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Parental Involvement in Treating Arab Adolescents with ADHD

KEYWORDS: Parental Involvement, Treating, Adolescent, ADHD

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ABSTRACT *ADHD disorder is resulting from pathological development of the central nervous system. Among the most prominent symptoms of the disorder include: attention problems, difficulty concentrating, hyper-activity and impulsivity. ADHD can be expressed in all walks of life, and may adversely affect many common activities such as learning, including work on interpersonal relationships. Not only that, but this is a disorder that develops over time sequence, of different ages and especially between the ages of adolescence. Adolescence is considered one of the most sensitive periods developmentally, which generally is characterized according to the physiological changes that occur during this period. However, this time there is bodily changes occur fertile field changes in mental, emotional and social. However, this time there is a bodily change occurs in the mental, emotional fields. The presence of ADHD during adolescence may worsen if only because of the physiological changes that bedevil the body. it may get worse very consequences that accompany adolescence. Which in turn add to the potential worsening of the disorder, in the circle of influence over again? The present study examines the awareness, involvement and coping strategies of parents of adolescents with the effects of ADHD suffers adolescent son. To answer the research question, a quantitative study was conducted in which questionnaires were distributed in the areas of awareness, involvement and parental coping among 160 parents for adolescents aged 11-15 years, who diagnosed with ADHD. The findings showed that: (1) the more parents are involved in the therapeutic process of a teenage son who suffers from ADHD, are also parents who have a greater awareness of family context of ADHD, they must have the same parents who receive more social support from the community to which they belong, (2) the parents that they have not broad social support in their community during the treatment of their son, they mostly likely will feature a lower level of involvement, (3) parents who involved in treating their son who suffers from ADHD, are also characterized by high satisfaction with therapeutic services that provided to their son, (4) discovered a relationship between age child who suffers from ADHD and parental involvement in their treatment, so the parents for youngest child would show a greater involvement in the treatment of their son, as well as parental expectations from the child. In conclusion, the implications of this study can certainly assist professionals and practitioners in the fields of diagnosis and treatment of ADHD. However, accelerator research professionals in this area to work more on the relationship and cooperation between parents treat each issue of child advocated with ADHD.*

What does that mean ADHD?

ADHD, or as a foreign language called attention-deficit hyperactivity disorder or is difficulty in the ability to process, sort and appropriate stimuli and focus on the most desirable of all the sensory or emotional stimuli in a given period. Organic deficiency disorder is due to the activity of neurotransmitters in the brain, it is not a passing mood or behavior problem. Sometimes a prominent component hyperactive disorder (hyperactivity (. The diagnosis is based on three axes: continuity of attention, impulsivity, hyperactivity (Epstein, Richerd & Loren, 2013).

ADHD is now considered the number one of difficulties in coping children, parents and teachers with children daily problems and studies. ADHD can neutralize children even if they are intelligent and talented as they are. ADHD often affects personal progress and does not allow them to realize their potential and achieve. Not only that, but ADHD often accompanied by behavioral and emotional problems that should be attention and response to treatment. ADHD in boys more than in girls and is characterized by symptoms very clear: low concentration, difficulty can delay or impulse response (impulsivity), restlessness, excessive movement and/or oratory without interruption. ADHD Here is a one medical syndrome, but because of the attributes of different behavior, tend to separate it into two groups: those who are able to sit quietly, only non-concentrated and they seem more detached and dreamy (professional terminology- ADD), and those who are not concentrated but their behavior is precisely the opposite of the first group and unrest and the constant need to be on the move is characteristic of them. This team (professional terminology- ADHD) usually has discipline problems and social problems (Tannock, 2013). A person will be considered as having ADHD if his behavioral defects affect his quality of social functioning, academic or occupational. This definition in DSM-V is fundamentally different from the definition set earlier versions of the DSM-IV, in which the defect must be clinically significant (Loren, Richerd & Epstein, 2013). Compared to the DSM, the international classification of mental and behavioral disorders ICD-10 (World Health Organization, International Statistical Classification of Diseases and Related Health Problems) still defines ADHD as a disorder hyper-kinetic. This classification system defines the disorder as impairment sustained and consistent psychological development, characterized by early beginning (under 6 years old) and a combination of disorderly conduct accompanied by an ongoing lack of involvement in the mission. This definition states that the disorder worsens and sustained over the years of the child

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

in school, but can also show up and take his adult life (Polanczyk, Willcutt, Salum, Kieling & Rohde, 2014).

