or disapprove of in other parents you know?

76. What parenting values and/or practices do you most admire in other parents you know?
77. Are there issues on which you would like to comment further?

Thank you for taking the necessary time to complete this questionnaire; your participation will ensure the project's success.

In a few months, I will be conducting additional interviews with some of the parents who participated in this survey. This will allow me to obtain more in-depth information on contemporary parenting experiences and concerns. If you are interested in participating further, please provide only your first name and your telephone number and/or email below. If you would prefer not to participate further, just leave it blank.

First Name ____________________________
Telephone ____________________________
Email ________________________________

To return questionnaire, see important mailing instructions on inside back cover. Mailing tabs are provided and postage is prepaid.

[COMMENTS, Cont'd]
APPENDIX C

Institutional Review Board Approval

The three following pages present the approval letters for the research protocols for the work presented in this dissertation. The project was initially approved September 8, 2003, and extended on September 9, 2004 and again on September 9, 2005.
September 8, 2003

Stracuzzi, Nena
Sociology
Horton Social Science Center
25 Hough Street
Dover, NH 03820

IRB #: 2923
Study: To Medicate or Not: Parenting Ideology in the Culture of Prozac
Approval Date: 09/08/2003

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed your response to its concerns and approved the protocol for your study.

Approval is granted to conduct your study as described in your protocol for one year from the approval date above. At the end of the approval date you will be asked to submit a report with regard to the involvement of human subjects in this study. If your study is still active, you may request an extension of IRB approval.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, Responsibilities of Directors of Research Studies Involving Human Subjects. (This document is also available at http://www.unh.edu/osr/compliance/IRB.html.) Please read this document carefully before commencing your work involving human subjects.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson
Regulatory Compliance Manager

cc: File
Advisor/Co-Investigator

Regulatory Compliance Office, Office of Sponsored Research, Service Building,
51 College Road, Durham, NH 03824-3585 * Fax: 603-862-3564
September 9, 2004

Stracuzzi, Nena
Sociology
Horton Social Science Center
25 Hough Street
Dover, NH 03820

IRB #: 2923
Study: To Medicate or Not: Parenting Ideology in the Culture of Prozac
Review Level: Full           Approval Expiration Date: 09/08/2005

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved your request for time extension for this study. Approval for this study expires on the date indicated above. At the end of the approval period you will be asked to submit a report with regard to the involvement of human subjects. If your study is still active, you may apply for extension of IRB approval through this office.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the document, Responsibilities of Directors of Research Studies Involving Human Subjects. This document is available at http://www.unh.edu/osr/compliance/IRB.html or from me.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson
Manager

cc: File
    Linda Blum
September 9, 2005

Nena Stracuzzi
Sociology, Horton SSC
25 Hough Street
Dover, NH 03820

IRB #: 2923
Study: To Medicate or Not: Parenting Ideology in the Culture of Prozac
Review Level: Full Approval Expiration Date: 09/08/2006

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved your request for time extension for this study. Approval for this study expires on the date indicated above. At the end of the approval period you will be asked to submit a report with regard to the involvement of human subjects. If your study is still active, you may apply for extension of IRB approval through this office.

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For the IRB,

Julie F. Simpson
Manager

cc: File
Linda Blum