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A THEMATIC ANALYSIS OF PERCEIVED CHANGES WITHIN THE CAREGIVER-CHILD RELATIONSHIP DUE TO CHILD'S MENTAL HEALTH TREATMENT

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DUE TO CHILD'S MENTAL HEALTH TREATMENT

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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To the admirable caregivers of this world whose efforts are at times unrecognized, this is an effort to bring your voices to light

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As I look back on this memorable academic journey, I gratefully reflect on the special individuals who were my fellow travelers.

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Abstract

Previous research has documented that in their facilitative role of helping children receive mental health services, caregivers are impacted in their daily, interpersonal/social, and emotional functioning. However, despite the significant challenges faced by caregivers, there is a dearth of research that examines how caregiver-child relationships are impacted due to the child's mental health treatment. This qualitative study examined caregivers' perception of changes that occurred in their caregiver-child relationship due to the mental health treatment received by their child. Semi-structured interviews were conducted with caregivers of children receiving pharmacological or counseling treatment for ADHD (Attention Deficit Hyperactivity Disorder), recruited through purposeful, criterion sampling. Transcribed interviews were analyzed utilizing reflexive thematic analysis with various measures in place to ensure the trustworthiness of the study. Four themes that reflected perceived changes in the caregiver-child relationship were inductively generated from the data: *emotional valence*, *shift in focus of interaction*, *accepting impact of child's mental health symptoms*, and *seeing hope in child*. These findings expand existing literature regarding the complexity of caregivers' experiences when coping with a child who has mental health symptoms.

Keywords: caregiver-child relationship, child mental health treatment

Chapter 1: Introduction

The prevalence of mental health issues among children and youth appear to be a growing concern in current society. Within the global context, the World Health Organization (2005) has stated that approximately one fifth of children and adolescents are impacted by mental health illness. These figures are also consistent in the United States as an estimated 13-20 % of children experience mental health illness in a given year (Perou et al., 2013). Furthermore, it is understood that of the 1.3 million children who receive mental health service in the United States, almost one third have two or more psychiatric diagnoses (Warner & Pottick, 2004) This widespread prevalence of mental health issues among children and youth lead mental health professionals to ponder about the impact in the family context, particularly in the lives of parents and caregivers.

Parents and caregivers play a pivotal role in the lives of children and youth who struggle with mental health concerns. In most situations, they are situated to be the first to observe early signs of mental health illness (Boulter & Rickwood, 2013). In addition, many children and adolescents are unlikely to seek professional assistance for their concerns, relying instead on support from family and friends (Rickwood, Deane, Wilson, & Ciarrochi, 2005). This situational context demonstrates the high degree of responsibility that parents and caregivers have in response to the mental health symptoms of their child. Furthermore, in their attempt to identify appropriate services for their child, parents undergo an arduous process (Boulter & Rickwood, 2013). This can be overwhelming, requiring persistence in reaching out to various mental health

providers in addition to facing resistance from individuals from their own support system.

Studies have documented that this pivotal caregiving role comes at a high price. The Great Smokey Mountains study showed that parents whose children received mental health services were more likely to report being depressed, worried, and tired while also seeing themselves as being incompetent in responding to their children's problems (Farmer, Burns, Angold, & Costello, 1997). Furthermore, the reality of their child receiving services negatively affected caregiver relationships with other family members, thus compromising previous sources of caregiver parental support. These findings illustrate that the mental health concerns of children profoundly impact those in their immediate support system in ways that may affect parental caregiver well-being, further compromising their ability to effectively advocate for their children's mental health needs. In spite of these findings, the complexity of childhood mental illness and its effects on the caregiver-child relationship has yet to be investigated.

Significance of the Study

As illustrated in the studies mentioned above, existing literature suggests that childhood mental illness directly impacts the daily and psychological functioning of family members. Yet, a gap remains in the literature that specifically focuses on the caregiver-child relationship within the context of the child's mental health concerns. The lack of investigation on the caregiver-child relationship is concerning, particularly given the fact that the quality of this relationship critically affects healthy child development (Schor & American Academy of Pediatrics, 2003). This speaks to the long-term implications of such studies in terms of how a deeper understanding of the caregiver-

child relationship, within the context of the child's mental health, can facilitate an optimally healthy developmental trajectory.

