

Research Thesis

**EFFECTIVENESS OF GROUP BASED COGNITIVE BEHAVIOR
THERAPY FOR IMPROVING COPING STRATEGIES AND QUALITY OF
LIFE AMONG CAREGIVERS OF CHILDREN WITH ADHD**



Researcher

ARSLAN SIDDIQUE

501-FSS/MSCP/F23

Supervisor

Dr. MAZHAR IQBAL BHATTI

Assistant Professor

Department of Psychology

Faculty of Social Sciences

International Islamic University, Islamabad

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By

ARSLAN SIDDIQUE

501-FSS/MSCP/F23

Department of Psychology

Faculty of Social Sciences

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By

Arslan Siddique

Registration No. 501-FSS/MSCP/F23

Thesis Approved

By



Dr. Mazhar Aqbal Bhatti
Supervisor



Dr. Maryam Khurshid
Internal Examiner



Dr. Zafar Ahmed
External Examiner



Assistant to Dean
Department of Psychology



Dean Faculty of Social Sciences

**INTERNATIONAL ISLAMIC UNIVERSITY, ISLAMABAD
(PAKISTAN)**

DECLARATION

I, Mr. Arslan Siddique, Registration No. 501-FSS/MSCP/F23 student of MS in Clinical Psychology, session 2023-2025, hereby declare that the matter printed in the thesis titled: `EFFECTIVENESS OF GROUP BASED COGNITIVE BEHAVIOR THERAPY FOR IMPROVING COPING STRATEGIES AND QUALITY OF LIFE AMONG CAREGIVERS OF CHILDREN WITH ADHD` is my own work and has not been printed, published and submitted as research work, thesis or publication in any form in any University, Research Institution etc in Pakistan or abroad.

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Certified that the research work contained in this thesis titled: ‘EFFECTIVENESS OF GROUP BASED COGNITIVE BEHAVIOR THERAPY FOR IMPROVING COPING STRATEGIES AND QUALITY OF LIFE AMONG CAREGIVERS OF CHILDREN WITH ADHD` has been carried out and completed by Mr. Arslan Siddique, Registration No: 501-FSS/MSCP/F23 under my supervision.

Date

Supervisor

Dr. Mazhar Iqbal Bhatti

Assistant Professor

Department of Psychology

International Islamic University

Islamabad

DEDICATION

All praise and gratitude are due to Almighty Allah (SWT), the Most Beneficent and Merciful, whose divine will and blessings enabled me to reach this significant milestone in my academic journey. It is through His guidance, the heartfelt prayers of my parents, and the unwavering support and dedication of my teachers that I have been able to successfully complete my MS thesis. I would like to dedicate this work to my beloved parents and my supervisor, whose crucial roles and constant support have been instrumental throughout this endeavor. I am deeply thankful to my supervisor, Chairman Department of Psychology, Dr. Mazhar Iqbal Bhatti, for his invaluable guidance, insightful feedback, and continuous encouragement throughout the course of this research. His mentorship has been a cornerstone in the completion of this thesis. My sincere appreciation also extends to my peer group for their encouragement, cooperation, and warm wishes, which have kept me motivated. I am especially grateful to my family for their endless support, love, and motivation that carried me through challenging times

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I solemnly declare that the current research entitled: ‘EFFECTIVENESS OF GROUP BASED COGNITIVE BEHAVIOR THERAPY FOR IMPROVING COPING STRATEGIES AND QUALITY OF LIFE AMONG CAREGIVERS OF CHILDREN WITH ADHD` is my personal work. It is not plagiarized nor copied from any other sources, and that I have followed all the research and ethical protocols. I am submitting this research to Department of Psychology, Faculty of Social Sciences, International Islamic University Islamabad as a partial fulfillment for the award of the degree of MS in Clinical Psychology. I also declare that I will not use this research for my degree program in future.

Abstract

Caregivers of children with Attention-Deficit/Hyperactivity Disorder (ADHD) usually experience high levels of stress and oppression, which can detrimental impact on their coping abilities and quality of life in general. Cognitive Behavioral Therapy (CBT), particularly when given in a group setting, has shown promise in improving psychological well-being and adaptive coping. This study focused to access the therapeutic efficacy of integrative, multicomponent, group-based Cognitive Behavioral Therapy (CBT) for caretaker of children with attention deficit hyperactivity disorder (ADHD). ADHD usually places a consequential emotional, physical, and psychological stress on caregivers, which can adversely impact the quality of their lives and coping capabilities. however, interventions are available for children with ADHD, the needs of caregivers remain neglected in existing research. This study investigated the impact of a structured, group-based CBT program that combines cognitive restructuring, relaxation techniques, and problem- solving skills to help caregivers manage stress and improve emotional well-being. Using a pre- and post-intervention design, the study assessed changes in coping strategies, and overall quality of life. For this purpose a total of 20 participants were recruited and divided into intervention and control group. WHOQOL-BREF and Coping Strategies Scale was used to collect data pre and post intervention. The findings of the paired-sample t-test for the control group revealed a slight improvement in quality of life from pre- to post-assessment, indicating minimal change over time. However, coping strategies among participants in the control group showed absence of significant difference among pre- and post-test scores, suggesting that no meaningful improvement occurred in this domain without the intervention. Similarly the findings revealed a significant improvement in both variables among experimental group following the intervention, indicating that participants experienced a higher quality of life

and demonstrated enhanced coping abilities after receiving group-based CBT. In the same way an independent samples t-test was performed to compare Quality of Life and Coping Strategies between the experimental and control groups after the intervention. The findings exhibited significant difference between the outcome of two groups, with the experimental group shows enhancement in both Quality of Life and Coping Strategies. The basic purpose of these findings was to put forward evidence for the effectiveness of a group-based, multicomponent CBT intervention in helping caregivers, offering a way to caregivers to manage their stress, enhance coping, and elevate their quality of life. This study will provide a deeper understanding for a more efficient, effective and reachable therapeutic approaches for caregivers of children with ADHD, with the capability to enhance caregiver, child and overall family outcomes.

Keywords: Group Based Cognitive Behavior Therapy, Quality of Life, Coping Strategies

INTRODUCTION

Coping Strategies

Coping strategies are the different approaches that individuals use to help them manage their stress, difficulties specially when it is associated with a caregiving role. These strategies can be adaptive or maladaptive, ranging from seeking social support, practicing mindfulness, or engaging in stress-reducing activities, to resorting to avoidance behaviors or denial. Effective coping strategies can help caregivers better manage the emotional and pragmatic requirements of caring for a child or individual with ADHD, enhancing their resilience and reducing the negative impact of caregiving.

Coping strategies can be expressed as different ways which may include behavioral and cognitive aspects which are employed to take care of both internal as well as external requirements of a stressful circumstances which in isolation are very difficult to manage. According to Lazarus and Folkman (1984), the two major ways to respond to coping includes, problem focused which puts attention on the reason behind a particular stress and emotion focused, which is distinctly manages the emotions related response to stress. In caregiving contexts, coping strategies are crucial for maintaining emotional stability and overall well-being, as caregivers often experience chronic stress due to the demands of supporting individuals with long-term conditions such as ADHD.

Carver et al. (1989) further expanded this concept through the development of the COPE Inventory, identifying adaptive strategies (e.g., active coping, positive reinterpretation, planning) and maladaptive strategies (e.g., denial, behavioral disengagement) that influence psychological

outcomes. Research indicates that caregivers who rely on adaptive coping mechanisms report lower levels of stress and higher quality of life compared to those who use avoidant or emotion-suppressing strategies (Vitaliano., 1991). Therefore it becomes very significant to better and fully understand the importance of group based CBT and its possible outcomes for enhancement of an individual`s overall wellbeing.

There has been a lot of studies conducted for essentially understanding what coping strategies are and their influence on individuals when dealing with anxiety, strain, stress or other emotion related challenges A study conducted by Lazarus and Folkman (1984) found out that coping strategies is a continuous changing mechanism which involves alteration and modifications in their cognitive and behavioral patterns when dealing with daily life challenges. These challenges may eventually be either internal or external and sometimes it can become too overwhelming manage. Thus it creates two different frameworks to deal with these issues. One is problem focused coping with the basic aim to handle the source of stress and the other is emotional centered approach which focuses on the repercussions of stress

When it comes to dealing with children having chronic neurodevelopmental conditions, it becomes very important for caregivers to use coping strategies in order to maintain their overall mental wellbeing through properly managing their stress and life quality. The kind of approach that caregivers use will significantly impact their outcomes. Previous studies have shown that adaptive coping strategies have shown or exhibited much better result than avoidance centered coping strategies which resulted in high stress, depression and low life satisfaction (Vitaliano et al.,1991). One study by Benson (2010) highlighted how adaptive coping strategies reduce the impact of stress and other challenges simply inducing better emotional regulation along with potent skills to solve problems. Hayes & Watson, (2013) also highlighted the influence of

Cognitive Behavioral Therapy (CBT) in cognitive restructuring of irrational thought patterns leading to enhanced emotional regulation.

In some of the fresh research studies, the concept of coping strategies have been identified as multiple different approaches of mental and behavioral nature which an individual utilizes to better deal with pressures of both internal and external identity specially when it is considered as something beyond their capacity (Danielsson et al., 2024)

A study by Craig et al. (2020) categorized coping strategies into problem focused (spotlight on the issue causing stress), emotionally anchored (dealing with the consequences of stress through emotional regulation) and avoidant based where the individual lessen interaction with stressful situations.

Throughout the findings of research studies, it becomes evident how much impactful coping strategies are in maintaining a life full of balance and wellbeing. The implications of coping strategies are not focused on a single point but rather it effects an individual as a whole in many different areas. Concentration must always be maintained on adaptive coping strategies for a better wellbeing specially among caregivers.

Quality of Life

In terms of caregivers, quality of life has been identified as an overall happiness, prosperity and satisfaction in relation to emotional health, physical health, social relationships and personal growth and achievements. Those caregivers who are dealing with children having ADHD tend to go through a lot of stress and difficulties which leads to a decreased level of quality of life.

There have been many different ways by which quality of life has been defined in previous studies. The World Health Organization (WHO) has broadly described it as the way an individual's self-assessment of where they are in life in terms of achievement, happiness, position in their relevant culture, community or value system. The inclusion of cultural and personal values highlight an important area because quality of life in general can be subjective to express and define differently (WHOQOL Group, 1995).

