Rev. Latino-Am. Enfermagem
2015 Nov.-Dec.;23(6):1090-6
DOI: 10.1590/0104-1169.0249.2653
www.eerp.usp.br/rlae

Original Article

Adolescents with attention deficit hyperactivity disorder and exposure to violence: parents' opinion[1]

Jaqueline Rodrigues Stefanini[2]
Zeyne Alves Pires Scherer[3]
Edson Arthur Scherer[4]
Luciana Aparecida Cavalin[5]
Mariana Santos Guazzelli[6]

Objective: to identify the opinion of parents or guardians of adolescents diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) about their children's exposure as perpetrators or victims of violence situations in family life or outside. Method: qualitative study with use of thematic oral history. Nine parents of 07 adolescents with ADHD participated. Data were collected from April to September of 2013 using thematic interview. The interviews were recorded at scheduled times at the participants' home, with an average duration of 30 minutes. The findings were submitted to inductive thematic analysis. Results: data analysis allowed the identification of the occurrence of "Conflicts in family life" and "Conflicts in the context of school and community". Parents reported the involvement of their children as victims, perpetrators and witnesses of physical and psychological violence, and the difficulty of them and the school to understand and handle these situations. Conclusion: violence occurs in ADHD adolescents' interpersonal relationships. Communication between health professionals, school and families is precarious. Through the systematization of nursing care, nurses can plan strategies that articulate support networks and interpersonal relationships of adolescents with the disorder (family and school).

Descriptors: Attention Deficit Hyperactivity Disorder; Adolescent; Family; Violence.

[1] Paper extracted from master's thesis "Parents' understanding about Attention Deficit Hyperactive Disorder in adolescents and their exposure to situations of violence", presented to Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil.

[2] Doctoral student, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil. Scholarship holder from Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq), Brazil.

[3] PhD, Professor, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, PAHO/WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil.

[4] PhD, Psychiatrist, Hospital das Clínicas, Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, SP, Brazil.

[5] MSc, Psychologist, Instituto Federal de Educação, Ciência e Tecnologia de São Paulo, São Paulo, SP, Brazil.

[6] Occupational Therapist.

Corresponding Author:
Zeyne Alves Pires Scherer
Universidade de São Paulo. Escola de Enfermagem de Ribeirão Preto
Departamento de Enfermagem Psiquiátrica e Ciências Humanas
Av. Bandeirantes, 3900
Bairro: Monte Alegre
CEP: 14040-902, Ribeirão Preto, SP, Brasil
E-mail: scherer@eerp.usp.br

Introduction

Psychiatric disorders affect about 10-20% of children and adolescents worldwide and are a major cause of health related disability in this age group[1]. Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that affects about 5% of children and adolescents worldwide[2-5].

Currently it is believed that ADHD is a chronic neurobiological disorder, with a genetic basis, caused by changes in the development of some brain areas. The prefrontal area and the main neurotransmitters involved in the disorder are affected by a hypo functioning of their functions and a decrease of blood supply in this region. ADHD characteristic symptoms are: attention deficit (related to organizing and planning capacity), hyperactivity (manifested through restlessness and agitation) and impulsivity (related to the loss of critical sense prior to the behavior and pursuit of immediate reward)[3].

It is known that the onset of violent behavior in children and adolescents is resulted by the interaction of biological, psychological and behavioral factors under social, cultural, family members' and colleagues' influence[6]. In families of low socioeconomic level, with low levels of affection, disharmonious and where parents do not monitor their children's activities, these tend to have widespread indifference and little affective bonding in interpersonal relationships. They become more vulnerable to the influence of colleagues who can lead them to get involved with aggressive people or drug users, and the consequent exposure to risky situations[7]. Thus, it is possible that episodes of violence caused and received by the individual with ADHD are present in different contexts experienced in adolescence. The literature portrays the dysfunctionality and presence of constant conflicts in families with children and adolescents with this disorder[8]. There are indications that their parents tend to employ methods to discipline them that can configure physical and/or psychological violence. Another aspect noted is that the indirect exposure to violence, i.e., to witness violence in the family, emotionally affects the person with ADHD[2].

Research on psychosocial factors related to violence of children and adolescents with ADHD is relevant because, regardless of the type, nature and level of intensity, violence in the different stages of human development can result in physical, psychological, social and behavioral consequences to the individual.