One of the few studies to explore the impact of the child's mental health illness on the parent-child relationship revealed the importance of a caregiver's affective connection with their child (Godress, Ozgul, Owen, & Foley-Evans, 2005). Among parents whose children had mental health concerns, those who described a secure affectional relational bond with their child reported positive emotional expression (e.g., excited, calm, affectionate, joyful, and cared for). In this study, a secure affectional bond referred to the secure attachment pattern derived from Attachment Theory, which is characterized by a child's primary caregiver (mother) being accessible and responsive to their child (Ainsworth, 1985). On the other hand, parents who described their parent-child relationship as anxious-ambivalent, associated with a primary caregiver's inconsistent response patterns (Ainsworth, 1985), reported greater expression of negative emotions (e.g., angry, sad, rejected, disappointed, and irritated). This study attempted to explore the grief experience of parents as they were coping with their child's mental health. While these findings revealed the powerful influence of early parent-child attachment patterns on emotional expressiveness between caregiver and child in the face of mental health, it failed to explore other potentially meaningful aspects of the parent-child relationship, such as expectations toward one another, and the nature, depth, and meaning of relational interactions. Furthermore, certain study characteristics limited the generalizability of findings. For example, the time since the initial diagnosis of the child's mental health ranged widely (from three months to 28 years), indicating considerable variance in the length of participant caregiving

experience specific to mental health symptoms. This study's findings and limitations highlight the need for further research focused on the caregiver-child relationship and its influence on caregiver well-being. The paucity of related studies on the topic speaks to the current state of literature and underscores the need to delve deeper into how a child's mental health impacts caregivers through the quality of the caregiver-child relationship.

Research Purpose

This qualitative inquiry was conducted to explore the caregiver-child relationship from the perspective of the primary caregiver whose child has received mental health treatment. Specifically, perceived changes in the caregiver-child relationship subsequent to the child's treatment were investigated. The diagnostic group of inquiry for this study was limited to children or youth diagnosed with ADHD (Attention Deficit Hyperactivity Disorder) who have received treatment either in the form of psychiatric medication or counseling services. For the purposes of this study, the term "caregiver" is used when referring to the adult fulfilling the primary caregiving role. Caregiver refers to all study participants, and includes biological parents, custodial parents, foster parents, and adoptive parents. The term "parent" will be employed only in reference to previous study findings, as necessary.

This study was designed to contribute to the field of counseling psychology in several ways. First, this study would fill the gap in the literature by providing a deeper understanding of perceived changes in the caregiver-child relationship within families that have a child dealing with a mental health illness. The diagnostic criteria of ADHD was selected because symptoms of ADHD, such as non-compliance and inattention, can significantly impair family functioning (Johnston & Mash, 2001), including the quality

of the caregiver-child relationship. Second, there could be potential treatment implications from the study. Findings that support the deterioration of the caregiver-child relationship due to the child receiving mental health treatment would aid counselors and psychologists in formulating family treatment plan and goals. Treatment goals can be modified to include interventions directed at improving the caregiver-child relationship. Conversely, findings that indicate improvement in the caregiver-child relationship when the child receives mental health treatment would trigger a deeper exploration to identify specific aspects of the treatment which promote improvement in the caregiver-child relationship. Such findings will also be potentially beneficial for mental health professionals working with children and their families.

Research Questions

The goal of this qualitative inquiry was to explore caregivers' perceived changes in the caregiver-child relationship due to received mental health treatment of the child. This study sought to answer the following overarching and specific research questions: How do caregivers perceive their relationship with their child has changed due to the mental health treatment (counseling or psychiatric medication) of the child?

Sub-Questions

1. How do caregivers describe any changes in their relationship with their child due to their child's mental health treatment?
2. How do caregivers describe differences in the caregiver-child interaction due to their child's mental health treatment?

Chapter 2: Literature Review

In this review of related literature, we examine the conceptual perspectives and empirical findings relevant to study concepts. This comprehensive review of extant literature is offered to provide the necessary background regarding the ways in which a child's mental health can impact the family. Due to the focus of the current study's research questions, this review ultimately will focus on the impact and perspective of the child's primary caregiver, whenever possible. Discussion of this literature accentuates the need to address the gap in research by exploring perceived changes in the caregiver-child relationship that results from a child's involvement in mental health treatment.

Caregivers and Child Mental Health

Research has well documented that caregivers play pivotal roles in navigating mental health treatment for their children. Caregivers identify the appropriate treatment source for their children, provide transportation, and carry the decision-making power to terminate services (Shanely, Reid, & Evans, 2008; Stiffman, Pescosolido, & Cabassa, 2004). In fact, Mayberry and Heflinger (2013) used the term "broker" to describe the wide range of tasks and responsibilities given to caregivers when navigating the process of seeking mental health treatment for their child. As we situate caregivers in the help-seeking role for their child's mental health concerns, we need to first recognize different facets of this complex experience. The first few sections of this literature review will cover the following areas: (a) stigma, (b) family burden, and (c) caregiver distress.

Stigma

Caregiving for a family member dealing with mental health in itself comes with many roles and responsibilities (Mayberry & Heflinger, 2013). This caregiving role is intensified when one takes careful consideration of existing stigma toward mental health.