One particular study by Farquhar (1995) detailed quality of life as both subjective and objective interpretation of life experiences which may include physical, social, material and psychological domains

Schipper (1990) expressed the importance of the role of personal feelings and emotions when evaluating quality of life. When an individual is going through positive instances in life, it will automatically reflect how they view and approach life as a whole. Another study by Skevington et al. (2004) pointed out that quality of life is not just about physical health but also the emotional aspect of dealing with life struggles and issue which impacts daily functioning

There have been numerous studies about quality of life from the perspective of different disciplines and the outcome involves definitions which have many overlapping views including the multilayered nature of it. The inclusion of all satisfaction from psychological, emotional, behavioral, physical and environmental domains makes quality of life significant (Ferrans, 2005).

A researcher Dijkers, (2007) was of the view that quality of life is what an individual finds satisfaction in or contentment with. These may be small moment of happiness or joy filled

time with family and peers. It could be what our society calls as an objective living standard or the person's subjective view of what makes them happy.

Similarly Skevington et al. (2004) in order to have an understanding of quality of life put an emphasis on WHOQOL model and the significance of cultural background and individual's value system along with the life goals and objectives they set. Another research study by Connell et al. (2012) described many different components of quality of life which according to him were central parts or components. These include independence, self-compassion, inclusion and active participation in meaningful activities.

A study by Karimi and Brazier (2016) expanded the view on quality of life by considering it something beyond just physical health. His view on quality of life was holistic which have an inclusion of a deeper understanding of humans, the impact of culture, the significance of social interactions and even personal ambitions, These are the factors which influence an individual's overall view of quality of life.

For caregivers, the quality of life is something multidimensional and a sort of subjective interpretation of how caregiving deeply impacts their overall health whether it's physical, psychological, social, financial and many ways spiritual as well.

Early family-caregiver work framed caregiver QoL as encompassing physical health, emotional functioning, social life and material circumstances, emphasizing that caregiving can reduce caregivers opportunities to pursue valued activities and thus lower life satisfaction (Weitzner et al., 1999).

Global definitions such as the WHO's WHOQOL formulation that QoL is a person's view of their place in life considering their cultural background, personal values, goals,

expectations, and priorities are regularly invoked in caregiver studies to stress subjectivity and cultural context. Empirical reviews and qualitative studies add that caregiver QoL includes role-specific elements (e.g., restrictions on leisure, financial strain, sleep disturbance), relational factors (emotional closeness or strain with the care recipient), and access to external supports; these dimensions are consistently reported across settings from dementia to chronic illness caregiving (Cheng et al., 2022).

Researchers also note conceptual distinctions QoL is a broader, positive-framed construct capturing overall life satisfaction and functioning, whereas burden measures the strain or stress of caregiving although the two are strongly correlated and interact (Hazzan et al., 2022).

Another study from Kerala, India (2024), in the context of palliative care, operationalizes QoL in caregivers as their health-related quality of life, assessing how caregiver burden (physical, emotional, social) interacts with age, perceived support, and the impact of caregiving tasks. The study shows aging caregivers often have significantly poorer QoL, especially when burden is high and support is low (Mosher et al., 2024)

In another study, Karahan and Özdemir (2020) conceptualized caregiver QoL as the outcome of an interaction between burden, resilience, and well-being, demonstrating that resilience positively predicted QoL, while higher burden reduced it. One study by Wheatley et al. (2021) focused on the caregiver quality of life. Those who are dealing with patients diagnosed with dementia, their quality of life was linked with changes of negative nature being witnessed in care receiver. The stress, strain and physical decline the patient is going through will have an impact the caregiver's quality of life

A study by Avellaneda et al. (2024) focused on the caregivers dealing with rare disease patients and identified many dimensions which includes physical health, mental fitness, community involvement and medical care access. The study also found out that social support or social networks acted as protective factors for caregivers dealing with stress. The study is a vital source of understanding the concept of quality of life.

Integrative, Multicomponent, Group-Based Cognitive Behavioral Therapy (CBT)

Group based Cognitive Behavioral Therapy (CBT) for caregivers dealing with children having ADHD is considered as an organized intervention having different attributes combining both cognitive and behavioral approaches with the purpose of dealing with stress and other requirements of caregivers. Enhancement of quality of life and coping strategies through educating, teaching different skills which can be of practical use signifies its importance. Group-based CBT allows caregivers to share experiences, build support networks, and learn from each other, promoting a feeling of a family or a community which eventually reduces isolation.

Integrative, multicomponent, group-based Cognitive Behavioral Therapy (CBT) has been conceptualized in the literature as a structured, skills-focused intervention that intentionally combines several therapeutic elements, cognitive restructuring, behavioral skills training, psychoeducation, problem-solving, and often adjunctive mindfulness or acceptance strategies delivered to multiple participants simultaneously and tailored to address interconnected targets (e.g., caregiver distress, parenting practices, and child behavior) rather than a single symptom domain. Researchers describe the integrative label to mean the deliberate blending of CBT's classical cognitive and behavioral techniques with complementary approaches (for example, positive-psychology exercises, relaxation/mindfulness practice, and behavior-management

strategies drawn from parent training), so the program both changes maladaptive thoughts and builds concrete behavioral repertoires for everyday caregiving demands (Popa et al., 2022).

The multicomponent aspect emphasizes that more than one active ingredient is present and measurable: sessions typically include (a) psychoeducation about the target condition (here, ADHD and its impact on family functioning), (b) cognitive techniques to identify and modify unhelpful beliefs and attributions (e.g., self-blame, catastrophizing about child symptoms), (c) behavioral/skills modules (problem solving, stress-management, communication and emotion-regulation strategies), and (d) practical parent-management strategies (contingency management, routines, reinforcement systems), all packaged so caregivers learn, practice, and generalize skills between sessions. Multicomponent programs are deliberately structured in many trials so that each component's aim, session content, home practice, and fidelity checks are explicit, which allows researchers to evaluate which components drive change and to preserve program integrity when delivered in groups or remotely (Schaffer, 2022)

Delivering these elements in a group format is described as offering distinct therapeutic mechanisms beyond those of individual therapy: group delivery provides vicarious learning (observing peers try strategies), normalization and mutual support (reducing stigma and isolation common among caregivers), opportunities for role-play and feedback in a more naturalistic social context, and efficiency/scalability for services. Group-based manuals for caregiver samples therefore explicitly weave peer-sharing and facilitated problem-solving into each module therapists both teach CBT skills and orchestrate group processes so members practice giving and receiving behavioral coaching and troubleshoot implementation barriers together. This group mechanism is cited as particularly valuable for caregiver outcomes such as coping strategy repertoire, perceived competence, and quality of life (Tamura et al., 2023).

Empirical descriptions of integrative, multicomponent, group-based CBT in caregiver and ADHD literature often note pragmatic adaptations: shortening session length, emphasizing home-practice sheets tied to everyday caregiving tasks, combining in-session skills rehearsal with brief between-session phone or digital check-ins, and including measurement of both caregiver outcomes (stress, coping strategies, quality of life, parental self-efficacy) and child outcomes (behavioral ratings, functional impairment). Authors therefore frame such programs as both clinically comprehensive targeting cognition, emotion, behavior, and social support and implementation-oriented, designed to be deliverable in real-world group settings (community clinics, schools, or online) with manuals, fidelity markers, and clear, measurable componentry (Popa et al., 2022)

In many studies, the term “*integrative*” is used to denote that the CBT program goes beyond pure cognitive restructuring or behavioral management to incorporate additional therapeutic modalities such as parent training, psychoeducation, problem-solving skills, emotion-regulation strategies, or even mindfulness practices. For example, one group CBT protocol for children/adolescents with ADHD described in Coelho et al. (2017) included six therapeutic goal-areas: (1) psycho-education about the disorder, (2) parent-training around routines and reinforcement, (3) children’s sessions based on cognitive-behavioral models (Beck-type cognitive theory), (4) behavioral change strategies, (5) family-environment redesign (routines/habits) and (6) social skills training (Coelho et al., 2017).

The advantage of group-based delivery is the added therapeutic mechanisms of social modeling, peer feedback, normalization, and mutual support, which individual therapy lacks. Such group formats for caregivers are particularly relevant when the aim is to enhance coping resources, reduce isolation, build peer support and share adaptive strategies. For instance, a

therapeutic-conversation intervention for caregivers of adolescents with ADHD employed both group sessions and parent (caregiver) sessions in groups, and found significant improvements in caregiver quality of life, worry, daily activities and family relationships (Therapeutic Conversations Intervention study, 2016)

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental condition marked by ongoing patterns of inattention, hyperactivity, and impulsivity that disrupt daily functioning or development. The onset of the symptoms is usually before the age of 12 and they usually continue through adolescence and even adulthood. There are many difficult aspects of having ADHD. Lack of focus, difficulty in organizing tasks, difficulty following directions and lack of control on impulses are among few. Hyperactivity may present as excessive movement or trouble staying seated, while impulsivity can result in rash decisions made without considering potential outcomes. ADHD is classified into three primary types depending on which symptoms are most prominent.

Inattentive Type: Marked primarily by difficulties with attention and focus, such as forgetfulness, lack of organization, and difficulty following through on tasks.

Hyperactive-Impulsive Type: Characterized mainly by intense fidgeting, difficulty staying at one place, problem remaining seated, and impulsive actions without thinking of the consequences.

Combined Type: Exhibits symptoms of both inattention and hyperactivity/impulsivity.

Attention-deficit/hyperactivity disorder (ADHD) is marked in the diagnostic and empirical literature as a persistent, developmentally inappropriate pattern of inattention and/or

hyperactivity-impulsivity that produces functional impairment across settings (e.g., home, school) and begins in childhood (American Psychiatric Association, 2013).

The World Health Organization's ICD-11 adopts a closely aligned formulation (renaming and subsuming older “hyperkinetic” categories), emphasizing early childhood onset, cross-situational impairment, and the possibility of predominantly inattentive or hyperactive/impulsive presentations. Contemporary reviews and clinical summaries further situate ADHD as a condition marked by deficits in executive functions (attention regulation, inhibitory control, working memory) with a strong genetic contribution and multifactorial environmental influences; researchers note that diagnosis is clinical (history + symptom checklists) because there are no definitive laboratory or imaging tests.

