Parental Angst Making and Revisiting Decisions About Treatment of Attention-Deficit/Hyperactivity Disorder

abstract

BACKGROUND: Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurobehavioral conditions of childhood and adolescence. Despite availability of effective treatment options, initiation of treatment is variable and persistence with therapeutic regimens is poor.

OBJECTIVE: We sought to better understand how parents make decisions about treatment for their child or adolescent with ADHD.

METHODS: We conducted a qualitative study among parents of children and adolescents; 52 parents participated in 1 of 12 focus groups. Parents answered questions about decision-making, information sharing, and sources of conflict and uncertainty. Sessions were audiotaped and transcribed verbatim. Themes were coded independently by 4 of the investigators, who then agreed on common themes.

RESULTS: Parents in our study made decisions about treatment for their child with ADHD in the midst of experiencing a variety of emotions as they witnessed child functional impairments at home and at school. In addition, parents felt stress as a result of their daily efforts to manage their child’s struggles. Multiple factors influenced the decision to initiate medication. Subsequently, revisiting the decision to give their child medicine for ADHD was common. Many parents contrasted time on and off medicine to help inform management decisions. Trials stopping medication were almost always parent- or child-initiated.

CONCLUSIONS: Decisions about medication use for children and adolescents with ADHD are made and frequently revisited by their parents. Choices are often made under stressful conditions and influenced by a variety of factors. Striking a balance between benefits and concerns is an ongoing process that is often informed by contrasting time on and off medication. Development of strategies to support families across the continuum of decisions faced while managing ADHD is warranted.

Contributors: William B. Brinkman, MD, MEd,* Susan N. Sherman, DPA,* April R. Zmitrovich, MPH, MSW,* Marty D. Visscher, PhD,* Lori E. Crosby, PsyD,* Kieran J. Phelan, MD, MSc,* and Edward F. Donovan, MD*  
*Department of Pediatrics, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio; *SNS Research, Cincinnati, Ohio

Key Words: ADHD, family/self-management, parent decision-making, adherence, treatment

Abbreviation: ADHD—attention-deficit/hyperactivity disorder

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Address correspondence to William B. Brinkman MD, MEd, Cincinnati Children’s Hospital Medical Center, 3333 Burnet Ave, ML 7035, Cincinnati, OH 45229-3039. E-mail: bill.brinkman@cchmc.org

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Attention-deficit/hyperactivity disorder (ADHD) is a common neurobehavioral disorder that affects children and adolescents. ADHD results in impairment of academic, social, and family functioning. Parenting a child with ADHD is stressful and can lead to feelings of inadequacy and self-blame. In addition, different conceptualizations of ADHD among parents can be a source of conflict as fathers more often than mothers tend to resist the label of ADHD and treatment with medication. Similar to other pediatric chronic conditions, parents play a key role in implementing treatment plans that are made during visits with their child’s doctor. Despite the efficacy of medication to reduce ADHD symptoms, medication initiation is variable, and medication continuity is poor because many children stop taking medicine and/or have extended gaps in medication supply. Although studies have identified child characteristics (e.g., age, race) and medication management factors (e.g., dosing regimen) related to medication continuity, factors that influence family decision-making have not been fully elucidated. The objective of this study was to better understand how parents make decisions about treatment for their child or adolescent with ADHD. We used qualitative research methods, because they are often useful in exploring complex, multi-faceted questions that may not be readily understood by more direct, close-ended quantitative survey methods. The methods were used to generate a theoretical framework for how parents approach ADHD treatment decision-making and not to test specific hypotheses.

PARTICIPANTS AND METHODS

With Cincinnati Children's Hospital Medical Center institutional review board approval, we conducted 12 focus groups with parents of children and adolescents with ADHD in July and August of 2006.

Sample

Parents were eligible to participate if their child had been diagnosed with ADHD, was between the ages of 6 and 17 years, and had been seen for ADHD in the past 2 years at 1 of 10 community-based pediatric practices in the Cincinnati/Northern Kentucky region. Children (n = 3596) were identified through a billing database. We stratified by gender and age (6–9, 10–12, 13–15, and 16–18 years of age) and randomly sampled an equal number from each stratum. This procedure enhanced sample variability by ensuring that parents of boys and girls at a full range of ages would have an equal opportunity to participate. Subsequently, parents (n = 233) received a letter from their child’s doctor inviting them to participate in the study. Thirteen parents indicated that they did not want to be contacted. The remaining parents received a follow-up telephone call. Ninety-eight parents could not be reached. Of the parents contacted by telephone (n = 122), 71% expressed interest in participating. Secondary telephone screening ensured that the sample included only the “parent” (e.g., biological parent, legal guardian, etc) who identified herself or himself as the child’s primary caregiver to ensure that participants had relevant experience making ADHD treatment decisions.