There have been different viewpoints of stigma to date. Link and Phelan (2001), breaking away from the more traditional view, state that "stigma exists when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation that allows these processes to unfold." They emphasize that it is social, economic, and political power that fuels stigma and therefore, multi-faceted and multi-leveled efforts are needed to overcome or change stigma. In the first ever report from the U.S Surgeon General on the topic of mental health and mental illness, stigma is discussed as a major barrier when it comes to mental health. (Satcher, 2000). Satcher (2000), who was Surgeon General at the time, expressed the urgency and importance in addressing mental health stigma because of its consequential impact on individuals affected by mental health concerns. In this report, Satcher (2000) discussed how stigma can take away hope from people because of the false belief that mental health is untreatable which leads to systemic impact such as reduced access to treatment opportunities and resources.

Similarly, Hinshaw (2005) noted the reality of mental health stigma operating at multiple levels ecologically within individuals, families, schools, communities, public media, and social policy. From this systemic perspective of stigma, we can consider how individuals dealing with mental health may need to consider how others perceive and interact with them within the context of home, school, and work. Furthermore, it can be anticipated that media, including social media platforms and service-related policies can send messages that communicate prejudice, stereotype, and shame, further exacerbating the stress and burden associated with mental health. Ultimately, these concerns rooted in stigma can impact an individual's decision to seek help for mental health concerns. In a

qualitative study that examined experiences of individuals who were currently engaging in mental health treatment, findings showed that the fear of further stigmatization can discourage future help-seeking behavior (Sokratis et al., 2004).

For this research study, it is important to acknowledge stigma within the context of caregivers navigating mental health treatment for their child. According to Mukolo, Heflinger, and Wallston (2010), stigma likely compounds the burden of care and affects caregiver's help-seeking behavior. In addition to the emotional and physical burden placed on caregivers as they cope with their child's mental health, we must consider the impact of societal and familial messages that communicate shame around mental health, which potentially increases the overall burden for caregivers. Furthermore, an increased threat of stigma in rural areas due to difficulty accessing services has been well documented (Wang et al., 2005). This is alarming because stigma ultimately reinforces pre-existing barriers of inadequate resources in the very communities where there may exist a greater need for individuals to connect with mental health providers.

Family Burden

Since decades ago, scholars have recognized the impact and implications of mental health illness on the individual's support system as indicated in their early definitions and descriptions of individuals' experiences of family mental health. Treudley (1946) described "burden on the family" as the consequences that family members experience in their daily routine as a result of the close contact with severely disturbed psychiatric patient. Similarly, Platt (1985) referred to "burden" as the "presence of problems, difficulties, or adverse events which affect the life of the psychiatric patients' significant others" (p. 383). Furthermore, Schene (1990) attempts to

view this concept of family burden through an integrative framework to attain a clearer understanding and thus, delineates the objective and subjective dimensions of family burden.

Objective Dimensions. Objective dimensions of family burden were defined as "the symptoms and behaviors of mental health patients within the social environments, and their consequences" (Schene, 1990, p. 289). Included are positive symptoms such as acting out, aggression, and hallucinations as well as negative symptoms such as withdrawal and detachment. Within the field of mental health, positive symptoms typically refer to symptoms that indicate distorted reality, while negative symptoms refer to deficits in aspects of functioning such as speech and affect (Barlow & Durand, 2012).

Thus, this objective dimension speaks about the burden experienced within the immediate interpersonal context of family members who have mental health concerns. Studies have documented the impact on parents in relation to this objective dimension of family burden. In a study carried out by Richardson, Cobham, McDermott, and Murray (2013), parents reported that they needed to adjust work schedules in order to bring their children to therapy, had limited time for themselves, and also experienced a financial burden due to the cost for mental health services. Similarly, mothers of children diagnosed with ADHD stated that they felt exhausted in their daily functioning due to the extensive time spent in organizing and supporting their child's activities (Cronin, 2004).

Subjective Dimensions. The subjective dimensions of family burden on the other hand, were described by Schene (1990) as the psychological consequences experienced by the family members. Although the terminology of *subjective burden* has

not been consistently used among different scholars, existing literature has illustrated the psychological consequences experienced by family members. In a study that examined the experiences of people who had a family member diagnosed with a serious mental health illness, Jones (2004) found that other family members experienced a complicated and varied array of emotions including anger, shame, and fear. Anger was experienced when family members were reminded of moments in family members' lives before being affected by the mental health issues. Meanwhile, fear arose from the possibility of the situation getting worse, while shame was closely related to the stigma toward mental health illnesses.