The Parenting Style Theory[9] was used to understand the feelings and meanings of parents of adolescents with ADHD about their children's behavior, the respective interpersonal relationships and conflict situations in family life or outside. This theory integrates the emotional and behavioral aspects, in which children are educated by different styles of parent behaviors, being these based on positive educational practices or negative educational practices. Positive practices lead children to develop prosocial behaviors and are known as positive monitoring and moral behavior. Physical and psychological abuse, relaxed discipline, negative monitoring, negligence and inconsistent punishment represent negative educational practices and are related to the development of anti-social behavior. Thus being, the parenting styles are fundamental in the individual socialization process[9].

In the present study we sought to identify the opinion of parents or guardians of adolescents diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) about their children's exposure as perpetrators or victims of violence situations in family life or outside.

Method

This is a qualitative study in which thematic oral history was used[10]. Nine parents of adolescent patients diagnosed with ADHD assisted at the Youth Psychiatric Outpatient Clinic (APQJ) of a public university hospital in the state of São Paulo participated. During the period of the study, the APQJ assisted 63 adolescents between 13 and 19 years old with different mental disorders 8 of them with a clinical diagnosis of ADHD. Inclusion criteria were: to be father, mother or guardian of the adolescent with ADHD, live in the same house and keep direct contact with him/her. The sample was composed by parents of 7 adolescents with ADHD. One patient was excluded for not living with his/her parents or guardians.

Data collection was conducted from April to September 2013. A thematic interview with questions previously developed by the researchers and submitted to appraise of three judges was used. The script contained data identifying the participants and open questions about the focus of interest of the study. The interviews were scheduled by telephone with the participants and it was requested the adolescent's absence during data collection. At the schedule time and date, the researcher presented the study's objectives and subjects signed Free and Informed Consent Forms (FICF). Interviews

were recorded, performed in a single meeting, in their homes, with an average duration of 30 minutes.

The data were organized through transcription, textualization and transcreation[10]. Transcreation was presented to the participants of the study to their assent, as proposed in the thematic oral history. Findings were submitted to inductive thematic analysis[11]. When presenting the results, subjects were identified by fictitious names.

The research project obtained approval by the Research Ethics Committee of the University of São Paulo at Ribeirão Preto College of Nursing (EERP-USP) under the process n° 013700/2012.

Results

Two couples and five mothers (one widow, one single and three married) were interviewed. The mothers' age ranged from 35 to 49 years old and the fathers were, respectively, 42 and 44. Concerning the educational background, one mother had completed elementary school and one father had completed secondary school, while the others had not completed elementary school (six mothers and one father). Regarding the Occupation/ Profession, according to the Major Occupational Groups of the Brazilian Classification of Occupations (CBO – Ministry of Labor and Employment), the nine individuals performed activities related to their educational background: two maidservants, two general services assistants, one housewife, one sewing assistant, one elderly caregiver, one driver licensed by Social Security and one self-employed worker. Based on the criteria of the Brazilian Institute of Geography and Statistics (IBGE), one family was part of the social class C, three of D and three of E.

The adolescents were males between 14 and 17 years old. Among the seven adolescents, four had quitted school, two were in high school and one was in elementary school. The period they were in psychiatric follow-up varied from four to nine years. Concerning treatment, five used medication continuously, one was followed up in psychiatric and psychotherapeutic care without medication, and one abandoned the treatment during the study.

From the analysis of the parents' narratives it was possible to construct two categories: "Conflicts in family life" and "Conflicts in the context of school and community". Those categories were described and exemplified with excerpts taken from the interviewee's speech.

Conflicts in family life

In this category it was identified the occurrence of violence among siblings, parents and the adolescent with ADHD. Physical and verbal violence occurred through swearing and body aggressions, including the use of objects. Conflict situations with the disordered person have led siblings to leave the family's home. Lack of parents' knowledge about the disorder and consequently their difficulty in imposing limits and rules to the adolescent with ADHD have generated misunderstandings, aggressions and punishments.