Data Collection

During recruitment, each parent answered a brief telephone screening questionnaire that included questions about the diagnosis and treatment of their child with ADHD as well as demographics. Parents provided written informed consent before participating in the focus group. Focus group sessions were held at Cincinnati Children’s Hospital Medical Center and 3 community-based outpatient centers. The focus groups averaged 1.5 hours in duration and were audiotaped. Each parent was reimbursed $50 for their time and travel expenses.

Focus groups were led by 1 of the investigators (Dr Sherman), an experienced focus group facilitator. The prompting questions used in the focus groups were developed during group meetings with all investigators and informed by the extant literature. Broad, open-ended questions were followed by more specific, probing questions to clarify the participants’ responses and to narrow the discussion. The questions were designed to explore parent experiences making decisions about management of their child with ADHD. The question guide was modified slightly in an iterative process as the focus groups progressed to accommodate new issues that were raised by parents. A consensus was reached by the investigators that thematic saturation (i.e., point at which new observations yielded no new information to challenge or elaborate the framework) was achieved by the conclusion of the 12th focus group and recruitment was terminated. Therefore, 52 of the 122 eligible and interested parents participated in the study. A copy of the focus group guide is available on request.

Data Analysis

Each focus group session was transcribed verbatim and entered in a computerized transcript database. We used a grounded theory approach to our data, whereby 4 investigators (Drs Brinkman, Sherman, and Visscher, and Ms Zmitrovich) read the transcripts and collaboratively identified emerging themes. Then, through group sessions, we labeled themes and constructed a codebook. Each reader then independently coded parent responses using the codebook.
Group meetings were held to discuss the codes assigned to statements and to arrive at consensus. Use of >1 investigator to analyze the raw data, such that the findings emerge through consensus between investigators, is a method to prevent the personal or disciplinary biases of a single researcher from excessively influencing the findings.\textsuperscript{17,20,22} A total of 501 unique supporting comments corroborated 8 major and 33 minor themes. By using the transcript database, the investigators generated a list of all verbatim quotes supporting each of the themes and together selected the most representative comments for presentation here ($n = 71$).

**RESULTS**

A total of 52 parents participated in 1 of 12 focus groups. Participant characteristics are presented in Table 1. Parents were predominantly mothers (82%), although 4 fathers, 3 grandmothers, 1 aunt, and 1 foster parent also participated. Self-reported race of participants was similar to the Cincinnati/Northern Kentucky general population; 32\% reported a high school education or less. Nearly all children (98\%) had tried medicine for ADHD.

The themes and representative verbatim quotes are presented in Tables 2, 3, and 4.

### Domain 1: Context of Decision-Making—Parent Stressors

Table 2 delineates the emotional context of decision-making for parents of children with ADHD. The themes of parental self-doubt, daily struggles at home and school, parental conflict with each other, and the emotional burden of decision-making impact the process parents experience in making treatment decisions for their children.

Parents experience a wide and complex variety of stressors as they decide how to help their child with ADHD. Many parents begin to doubt their parenting skills and/or blame themselves for the difficulties encountered by their child (theme 1). Parenting skills are challenged on a daily basis and parenting becomes very taxing and largely punitive rather than rewarding (theme 2). Many parents have stressful conflicts with their child about homework completion and following instructions. Stress also results from the sheer amount of effort required to parent a child with ADHD and the ineffectiveness of those efforts. Parents report that issues surrounding their child’s struggles at times permeate their immediate and extended families and often their personal lives, resulting in tumult, dissension, and dysfunction. In addition, parents are stressed by their child’s struggles at school and/or feel external pressure from school personnel to take action (theme 3).

For some parents, ADHD is a divisive issue, with mothers and fathers coming to different conclusions about the nature of their child’s behavior and the appropriateness of treatment (theme 4). Parents experience a gamut of emotions when deciding about treatment for their child with ADHD. Emotions include anger, disappointment, desperation, and ambivalence (theme 5). Some parents identified 1 of these stressors, whereas others cited the cumulative effect of multiple stressors.