Research also emphasizes ADHD's broad impact on academic, social, and family functioning and on caregiver burden, which is why many intervention studies (including those addressing caregivers) begin by referencing the diagnostic definitions and functional impairment criteria above (CDC, 2024).

Research has further elaborated that ADHD encompasses two major dimensions: inattention marked by difficulties sustaining attention, following instructions, organizing tasks, and frequent forgetfulness and hyperactivity-impulsivity, reflected in restlessness, excessive talking, interjecting others, and an inability to wait for one's turn (Walser et al., 2021). These symptoms often manifest differently across development; for instance, while overt hyperactivity tends to decrease with age, inattention and executive dysfunction typically persist into adolescence and adulthood (Faraone et al., 2021).

Studies indicate that ADHD is not limited to childhood, with 40%–60% of diagnosed children continuing to show impairing symptoms in adult life, which highlights its chronic and pervasive nature (Faraone et al., 2021).

Beyond the diagnostic symptoms, researchers conceptualize ADHD as a multifactorial and heterogeneous disorder with biological, genetic, and environmental underpinnings (Thapar et al., 2016). Neuroimaging studies have identified alterations in frontostriatal and prefrontal circuits associated with deficits in attention regulation, impulse control, and working memory (Cortese et al., 2012).

However, despite strong evidence for heritability and neurobiological correlates, there are no definitive biomarkers for ADHD diagnosis; it remains a clinically determined disorder based on behavioral and functional criteria (Sonuga-Barke et al., 2020). Comorbidity with learning disorders, anxiety, and conduct problems is also frequently reported, which further complicates diagnosis and treatment (Biederman et al., 2021).

From a psychosocial perspective, the impairments associated with ADHD extend beyond the individual, influencing family functioning and caregiver wellbeing. Children with ADHD often exhibit behavioral dysregulation and academic difficulties that place significant stress on parents and caregivers, contributing to emotional exhaustion, reduced quality of life, and increased psychological distress (Cortese et al., 2020).

Literature Review

Caregiver burden among individuals caring for children with Attention Deficit Hyperactivity Disorder (ADHD) is a significant area of study in psychological research. ADHD, which is marked by occurring inattention, excessive activity, and impulsive behavior, hand out unique challenges to caregivers. Caregivers frequently report higher levels of stress, anxiety, depression, and overall dissatisfaction with life due to the disruptive behaviors linked with ADHD (Barkley, 2006). The burden that includes both emotional and physical strain can also result in financial hardships due to the time and energy committed to managing the needs of children. Studies suggest that caregivers of children with ADHD are at greater threat of unroll chronic health conditions, which include depression and anxiety as compared to those caring for children without developmental or behavioral disorders (Saini et al., 2019).

The effect of caregiver burden on quality of life is overwhelming. Caregivers frequently experience reduced personal fulfillment, strained relationships, and limited social engagement. The role of caregiver is demanding and isolating, particularly when the child's behavior causes difficulties in school, at home, and in social settings. A study found that caregivers of children with ADHD report lessen quality of life scores in comparison to caregivers of children with other disabilities (Abidin, 1995). Moreover, caregiver burden is associated with difficulties in maintaining employment, pursuing personal interests and having time for self-care.

Caregivers adopt a variety of methods to manage stress associated with caring for children with ADHD in terms of coping strategies. According to Kaugars et al. (2004), versatile ways of coping, including reaching out for social support and using relaxation techniques and engaging in problem-solving, can bring down caregiver distress. These strategies have been

associated with increased satisfaction and better psychological outcomes with caregiving. Instead, maladaptive coping strategies like denial, avoidance, emotional withdrawal, tend to exacerbate stress and lead to negative mental health outcomes (O'Neill & Johnson, 2008). It has been observed that caregivers who use maladaptive strategies experience enhance phases of anxiety and depression (Bennett et al., 2013), which further impair their ability to provide effective care.

Cognitive Behavioral Therapy has shown to be exceptionally successful approach for caregivers dealing with ADHD-related stress. CBT targets cognitive distortions and behaviors that contribute to emotional challenges and maladaptive coping. Group-based CBT has shown results for improving coping strategies and reducing caregiver stress. According to Jones et al., (2013), group-based CBT presents the benefits of social support as caregivers share experiences and advice in a supportive environment. This sense of affinity helps to reduce feelings of isolation and provides caregivers with a network of peers who understand the challenges they face.

Integrative, multicomponent CBT interventions that combine cognitive restructuring, relaxation training and problem-solving skills are especially beneficial in addressing the multifaceted nature of caregiver stress. Singer et al., (2017) shown that caregivers who participated in group-based CBT showed significant reductions in anxiety, depression and overall stress. These interventions not only help caregivers develop adaptive coping skills but also teach relaxation techniques to control the physical symptoms of stress. The multifaceted approach of integrative CBT make sure that caregivers have the tools to address both emotional and practical needs and making it a complete solution for reducing caregiver burden.

Besides these findings, an abundance of research supports the efficacy of CBT in enhancing the general quality of life for caregivers of children with ADHD. A study by Barkley et al. (2008) exhibits that caregivers who underwent CBT display higher satisfaction with their caregiving roles, better emotional well-being and improved relationships with their children. Likewise, a study by Anderson et al., (2015) indicates that caregivers who participated in CBT experienced increased self-efficacy, meaning they felt more capable of managing their child's behavior and their caregiving duties.

While CBT has shown positive effects, it is important to acknowledge the need for extended research to explore the long-term gains of CBT for caregivers of children with ADHD. Long-term studies could help determine the resilience of the effects of CBT and how it impacts ability of caregivers to maintain improvements in their quality of life and coping strategies. In addition to that, there is a need for research on how cultural, familial and socioeconomic factors influence the efficacy of CBT for caregivers. Tailoring CBT interventions to fit the unique needs of various caregiver populations may enhance the effectiveness of these interventions.

Finally, the literature supports the effectiveness of integrative, multicomponent, group-based CBT as an intervention to lower caregiver burden, improve coping strategies and add to the quality of life for caregivers of children with ADHD. As Group-based CBT provides both therapeutic techniques and peer support, it offers a promising solution to mitigate the stress that caregivers face. However, further research is needed to strain these interventions and explore factors that could influence their success over different caregiver populations.

Caregiving for children with ADHD is consistently related with heightened stress, impaired coping and decreased quality of life for parents and other caregivers, creating a strong

rationale for caregiver-focused psychosocial interventions (Quatrosi et al., 2025). Various systematic reviews and meta-analyses underscore parent-focused psychosocial treatments, most firmly behavioral parent training (BPT) but also CBT-informed and multicomponent programs produce measurable improvements in parental outcomes (reduced stress, greater parenting sense of competence) and on occasion improvements in caregiver mental health and family functioning (Chacko et al., 2024). Significantly, these reviews show that interventions bringing parents and families have ultimate benefits for child outcomes and suggest that caregiver acquire in coping and reduced distress are clinically meaningful for the family system (Groenman et al., 2022).

Proof specific to group-delivered form is promising group CBT protocols, CBT informed parenting programs and structured parent support groups have been tested in quasi-experimental, pilot and randomized designs and show consistent reductions in parental stress and anxiety, improvements in coping skills (cognitive reframing, behavioral problem-solving, stress management) and gains on some QoL indices (Vacher et al., 2022). For instance, trials that integrated parent CBT modules (psychoeducation, cognitive restructuring about parenting beliefs, skills rehearsal and problem-solving) disclose improvements in parental cognitions and psychological well-being, and several programs delivered in a group format also improved parent describe coping strategies and perceived quality of life (Kim, 2013).

Group delivery emerge to offer two interacting mechanisms of effect: (a) acquisition of CBT skill sets (for example, identifying automatic thoughts, alternative appraisals, behavioral experiments, structured problem solving) that head on strengthen adaptive coping; and (b) peer support, normalization and modeling that lower isolation and enhance practical problem-solving an effect clone across parent support and mindful-parenting group trials (Wong et al., 2023).

Meta-analytic and large review evidence suggests that while BPT has the strongest and most consistent evidence base for reducing child behavior problems and improving parental outcomes, CBT and CBT-informed parent programs (including group CBT) widen benefits to parental mental health domains such as reduction in depressive and anxiety symptoms and to coping skills that are not always the primary target of BPT (Tourjman et al., 2022).

A review of study conducted in 2022 on psychosocial interventions classified CBT, caregiver training and multicomponent approaches together and spotlight that caregiver-targeted programs decent reduce parenting stress and increase parenting competence with several programs measuring improved caregiver well-being or QoL as a secondary outcome (Tourjman et al., 2022). More recent controlled studies and feasibility trials of group CBT or CBGT (modified cognitive-behavioral group therapy) have likewise reported reductions in parental stress and improvements in family functioning and QoL subscales, though effect sizes and resilience differ by study and outcome measure (Chen et al., 2024)

Systematically, CBT-based group interventions improve coping through skill acquisition (cognitive restructuring, behavioral rehearsal, structured problem solving, activity scheduling) which straight addresses maladaptive appraisals and avoidance that raise stress in caregivers of children with chronic behavioral difficulties. At one and the same time, the group context provides social comparison, vicarious learning and mutual practical advice that add to self-efficacy, a core mediator of coping and QoL improvements (Wong et al., 2023). Trials that measured negotiator notice that increases in parental self-efficacy and reductions in maladaptive parental cognitions partly explain post-treatment improvements in both caregiver stress and life-satisfaction measures (Vacher et al., 2022).

Nevertheless, there are important limitations in the evidence that must temper strong causal claims. First, many trials of parent-focused CBT are small, quasi-experimental or pilot studies with short follow-up windows; when larger meta-analyses collapse across psychosocial modalities, behavioral parent training dominates the literature and has stronger duplicate than group CBT per se (Groenman et al., 2022). Second, outcome heterogeneity (different measures of coping, parenting stress, QoL and inconsistent timing of follow-up) makes combined estimates of efficacy for caregiver QoL imprecise and restrict conclusions about long-term benefit (Danckaerts et al., 2010). Third, moderators like as parental ADHD symptoms, socioeconomic stressors and comorbid child psychopathology influence outcomes: parents with higher ADHD symptoms or greater life stress may appear smaller gains but for interventions are adapted (Groenman et al., 2022).

proportional few RCTs isolate group CBT as the only active ingredient (many combine psychoeducation, behavioral skills training and CBT techniques) so attributing effects uniquely to the CBT component essential vigilance (Vacher et al., 2022). Generally, the convergent evidence supports a cautious, evidence-informed conclusion suggesting group-delivered CBT and CBT-informed parent programs are a promising and practical approach for improving coping strategies and aspects of caregiver quality of life amid parents of children with ADHD, principally through (1) CBT skill acquisition that improves cognitive and behavioral coping and (2) peer/group processes that reduce isolation and enhance self-efficacy (Wong et al., 2023).