Family members also experience a sense of loss as they cope with the mental health illness of their family member (Solomon & Drane, 1996; Jones, 2004). The term, "loss" describes various forms of changes perceived by other family members that must be coped with. These changes include loss of life opportunities, loss of relationships as well as loss of personality for the family member dealing with mental health issues (Solomon & Drane, 1996; Jones, 2004; Richardson, Cobham, McDermott, & Murray, 2013). According to Solomon and Draine (1996), the emotional response of family members to other members' mental health illness may be similar to the grief response of death. While there is a certain level of adjustment with the death of a family member, grief tasks for surviving family members will remain indefinitely due to the on-going nature of emotional responses to the loss. Similarly, emotional adjustment to mental health of a family member continues due to the on-going social relationship with other family members.

Richardson, Cobham, McDermott, and Murray (2013) were also able to demonstrate that in the absence of substantial change, parents expressed the feeling of hopelessness. For these parents, the feeling of hopelessness was situated on a continuum that eventually led them to confront concerns of incompetence due to the lack of control they had in their children's lives.

Distinguishing the two dimensions of family burden is central to identifying the distinct elements that can be investigated when studying family burden. Findings from related literature also demonstrated that it is both the individual and family that are impacted by an individual's mental health illness. A longitudinal study has documented that effects of child functioning on parent well-being increases over time (Early, Gregoire, & McDonald, 2002). Due to the likelihood for the mental health treatment process to last for an extended period, concerns for the long-term well-being of the parent/caregiver arises and how it may bring about potential changes in the caregiver-child relationship.

Caregiver Distress

The concept of distress has also been introduced by previous scholars in relation to how children's mental health illness impacts the functioning and well-being of caregivers. In their study, Duchovic, Gerkensmeyer, and Wu (2009) showed that both internalizing and externalizing behavior of children were significantly associated with parental distress. Examples of externalizing behavior described in the study were hyperactivity, impulsivity, fighting, and disobedience while internalizing behavior included symptoms of anxiety, depression, social withdrawal, and compulsive or

suicidal thoughts. Furthermore, perceived personal control was found to moderate the impact of internalizing child behaviors on parental subjective distress.

Building on the work of current scholars, Brannan, Heflinger, and Bickman (1997) introduced the term "caregiver strain" in the context of caregiving for those with special needs. Consistent with how the terms family burden and caregiver distress are used in this area of research, caregiver strain is used to describe the demands, responsibilities, difficulties, and negative psychological consequences when caring for individual with mental health concerns. Similar to the concept of family burden, caregiver strain is divided into objective and subjective dimensions. However, a distinction lies in further separation of the subjective dimension into internalized and externalized subjective caregiver strain. Internalized subjective caregiver strain refers to feelings internalized by the caregiver as a response to taking care of a child with emotional or behavioral disturbance. Examples include the caregiver feeling sad, worrying about child's or family's future, as well as feeling tired or strained. Meanwhile, the externalized subjective strain dimension describes negative feelings directed at the child. Examples are resentment, anger, embarrassment or relating poorly with the child. Furthermore, it is important to note that the term, caregiver strain introduced by Brannan, Heflinger, and Bickman (1997) expands the definition of caregivers to include individuals such as foster parents or relatives.

Despite some variability in language, existing conceptual and empirical studies show that the impact of a child's mental health concerns on the well-being of caregivers has been explored from as early as the 1950's (Clausen & Yarrow, 1955). However, as

stated earlier, previous research has not expanded their scope to investigate the impact of a child's mental health concerns on the caregiver-child relationship.

Caregiving

While researchers may vary in terms of the conceptual terminology used, the abovementioned sections indicate a focus on the negative aspect of caregiving. However, it is also important to argue that in their roles as caregivers of family members dealing with mental health concerns, caregivers' experiences are not only limited to difficulties and challenges. Szmukler (1996) criticized the term "burden", describing it as pejorative because of its underlying indication that caregivers respond in a passive manner, which easily leads to an assumption that the manner in which caregivers respond is "unchangeable." Instead, Szmukler (1996) asserts that "caregiving" is the more appropriate term as it is inclusive of both the negative and positive aspects of caregivers' experiences.

Studies describing the positive outcome from caretaking experiences have been documented across a broad range of medical and mental health conditions. Analysis of books containing narratives of parents whose children dealt with a variety of medical and mental health conditions showed parents to describe their lives as more enriching and meaningful due to their caregiving experiences (Mullins, 1987). Similar results were found in a study that examined *enrichment* and *stress* among parents whose children had severe emotional disorders. Yatchmenoff et al. (1998) referred to enrichment as the conceptualization of positive aspects of a situation while stress was referred to as caregivers' internal experiences with distress. While results indicated that parents did experience significant levels of stress particularly in their emotional well-being, health,

and outlook on life, they identified areas of enrichment in terms of self-concept (how they viewed themselves) as well as in their relationships with others, illustrating the complexity of the caregivers' experience.