### Domain 2: Factors That Influence the Decision to Initiate Medication (Table 3)

Many factors influence whether parents choose to initiate medication for their child with ADHD. Parents described factors that supported the initiation of medicine (theme 6a) as well as factors that delayed their decision to do so (theme 6b). These factors are contrasted in Table 3. Recognition that their child is suffering from functional impairments is a key factor that prompts parents to initiate medication. Many parents stated they had been in denial that their child had a problem. Communication with the child’s teacher impacted problem recognition for many parents. Parents reported that acceptance of the diagnosis of ADHD was an important factor. Stories from personal and/or third party experiences with ADHD and medication are often influential. Physician and family support are very influential factors as well. Information from a variety of media was also important. For some parents, espousing belief in a biomedical model for ADHD facilitated initiation of medication. For others, concern about stigma was a barrier to treatment. Parents also reported many concerns that delayed initiation of medication, including a general reluctance to use medicine, the belief that medicines should not be relied on as a solution for behavioral problems.

### TABLE 1 Participant Characteristics

<table>
<thead>
<tr>
<th>Age of parents, y</th>
<th>$n$ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;19</td>
<td>0</td>
</tr>
<tr>
<td>20–29</td>
<td>5 (8)</td>
</tr>
<tr>
<td>30–39</td>
<td>19 (37)</td>
</tr>
<tr>
<td>40–49</td>
<td>18 (35)</td>
</tr>
<tr>
<td>50–59</td>
<td>9 (17)</td>
</tr>
<tr>
<td>60–69</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>52 (100)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>39 (75)</td>
</tr>
<tr>
<td>Black</td>
<td>13 (25)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>≤8th grade</td>
<td>0</td>
</tr>
<tr>
<td>Some high school</td>
<td>4 (8)</td>
</tr>
<tr>
<td>High school graduate/GED</td>
<td>13 (25)</td>
</tr>
<tr>
<td>Technical or trade school</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Some college</td>
<td>11 (21)</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>4 (8)</td>
</tr>
<tr>
<td>College degree</td>
<td>16 (30)</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Child gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>31 (60)</td>
</tr>
<tr>
<td>Female</td>
<td>21 (40)</td>
</tr>
<tr>
<td>Years since child was diagnosed with ADHD, mean (SD)</td>
<td>4.4 (3.7)</td>
</tr>
</tbody>
</table>

GED indicates general equivalency diploma.
and fears about drug addiction and adverse effects. Facilitators of medication initiation included failure of non-medication treatment modalities, parent awareness of potential long-term consequences of ADHD, and viewing stimulants as an established medication. Viewing the initiation of medication as a time-limited trial was a strong facilitator. Many parents reported that their child’s doctor introduced the idea of trying medicine for a month to see if it would helpful for their child. This approach reduced anxieties for many parents. Parents reported that experiences during the trial of medicine help to inform subsequent decisions about whether to continue medication. Perceived benefits were weighed against the adverse effects experienced. For some, the decision to continue medicine became easy, because the benefits far outweighed the adverse effects. For others, uncertainty persisted as they tried additional dosages and/or medications after experiencing inadequate benefit or intolerable adverse effects. This led to frustration and disillusionment about medication treatment for some families.

### Domain 3: Continued Doubt and Uncertainty (Table 4)

Many parents reported revisiting the decision of whether to keep giving their child medication for ADHD (theme 7). Many parents had lingering concerns about medication despite perceived efficacy. Some parents revisited the decision because of conflicts with their child about taking medicine. Many parents wondered how long their child would need medication with some hoping their child would outgrow ADHD and others worried that the need for medication would continue. Many parents reported uncertainty about the continued need for medication.

An unexpected theme that emerged from the focus groups was that many parents reported that contrasting their child’s experiences on and off medication helped inform decisions about whether to persist with medication (theme 8). This theme was not a part of the interview guide, yet it appeared as parents spontaneously shared their thoughts about revisiting decisions. For some, time off medicine was unintentional and the result of their child forgetting to take the medicine. For many, medicine was intentionally discontinued as a trial to see if the child still benefited from the medicine. Parents reported trials stopping medicine that were doctor-, parent-, and child-initiated. It is noteworthy that such trials were seldom coordinated by the child’s doctor. Trials stopping medicine convinced some parents of their child’s continued need for treatment, whereas...
TABLE 3  Domain 2: Factors That Influence the Decision to Initiate Medication