Group-based CBT interventions have been appearing to enhance coping strategies and improve complete quality of life among caregivers through skill development, cognitive restructuring, and emotional regulation. As Coelho et al. (2018) display that group-based CBT

for children with ADHD when combined with medication and not only reduced ADHD symptoms but also improved parental stress and family functioning.

The study by Pan et al. (2024) found that integrating CBT with pharmacological treatment resulted in notable improvements in both psychological symptoms and vary domains of quality of life among parents over a one-year follow-up period. Research has repeatedly identified that parents of children with ADHD undertake greater emotional strain, anxiety, and reduced quality of life in contrast to parents of neurotypical children (Ahmed et al., 2022).

Group interventions deep rooted in CBT principles which ordinarily include psychoeducation, cognitive restructuring, and behavioral skill-building, have been effective in reducing caregiver stress and enhancing adaptive coping mechanisms (Zhang et al., 2021). Further, systematic reviews highlight that multicomponent group CBT programs be like to exceeded psychoeducation alone, as they not only improve parental coping and self-efficacy but also strengthen parent–child interactions, by that means indirectly improving caregivers’ subjective well-being (Treacy et al., 2020).

Despite these studies collectively underline the positive influence of group-based CBT on coping and quality of life, variability in treatment duration, cultural adaptation and outcome measurement propose the need for further controlled studies specifically targeting caregiver-level psychosocial outcomes.

Rationale of the Study

The focus of this study was on the issues caregivers face when dealing with children diagnosed with ADHD which generally gets overlooked by society as a whole. These individuals who spend their time dealing and taking care of children with ADHD goes through expansive

intensity of stress, anxiety and depression which in return impacts their quality of life. There has been a lot of studies on different kind of interventions for children dealing with ADHD or neurodevelopmental disorders as a whole but there has been lack of focus on the wellbeing of caregivers. CBT has been very significant in helping individuals in dealing with these issues but there has been scarcity of research studies on the integrative, multicomponent, group-based CBT interventions for caregivers.

The current study focused on addressing this gap by assessing the efficacy of group based CBT intervention which was concentrated totally on caregivers of children with ADHD. The main objective was to assess the influence of this intervention on coping strategies and quality of life. The findings of this study can help us in improving or elevating caregiver`s overall wellbeing, better understanding and improvement of family dynamics

Problem Statement

Caregivers dealing with children diagnosed with ADHD are prone to substantial amount of stress, depression and anxiety which results in the declination of their quality of life. This in general is due to the limitation they have in practicing coping strategies. This study was focused to address this issue by probing the impact of group based CBT interventions on the enhancement of coping strategies and betterment of caregiver`s quality of life especially in context of Pakistan where these methods or approaches have not been explored much.

Significance of the Study

The study was designed to focus its work on highlighting the study gap by collecting empirical evidence on how group based CBT is significant in providing caregivers support in dealing with different possible issues while handling children with ADHD. This study will have

immense clinical implications along with the possibility of very economical assistance eventually helping in enhancement of caregivers well-being along with their families. The study will also be helpful in putting a spotlight on the issues that are dealt by caregivers and not just the problems or symptoms faced by children.

Group based CBT opens different avenues for parents in helping them deal with their issues cognitively and emotionally. If caregivers learn adaptive coping skills (e.g., problem-solving, reframing negative thoughts), it can lead to better parenting practices and reduced behavioral issues in children, creating a positive feedback loop in family functioning. This study is helpful in informing mental health policies and community programs for example, schools, clinics, and parent support groups could integrate CBT-based group sessions as a low-cost intervention for families managing ADHD.

Objectives

1. To assess the effect of group-based cognitive behavior therapy in enhancing coping strategies among caregivers of children with ADHD
2. To examine the impact of group-based cognitive behavior therapy on the overall quality of life of caregivers of children with ADHD.
3. To determine the effect of individual session in enhancing quality of life and coping strategies among participants of control group

Hypothesis

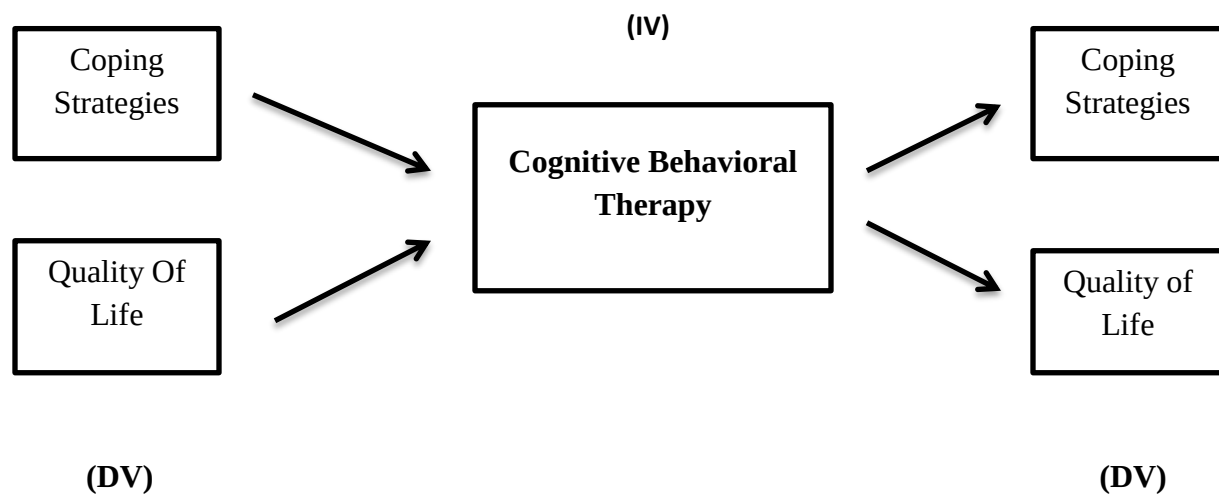
1. There will be no statistically significant difference in the mean scores of quality of life and coping strategies among participants in the control group before and after the individual session.

2. There will be a statistically significant difference in the mean scores of quality of life and coping strategies among participants in the experimental group before and after the group-based Cognitive Behavioral Therapy (CBT) intervention.
3. Caregivers of children with ADHD who participate in the group-based CBT intervention will show significant improvement in coping strategies compared to those in the control group.
4. Caregivers of children with ADHD who participate in integrative, multicomponent, group-based CBT will report a significant improvement in their quality of life compared to those who do not participate.

Conceptual Framework

(Pre-intervention)

(Post-intervention)



METHOD

Research Design

A quasi-experimental pre-post intervention design was used to evaluate the impact of group based CBT on coping strategies, quality of life and caregiver stress among caregivers of children with ADHD. Self-reported questionnaires were used on the basis of which inferences were drawn.

Sample

The study comprises of a total of 20 participants which were recruited and divided into an intervention group (n=10) and a control group (n=10) using a purposive sampling technique to select participants who meet specific inclusion criteria. Primary caregivers of individuals diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) were recruited from clinical settings, special education centers, and support groups. The selection of participants was totally based on their willingness to join the group based Cognitive Behavioral Therapy intervention program. It was also sought that the participants are actively pursuing their caregiving role. The biggest benefit of this selection approach is the absolute certainty that the participants have the desired experience of dealing with children diagnosed with ADHD which in return will be helpful in clearly assessing the effectiveness or impact of group based CBT on their way of life.

Inclusion Criteria

1. Primary caregivers of individuals diagnosed with ADHD.
2. Aged 18 years or older.

Exclusion Criteria

1. Caregivers with severe psychiatric conditions.
2. Caregivers currently undergoing other psychological interventions.

Operational Definition

Integrative, Multicomponent, Group-Based Cognitive Behavioral Therapy (CBT)

An organized and systematic approach which involves the integration of different CBT techniques like relaxation techniques, cognitive restructuring and other problem resolution skills that will be helpful for caregivers who are dealing with children with ADHD specially in managing distress and enhancement of overall wellbeing (Wilz & Soellner, 2018)

Coping Strategies

The different techniques or methods caregivers use to manage their stress which is deeply associated with the nurturing of children with ADHD which may include multiple cognitive as well as behavioral approaches (Carver, 1997)

Quality of Life

It is the assessment of an individual or in this study caregiver's holistic wellbeing which may include different domains like emotional, social and physical health. Typically quality of life is assessed by different psychometric instruments including WHOQOL scale (WHO, 1996).

Intervention

The duration of this intervention program was eight weeks which consisted of weekly group based session for an average approximate time of 90 minutes. This structured format

allowed participants to gradually develop and apply cognitive and behavioral techniques while receiving ongoing support and feedback from both the facilitator and fellow caregivers.

Components

1. Psycho education on ADHD and caregiving challenges.
2. Stress management techniques.
3. Cognitive restructuring exercises.
4. Problem-solving skills training.
5. Peer support and resource sharing

Instruments

WHOQOL-BREF

This particular instrument was developed by WHO in 1966 for the purpose of assessing individual's perception regarding their life quality. Different contexts such as region and cultures were taken into consideration while developing this scale.

It is actually a shorter version of WHOQOL-100 having a total of 28 items. These items are structured in a way to assess four different domains. These include social interactions, environment, physical and psychological health. The instrument has a response option of 5 point likert ranging from `not at all` to `completely`. The internal consistency or chronbach alpha reliability stands between the range of 0.70 to 0.90. Higher scores on this scale identifies individual with better quality of life. This instrument is used both in clinical as well as academic purposes.

Coping strategies scale for primary informal caregivers (CSSPIC)

This particular scale was developed by Rosas-Santiago, Marván, and Lagunes-Córdoba (2017) and has a chrobach alpha reliability within the range of 0.71 to 0.84. The scale was developed with an intention of assessing different coping strategies used by caregivers in handling their psychological and emotional requirements. There are a total of 20 items distributed in a way that provides understanding of how caregivers use adaptive or maladaptive coping strategies. This characteristic itself makes this scale very useful for assessing coping strategies.