Positive impact for caregivers was also seen in improvement in relationships among fathers whose children had schizophrenia (Wiens & Daniluk, 2009). In a study aimed to give voice to fathers whose children had been diagnosed with schizophrenia, results showed that despite fathers experiencing sadness and loss, they also gained a sense of admiration for their child. Furthermore, participants reported experiences of growth both at the individual and relational/interpersonal level. One father stated that he was able to develop a father-son relationship that he felt should have been developed years ago. In addition, most of the six participants reported having greater commitment to their marriage and family. Boulter and Rickwood (2013) found that in addition to feeling validated, parents perceived the treatment experience for their children to be beneficial for being able to receive useful strategies. Thus, a contributing factor to positive changes in the relationships of caregivers could include strategies learned through the mental health treatment of their child.

The accumulation of findings from abovementioned studies spark initiative for future research to further explore how the child's mental health treatment plays a role in growth-fostering experiences described by caregivers. Current literature has illustrated the variety of ways in terms of how the child's mental health treatment can lead to positive experiences and growth for the caregivers at both the individual and interpersonal level. The aim of this study is to further explore the impact of the child's mental health treatment at the interpersonal level of the caregivers, particularly within

the context of the caregiver-child relationship. Findings will expand existing literature about the complexity of the caregivers' experiences in dealing with a child who has mental health symptoms.

Comparative Research

Clinically-Relevant Comparative Studies

A review of related literature shows that past scholars have conducted empirical studies employing comparison groups in this area of interest. In a study that compared the caregiving experiences for depression and schizophrenia, Van Wijngaarden et al. (2009) found that differences in roles due to the nature of the patient's diagnosis led to varying impact on the caregiver. Caregivers for schizophrenia family members were more engaged in the daily functioning of the patients and thus, were more worried about their future. Meanwhile, caregivers of depression patients experienced more interpersonal tension. These findings reflect the varying roles that caregivers may have depending on the diagnosis of the patient and their subsequent impact on the lives of caregivers.

Cronin (2004) sought to compare experiences of families with children diagnosed with ADHD and cystic fibrosis. More specifically, the purpose of this study was to investigate whether families dealing with a child's hidden impairment differ depending on whether the nature of impairment is physical or behavioral. Interview responses demonstrated that mothers of children diagnosed with ADHD were more likely to express exhaustion and frustration compared to mothers of children diagnosed with cystic fibrosis. With such findings, it is important to take into consideration the traits of the two groups. Typically, ADHD symptoms result in children being more

hyperactive which may require increased mobility from the caregivers. Thus, it is possible that the specific nature of the ADHD symptoms is the determining factor that results in experiences of exhaustion and frustration for parents.

Similar responses and behavior by parents toward their children diagnosed with ADHD have been documented. In studies that have examined both father-child and mother-child relationships of parents whose children have ADHD, results indicate that parents of children with ADHD tend to be more controlling, engage in overprotective behavior, and express less care toward their children (Chang, Chiu, & Gau, 2013; Gau & Chang, 2013). Gerdez, Hoza, and Pelham (2003) also found mothers of ADHD boys to be less warm and both mothers and fathers to be power-assertive when compared with the control group. Furthermore, Tzang, Chang, and Liu (2009) found that in comparison to the inattentive subtype of ADHD, the combined subtype was associated more with parent stress. These results indicate that the intensity/severity associated within a particular diagnosis can strongly influence the response of the caregiver.

The experience of caregiving may vary in the context of the caregiver-child relationship. Parent caretakers primarily report experiencing feelings of guilt and burden. In contrast, relatives who perform the primary caretaking role perceive the toll on the family to be more of an objective experience and report strains such as interruption of personal time, missing work, neglecting duties, feeling isolated, and toll taking on the family (Harrison, Richman, & Vittimberga, 2000; Strawbridge et al., 1997). Furthermore, when compared with other relatives who serve as caretakers, parent caretakers report a greater effect on emotionality, including social isolation, sadness, and embarrassment (Taylor-Richardson, Heflinger, & Brown, 2006).

Role-Relevant Comparative Studies

Comparison studies also revealed similarities among different groups of caregivers. Heflinger and Brannan (2006) compared caregiver strain between caregivers of youth in substance abuse treatment and caregivers of youth experiencing mental health symptoms. Findings showed that caregivers from both groups shared similarities in terms of good to fair range for physical health, moderate levels of depression, as well as similar levels of substance use. Furthermore, Heflinger and Taylor-Richardson (2004) demonstrated that the level of caregiver strain experienced by relative caregivers was similar to caregiver strain experienced by parents. It seems evident from these findings that when caregivers' roles involve attending to particular behavioral or emotional concerns, the increased level of distress in their daily functioning is an unavoidable consequence of the role.