<table>
<thead>
<tr>
<th>Theme 6a: Factors That Support Initiation of Medication</th>
<th>Theme 6b: Factors That Delay Initiation of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent recognition of child functional impairments</td>
<td>Parent denial that their child has a problem</td>
</tr>
<tr>
<td>“...as she got older it was more apparent that I did really need to treat her symptoms to make her function in the classroom better, to feel better about herself, and more functional in our home and even outside our home, socially with peers or anyone, it had to happen.”</td>
<td>“I think I kind of fought it tooth and nail. I just kept comparing him to other boys, in my mind thinking he’s just active. I didn’t think there was anything wrong with him.”</td>
</tr>
<tr>
<td>Teacher identified problem</td>
<td>“...I found it hard to believe that he was as bad as they were all saying he was in school. I mean bad not in terms of behavior, but just complete inability to function in the classroom.”</td>
</tr>
<tr>
<td>“His teacher is the one who noticed it. He couldn’t focus on the board.”</td>
<td>Poor communication with teacher</td>
</tr>
<tr>
<td>“His [preschool] teacher helped me out because he wouldn’t sit still. ... She called me and said, ‘I think your son has ADHD.'”</td>
<td>“At the end of the year I got a little folder and daydreaming was written all over it. The teacher never said anything to me about it.”</td>
</tr>
<tr>
<td>Acceptance of diagnosis</td>
<td>“...the teacher didn’t say ‘I think he has this’, but, ‘You should really work on a lot of reading and all of that.’ I had this feeling she was trying to tell me something but she wasn’t really allowed to.”</td>
</tr>
<tr>
<td>“...Acceptance of the diagnosis. It was a relief that we know what we’re treating and know that what we are going [to do] is the right thing.”</td>
<td>Lack of confidence in diagnosis</td>
</tr>
<tr>
<td>Story or experience that supports treatment with medicine</td>
<td>“We struggled and are still struggling with the diagnosis. She carries that label of ADD, but we are not entirely sure.”</td>
</tr>
<tr>
<td>“I think part of the reason I was not averse to medicine is that my cousin has a child who is 5 years older than my son who is ADD and I saw how it helped him.”</td>
<td>Story or experience that opposes treatment with medication</td>
</tr>
<tr>
<td>“For me, it helped talking to other parents. I talked to a lot of parents that did use medicine and it seemed to help their child.”</td>
<td>“I had a niece on [medication] who was more like a vegetable, didn’t want to eat, talk, play, nothing.”</td>
</tr>
<tr>
<td>Positive relationship with child’s doctor</td>
<td>“The side effects of the drugs and all the horror stories that you hear. His mom [child’s grandmother] is a nurse, and so I hear it all the time. She doesn’t agree with the medicine.”</td>
</tr>
<tr>
<td>“I had such confidence in my doctor. We talked it through for such a long time.”</td>
<td>Lack of physician support and/or trust</td>
</tr>
<tr>
<td>“The first thing he [pediatrician] said to me was, ‘I want you to calm down. You are not a bad parent. I actually didn’t expect that. I sort of expected him to be like, ‘Here’s the problem. Here’s how we are going to manage it.’ He was actually more comforting to me than anything.”</td>
<td>“I felt intimidated by him because I knew he talked basically and he didn’t want to hear any questions from you.”</td>
</tr>
<tr>
<td>Extended family support</td>
<td>“A lot of times I feel ignored. ... I have read, I have researched ... when I am sitting here trying to talk to you [pediatrician] ... you are not listening to me.”</td>
</tr>
<tr>
<td>“My mom and dad are my support system. Basically, whatever decisions I tend to make, they stand behind me.”</td>
<td>Other information sources that oppose treatment with medicine</td>
</tr>
<tr>
<td>“My Dad was very adamant that we get her on medication, because I was on Ritalin as a child, my little brother was on Ritalin, and he saw it really seemed to help us.”</td>
<td>“I think through the years they had too many things in magazines and so many things on television that scare you half to death when it comes to Ritalin. You don’t want to do anything to harm your child and you are at a disadvantage, because you are not part of the medical community. You have to rely on your doctor.”</td>
</tr>
<tr>
<td>Other information sources that support treatment with medicine</td>
<td>Stigma</td>
</tr>
<tr>
<td>“I went to the library and got books about it. I read and it was definitely my son.”</td>
<td>External stigma: “I don’t want my child or anyone else’s child to be labeled.”</td>
</tr>
<tr>
<td>“When I got on some Web site that had a lot of conversation, people’s input, I said, my son needs help beyond the things we are doing nonmedication.”</td>
<td>Internal stigma: “She just feels different, because she knows she has to take [medication] every day and most kids don’t.”</td>
</tr>
<tr>
<td>Parent belief in biomedical model of treatment for ADHD</td>
<td>General reluctance to use medications</td>
</tr>
<tr>
<td>“I guess I am more open to the medication because I’ve been on thyroid medicine since 1992, and I know how I can’t function to my best abilities if I don’t take it. ... why would I deny my child a medicine that’s gonna help them get through life?”</td>
<td>“I was scared. What have I done? It’s like, I know my child is suffering, but drugs? Is there another way?”</td>
</tr>
<tr>
<td>Failure of other treatment modalities</td>
<td>Giving your child medication that affects their brain. I was pretty scared about it and still am. There is still a part of me that thinks I don’t care that kids have been on this for 50 years, I don’t like it.”</td>
</tr>
<tr>
<td>“I think that there was an element of disappointment that we had to resort to medication. ... We wished that we had been able to somehow find a way to manage this without medication, but clearly, that’s not the case. We’ve done our best, given it our best shot. [Son] is still suffering. We are gonna give it a trial of medication.”</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 4 Domain 3: Continued Doubt and Uncertainty