Sometimes he is kind of boisterous, answer, fights with his brother. He loves fighting with his brother. (Maria)

When his brother arrives, they already start to catch each other, cussing and fighting a lot. He and his siblings fight all the time. They can not see each other. One of the siblings, who don't live here anymore, has already fought with him today. The other day my other son drank alcohol and attacked me, Mateus gave him two blows. (Carla)

At home he fights with his brother, his sister doesn't talk to him anymore, and the other brother fought with him and left home, and doesn't live here anymore. (Joana)

I ask him to do things, he grumbles. I order, I've got to rebuke, scream, and then he obeys. You can talk to him, prohibit from using computer, hit him, there is no way, he doesn't obey. I fought a lot; I used to hit him because I thought it was a temper tantrum, because everything I said he started crying, stopped and did not obey. I got stressed and hit him. I hit him, prohibited from using computer, television and DVD player, and grounded him. (Maria)

I talked to him, sometimes hit him, because I thought I had to hit to make him stop. I thought that it was nothing, that it was not important. Sometimes it is hard setting rules, because he does not accept. He always has some moments of discussion with his father. My husband thought I was inventing a disease. That Paulo did that because he wanted to. There were fights every other day. I was about to take my stuff and go away. They fought in hand-to-hand combat, his father and him. He gets aggressive; I told him that a son has to obey his father. (Neusa)

You say something, he call names and breaks things. I can't keep him home anymore because he attacks and goes away and if I really arrest him home, he will break everything. I grounded him because we thought it was a child's boisterousness, a kid thing. I tied up him, tied up his bike, arrested him in his bedroom. There was a day that he was nervous, told me to shut up, I attacked him, he also attacked me. I caught him by the neck and held it. I held him for about 20 minutes. (José)

The family environment in which adolescents of the study live is permeated by different conflicts. Parents

change physical aggression in children's presence, who have opposing postures when reprehending the adolescents and who justify their conjugal conflicts as being a result of their children's fight. There was a report that the disordered person came to intercede in a parents' fight.

My husband always threw my stuff on the floor. He did not attack me, but threw things on the floor and cussed. Once we started fighting and João was near. I fought with my husband, threw a pillow at him and told him to be quiet and we started smacking. I called the police. After that day he did not attack me anymore. João participated in everything. Until today we fight, argue, he doesn't hit me anymore, doesn't touch me, but we fight. What he does is not right. (Maria)

My husband travels a lot, working out of town. We had little fights, it began to come into conflict, to fight, I came to attack my husband. Pedro got involved in the fight. So it was really hard! (Silvia)

When I am going to rebuke him, his mom tells me to keep quiet, shut up, then who was damaged? It can not be this way. When he wants to inversely manipulate us, put me against his mother, André puts and he can do that. His mother and I fought almost the whole time of our marriage because of children's fight. Then we send each other to that place, to hell. She cussed me; I cussed her, so what? (José)

Conflicts in the context of school and community

In this category parents reported violence situations in the scholar context and fights in the streets with the involvement of teachers, students, friends and strangers. Parents described that, in the school's context, children were not understood, did not receive support from teachers or principals. They suffered discrimination, were excluded, and considered mentally ill, lazy or vagabond. They were blamed for what others did. Their children, in turn, presented aggressive behaviors either verbally or physically with colleagues and teachers, contributing to segregation and even expulsion from school. On the other hand, parents reported that their children suffered, presented difficulty of adapting to school with somatic symptoms (vomiting, fever) and had no incentive to study, resulting in disinterest and school dropout.

He attacked children at school. Nowadays he is prohibited to enter school. When he goes, he stays in the yard listening to music. He was aggressive, cussed, abused the teacher. He had a "potty mouth", said bad languages. (Lusia)

Teachers did not tolerate him inside classroom. No one knew how to deal with him. He went to school, but it didn't work. He was expelled from there. They said he stepped on the teacher's heel. He says he didn't step, she says he stepped and it turned into a mess. He ended up in jail, there was a police report, they made a big mess! He was expelled from there. Later the judge said he couldn't stay without studying. (Joana)

At school they said that he was lazy, bum and didn't like to do things. Nowadays he doesn't attend school. When he went, he fought with teachers and friends. Aggressive, he couldn't do it, but to teachers he didn't want to do. (Carla)

The school had no dialogue with my son, he was excluded. When Pedro started school it was very complicated, he did not adapt to it. Many times I had to pick him up at school, because he threw up, had fever, cried and hindered the other students. This hindered too much coexistence in school. Teachers did not understand Pedro's problem. It was a very complicated job for me to explain to teachers, until they understood. Before that the hyperactive was considered crazy. In people's mouth, my son was crazy. Pedro didn't want to study anymore because at school he was "the crazy". It only discouraged him, there was no incentive. So he didn't want to study. (Silvia)