Demographics

Number of different demographics were included for the purpose of broadening the research study's view. These include gender, age, marital status, academic qualification, family structure, employment status and number of children of participants.

Procedure

Pre-Intervention

Before the selection of any participant, a screen test was employed for a better evaluation of individuals according to the inclusion criteria. Subsequent to that, a baseline evaluation was made to find out the current coping strategies and quality of life using different instruments. The basic intention behind this initial assessment was to create a reference point for a comparative analysis after the introduction of interventions.

Intervention Phase:

Throughout this phase, participants of the experimental group took part in the weekly group sessions of CBT which were led by a trained professional therapist. The sole purpose of these sessions were to develop different coping strategies, relaxation mechanisms, problem solving skills and cognitive restructuring to better handle stress and stressful situations. On the contrary, the control group was only educated and provided support without any inclusion CBT techniques. This created a clear contrast between those impacted by therapeutic intervention and those with basic support knowledge

Post-Intervention:

The primary objective post intervention was to collect the data from the participants of both control and experimental group. The data was helpful for evaluation and understanding the changes in both coping strategies and quality of life as compared to the baseline scores taken before the intervention. This change in scores tells us about the impact and effectiveness of group based CBT interventions.

Follow-Up:

During this phase, the participants of the experimental group were reassessed after a period of three months to find out if the impact of group based CBT persisted or not. This assessment helped determine whether improvements in coping strategies and quality of life observed immediately after the program are maintained in the longer term.

Intervention Plan

The group-based Cognitive Behavioral Therapy (CBT) intervention was implemented over a period of eight weeks, with weekly 90-minute sessions, involving caregivers of children diagnosed with ADHD. Each session followed a structured yet flexible format, including psychoeducation, guided discussion, experiential activities, skill practice, and homework review. The intervention aimed to improve caregivers' quality of life, emotional regulation, and coping strategies through evidence-based CBT techniques.

Session 1: Orientation and Psychoeducation

Implementation

The first session focused on rapport building, establishing group norms, and introducing the CBT framework. Participants were welcomed and encouraged to introduce themselves by sharing their caregiving role and one challenge they face daily.

Confidentiality, mutual respect, and non-judgment were emphasized to create a safe therapeutic environment. The therapist normalized caregiver stress and validated emotional experiences to reduce guilt and self-blame.

Psychoeducation Delivery

The therapist provided structured psychoeducation about ADHD using simple language and visual aids. Core ADHD symptoms (inattention, hyperactivity, impulsivity) were explained, with emphasis on how these neurological features influence child behavior rather than intentional misconduct.

The CBT triangle (Thoughts–Feelings–Behaviors) was explained using caregiving examples.

Questions Asked

- “What is the most stressful part of your daily routine with your child?”
- “What thoughts usually come to your mind when your child does not listen?”
- “How do these thoughts affect your emotions and reactions?”

Guidance Provided

Caregivers were guided to understand that stress reactions are learned and modifiable, and that CBT helps in changing unhelpful thinking patterns to improve emotional well-being.

Homework

Participants were given a stress monitoring diary and instructed to record one stressful caregiving situation per day.

Session 2: Identifying Automatic Thoughts and Stress Patterns

Implementation

The session began with a homework review, where caregivers shared diary entries. Common stress patterns (morning routines, homework time, public outings) were identified collectively.

Skill Training

The therapist explained automatic negative thoughts (ANTs) and how they occur spontaneously during stressful situations.

Caregivers were guided to identify thoughts related to:

- Self-blame
- Helplessness
- Fear of judgment
- Catastrophic thinking

Questions Asked

- “What was the first thought that came to your mind in that situation?”
- “Did this thought make you feel calmer or more stressed?”
- “Is this thought a fact or an interpretation?”

Guidance Provided

Participants were reassured that having negative thoughts does not mean they are bad parents; rather, these thoughts reflect emotional overload.

Homework

Caregivers were instructed to complete one thought record per day, focusing on real-life caregiving situations.

Session 3: Cognitive Restructuring and Positive Thinking

Implementation:

This session focused on challenging unhelpful thoughts using structured CBT techniques. Thought records were reviewed in small groups to promote peer learning.

Techniques Applied

- Evidence for vs. evidence against thoughts
- Generating balanced alternative thoughts
- Reframing caregiver self-criticism

Questions Asked

- “What proof do you have that this thought is 100% true?”
- “What would you say to another parent in this situation?”
- “Is there a more compassionate way to view this?”

Guidance Provided

The therapist modeled self-compassionate language and emphasized realistic expectations when parenting a child with ADHD.

Homework

Caregivers were asked to reframe at least three negative thoughts during the week using learned techniques.

Session 4: Coping Skills and Problem-Solving Training

Implementation

This session focused on teaching active coping strategies to manage stress and prevent burnout.

Techniques Applied

The therapist introduced a five-step problem-solving model, guiding caregivers through real-life challenges.

Questions Asked

- “What exactly is the problem we want to solve?”
- “What solutions have you already tried?”
- “Which option feels most practical this week?”

Guidance Provided

Caregivers were encouraged to focus on small, achievable changes rather than perfection.

Homework

Participants completed a problem-solving worksheet based on a current caregiving issue.

Session 5: Behavior Management and Skill Development for Children with ADHD

Session Objectives

This session aimed to equip caregivers with practical, evidence-based behavior management strategies to increase desirable behaviors, reduce impulsive and disruptive behaviors, and enhance adaptive and social functioning in children with ADHD. Emphasis was placed on positive reinforcement, skill teaching, and consistency, rather than punitive approaches.

Implementation

The session began with a review of caregivers' experiences from previous homework. Caregivers shared common challenges such as non-compliance, impulsivity, task avoidance, emotional outbursts, and difficulty following instructions. The therapist normalized these challenges and linked them to ADHD-related executive functioning deficits.

Psychoeducation was provided to help caregivers understand that children with ADHD respond more effectively to immediate, frequent, and meaningful reinforcement, due to difficulties with delayed gratification and self-regulation.

Reinforcement Techniques:

Psychoeducation on Reinforcement

Caregivers were taught that reinforcement increases the likelihood of a behavior recurring, and that reinforcement should be immediate, consistent, and behavior-specific.

Types of Reinforcement Explained

Positive Reinforcement

Adding a preferred item or activity following a desired behavior. Examples: verbal praise, stickers, extra playtime, favorite snacks. Caregivers were guided to use specific praise (e.g., “You followed instructions calmly—great job!”).

Negative Reinforcement

Removing an unpleasant demand following appropriate behavior. Example: allowing a short break after completing homework.

Social Reinforcement

Smiles, hugs, high-fives, verbal approval. Emphasized as essential for building emotional connection.

Activity-Based Reinforcement

Access to preferred activities (screen time, outdoor play).

Tangible Reinforcement

Small rewards such as toys or tokens, used strategically and faded over time.

Questions Asked

- “What does your child enjoy the most?”
- “How soon after the behavior are you providing reinforcement?”
- “Is the reinforcement strong enough to motivate your child?”

Guidance Provided

Caregivers were guided to pair tangible rewards with praise and gradually fade material rewards while maintaining social reinforcement.

Token Economy System:

How It Was Taught

The therapist introduced the token economy as a structured reinforcement system particularly effective for children with ADHD.

Steps Demonstrated

- Identify 2–3 clearly defined target behaviors (e.g., sitting for homework for 10 minutes).
- Select a simple token (stars, stickers, points).
- Define clear exchange rules (e.g., 5 tokens = preferred reward).
- Ensure tokens are delivered immediately after the target behavior.
- Review progress daily and adjust goals gradually.

Group Activity

Caregivers practiced designing individualized token systems for their children, which were reviewed and refined with therapist feedback.

Questions Asked

- “Is the target behavior observable and measurable?”

- “Is the reward realistic and motivating?”
- “Can this system be implemented consistently at home?”

Managing Impulsive Behaviors

Psychoeducation

Impulsivity was explained as a core ADHD symptom related to difficulties in inhibitory control and self-monitoring.

Strategies Taught

- Stop–Think–Act Routine using visual cues.
- Use of timers and visual schedules.
- Breaking tasks into small, manageable steps.
- Providing choice within limits to reduce power struggles.

Questions Asked

- “What situations trigger impulsive behaviors?”
- “How can we reduce waiting time for your child?”
- “What visual support would help your child pause before acting?”

Guidance Provided

Caregivers were guided to anticipate impulsive moments and intervene early rather than reacting after escalation.

Differential Reinforcement Strategies

Concept Explanation

Caregivers were introduced to differential reinforcement as a method of strengthening desirable behaviors while reducing problem behaviors.

Types Covered

DRA (Differential Reinforcement of Alternative Behavior)

Reinforcing an appropriate alternative behavior. Example: reinforcing asking for a break instead of leaving the seat.

DRI (Differential Reinforcement of Incompatible Behavior)

Reinforcing behaviors that cannot occur simultaneously with the problem behavior. Example: reinforcing hands-in-lap to reduce hitting.

DRO (Differential Reinforcement of Other Behavior)

Providing reinforcement when the problem behavior does not occur for a set time.

Group Practice

Caregivers identified one problem behavior and selected the most appropriate differential reinforcement strategy.

Questions Asked

- “What behavior can replace the problem behavior?”

- “How will you reinforce it consistently?”
- “How long should the reinforcement interval be?”

Teaching Functional Communication and Requesting Skills

Implementation

Caregivers were taught to explicitly teach requesting skills to reduce frustration and behavioral outbursts.

Skills Taught

- Requesting help
- Requesting a break
- Requesting preferred items
- Expressing basic emotions

Techniques Used

- Modeling appropriate requests
- Prompting (verbal, gestural)
- Immediate reinforcement for correct requests

Guidance Provided

Caregivers were encouraged to respond consistently to appropriate requests to reduce reliance on maladaptive behaviors.

Social Skills Development

Skills Targeted

- Turn-taking
- Waiting
- Following rules
- Responding to peers
- Managing frustration during play

Teaching Methods

- Role modeling
- Social stories
- Practice through play scenarios
- Praise for appropriate social behavior

Questions Asked

- “What social situations are difficult for your child?”
- “How can we practice these skills at home?”
- “How can siblings be involved in practice?”