Theme 7: Medication decisions revisited

<table>
<thead>
<tr>
<th>Awareness of potential long-term consequences of unmedicated ADHD</th>
<th>Parent concern about relying on medicine to fix things</th>
</tr>
</thead>
<tbody>
<tr>
<td>“He [child’s father] didn’t even make it through school. It’s ruined his life. Had no recognition of it back in those days. ... He was punished all the time, because he was always in trouble.”</td>
<td>“My feeling is that I don’t want her, even though she is young, to think that she can pop a pill and the world is going to be okay. Medicine is gonna take all the pain away and make everything better.”</td>
</tr>
</tbody>
</table>

Stimulant viewed as established medicine

“... Ritalin, as we found out, has been around for so long—50 years. I felt like it was probably more safe than these new asthma/allergy medicines.”

Initiation of medication viewed as a time-limited trial

“I didn’t feel locked into it. My doctor said, ‘Let’s try it. Let’s give it some chance to see if it will help him.’ So then I felt more comfortable.”

“It seems it would be a good idea to dip your toe in the water to see how it feels before you jump into the pool.”

Failure: “My son actually started talking about wanting to stop taking the medicine. That was another test we had to just see. I thought if I can navigate him through it, we’ll be okay. When he flipped back and said, ‘I think I need it;’ I was like, ‘Great.’”

DISCUSSION

Parents in our study made decisions about treatment for their child with ADHD in the midst of experiencing a variety of emotions as they witnessed child functional impairments at home and at school. In addition, parents felt stress as a result of their daily efforts to manage their child’s struggles. Mul-
multiple factors influenced the decision to initiate medication. Subsequently, re-
visiting the decision to give their child medicine for ADHD was common. Many
parents contrasted time on and off medicine to help inform management
decisions. Trials stopping medication were almost always parent- or child-
initiated.

This study has several limitations. First, the findings were from a sample
of mainly mothers who were white or black. Also, nearly all parents had tried
medicine for their child with ADHD. Perspectives may or may not differ
from those of fathers or parents of other cultural backgrounds and par-
ents who do not initiate medication. In addition, it is difficult to separate par-
ent views of diagnostic uncertainty, la-
beling terms, and conceptualization of
the disorder, because these feelings and perceptions coalesce and impact
decisions about treatment. Qualitative
research offers a rigorous alternative
to armchair hypothesizing in areas for
which insight may not be well estab-
lished or for which conventional theo-
ries seem inadequate.17 In this case,
what was not well understood was
how parents make decisions about
treatment for their child or adolescent
with ADHD. Using focus groups, we
probed, in-depth, the perspectives of a

group of parents of children and ado-
lescents with ADHD. Interpretations of
the parents’ statements were made by
consensus of a group of readers with
varying perspectives. Together, the au-
thors developed an explanation of how
parents make ADHD treatment deci-
sions. This study was not meant to pro-
duce any conclusion about the phe-
nomenon under study that could be
generalized to all parents of children
with ADHD. Opportunities exist for
quantitative investigations to test the
implied hypotheses about relations-
ships between variables identified that
influenced parents in our study.17

It is possible that the group setting
may have inhibited some parents from
participating in these focus groups. It
is also possible that parents who
struggled were more likely to choose
to participate. For many parents the
group discussion seemed to have a ca-
thartic effect. Some parents yielded an
unanticipated source of support as
they exchanged information about
ADHD-related resources and/or ex-
changed telephone numbers after the
focus group concluded. Despite these
limitations, this study suggests that
a variety of factors influence the de-
cision to initiate medication. Our an-
alysis of parent comments corrobo-
rates previous work in this area and
provides a far more comprehensive
collection of factors than previous
studies.4–7,25–35 Previous efforts imple-
menting the American Academy of Pe-
diatrics clinical practice guidelines for
the diagnosis and treatment of ADHD
demonstrated a need to augment the
time-constrained efforts of physicians
to educate and support parents.36 Fu-
ture studies are needed to develop and
test systems to support parents facing
treatment decisions for their child
newly diagnosed with ADHD.