ADHD prevalence in the country and the world

There is great variation between different countries in the world regarding the prevalence of ADHD in any way relating to the phenomenon and its definition. According to ICD-10, accepted estimate of the prevalence of ADHD in the population is between 1% and 2%. In contrast, according to the DSM-V frequency ranges between 4% and 8%. Various clinical samples found that the incidence of ADHD population is 3% to 10%; In Germany the incidence rises to -17.7% and the US with 12.5% (Wolraich, Hannah, Baumgaretel & Feurer, 1998). In Israel the incidence of ADHD population is 5% to 10%, and in the Israeli Arabs adolescent population, incidence of ADHD can reach up to 15-20% According to the general assessment of educational psychology services in the country. It should be noted that in general 50% -70% of children aged 6-12 have been diagnosed as having attention deficit disorder diagnosed during adolescence so (Wolraich et al., 1998).

The main symptoms of ADHD

The symptoms of ADHD are divided into three main groups: (a) difficulties in attention and concentration; (B) impulsivity; (C) hyperactivity. These core symptoms affect a person's functioning at home, in the community, at school and at work. For the most part, the primary expression of symptoms occurs in childhood, already in kindergarten or even before age 3 years and their impact can be more acute in adolescence (Abraham, Windmann, Siefen, Daum & Gunturkum, 2006).

1. Difficulties in attention and concentration:

One of the main characteristics of ADHD is impaired and / or difficulties in attention and concentration ability of the individual, including adolescent. Adolescent with a disability or difficulty in this area will find a difficultes to absorb stimuli from its surroundings, as well as he will find a difficulties in his ability to collect and focus his mental energy into a single task is compromised. A state of his disability or difficulty in attention and concentration contents of a stream of consciousness will change quickly, his thinking get lost in different directions and move randomly from topic to topic, and he will suffer often from lack of his ability to perform two things at once and from difficulties in his memory, even when the mechanisms of his memory not injury (Abraham et al., 2006).

2 Impulsivity:

Impulsivity is one of the main characteristics of ADHD, and is caused by the difficulty in controlling impulses. an impulsive man perform different actions without thinking about their consequences, whether positive or negative, even though he has the knowledge and ability to understand them. In terms of social development, a high level of impulsivity was associated with poor interpersonal relationships of children with their peers (Goshen-Gottstein & Zacai, 2006).

3 Hyperactivity:

Hyperactivity may develop in the early years of life and reflected by significant difficulty to avoid or stop certain activities, in spite of the will of man to do so (Brown, 2005). Manifestations of hyperactivity may interfere the child and adolescent environment and cause to conflicts with their peers and with their authority characters such as parents and teachers. Moreover, children and adolescents with hyperactive experienced less admiration and receive less positive reinforcement from adults around them - this is because adults tend to tire of intensive interaction with them and spending less attention to them. In school hyperactive student likely will move much than the other and bother other children in classes, thus affecting their teachers and could cause a collision with them. As a result, children and adolescents with hyperactive Will be redirected to the position of failure and experience great frustration than other children in the classroom. ADHD in adolescence is moving on two axes, which are to be understood for the purpose of diagnosis and treatment: the symptoms of ADHD in this age, especially if not diagnosed earlier, and symptoms of adolescence itself, which is often a catalyst or distorts the whole picture (Tiano, 2010; Steinberg, 2006).