Family Systems

This research study attempts to study a particular relationship within a family setting and thus, it is helpful to situate the topic of study (caregiver-child relationship) within a family systems model. For the conceptual framework of this study, the McMaster Approach to Families will be used. The section below provides an overview and assumptions of the model.

McMaster Model of Family Functioning

In addition to guiding effective family treatment, the McMaster Approach to Families was developed to help in understanding the basic concepts that describe family functioning (Miller, Ryan, Keitner, Bishop, & Epstein, 2000). There are five assumptions underlying this approach: (1) all parts of the family are interrelated, (2) one part of the

family cannot be understood in isolation, (3) family functioning cannot be fully understood by simply understanding each of the individual family members or subgroups, (4) family structure and organization are important factors that strongly influence and determine behavior of family members, and (5) the transactional patterns of family system strongly shape the behavior of family members. These assumptions emphasize the elaborate nature of interactions that shape family functioning. While these assumptions describe the functioning of the family as one unit, these family unit interactions and transactions also influence individual relationships among family members, which is the area of focus in this study.

Dimensions. Miller et al. (2000) describe the six dimensions of the McMaster Model while clearly articulating that these dimensions are not an exhaustive list and that no single dimension is higher in importance than others. The dimension of *problem-solving* defines how families address problems in order to attain effective family functioning. In relation to this study, this dimension speaks to the process of caregivers recognizing their child's mental health symptoms and seeking appropriate treatment. Furthermore, it relates to the nature of the caregiver's response to their child's mental health symptoms which may require caregivers to cope with their child's difficulty in a number of social and familial settings (Simpson, Cohen, Bloom, & Blumberg, 2009). Miller et al. (2000) also note that problems are categorized as either *instrumental* (relating to day to day events) or *affective* (those related to feelings and emotions).

The dimension of *communication* describes the verbal information of exchange within a family while the dimension of *affective responsiveness* describes the family's ability to respond to various stimuli with the appropriate quality and quantity of feelings.

With the focus of this study being the caregiver-child relationship, the researcher paid close attention to how caregivers described changes in the quality of communication with the child. The researcher was also attentive to the expression of emotions by both the caregiver and child.

The dimension of *roles* defines the individual functions of each family member which can consequently shape recurrent patterns of behavior. The dimension of *affective involvement* is defined as the degree to which family members demonstrate interest in the lives of other family members. In relation to this study, both dimensions emphasize the situational context of interactions occurring between caregiver and child that may shine light on the quality and extent of the interaction between the caregiver and child.

The last dimension of *behavioral control* is defined as the pattern adopted by the family in handling situations that involve physical danger, meeting and expressing psychobiological needs or drives, and those involving interpersonal socializing behavior. In relation to the caregiver-child relationship, this dimension relates to the family norms, rules, and expectations that may influence the daily interaction between a caregiver and their child.

The McMaster model described above provides a framework for understanding factors and elements within a family system that can contribute to a higher level of effective family functioning. For example, in relation to this study, some of the interview questions reflected the abovementioned dimensions such as, “What emotions did you notice in response to your child’s [mental health] symptoms?” Furthermore, this framework served as a foundation for the researcher during the analysis and interpretation stages of the study.

This study will attempt to fill a major gap in the literature of caregivers' experience of children/youth dealing with mental health concerns by exploring how caregivers perceive the caregiver-child relationship to have changed due to the mental health treatment received by the child or youth. As illustrated in the review of related literature above, the majority of past studies focused on parents' and caregivers' level of burden and strain. Given the documented empirical evidence on how parents and caregivers are impacted by children's mental health concerns in a variety of ways, a study that explores the perceived changes in the caregiver-child relationship is warranted. Findings from this study will provide greater insight into the impact of a child's mental health on the entire family unit, particularly the caregiver-child relationship.

Chapter 3: Research Methods

The goal of this qualitative study was to obtain a deeper understanding of caregivers' experiences with their child's mental health treatment and to further explore how they perceive the caregiver-child relationship to have changed due to treatment received by the child. Ultimately, the researcher's ontological and epistemological assumptions based on the constructivist/interpretive paradigm resulted in the selection of a qualitative phenomenological methodology utilizing reflexive thematic analysis. This theoretical framework is exemplified in Figure 1 of the appendix.

The following sections include a review of the study's philosophical research paradigm, its methodological design, and its method of analysis, including the role of the researcher, the study participants, the sources of data, and the data analysis procedures.

The chapter concludes with a discussion of trustworthiness regarding these methods and a description of relevant ethical considerations.

Philosophical Paradigm

The paradigm which guides qualitative research is an underlying, basic belief system that influences data gathering, analysis, and standards by which the study is judged (Morrow & Smith, 2000). Ponterotto (2005) emphasizes the importance of explicitly outlining the paradigm from which the study is being conducted, as the paradigm provides readers with the context of the data interpretation process.