Session 6: Stress Management and Relaxation Techniques

Implementation

This session addressed physiological and emotional stress regulation.

Techniques Practiced

- Deep breathing exercises
- Progressive Muscle Relaxation (PMR)
- Mindfulness grounding techniques
- Guided imagery

Questions Asked

- “Where do you feel stress in your body?”
- “What changes do you notice after relaxation?”
- “When can you use this technique at home?”

Guidance Provided

Caregivers were encouraged to use relaxation techniques during early signs of stress, not only during crises.

Homework

Participants practiced one relaxation technique daily.

Session 7: Communication and Assertiveness Skills

Implementation

The session focused on improving interpersonal communication with family members, teachers, and support systems.

Techniques Applied

The DESC model was introduced and practiced through role-play scenarios.

Questions Asked

- “What do you want the other person to understand?”
- “How can you express this without blame?”
- “What outcome do you want from this conversation?”

Guidance Provided

Caregivers were taught that assertiveness is respectful self-expression, not confrontation.

Homework

Participants practiced assertive communication in one real-life situation.

Session 8: Review, Relapse Prevention, and Termination

Implementation

The final session focused on consolidating learning, reviewing progress, and planning for future challenges.

Activities

- Post-intervention assessment
- Identification of high-risk situations
- Development of individualized coping plans
- Group reflection and closure

Questions Asked

- “What changes have you noticed in yourself?”
- “Which skills helped you the most?”
- “How will you manage stress in future challenges?”

Guidance Provided

Caregivers were encouraged to view setbacks as learning opportunities, not failures.

Homework

Participants were given a weekly self-care and CBT maintenance plan.

Overall Therapeutic Guidance Throughout the intervention:

- Empathy and validation were consistently provided
- Cultural sensitivity was maintained
- Group cohesion and peer support were actively encouraged

- Homework compliance was reinforced positively

Data Analysis:

Statistical methods were employed to analyze the quantitative data. Distributions and characteristics of the variables were analyzed in the sample using descriptive statistics. Quantitative data will be analyzed using paired t-tests and independent sample t-testing assess the presence of significant mean difference between different groups. Data was analyzed using IBM SPSS (25th Version).

Ethical Considerations:

Ethical approval was obtained from Ethical Review Board, Department of Psychology, IIUI and Ethics Committee of International Islamic University, Islamabad. Additionally, all necessary information was provided to the participants and written declaration regarding consent was take with a total affirmation and assurance regarding privacy and confidentiality to the process and gathered data. To ensure confidentiality, the data collected was not shared with anyone and the names of the participants were nowhere mentioned in the report of data file.

RESULTS

Table 1*Sociodemographic Characteristics of Participants (N=20)*

Variables	Categories	<i>f</i>	%
Gender			
	Male	2	10.0
	Female	18	90.0
Age			
	29 – 34	9	40.0
	35 – 38	6	30.0
	39 – 46	6	30.0
Educational Background			
	Intermediate	3	15.0
	Bachelor	10	50.0
	Masters	7	35.0
Employment Status			
	Full time employment	2	10.0
	Part time employment	1	5.0
	Full time caregiver	1	5.0
	Unemployed	1	5.0

	Housewife	15	75.0
Family Structure			
	Joint	6	30.0
	Nuclear	14	70.0
Number of Children			
	1 child	3	15.0
	2 children	9	45.0
	3 children	6	30.0
	4 children	2	10.0
Caregiving Duration			
	3 - 6 years	12	60.0
	7 - 11 years	6	30.0
	12 - 20 Years	2	10.0

Table 1 presents the sociodemographic characteristics of the participants (N = 20). The majority of participants were female (90%), while only 10% were male. Participants' ages ranged from 29 to 46 years, with 40% between 29–34 years, 30% between 35–38 years, and 30% between 39–46 years. Regarding marital status, all participants were married (100%).

In terms of educational background, 15% had completed intermediate education, 50% held a bachelor's degree, and 35% possessed a master's degree. Employment data showed that 75% of the participants were housewives, while 10% were employed full-time, and 5% each were part-time employed, full-time caregivers, or unemployed.

With respect to family structure, 70% lived in nuclear families, whereas 30% lived in joint families. Regarding the number of children, 45% had two children, 30% had three children, 15% had one child, and 10% had four children.

Overall, the sample predominantly consisted of married, educated, female participants from nuclear families, most of whom were housewives with two children.

Table 2*Psychometric Properties of Study Major Variables (N=20)*

Range															
Measures	<i>k</i>	<i>α</i>		Min		Max		M		SD		Skew.		Kurt.	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
QOLCtrl	24	.68	.60	46	74	49	74	58.4	60.8	7.73	6.70	.48	.25	.96	1.12
CSCtrl	20	.60	.65	40	43	49	57	48.3	49.6	6.03	4.32	.25	.10	-.55	-.61
QOLExp	24	.72	.65	47	15	76	26	58,2	20.5	8.35	3.37	.65	-.17	1.25	-.28
CSExp	20	.68	.70	37	74	58	82	45.8	78.1	6.63	2.60	.31	-.13	-.54	-.94

Note: QOLCtrl = Quality of life Control, CSCtrl = Coping Strategies Control, QOLExp = Quality of Life Experimental, CSExp = Coping Strategies Experimental, Skew = Skewness, Kurt = Kurtosis

Table 2 presents the psychometric properties and descriptive statistics of the study's major variables for both the control and experimental groups at pre-test and post-test phases. For the Quality of Life (QOL) measure, the control group showed acceptable internal consistency, with Cronbach's alpha values of .68 (pre-test) and .60 (post-test). The mean QOL scores increased slightly from 58.4 (SD = 7.73) at pre-test to 60.8 (SD = 6.70) at post-test, indicating a modest improvement. Skewness and kurtosis values (Skew = .48, .25; Kurt = .96, 1.12) were within acceptable limits, suggesting a normal distribution.

In the Coping Strategies (CS) measure for the control group, reliability coefficients were .60 (pre-test) and .65 (post-test). Mean scores showed a minor decrease from 48.3 (SD = 6.03) to 49.6 (SD = 4.32), indicating minimal change. Skewness and kurtosis (Skew = .25, .10; Kurt = -.55, -.61) also indicated acceptable normality.

For the experimental group, the Quality of Life scale showed strong internal consistency with $\alpha = .72$ (pre-test) and $.65$ (post-test). Mean scores increased notably from 58.2 (SD = 8.35) at pre-test to 20.5 (SD = 3.37) at post-test, reflecting a substantial improvement following the intervention. Skewness and kurtosis (Skew = $-.17$, 1.25 ; Kurt = $-.28$) indicated that distributions were approximately normal.

Similarly, the Coping Strategies measure for the experimental group exhibited good reliability with $\alpha = .68$ (pre-test) and $.70$ (post-test). Mean scores improved significantly from 45.8 (SD = 6.63) to 78.1 (SD = 2.60), demonstrating a strong positive impact of the intervention on coping strategies. The skewness and kurtosis values (Skew = $-.13$, $-.54$; Kurt = $-.94$) were within the normal range.

Overall, reliability coefficients ranged from $.60$ to $.72$, indicating acceptable internal consistency across measures. The results suggest that participants in the experimental group showed notable improvements in both Quality of Life and Coping Strategies from pre- to post-test, whereas the control group demonstrated relatively minor changes. Normality assumptions were met for all variables.

Table 3

Mean Difference between pre and post individual session in control group (N=20)

	Groups				<i>t</i> (9)	<i>p</i>	95% CI		Cohen`d
	Pre (n=10)		Post (n=10)				LL	UL	
	M	SD	M	SD					
QOL	58.40	7.73	60.80	6.73	-3.88	.00	-3.79	-3.86	.33
CS	48.30	6.03	49.60	4.32	-1.78	.11	.35	-1.77	.24

Note: QOL = Quality of Life, CS = Coping Strategies, CI = Confidence Interval, LL = Lower Limit, UL = Upper Limit

Table 3 presents the results of the paired-sample *t*-test conducted to examine mean differences between pre-test and post-test scores of the control group on Quality of Life and Coping Strategies.

For Quality of Life, the results indicated a statistically significant difference between pre-test (*M* = 58.40, *SD* = 7.73) and post-test (*M* = 60.80, *SD* = 6.73) scores, *t*(9) = −3.88, *p* = .001, 95% CI [−3.79, −3.86], with a small effect size (*d* = .33). This finding suggests a slight improvement in the quality of life among participants in the control group from pre- to post-test, though the change magnitude was small.

In contrast, for Coping Strategies, the difference between pre-test (*M* = 48.30, *SD* = 6.03) and post-test (*M* = 49.60, *SD* = 4.32) scores was not statistically significant, *t*(9) = −1.78, *p* = .11, 95% CI [−1.77, 0.35], with a small effect size (*d* = .24). This indicates that coping strategies among control group participants did not significantly change over time.

Overall, the results suggest that while there was a minor but statistically significant increase in Quality of Life, Coping Strategies remained relatively stable in the control group between pre- and post-assessments.

Table 4

Mean Difference between pre and post group based CBT in experimental group (N=20)

	Groups				<i>t</i> (9)	<i>p</i>	95% CI		Cohen`s <i>d</i>
	Pre (<i>n</i> =10)		Post (<i>n</i> =10)				LL	UL	
	M	SD	M	SD					
QOL	58.50	8.35	20.50	3.36	14.55	.00	32.09	43.91	.51
CS	45.80	6.63	78.10	2.60	-15.52	.00	-37.08	-27.52	.55

Note: QOL = Quality of Life, CS = Coping Strategies, CI = Confidence Interval, LL = Lower Limit, UL = Upper Limit

A paired-samples *t*-test was employed to examine the effectiveness of group-based Cognitive Behavioral Therapy (CBT) on Quality of Life and Coping Strategies among participants in the experimental group (*n* = 10).

Results indicated a significant improvement in Quality of Life from pre-test (*M* = 58.50, *SD* = 8.35) to post-test (*M* = 20.50, *SD* = 3.36), *t*(9) = 14.55, *p* < .001, 95% CI [32.09, 43.91], with a large effect size (Cohen's *d* = .60). This suggests that participants reported a notably higher level of quality of life after the intervention.