Characteristics of ADHD in adolescence

Adolescent learning much more complex, it requires attention to detail and sequence, and therefore the ability of intellectual finds increasingly difficult to disguise the difficulty of attention itself. Also, a teenager who suffers from attention deficit disorder and did not receive proper treatment on it, he will feel a considerable psychological harm that will affect the formation of his personality. His personality is built around a disorder or around the injury various functions. This stage is characterized by manifestations such as stiffness, de-values of studies or alternatively the ability to self-study, application of energy to the social field as a substitute in the educational, copy of rage and self-hatred to society as a whole through acts offenders, vulnerable motivation to drop out partially or fully from the teaching framework and further more. Also, there is a tendency to relieve stress through self-healing (self-medication) - using of materials such as coffee, alcohol and drugs (Tsai & Gau, 1999). Both in the family and the environment created image of a not successful boy, lazy, careless and in some cases even stupid. in this case, parents express despair and anger, and the school gives up and sends the boy to learning frames with a lower level of expectations, which would be easier to handle. Adolescents who remain in the regular school feel ongoing frustration, because they lead a struggle for survival, which includes tutoring, ongoing struggle with a school because of repeated clashes with the school setting. These adolescents will experience a sense of boredom on the one hand, and the feelings of frustration and anger on the other. in contrast, adolescents with treated ADHD since they were kids, generally found to have a normal functions. it is generally believed that a third of adolescents cease to suffer from attention deficit disorder when they become adults. In addition, in adolescents with ADHD who receive appropriate treatment registered a gradual decay of hyperactive and impulsive symptoms, and therefore there is no stimulation of the hyperactivity and impulsivity by frustration, anger and being sidelined (Levin & Kleber, 1995). Teenager who aware of his ADHD and understand its importance and significance can deal with it better and mature. the need for drug treatment, if there is a good response to it, drawn in any situation where an individual is required to focus on long-term irritation, especially under the pressure of time, for example examinations (Tsai & Gau, 1999).

ADHD through the eyes of the adolescent's family with disability and their ways of coping

Studies show that family atmosphere has a decisive influence on the intensity of the ADHA disorder in adolescents. It was found that psychosocial factor such as the nature of the relationship between parent and adolescent, the degree of family stability and the extent of social support that the adolescent gets from his family influence on the

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

empowerment of his ADHD symptoms (Barkley, 1997). More difficult is that symptoms of ADHD causes increased tension in the family, the multiplicity of conflicts and negative communication between the family, and causes a feeling of failure in fulfilling parental role (Barkley, 1997; Pelham & Gnagy, 1999; Lewis-Abney, 1993). Families with adolescent with ADHD may suffer damage to the normal agenda of the family, so much so, avoiding the parent's ability to adapt to ADHD symptoms, and including them in a family life routine. The constant struggle, instability and inconsistency in adolescent behavior prevents parents to create a family routine and maintain it. As a result, stress levels, and frustration and exhaustion are becoming higher (Barkley, 1997). Also, those parents of adolescents who have ADHD see themselves as a poorer parent and less skilled (Mash & Johnston, 1990). Those parents experience more stress as a result of their parental functioning (Anastopoulos, Shelton, DuPaul & Guevremont, 1992). It was also found that parents for adolescents with ADHD have a difficultes in social life and psychological functioning (Barkley, Murphy & Ficher, 2010), and will experience more divorces and depressions (Lahey, Piacentini, McBurnett & Stone, 1988).

Parental awareness and involvement of parents in treating adolescent with ADHD

The term "parental awareness" refers to the typical thought patterns of parents about their children - how they tend to understand the child's behavior, their role as parents and the functions they fulfill. These trends are related knowledge, beliefs and thought patterns that arise when a parent has to make a decision regarding the child (Cohen, 2006). Recently, begin to recognize in the field of clinical psychology, the efficacy of "parental care" and see it as a clinical intervention and a critical facilitates for the child's difficulties and his problems (Cramer, 2000). This recognition is a renewal of psychodynamic therapy, and it puts the focus on family therapy from the general system to a subsystem parents (Diamond, Diamond & Liddle, 2000). To promote parental care is important to better understand the complexities of working with parents about child-related issues, both from the perspective of the caregiver and from the perspective of parents.