Constructivist/Interpretive Paradigm

The current study was conducted from a constructivist/interpretive paradigm which posits that there are multiple versions of reality (Ponterotto, 2005). This paradigm grew out of the philosophy of Edmund Husserl's phenomenology with its primary focus on understanding the world of human experience (Mertens, 2005). The goals of a constructivist/interpretivist inquiry are both idiographic (focus on individual as unique entity) and emic (individual specific) and it is the participant-researcher interaction that facilitates the understanding of the participant's lived experiences (Ponterotto, 2005). The positions of constructivism/interpretivist surrounding the ontology (the nature of reality), epistemology (how knowledge is acquired), axiology (what is valued in the research), and rhetoric (the language used to present the research) are outlined below.

Ontology. Ontology speaks to the nature of reality and seeks to address "what is the form and nature of reality, and what can be known about that reality?" (Ponterotto, 2005, p. 130). A constructivist/interpretivist paradigm recognizes multiple, constructed realities, stating that reality is a subjective and individual experience influenced by an

individual's social context, lived experiences, and the researcher-participant interaction (Ponterotto, 2005). As such, from the constructivist/interpretive paradigm, there exists no single reality or truth. Instead, individuals create (or construct) reality based on their own knowledge and understanding of the world through reflection on lived experiences. From this ontological perspective, the researcher sought to deepen the field's understanding of how caregivers experience parent-child relationship changes following the child's mental health treatment. By conducting in-depth interviews with caregivers, the researcher's goal was to draw out the individual experiences of caregiving as it pertains to the parent-child relationship. With the constructivist/interpretivist form of inquiry honoring each participant's unique experiences, Ponterotto (2005) states that data collection may involve a smaller sample size but include more researcher-participant interaction through interviews that are longer in duration, in addition to having follow-up contact with participants.

Epistemology. The epistemology of a paradigm describes the relationship between the "knower" (the research participant) and the "would-be knower" (the researcher; Ponterotto, 2005). Constructivists assert that reality is socially constructed and therefore, the dynamic researcher-participant interaction is central to understanding the "lived experience" (*Erlebnis*) of participants (Ponterotto, 2005). The researcher viewed each contact with potential participants as an opportunity to build rapport and establish close, interpersonal relationships. Furthermore, the interviews provided a setting for in-depth interaction and dialogue which facilitated the researcher and participant to reach deeper insight into the participants' lived experience (Ponterotto, 2005) within the context of the caregiver-child relationship.

Axiology. Axiology speaks to the role that one's values has on the research study (Morrow, 2007). In contrast to positivist and postpositivist paradigms which argue that there is no place for one's values in research, a constructivist/interpretivist maintains that a researcher's values and lived experiences cannot be separated from the research process (Ponterotto, 2005). In fact, Ponterotto (2005) considers close interpersonal contact with participants to be necessary in a study conducted through the constructivist lens; it is fallacy to even consider the possibility that the researcher's values could be eliminated. In this study, the researcher was transparent about the existence of his own values and assumptions, explicitly acknowledged them, and continually reflected on how they could be impacting his role as the researcher.

Rhetorical structure. Rhetorical structure describes the style of language that is used in presenting a research study (Ponterotto, 2005). The overall rhetorical assumption of qualitative research moves away from the omniscient researcher seeking a single, quantifiable truth. Instead, consistent with the constructivist/interpretive perspective, the focus of the language used to present research assumes that reality is fundamentally shaped or created by individuals as they experience and observe life experiences. Fundamentally, the research reports the perspective of the research participants as reality. Although not required, the rhetorical structure of a constructivist inquiry may be presented in first person. However, it is expected that the researcher's humanistic, descriptive, and interpretive writing should reflect the reality of participants' perspective and experience as known truth. Furthermore, the researcher's own experiences, expectations, biases, values, and emotional reactions should be acknowledged and reflected upon throughout (Ponterotto, 2005).

Research Methodology

Methodology describes the rationale for the research approach, and is strongly influenced by one's stance on ontology, epistemology, and axiology (Ponterotto, 2005). As such, the constructivist/interpretivist underpinnings informed the researcher's understanding of the current study and guided the selection of the study's methodology. With its emphasis on the researcher-participant interaction, constructivism/interpretivist approaches rely on naturalistic modes of inquiry common within qualitative research methodologies, which may include in-depth face-to-face interviewing and participant observation (Ponterotto, 2005).

Phenomenological Qualitative Research Methodology

Through this study, the researcher hoped to delve deeper into how a child's mental health treatment may impact the caregiver-child relationship as experienced by the caregiver. Specifically, the researcher sought to understand how parent caregivers experience change in their relationship with their child due to the child's mental health treatment. A qualitative mode of inquiry was chosen because it involves asking the why and how of human interactions (Agee, 2009), which in this case, refers to the caregiver-child relationship.