The teacher has no patience, the principal acts as a sergeant. Anything that happens, they ask me to leave my child home for one week. The other day, a guy attacked him in the cafeteria and strangled him. They said it was a big fight, it was impossible to separate. After that day he said: mom I don't want to go to school anymore. Then I didn't send him anymore. At school it is like that, kids took advantage that André was "the problem", they "messed around" and everything was his fault. He grew up angry with the school, he doesn't like to study. (Camila)

Just like in school, in relationships with family, friends and strangers, parents realized that people were unaware of ADHD, discriminating their children, treating them as "crazy" or "impolite". According to the parents, their children are impulsive, react with aggression (verbal or physical), lie and believe in things they imagine. For that reason they get involved in fights outside home, which may culminate in death threats. The parents show their concerns and confess that they do not know what to do.

He was practically excluded, I avoided taking him to relatives' houses, I stayed home with him more frequently. People outside the situation don't understand, they think the child is crazy, impolite. (Silvia)

Outside home he was very quarrelsome. At first he was very aggressive. With friends, he still fights a lot. (Lusia)

The policeman has already asked me to go to the police station when he was studying, I said "look Dr. I do not spoil him, I know his defects, but he has this attention deficit and I don't know what to do anymore". During the treatment the mood is

different, stopped a little with street fighting. A little thing like that, he already fights, either with his brothers or with a strange in the street. He fought too much with everyone in the street. I do not know what happened, he and a guy discussed in a party, the guy attacked him and he beat the guy. The boy even talked about killing him. (Carla)

He screamed at the others, fought with anyone in the street. He lies a lot, creates many things from his mind. He is explosive, starts screaming and really says what he wants to say, he doesn't care. (Joana)

Discussion

ADHD treatment guidelines recommend multimodal approaches, including pharmacotherapy and psychosocial interventions as the more effectives[3,12]. In our study, among the seven adolescents with ADHD, only one was in psychotherapeutic follow-up associated with medication use, and one abandoned the treatment during data collection. Lack of integration between the different therapeutic care services on treatment may difficult the understanding of the ADHD phenomenon.

Scientific literature has shown a strong association of a combination of family environment factors with psychological disorders, including ADHD. The aforementioned family factors include low income, low parental education, large families, paternal criminality, maternal mental disorder, serious disagreements between parents and adopted children[2,12-14]. Dysfunctional family environments in which aggression occur between parents and between siblings show greater association with ADHD diagnosis[2,12-14]. In this study, among these factors were found the parents' low income and education, the presence of fights between siblings and verbal and physical aggression between parents, witnessed by children.

It was possible to notice in the study that parents have difficulty in recognizing that their child has a mental disorder. They confuse the common behaviors of an ADHD adolescent with "tantrum, mischief-making, kid's thing", disobedience. They complain about stress triggered by difficulties concerning their children's behavior. Literature shows that parents understand incompetence as disobedience and that this added to the stress that they and their children are subject, end up to increase negative educational practices[15-17].

Literature does not consider aggressiveness as an ADHD characteristic, but impulsive acts of adolescents may be interpreted as indiscipline and opposition, a situation which may develop rebellious and aggressive behaviors in reaction to the hostile environment generated by these behaviors[2]. Therefore, violent behaviors of people with ADHD can be characterized as reactive[17]. Exposure to violence situations may be an ADHD consequence, because the presence of adolescents with this diagnosis tends to facilitate home instability and poorer family functioning[2,12]. On the other hand, researches have shown that exposure to domestic violence, such as witnessing the father's violence against the mother or being victim of different types of aggression, especially when combined with physical abuse, tends to increase the diagnosis of ADHD in children and adolescents[2, 12, 14].

In this study participants made reference to marital relationship problems, relating them to discussions or differences of opinion as to how to deal with their ADHD children, as well as reports of exchanges of verbal and physical assaults witnessed by the adolescents. It was even quoted a situation of a mother that interposes father's conduct in dealing with their child on his presence, exposing him to the double bind situation. Double bind is a concept developed by Gregory Bateson[18] (member of the Palo Alto Group, California) in 1956, to refer to contradictious relationships in which affective and aggressive behaviors are expressed simultaneously. It involves two or more people heavily emotionally involved and who can not be separated from each other. Exposure to this paradoxical message may lead the child to experience insecurity, react with aggression, fear and emotional avoidance, which can take him/her to have difficulty in understanding and identifying with others.