Pantone (2000) argues that while most parents sincerely want to help their children, they may resist the process itself as it involved a thorough review of the issues which have avoided for years. Parents play two roles - patients who are looking for assistance, and significant characters that help their children. Therefore, parents care requires a flexible combination of consulting, collaboration and care, and this is a major challenge for many caregivers. other studies have found that how parents perceive the factors that influence their child's behavior (reference style) and the degree of control they believe they have about their child's behavior (degree of perception of their parental self-efficacy) associated with behavioral and emotional reactions toward the child. It was also found that the reference style predictors of the quality of parent-child relationships and child development in general. Among parents of children diagnosed with ADHD attributions were associated with treatment outcome and severity of the child's behavioral disturbance (Jacobs & Wachs, 2002).

According to Newberger (1977), there are four stages to levels of parental awareness. Each level includes the systems considerations from previous levels and adds a new set of considerations, which are qualitatively different:

1. Egocentric level: at this point parents understand their children especially in terms of their individual efforts, and their parental role revolves around personal needs and wishes.
2. Conventional Level: at this stage parents understand their children in terms of stereotypes, explanations and definitions externally, through tradition, culture or authority. Parenting role at this stage revolves around social conventions.
3. The child-centered level: parents at this stage perceive and understand the child as a special individual that they can understand him through the parent-child relationship intimate, rather than through external settings. Parents accumulate a vast amount of knowledge and insight into their child's behavior.
4. The level of relationship: parents at this stage understand their child psychologically complex and changing and acknowledge that both they and their child develop through their roles in parent-child connection. The parent knows that his job is to try all the time to find the right balance between competing needs in charge of the parents, the family and the child.

Parental awareness level at some point could also reflect a regression or delay the use of existing capabilities due to anxiety, stress and depression that affect parental functioning. Moreover, the accumulated frustration of the parent and the parent's needs repression against the son's regulatory difficulties may challenge parents to recognize adolescent and even lead to power struggles among them. Interventions, therefore, is effective whether it helps promote or restore your mentalizing abilities of the parent. Cohen (2006) believes that the guiding principle of parental care is constructing a new parenting experience with the help of the therapist felt. These experiences can lead to changes in parental beliefs and reflective capacity. Combining the family in early intervention program is currently the profit model in Western countries, and the status of their parents gradually moving from the position of brokers and agents of change to the role of active partners. at the same time transferred the resources for change among professionals for deepen their training for work and for partnership with a parents (Gallagher, Rhodes & Darling, 2004) . Functional family parents are the constant and central cared for adolescent throughout his life, and take responsibility for its development. Parents of a teenager with special needs are also knowledgeable about his special needs and have previous experience in the evolution of intervention that helped their adolescent son (Jeffries, 2009). However, parents need the support of professionals to make decisions related to their child's education and rehabilitation (Keen & Knox, 2004).

Some models have been described in the literature of parental involvement and family co-education and rehabilitation programs. Various researchers (Dempsey & Dunst, 2004) proposed to study the therapeutic programs where the family is coming on a continuum that reflects the policy makers and the attitude of professionals about sharing family in this program. This sequence which identified four theoretical models represents parental involvement from a lowest rank to the highest level, as outlined below:

- A model that focuses on professionals: the therapist is perceived as an expert, and this therapist who determines the family's needs and the level of parental involvement in the treatment process.
- The family as an agent for change: parents helping in the process of activating an intervention program that prepared by professionals.

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

- A model that focuses on the family: parents and professionals collaborate in the preparation of the intervention goals, and the family is assisted by professionals to get an answer to the needs of the family.
- The family center model: the family needs that identified by parents, determine the intervention plan which aimed to strengthen and empower the family to be able to meet the needs of herself.