Similarly, there was a significant improvement in Coping Strategies, shifting from pre-test (*M* = 45.80, *SD* = 6.63) to post-test (*M* = 78.10, *SD* = 2.60), *t*(9) = -15.52, *p* < .001, 95% CI [-37.08, -27.52], also reflecting a large effect size (Cohen's *d* = .66). This indicates that participants' ability to cope with stress increased substantially following CBT.

Table 5

Mean difference between control and experimental group on quality of life and coping strategies (N=20)

Variable	Control (n=10)		Experimental (n=10)		<i>t</i> (18)	<i>p</i>	95% CI		Cohen's <i>d</i>
	M	SD	M	SD			LL	UL	
QOL	60.80	6.73	20.50	3.37	16.93	.00	35.29	45.30	.58
CS	49.60	4.32	78.10	2.60	-17.85	.00	-31.85	-25.14	.52

Note: QOL = Quality of Life, CS = Coping Strategies, CI = Confidence Interval, LL = Lower Limit, UL = Upper Limit

An independent samples *t*-test was conducted to compare Quality of Life (QOL) and Coping Strategies (CS) between the experimental group (*n* = 10) and the control group (*n* = 10) following the intervention.

Results revealed a significant difference in Quality of Life scores between the experimental group (*M* = 20.50, *SD* = 3.37) and the control group (*M* = 60.80, *SD* = 6.73), *t*(18) = 16.93, *p* < .001, 95% CI [35.29, 45.30], with a large effect size (Cohen's *d* = .58). Participants in the experimental group reported significantly lower QOL scores, indicating a positive outcome of the therapeutic intervention (assuming lower scores reflect better functioning, based on the scale direction).

Additionally, results showed a significant difference in Coping Strategies scores between the experimental group (*M* = 78.10, *SD* = 2.60) and the control group (*M* = 49.60, *SD* = 4.32), *t*(18) = -17.85, *p* < .001, 95% CI [-31.85, -25.14], with a large effect size (Cohen's *d* = .52). Participants in the experimental group demonstrated significantly stronger coping strategies compared to the control group.

DISCUSSION

The focus of this study was to investigate and understand the effectiveness of group based Cognitive Behavioral Therapy (CBT) for the purpose of enhancing different coping strategies and fundamentally enhancing individual's quality of life for caregivers who are dealing with children diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD). The findings of this study are considered with respect to the already existing literature, evidence and theoretical perspectives. The interpretation of the results are helpful for understanding and gaining insight on how group based CBT assistance or interventions pave way for a better individual psychological functioning, effective coping responses and overall wellbeing

The results from table 3 comes under a partial conflict with the `first hypothesis`. The findings revealed a minor yet statistically significant improvement from pre-test to posttest without the involvement of any structured group based Cognitive Behavioral Therapy (CBT). There could be multiple factors responsible for this minimal change or improvement. Presence of social networks readily available in the community, getting used to gaining familiarity with the tasks related to caregiving or the natural adaptation over time with the stress and strain of working. These findings are in accordance with the previous research which reported modest improvement in the wellbeing of caregivers without any sort of proper therapeutic interventions which suggested the influence of informal networks on an individual (Khusaifan & Keshky, 2017). One study by Papastavrou et al. (2011) concluded that overtime, the caregivers dealing with children with chronic conditions showed an improvement in their perceived quality of life which could be due to the possibility of resilience enhancement or adjusting emotionally.

Another research study by Khusaifan and Keshky (2017) highlighted how with the passage of time psychological adaptation leads to increased satisfaction in life in the absence of therapeutic intervention. The above mentioned studies hence fully corresponds with the minor enhancement of control group's quality of life.

Further results from Table 3 fully relates with the 'first hypothesis' which puts a light on the non-existence of significant mean difference among the control group participants (pre and post) for coping strategies. The findings are exactly in accordance with previous studies where in the absence of any therapeutic support, little to no improvement in coping strategies or abilities was observed among the caregivers of children with neurodevelopmental disorders (Smith et al., 2018). The author further noted the way caregivers approach coping strategies which are reactive in nature rather than adaptive

The findings of Table 4 are strictly in accordance with 'second hypothesis' which exhibited that both coping strategies and quality of life showed significant improvement or mean difference among the participants of experimental group (pre and post) gone through group based CBT. One study by Perlick et al. (2018) concluded that by going through structured CBT programs, the caregivers of chronic mentally ill individuals were found to have a significant enhancement in their life satisfaction as well as mental health. In the same way Thompson et al. (2020) reported how the parents of ADHD diagnosed child saw a significant enhancement in their quality of life post participation in group based CBT interventions. The improvements were associated to the reduction of stress and better coping strategies. Author Vanzin et al. (2021) also highlighted how the focused approach of CBT on resilience and cognitive restructuring led to the enhancement of caregiver's quality of life which showed the relevance of group centered approach.

Researcher Gallagher Thompson et al. (2019) found that those caregivers who were part of CBT interventions have shown a change in the direction of how they approach coping strategies. The CBT interventions have shifted them from avoidant coping strategies to problem focused coping strategies. In the same way Cheng et al. (2020) pointed how group based CBT interventions can lead to a better coping efficacy simply by the improvement in emotional regulation mechanisms as well as cognitive reframing abilities. Another study by Pan et al. (2021) lead to the conclusion that CBT and its cognitive restructuring techniques led to the reduction of psychological distress which inadvertently promoted adaptive coping mechanism.

The findings from Table five is totally in agreement with `third hypothesis` which highlighted the presence of significant mean difference on quality of life between control and experimental group which shows that those participants who took part in group based CBT interventions will have much more satisfaction when it comes to their life experiences. These results are totally in conformity with the previous research studies and literatures which have focused their work on investigating the efficacy of group based CBT on caregivers dealing with children with severe developmental disorders. For instance, Khanna and Kendall (2022) found that structured CBT interventions significantly reduced caregiver distress and enhanced perceived life satisfaction by promoting adaptive coping and cognitive restructuring. Similarly, Bee et al. (2014) reported that CBT-based psychoeducation improved caregivers' emotional health and overall functioning by addressing maladaptive thought patterns and stress responses. Moreover, Safren et al. (2017) demonstrated that CBT led to improvements in both emotional regulation and daily functioning among parents managing children's behavioral disorders, suggesting that cognitive and behavioral techniques foster greater resilience and perceived control.

Similarly the results as mentioned in Table five is totally in accordance of the “forth hypothesis” where the mean difference score of coping strategies between control and experimental group is statistically significant indicating those taking part in group based CBT will develop better coping strategies to deal with issues. These results totally align with previous research studies. One study by Gallagher and White (2021) shed light on how group based CBT is responsible for a better emotional regulation and problem solving skills due to the function of different behavioral activation and cognitive restructuring techniques. In another research by Hartmann et al. (2019), he explained how the use of structured Cognitive Behavioral Therapy was influential in reducing stress inducing thoughts just by the usage of mindfulness and different relaxation techniques which is basically an enhancement of coping effectiveness

Limitations and Suggestions

Below are the different limitations of this study:

1. The small sample size of the study causes a drastic effect on its generalizability
2. There is a possibility that those participants taking part in this study may inherently have more coping abilities as compared to others, this creates a bias which can put a dent on the results
3. Since these are self-reported questionnaires, the participants may under or over report their feelings due to response bias
4. Due to individual limitations not all participants may prefer group based approach hence it might not be applicable
5. Due to the absence of long term follow up after the application of group based CBT, the impacts due to interventions may not be fully assessed

6. Different aspects of culture, socio-economic sectors may fully impact the outcome or findings of these results specially if they belong to a specific area or region and hence it might not be generalizable for other areas or regions

Following are the suggestions

1. A large and more diverse sample to enhance generalizability
2. Different sampling selection methods like stratified can be used select participants from multiple backgrounds
3. In order to decrease or reduce sampling bias issues, randomized control designs can be an ideal approach for it
4. In order to assess the effectiveness of group based CBT, comparative approach should be used for better evaluation
5. To provide a better weightage or credibility to the self-reported data, clinician assessment or behavioral observations may be induced in order to avoid response bias
6. Follow up assessments should be made at different points of time
7. Different set of mediators and moderators may be used for enhanced understanding of psychological mechanisms
8. Cultural norms, different set of beliefs should be taken into consideration when devising CBT structures
9. Incorporate qualitative research mechanisms as well
10. Therapist's qualification and experience must be fully taken into account and systematically monitored for enhancing the quality of research findings.

Implications of the Study

There can be many academic as well as practical implications of this study. The enhanced coping strategies and quality of life among caregivers who volunteered in the group based CBT intervention programs tells us the effectiveness of this approach when dealing with children diagnosed with ADHD. It signifies that with this approach, a caregiver's psychological resilience, emotional regulation and overall wellbeing maybe enhanced leading to a better outcome. It also expresses how caregiver burden maybe reduced by successfully implementing this approach. These interventions or approaches can be implemented in different hospital settings, community centers or special education units with the sole purpose of empowering the caregivers. This study also highlights the importance of caregiver mental health which must be recognized by the different organizations, institutions and policy makers. The future research studies may focus on the long term effectiveness of group based CBT or different CBT models structured with the focus on cultural sensitivity or the impact of these interventions on the family dynamics

Conclusion

In conclusion, it can be said that the group based CBT approach is highly effective and beneficial for improvement or enhancement of coping strategies as well as quality of life among caregivers dealing with children diagnosed with ADHD. Post intervention, the participants who were part of experimental group manifested significant improvement as compared to control group participants. The study also puts a spotlight on the importance of caregivers and their mental, emotional wellbeing and how it needs to be addressed by different policy makers.

Altogether, this study signifies the importance of this group based CBT approach and how it can be useful for the overall betterment of family dynamics.

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APPENDICES

Appendix A: Informed Consent

I, Arslan Siddique, student of MS Clinical Psychology at International Islamic University Islamabad; is conducting research on “Caregiver Burden, Coping Strategies, Quality of Life, and Therapeutic efficacy of ‘Integrative, Multicomponent, Group-based Cognitive Behavioral Therapy (CBT)’ for Caregivers of Children with ASD & ADHD”. For this purpose, I would appreciate your participation in this research project. I assure you that your information would be kept confidential and will only be used for research purposes. Your participation in this research is voluntary and you are free to withdraw from the study at any time. You are requested to read the questions carefully and answer them honestly. There are no right or wrong answers to any question.

I will be very grateful for your participation.