Parents of children and adolescents with ADHD tend to consider themselves less competent in their role as parents and react more negatively to the symptoms of inattention and impulsivity and hyperactivity behaviors[19]. In this study, some of the respondents, in outburst tone, said they did not know how to act with children.

In an attempt to set limits and rules, parents of adolescents with ADHD end up favoring the occurrence of violence situations. The violence naturalization as children's educational practice, especially to correct their behaviors, may be characterized as a negative educational practice, resulting in the development of anti-social behavior in children[9,20]. In this way, the family, which should be the first instance of social inclusion, often contributes to segregate the person with ADHD. It is common to see children with behavior disorders being restrained with ropes, bandages or isolated in rooms without any stimulus[21]. The punishments applied to the

adolescents may compromise the disorder prognosis. Young people with ADHD submitted to maltreatment in childhood have a greater risk of psychoactive substance use, involvement in crimes and prison[5].

Outside the home environment, with friends and relatives, in school life, with teachers and classmates, adolescents with the disorder tend to repeat behaviors that they have at home. They get involved in conflicts, with verbal and physical aggressions, either as victims or as perpetrators[4,17,22]. When exposing themselves to these situations, they end up in risk of social exclusion.

The adolescent with ADHD tends to present several kinds of academic problems and, as a result, difficulties to remain in the school system and complete their studies[17,22]. In addition, they are victims of mocking, prejudices and labels such as "stupid, problem-student, different, annoying, irresponsible, negative-leader, bully, disconnected and inattentive". Similarly, parents' subject of the present research mentioned the following treatments given to their children at school: "lazy, bum, crazy, the problem, the one who didn't like to do things." As a result of the disorder difficulties and how the adolescents were treated in school life, 4 of them ended up quitting school. Parents realized that their children were not understood in the school context and denoted frustration by the lack of support from teachers and school.

A study with elementary school teachers, found that dealing with students with ADHD and their families mobilizes in them intense feelings like irritation, impatience, fear and fatigue[23]. Teachers' knowledge about the disorder refers to organic and psychological causes, family conflicts and parental difficulty in imposing limits. However, there are still teachers who disagree with the medical diagnosis of ADHD[23]. On the other hand, ADHD is presented as one of the potential treatable causes of poor scholar performance and would deserve more attention from educators. Teachers can be of great help in the early detection of the disorder and referral to appropriate investigation and treatment[24].

School and relatives show difficulties to understand, live together and deal with the adolescent with ADHD. Negative educational practices of parents and teachers may foment situations of conflict, violence and exclusion[9]. The literature has shown differences in the recognition of ADHD by parents and teachers. Parents identify more easily the ADHD symptoms compared to teachers who demonstrate a tendency to evaluate from neurocognitive aspects[13,25].

Conclusion

It was possible to understand through the results of this study that violence occurs in the interpersonal relations of adolescents with ADHD and that communication between health and school professionals and families is precarious. People with ADHD may be talented, creative and successful, but without the adequate support to dialogue about these skills and knowledge end up being private of overcoming their limitations. In this perspective, it is considered important the interdisciplinary practice of health professionals together with parents with interventions that aimed to promote pro-social behaviors and aggravations prevention, either in health institutions or at schools. Therefore, the treatment of ADHD requires a systemic approach, with the participation of the adolescent, family and teachers.

The nurse through the systematization of nursing care (SNC) can contribute with the planning of intervention strategies that articulate support networks and the interpersonal relationships of ADHD adolescents (family and school). One of the aspects to be addressed is the violence experienced by patients with the disorder, either as victims or as perpetrators. In this way, it is expected that the health professional participate in the process of development and implementation of mechanisms of confrontation of the violence.

References

1. Kieling C, Baker–Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: evidence for action. Lancet. 2011;378:1515–25.

2. Pires TO, Silva CMFP, Assis SG. Family environment and attention deficit hyperactivity disorder. Rev Saúde Pública. 2012;46(4):624-32.

3. Dias TG, Kieling C, Graeff-Martins AS, Moriyama TS, Rohde LA, Polanczyk GV. Developments and challenges in the diagnosis and treatment of ADHD. Rev Bras Psiquiatr. 2013;35(Suppl 1):40-50.

4. Reinhardt MC, Reinhardt CAU. Attention deficit-hyperactivity disorder, comorbidities, and risk situations. J Pediatr. 2013;89(2):124-30.