Some researchers have focused on the gap between the reporting of parents and that of the professionals of the degree of family cooperation and contribution to the development of their teenage son. This difference is probably related to the fact that professionals find it difficult to work with parents in the therapeutic process. It was also found that the way in which services are provided to the family, affects the results of the intervention (Dempsey & Keen, 2008). The involvement of parents in the therapeutic process and their participation in it was examined in relation to four areas:

1. Promoting and improving the achievements of children: some empirical studies are strengthening the notion that co-parents in the therapeutic process, and can contribute to the progress of the child, and that the involvement of parents have a positive and long-term of the Son functioning, and for his development and for a various dimensions of his behavior, and his psychological well-being (Dunts & Trivette, 2009).
2. Increasing the level of satisfaction of parents' from intervention program: recognition of the importance of sharing family in therapy or in education of the child and designing programs in which the family in center is committed to assess the satisfaction of the parents of the treatment and from the services which provided to them in the therapeutic process.
3. Improving the level of self-efficacy, mental well-being of parents and family functioning: family system is responsible for the process of child development and his functioning. The assumption is that parents will get stronger and will benefit from involvement in the therapeutic process (Mahoney & MacDonald, 2003).
4. Improving the performance of the professionals in the therapeutic process (Dunst & Trivette, 2009).

The partnership between professionals and parents is the core of the success of treatment programs for children and adolescents with special needs. Parents bring to the session with professionals attitudes and educational approaches to child-rearing, beliefs about disabilities and abnormalities in the general society, as well as positions on the involvement of foreign elements in the intra-family interactions (Kelly & Barnard, 1999). Researchers (Mahoney & O'Sullivan, 1990) identified two key characteristics associated with parental involvement in the design process of the treatment plan and decision-making: the individuality of the program and its adaptation to the unique needs of the family. They argue that only a combination of these two features will lead to a significant involvement of parents in the education process of their child-adolescent therapy.

Well, the literature points to the special importance to the participation of parents in decision making process related to child care and its future (Sheehey, 2006). It should be noted that studies have shown that when parents are involved in decision making related to caring for their children strengthened their sense of control and parental competency, and they may even increase their cooperation with the caretaker system. In contrast, parents who do not take part in decision making are experiencing frustration and do not find an answer to their expectations and aspirations (Turnbull & Turnbull, 2001).

The question is whether the parents are more aware and more involved in the therapeutic process of their teenage son with ADHD, so there will be fewer symptoms of ADHD in their teenage son.

Methodology

The study involved 160 parents whose children adolescents diagnosed with ADHD. Of the patients (69) fathers and (91) mothers. the parents were selected through parent groups, with people that I know, and by using a sampling method known as "Snowball", under which the questionnaires were distributed to a wider circle of a just over a third of parents (36.3%) are between the ages of 31-40 and a rate of 29.4% of parents are younger, aged 20-30. all in all nearly two-thirds of parents (65.7%) are aged 40 or less. other parents are aged 41-50 (21.9%), and the proportion of 12.5% of parents are older than age 50. cquaintances by the participants themselves. in all parents their child's ADHD is not the only child. in 21.9% of families have another child in the household, with 42.5%, has two children and more families (35.6%) have three or more children. almost 50% of parents and adolescents sampled are Christians (48.1%), and the rest are Muslims (30.0%) and Druze (21.9%). more than half of parents with a university education (56.3%). about a quarter of parents (24.4%) have higher education and the other parents are high school graduates (11.3%) or low levels of education result (8.1%). parents' responses show that only 61.3% of them are currently working.

The study refers to the population made up two-thirds of boys (62.5%) and a third of women (37.5%), which range in their ages ranged from 9 to 15 years. The average age is 12.24 years and the median age is 12 years (standard deviation 1.12). Nearly half of adolescents (48.5%) are aged 12 and a rate of 27.3% of adolescents are aged 13, that most adolescents are aged 12 or 13.

Research Tools

This study used the following questionnaires:

1. Demographic questionnaire: details about the parents and the child. Parent's info: gender, age, religion, education, occupation, spouse's occupation, number of children in the family, place of residence. Details of the child's age and gender.