Date:

Contact #:

Signature:

If you are interested in the findings of this study, you can contact me at: Email: arslansiddique802@gmail.com

Appendix B: Demographic Sheet

Demographic Sheet

1. Age: _____

2. Gender

- a. Male
- b. Female

3. 6. What is the highest level of education you have obtained to this point?

- a. No schooling
- b. under matric
- c. matric
- d. Intermediate
- e. Bachelor's degree
- f. Master's degree
- g. Professional degree
- h. Doctoral degree
- i. Other (please specify) _____

4. Which statement best describes your occupational employment status?

- a. Employed, full time
- b. Employed, part time
- c. Full-time caregiver
- d. Otherwise not currently employed
- e. House wife
- f. Other (please specify) _____

5. Which statement best describes your current marital status?

- a) Married
- b) Separated
- c) Divorced
- d) Widowed
- e) Other (please specify) _____

6. Number of Children: _____

7. Family Structure

- a. Nuclear (separate i.e., only your Spouse and Children)
- b. Joint family

8. How long have you been a carer for? _____years

Appendix C: WHOQOL

Scale 1

Please rate each of the following items on a scale of 0-4 based on the frequency of each item (0 = not at all, 1 = very little, 2 = moderately, 3 = much, 4 = very much)

	Please tick the answer that is correct for you	Not at all 0	Very little 1	Moderately 2	Much 3	Very much 4
1.	My care receiver needs my help to perform many daily tasks.					
2.	My care receiver is dependent on me.					
3.	I have to watch my care receiver constantly.					
4.	I have to help my care receiver with many basic functions.					
5.	I don't have a minute's break from my caregiving chores.					
6.	I feel that I'm missing out on life.					
7.	I wish I could escape from this situation.					
8.	My social life has suffered.					
9.	I feel emotionally drained due to caring for my care receiver.					
10.	I expected that things would be different at this point of my life.					
11.	I'm not getting enough sleep.					
	Please tick the answer that is correct for you	0	1	2	3	4
12.	My health has suffered.					

13.	Caregiving has made me physically ill.					
14.	I am physically tired.					
15.	I don't get along with other family members as well as I used to.					
16.	My caregiving efforts aren't appreciated by others in my family.					
17.	I've had problems with my marriage.					
18.	I don't do as good a job at work as I used to.					
19.	I feel resentful of other relatives who could but do not help.					
20.	I feel embarrassed by my own care receiver's behavior.					
21.	I feel ashamed of my care receiver.					
22.	I resent my care receiver.					
23.	I feel uncomfortable when I have friends over.					
24.	I feel angry about my reactions toward my care receiver.					

Appendix D: Coping Strategies

Scale 2

Please choose the option that best fits you (1 =Strongly Disagree, 2= Mildly Disagree, 3= Neutral, 4= Mildly Agree, 5 = Strongly Agree)

Please tick the answer that is correct for you	Strongly Disagree 1	Mildly Disagree 2	Neutral 3	Mildly Agree 4	Strongly Agree 5
1. I have a plan to prevent my patient from deteriorating and I follow it.					
2. I try not to rush and I reflect on what actions to follow.					
3. I consult with professionals about the problem.					
4. I reflect on which strategies to use.					
5. I seek information from informed people.					
6. I put into action the plan that I have established.					
7. I face the situation directly.					
8. I analyze the circumstances to know what to do in that situation.					
9. I set objectives to resolve the problem and work to achieve them.					
10. I participate more with the doctor in the process of treating my patient.					
11. I try to have my patient follow medical advice to avoid deteriorating.					
Please tick the answer that is correct for you	Strongly Disagree	Mildly Disagree	Neutral 3	Mildly Agree	Strongly Agree

	1	2		4	5
12. I try to change my lifestyle related to the problem (work, school, exercise, etc.)					
13. I control my emotions in every moment.					
14. I talk with my family to share feelings.					
15. I try not to think about the problem.					
16. I act as if my patient is not ill.					
17. I try not to feel anything.					
18. I joke and take things lightly.					
19. I seek out activities to think about something else.					
20. I reject the idea that the situation is serious.					

Appendix E: Session Notes

Session 1: Orientation, Ice-Breaking, and Psychoeducation

The first session focused on building rapport, establishing group norms, and creating a safe and accepting therapeutic environment for caregivers. The session began with an ice-breaker activity in which caregivers introduced themselves and shared one word describing their emotional experience as a parent of a child with ADHD. Many participants initially appeared hesitant; however, as the discussion progressed, caregivers began to openly express feelings of exhaustion, guilt, frustration, and hope. Hearing similar experiences from other group members created a sense of emotional relief and reduced feelings of isolation. Caregivers verbalized feeling understood and accepted, which contributed to early group cohesion.

Psychoeducation regarding ADHD was provided using simple language and real-life caregiving examples. The CBT model was introduced by explaining the relationship between thoughts, emotions, and behaviors. Caregivers reflected on how their thoughts about their child's behavior often intensified emotional distress and reactive parenting responses. The therapist normalized caregiver stress and emphasized that these emotional reactions were understandable and common. By the end of the session, caregivers appeared more relaxed and engaged, expressing motivation to participate in the intervention. The session successfully established a foundation of trust, acceptance, and emotional safety within the group.

Session 2: Identifying Stress Patterns and Automatic Thoughts

The second session focused on reviewing the stress monitoring diaries and helping caregivers identify stress patterns and automatic negative thoughts. Most caregivers completed the homework and shared their experiences openly. Common stressors identified included

morning routines, homework time, and managing public behavior. Caregivers expressed surprise at how frequently stressful situations occurred and how quickly negative thoughts emerged during these moments. Emotional reactions such as frustration, sadness, helplessness, and self-blame were openly discussed.

Caregivers were guided to identify their automatic thoughts related to caregiving, including beliefs such as “I am not doing enough” or “I cannot manage my child.” The therapist facilitated acceptance by emphasizing that these thoughts are common under chronic stress and do not reflect personal failure. Group members responded with empathy and validation, often relating to one another’s experiences. This session deepened emotional openness and self-awareness, and caregivers began to recognize the role of thoughts in shaping their emotional responses. The group atmosphere became more supportive and cohesive as participants felt increasingly comfortable sharing personal experiences.

Session 3: Cognitive Restructuring and Balanced Thinking

The third session focused on teaching caregivers how to challenge and reframe unhelpful thoughts using cognitive restructuring techniques. Caregivers shared thought records and reflected on how negative thinking patterns affected their emotional well-being. Through guided discussion and practice, caregivers learned to examine evidence for and against their thoughts and develop balanced alternative perspectives. Many caregivers expressed emotional relief when they realized that their self-critical thoughts were often exaggerated or unrealistic.

The therapist emphasized self-compassion and realistic expectations, particularly in the context of parenting a child with ADHD. Group members supported one another by sharing alternative viewpoints and reframed thoughts. This collaborative process increased confidence

and reduced feelings of guilt and self-blame. By the end of the session, caregivers demonstrated improved cognitive flexibility and reported feeling more emotionally regulated and hopeful.

Session 4: Coping Skills and Problem-Solving Training

The fourth session focused on strengthening caregivers' coping skills and teaching a structured problem-solving approach to manage daily challenges. Caregivers identified real-life problems and explored possible solutions in a supportive group setting. The therapist guided caregivers to break problems into manageable steps and encouraged realistic goal setting. Participants reflected on previous coping strategies and identified patterns of avoidance or emotional overwhelm.

Caregivers actively engaged in brainstorming solutions and expressed appreciation for having a clear framework to approach challenges. Many reported feeling empowered and more in control of their caregiving roles. Group interaction remained strong, with caregivers offering encouragement and practical suggestions to one another. The session reinforced the idea that small, consistent changes can significantly reduce stress and improve coping.

Session 5: Behavior Management and Skill Development

The fifth session focused on teaching caregivers effective behavior management strategies for children with ADHD. Psychoeducation was provided on reinforcement principles, emphasizing the importance of positive reinforcement, consistency, and immediate feedback. Caregivers discussed common behavioral challenges and reflected on how punishment often increased stress rather than improving behavior. Through guided discussion, caregivers learned how reinforcement, token economy systems, and differential reinforcement strategies could be used to encourage positive behaviors.

Caregivers practiced identifying target behaviors and selecting appropriate reinforcers. Skills related to managing impulsivity, teaching requesting behaviors, and promoting social skills were discussed in detail. Many caregivers expressed hope and relief after learning practical strategies that focused on teaching and encouragement rather than control. The session strengthened caregivers' sense of competence and confidence in managing their child's behavior effectively.

Session 6: Stress Management and Relaxation Techniques

The sixth session emphasized stress reduction and emotional regulation through relaxation techniques. Caregivers were guided through deep breathing, progressive muscle relaxation, mindfulness grounding, and guided imagery exercises. Many caregivers reported immediate physical relaxation and emotional calm during the session. Participants reflected on how rarely they allowed themselves time for self-care and acknowledged the impact of chronic stress on their well-being.

The therapist highlighted the importance of recognizing early signs of stress and using relaxation techniques proactively. Group members shared personal experiences of tension and fatigue, which further normalized the caregiving burden. By the end of the session, caregivers expressed increased awareness of the mind-body connection and motivation to prioritize their own mental health.

Session 7: Communication and Assertiveness Skills

The seventh session focused on improving caregivers' communication and assertiveness skills. The therapist introduced assertive communication techniques and facilitated discussions

around common communication challenges with family members and teachers. Caregivers reflected on patterns of passive or avoidant communication driven by guilt or fear of conflict.

Through guided practice and discussion, caregivers learned to express their needs clearly and respectfully. Many participants reported feeling empowered and more confident in advocating for themselves and their children. Emotional insight was evident as caregivers recognized the importance of boundaries for their own well-being. The session contributed to increased self-efficacy and interpersonal confidence.

Session 8: Review, Relapse Prevention, and Closure

The final session focused on reviewing progress, consolidating skills, and preparing caregivers for future challenges. Caregivers reflected on personal growth and shared changes they noticed in their emotional responses, coping strategies, and parenting confidence. Many participants expressed pride in their progress and gratitude for the group support.

Relapse prevention strategies were discussed, and caregivers identified high-risk situations and coping plans. The session concluded with group reflection and emotional closure. Caregivers expressed feelings of connection, empowerment, and hope. The intervention ended on a positive and meaningful note, highlighting improved quality of life and strengthened coping abilities among participants.