5. De Sanctis VA, Newcorn JH, Halperin JM. A prospective look at substance use and criminal behavior in urban ADHD youth: what is the role of maltreatment history on outcome? Atten Defic Hyperact Disord. 2014;6(2):79-86.

6. Dahlberg LL, Krug EG. Violência: um problema global de saúde pública. Ciência & Saúde Coletiva. 2007;11(Suppl):1163-78.

7. Gallo AE, Williams LCA. Adolescentes em conflito com a lei: uma revisão dos fatores de risco para a conduta infracional. Psicol Teor Prat. 2005;7(1):81-95.

8. Flores SM, Salum GA, Manfro GG. Dysfunctional family environments and childhood psychopathology: the role of psychiatric comorbidity. Trends Psychiatry Psychother. 2014;36(3):147-51.

9. Sampaio ITA, Gomide PIC. Inventário de estilos parentais (IEP) – Gomide (2006) percurso de padronização e normatização. Psicol Argum. 2007;25(48):15-26.

10. Meihy JCSB, Holanda F. História oral: como fazer, como pensar. 2a ed. São Paulo: Contexto; 2013. 175 p.

11. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.

12. Richards LME. It is time for a more integrated bio-psycho-social approach to ADHD. Clin Child Psychol Psychiatry. 2012;18(4):483–503.

13. Pires TO, Silva CMFP, Assis SG. Association between family environment and attention deficit hyperactivity disorder in children – mothers' and teachers' views. BMC Psychiatry. 2013;13:215-23.

14. Vasconcelos MM, Malheiros AFA, Werner J Junior, Brito AR, Barbosa JB, Santos ISSO, et al. Contribuição dos fatores de risco psicossociais para o transtorno de déficit de atenção/hiperatividade. Arq Neuropsiquiatr. 2005;63(1):68-74.

15. Kunrath LH, Wagner A, De-Jou GY. A educação dos filhos com transtorno de déficit de atenção e hiperatividade: o que fazer? Psicol Rev. 2006;12(20):235-50.

16. Bargas JA, Lipp MEN. Estresse e estilo parental materno no transtorno de déficit de atenção e hiperatividade. Psicol Esc Educ. 2013;17(2):205-13.

17. Araiza JFR. El trastorno por déficit de atención con y sin hiperactividad (TDA/H) y la violencia: revisión de la bibliografía. Salud Mental. 2014;37:75-82.

18. Bateson G, Jackson DD, Haley J, Weakland J. Toward a Theory of Schizophrenia. Behav Sci. [Internet]. 1956 [acesso 4 dez 2014];1(4):251–64. Disponível em: http://www.psychodyssey.net/wp-content/uploads/2012/05/TOWARD-A-THEORY-OF-SCHIZOPHRENIA-2.pdf.

19. Guilherme PR, Mattos P, Serra-Pinheiro MA, Regalla MA. Conflitos conjugais e familiares e presença de transtorno de déficit de atenção e hiperatividade (TDAH) na prole: revisão sistemática. J Bras Psiquiatr. 2007;56(3):201-7.

20. Silva LL, Coelho EBS, Caponi SNC. Violência silenciosa: violência psicológica como condição da violência física doméstica. Interface. 2007;11(21):93-103.

21. Ministério da Saúde (BR). Violência Intrafamiliar: orientação para prática em serviço [Internet]. Brasilia (DF): Secretaria de Políticas de Saúde; Ministério da Saúde; 2002. [acesso 31 mar 2015]. Caderno de Atenção Básica n°8. Disponível em http://bvsms.saude.gov.br/bvs/publicacoes/cd05_19.pdf.

22. Rangel EBR Júnior, Loos H. Escola e desenvolvimento psicossocial segundo percepções de jovens com TDAH. Paidéia. 2011;21(50):373-82.

23. Landskron LMF; Sperb TM. Narrativas de professores sobre TDAH: um estudo de caso coletivo. Psicol Esc Educ. 2008;12(1):153-67.

24. Pastura G, Mattos P, Araújo APQC. Prevalência do transtorno de déficit de atenção e hiperatividade e suas comorbidades em uma amostra de escolares. Arq Neuropsiquiatr. 2007;65(4):1078-83.

25. Coutinho G, Mattos P, Schmitz M, Fortes D, Borges M. Concordância entre relato de pais e professores para sintomas de TDAH: resultados de uma amostra clínica Brasileira. Rev Psiq Clín. 2009;36(3):97-100.

Received: June 28th 2014
Accepted: May 3rd 2015