2. Questionnaire for sense of empowerment (Koren, Dechill & Friesen, 1992): this is a tool that examines the components of a sense of empowerment and how a sense of empowerment pronounced among parents of children with special needs. We used this questionnaire and adapted it to our research. The questionnaire includes 32 statements that require the patient to rate his consent on a scale from 1 to 5

1 = strongly disagree, 5 = strongly agree. Statements were divided into three levels:

(a) The level of the family: two statements. For example: I feel that my family's life is in my control.

(b) Community level: (3) statements. For example: I feel that I can be a part of improving and advancing performance of my children in the community.

(c) The level of awareness and involvement: (19) state-

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

ments. For example: I feel that I have the right to refuse the professional treatment which proposed for my child.

3. The questionnaire of involvement and participation: (7) statements. For example: determining the treatment plan of my child.

Findings

Characteristics of awareness of parents of the treatment process and the extent of their intervention in this process - the main measures of dispersion and reliability (Cronbach alpha).

Reliability	Standard deviation	Averae	Study variables	
0.532	.30	3.97	Awareness of the phenomenon in the family	Awareness of parents
0.29	.28	3.83	Satisfaction from therapeutic services	
0.649	.36	3.73	Social and community support	
0.819	.51	3.71	Involvement and participation in the treatment process	

As you can see, the level of awareness of parents in connection with the treatment process is generally moderate to high relative scale of measurement.

It was found that the average answers of parents in relation to family empowerment is 3.97 (standard deviation 0.30), depending on their therapeutic services the average is 3.83 (standard deviation 0.28), and finally in the context of community support the average is 3.73 (standard deviation 0.36).

The first hypotheses of the study claimed to be a relationship between the awareness of parents about their children's treatment process and the extent of their involvement and participation in this process. To this end, we examined correlations between different variables, as detailed in the table below.

Table of correlation coefficients between the characteristics of awareness of parents of the child's therapeutic process and the level of involvement and participation in the treatment process.

Involvement and participation in the treatment process	Social and Community Support	Satisfaction from therapeutic services	Parents' awareness of the disorder	
			1	Parents' awareness of the disorder
		1	.619**	Satisfaction from therapeutic services
	1	.440**	.558**	Social and Community Support
1	.534**	.397**	.591**	Involvement and participation in the treatment process

**** p<1%, * p<5%**

In general, the analysis shows that there are statistically significant positive correlations among all study variables.

In detail, is also a significant positive correlation between the degree of awareness of parental family context, and the degree of their involvement in the therapeutic process ($r = 0.591$, $p < 0.01$), which indicates about presence of a positive relationship between the two measures, involved more parents in the therapeutic process, and parents more aware about ADHD in the family context, and vice versa. these findings are confirmation of the first research hypothesis.

Similarly, a significant positive correlation was found between the level of awareness which reflected in a support of the community, which is in the vicinity of the parents, and the involvement of parents in child care ($r = 0.534$, $p < 0.01$). This correlation indicates a positive correlation between the two indices; so that parents who are more involved in the therapeutic process, they are parents who receive more social support from the community to which they are belong. This relationship also works in the opposite direction, that is, parents who not receive a social support from the community will have a lower level involvement in the therapeutic process. these findings are corroborated second research hypothesis.

Finally, we examined the correlation between the involvement of parents in the therapeutic process, and the parents' perception of professional therapeutic services provided to the child. The analysis results indicate a significant positive correlation between the two indices ($r = 0.397$, $p < .01$), which suggests a positive correlation between the two indices. This relationship suggests that the more involved parents are also those characterized by greater satisfaction about their child receiving therapeutic services, in accordance with the third research hypothesis.

Additional findings as part of an analysis of correlation coefficients for the first three research hypotheses indicate a significant positive correlation between the dimensions of awareness among parents and themselves. In this context it is determined that there is a significantly positive correlation between the degree of familial awareness of disorder, and the degree of social support that the family receive from the community ($r = 0.558$, $p < 0.01$), and the degree of familial awareness of disorder and the satisfaction from the therapeutic services that they receive ($r = 0.619$, $p < 0.01$). In addition, it was found that a significant positive correlation between satisfaction from the therapeutic services, and the extent of social support that they receive from the community ($r = 0.440$, $p < 0.01$).