After initiating treatment, stopping
and restarting medicine for ADHD is
common.11,37,38 Qualitative methods,
such as those employed in the current
study, are essential to develop a richer
understanding of this phenomenon.
Parents in the current study and oth-
erness8,28,40 continue to experience fears
and worries related to the potential for
long-term adverse effects, even if their
child shows marked improvement.
This phenomenon is especially perti-
nent given ongoing public discussion
of the effect of stimulant medications
on growth14,47 and the possible linkage
between sudden cardiac death and the
use of ADHD medications.8,45–47 Past
and present experience of adverse effects
is also a cause for concern. In some
cases, lack of child willingness to take
medicine is a significant challenge. It is
noteworthy that child refusal to take
medication continues to be a signifi-
cant issue despite the advent of ex-
tended release preparations that elim-
inate the need for a daily visit to the
school nurse’s office and thereby re-
move much of the stigma of taking
medication for ADHD. Parents weigh
medication concerns and challenges
against the functional improvements
seen at home and at school. It is ex-
pected that children and adolescents
and their parents question whether
their goals can be achieved without
medication. Contrasting time on and
off medication is a rational way to in-
form decisions about the continued
necessity of treatment. Although this
may run counter to traditional ideas
about “adherence” and lead to some
second guessing for those whose
problems recur off medication, such
trials are likely to reduce a great deal
of anxiety and uncertainty on the part
of children and adolescents, their par-
ents, and physicians.

Given the low rates of ADHD medication
follow-up that have been document-
ed,48–52 it is not surprising that parents
in this study rarely reported physician
involvement in trials stopping medica-
tion. To our knowledge, there are no
estimates in the literature for how of-
ten physicians coordinate such trials.
The American Academy of Pediatrics
clinical practice guideline for the

treatment of ADHD53 emphasizes the
importance of ongoing monitoring of
target outcomes and adherence to the

treatment plan, but does not explicitly
discuss trials of medication discontin-
uation. Recently, authors of the Multi-
modal Treatment Study of ADHD in Chil-
dren have recommended this practice
to determine if there is continued need
for medication or if symptoms have re-
mitted.54,55 Recently updated ADHD
treatment guidelines from the Ameri-
can Academy of Child and Adolescent Psychiatry and the Institute for Clinical Systems Improvement provide guidance for the conduct of such trials stopping medication: “(1) consider annually when stable and doing well; (2) best when there are few transitions or demands (eg, midschool year); (3) avoid at beginning of any school year, especially at the start of junior/senior high school; and (4) try discontinuing medications for 2 to 4 weeks with close monitoring of target outcomes.” Anecdotally, some families who stop treatment on their own face a crisis (eg, school failure, delinquency, etc) before they resume medication. This begs the question, how much struggle is necessary to raise awareness of the continued need for medicine? Future studies should test whether physician-directed trials of medication discontinuation can identify children and adolescents with ADHD who continue to suffer from functional impairments in a timely manner and avert undesirable outcomes. Studies are also needed to identify additional reasons why children with persistent ADHD symptoms stop and/or restart medication treatment. The current study elicited the parent perspective on ADHD treatment decision-making. Additional studies are needed that elicit the perspectives of children and adolescents with ADHD as well as the views of their primary care doctor.

CONCLUSIONS

This study provides evidence that decisions about medication for children and adolescents with ADHD are made and frequently revisited by their parents. Choices are often made under stressful conditions and a variety of factors influence these decisions.

Striking a balance between benefits and concerns is an ongoing process that is often informed by contrasting time on and off medication. Development of strategies to support families across the continuum of decisions faced while managing ADHD is warranted. Future studies are needed to determine the efficacy of such interventions and guide their implementation in clinical practice.

ACKNOWLEDGMENTS

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Parental Angst Making and Revisiting Decisions About Treatment of Attention-Deficit/Hyperactivity Disorder


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