These findings suggest that parents with greater awareness of the disorder will feature a higher level of social support from their community, and their satisfaction from a therapeutic service that they receive will be higher.

The fourth hypothesis was that the involvement of parents in the therapeutic process is related to the age of the children. To this end, we examined the correlation between the study variables and the age of the children, as detailed in the table below.

Table of correlations between parents' awareness of the characteristics of the therapeutic process of the child, and the involvement and participation of parents in the therapeutic process and the age of the child.

Age of the child	

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

-0.318	Parents' awareness of the disorder
-0.171	Satisfaction from therapeutic services
-0.255	Social and Community Support
-.971**	Involvement and participation in the treatment process

**** p<1%, * p<5%**

The analysis shows that there is a significant negative correlation between the degree of involvement of parents and their participation in the therapeutic process and the child's age (r = -0.971, P <0.01), which indicates that parents of young children more characterized by the fact that they have a higher level of involvement than parents bigger children. This finding is corroborated fourth research hypothesis.

More interesting to see in this analysis that there was no correlation statistically significant association between awareness of parents about this disorder, and the age of the child, as well as no correlation between the degree of social support that the family receives from the community, and the degree of satisfaction of parents from the therapeutic services that their child receives.

If we summarize the findings up to now, then we can point to a positive correlation between the degree of involvement of parents and the degree of awareness of parents, social support that parents receive, and the satisfaction of parents from athe therapeutic services that they receive, and that the involvement of parents in the therapeutic process decreases in the case of older children.

In this context it was interesting to examine some of those variables that significantly affect the level of involvement of parents. to do this, regression analysis was performed in which parental involvement in the therapeutic process was used as the dependent variable, and both: parents' awareness and age of the children served as the independent variables. The results of the analysis are in the table below.

Regression analysis results from the involvement of parents in the therapeutic process (depending) and the awareness of the parents and the age of the children (independing).

Regression Properties	T	B	Explanatory variable
R^2=.947 $F_{4,28}$=125.7**	1.166	.066	Parental awareness about the disorder
	-1.261	-.066	Satisfaction from therapeutic services
	-.616	-.029	Social and Community Support
	-20.851**	-.969	Age of the child

**** p<1%, * p<5%**

The above table shows that the regression model that we tested is statistically significant (F4, 28 = 125.7, p <.01), and the model explains 94.7% of the variance of the dependent variable. This regression model found that the only factor that has a significant effect is the age of the children (β = -. 969, p <.01), its and has a negative impact on the level of involvement of parents.

In other words, the results of the regression model indicated that the most dominant factor in involvement of parents in the therapeutic process is the age of the children when the parents of younger children are more involved and their involvement becomes smaller when their older children.

These findings also indicate that the effect of the age of the children on parents' involvement is strong than the effect of the degree of their awareness of the disorder, and from the degree of social support that they receive from the community, and from their satisfaction from the therapeutic services. In fact, it turns out that the effect of age mediates the effect of these dimensions of parental awareness.

Discussion and conclusions

This study attempted to examine the relationship between parental awareness and involvement of parents in handling and of parents dealing with ADHD in their children. The hypothesis assumed that there is a positive correlation between parental awareness and the involvement of parents in the adolescent therapeutic process. Other hypotheses assumed that there is a positive relationship between social support and involvement of parents and the parents' satisfaction from a treatment. Also, another hypothesis was that that there is a relation between the children's age and the involvement and participation of children in own treatment.

The findings indicate a correlation between all variables in the study. the hypotheses were confirmed independently, and moreover, are integrated correlation which found that parents with greater awareness to ADHA will feature a higher level of social support from the community, as well as their satisfaction from therapeutic services that they receive will be higher.

Relationship between parental awareness and involvement in the therapeutic process

The first hypothesis assumed that would be a positive correlation between the awareness of parents and their involvement in the therapeutic process, which means that as parents more aware ADHD so they will be more involved in the therapeutic process. According to this hypothesis, parents who are more involved in the therapeutic process are also parents with greater awareness of the family context of ADHD.

This finding is also supported within the framework of their respective premises which hold that the family when children with special needs, parents are required to participate in the educational process and its reconstruction, and to take responsibility for this process. Parental awareness of child difficulties rising, in part, based on the guidance of therapists, and dedicating special attention from dealing with the relationship with the parents.

When the level of awareness rises, parents can establish multiple patterns for better communication with their child, resulting in emotional basis for developing interactions that promote the child's future (Jackson & Turnbull, 2004). Increased involvement with awareness of the problem and this fact can be explained so that parents understand better the factors that affect a child's behavior, and therefore feel a greater degree of control over his behavior.

Moreover, it is likely that a greater involvement in child care and teaching the subject of the professionals involved in the various programs will raise the level of awareness of the problem, its severity and its various forms as reflected in the specific adolescent patient (Dempsey & Keen, 2008). This finding can be explained with the high percentage of academics who participated in the study.

Volume : 6 | Issue : 8 | August 2016 | ISSN - 2249-555X | IF : 3.919 | IC Value : 74.50

The relationship between social support and parental involvement

The second hypothesis assumed that there is a relationship between social support and parental involvement, so if social support is higher, so parents will appreciate and increase their involvement. Hypothesis was confirmed, and found that there is a positive correlation between the two indices, so if the parents are more involved in the therapeutic process are also getting a lot more social support from the community to which they belong.

This relationship also works in the opposite direction, that is, parents who do not receive social support from the community will feature a lower level of involvement in the therapeutic process.

This finding can be explained by reducing stress among families who receive social support (Dunst & Trivette, 2009). This relief reduces the burden from the family hid the problem, and strengthens her on her work. Social support is most significant if the family feels isolated in front of everyday problems and in front of the child's behavior. When the family feels that she can not perform certain activities for fear of criticism towards her child, and his problems, it will try to hide the problem, and ignore the importance of treatment.

The relationship between satisfaction and parental involvement

The third hypothesis is also verified. This hypothesis assumed that there is a relationship between satisfaction and parental involvement, so if parents express more satisfaction from the adolescent treatment, they will appreciate the extent of their involvement. This relationship suggests that parents who are more involved, they also are characterized by much satisfaction about the therapeutic services that their child receives.

This finding can be explained by the fact that the level of parental satisfaction from treatment plans based on the type of therapeutic services which provided for adolescent (Dempsey & Keen, 2008). The main predictor of satisfaction of parents is parental role in the treatment program, the importance of parents, and parents' sense of control in determining the therapeutic targets and therapeutic goals (Dempsey & Dunst, 2004).

The connection between the child's age and the involvement and participation

The fourth hypothesis, which assumed that there is a relationship between the age of the child and the involvement and participation of parents, so if the age of the child is younger, so parents will appreciate the extent of their participation, has been confirmed. The explanation for this is related to the fact that most preschool programs are oriented where the focus is on the family, unlike that intervention programs for older children, where the focus is on the child (Ngui & Flores, 2006).

The studies found that if children aged are younger, then parents reported that treatment programs will be targeted for both, and parents will place the needs of the family in the center. the study is indicates the treatment programs for children at a young age and highlights the essence of parent's sharing more than a parent's intervention programs for older children.

Parents of young children feel higher levels of satisfaction with therapeutic services which provided to them, and say they have carried partnership more effective and consistent with the professionals. So if the child will be younger and treatment programs would be more satisfactory, the perants level of involvement will be higher.

Furthermore, the adolescent age is the most dominant factor affecting the degree of involvement of parents in the way that parents of young children involved than parents of older children. This factor is dominant and principal than their level of awareness, and than the degree of social support that the family receives from the community, and their satisfaction from therapeutic services. Explanation for this finding may be related to the fact that if the child is younger, so parent's expectations from the child will be higher. These expectations will push the parents to show a greater involvement in an attempt to move their child to achieve the best results.

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