More specifically, the current study utilized phenomenological qualitative methodology which focuses on the commonality of a lived experience within a particular group. From the phenomenological lens, emphasis is placed on describing, understanding, and interpreting the meaning of life experiences. Phenomenological research is based on:

> the assumption that *there is an essence or essences to shared experience*. These essences are the core meanings mutually understood through a phenomenon commonly experienced.,. for example, the essences of loneliness, the essence of being a mother, the essence of being a participant in a particular program. *The assumption of essence… becomes the defining characteristic of a purely phenomenological study.* [p. 70, emphasis in original]

Moving beyond basic qualitative research which focuses on how people make sense of their lives and their experiences, phenomenology views meaning making as the quintessential element of the human experience (Patton, 2002). This makes phenomenology, "well suited for studying affective, emotional, and often intense human experiences" (Merriam, 2009, p. 26).

Phenomenology provided the overarching framework for the researcher to explore, understand, and interpret the participants' lived experience of changes that occurred in their parent-child relationship resulting from their child receiving mental health intervention. Consistent with the phenomenological perspective, the researcher directly investigated and described the caregiver-child relational change (i.e., the phenomena) as consciously experienced by caregiver participants, based on empirical observation (rather than theoretical deduction), and as free as possible from unexamined preconceptions and presuppositions (Crotty, 1998). The researcher's focus on the experience of relational change reflects a phenomenological emphasis on the "affective, emotional and intense human experience" (Merriam, 2009). Thus, the nature of the research question itself clearly elicits a phenomenological approach.

Phenomenology is consistent with the epistemology of this study in that participants were guided to express personal meaning derived from their lived parent-child relational experience. In sum, phenomenology allowed the researcher to identify the universal meaning of the parent caregiver experience which resulted in a more profound understanding of caregiver-child relational change following the child's treatment (Creswell, 2013; Crotty, 1998).

Research Methods

This section describes the strategies that were used to recruit participants and to collect data. This is followed by a description of the study's analytic procedures. The specific research methods selected and employed for this study were aligned with the epistemological assumptions detailed above and provides sufficient information to allow the reader to evaluate the rigor of the research process and findings. In addition to a description of these procedures, the researcher's rationale for choices made are presented. Fundamental to the study's phenomenological epistemological stance, this section begins with a discussion of researcher subjectivity.

Researcher-as-Instruments

This qualitative study used interpretive techniques to describe, code, translate, and identify themes derived from individuals within the context of their own worldview. Merriam (2009) states that a key characteristic of qualitative research is the researcher's role as a primary instrument because of the researcher's ability to be adaptive when collecting or analyzing data. Morrow and Smith (2000) and Ponterotto (2005) further highlight this defining characteristic, asserting that the researcher's presence in the study and the researcher-participant interaction can facilitate the participants' discovery of

meaning regarding their experiences being studied. Due to the close involvement of the researcher as the primary instrument in the collection of data for the study, open acknowledgement and disclosure of the researcher's identities, assumptions, and beliefs regarding the phenomenon of study were critical to establishing empirical trustworthiness.

Researcher Subjectivity. The following statements regarding the researcher's subjectivity are provided so that all related researcher experiences are presented transparently. This ensures that the reader can critically examine the truthfulness of the research as being bias free, contributing to the validity of the research and to the reader's assessment of the researcher's ability to remain in epoche. From the perspective of qualitative research, epoche involves the recognition that significant remembered events experienced by a researcher may impact data collection and would therefore need to be acknowledged and set aside during data collection.

As a researcher engaging in a phenomenological study of caregiver views of changes in the caregiver-child relationship, numerous personal and professional life experiences have shaped the researcher's views. Therefore, throughout the study, the researcher was honest and upfront, and careful to accurately represent the participants' experiences. The researcher's relatability was twofold; connections between the researcher and the study participants fostered trust and openness due to the researcher's experience as a humanistic therapist with shared experience contributing to the ability to feel empathy with participants based on the shared experience as a caregiver. Furthermore, the researcher recognized the need to self-monitor any personal subjectivity, and to focus the study solely on the participants' experiences with recognition that,

although similar in some forms to that of the researcher with regards to shared caregiving experiences, there would likely be many differences, as well. Therefore, the researcher took extra effort to ensure participants were provided with the space to openly share their story and experiences.

Researcher Identities. Several lived experiences have shaped the perspective of the researcher while engaged in this phenomenological study of parent caregivers. At the time of the study, the researcher identified as Asian, heterosexual, male, able-bodied, Christian, lower middle-class, international student from South Korea. The researcher is professionally trained as a mental health therapist with a Masters' degree in clinical mental health counseling. At the time of the study, the researcher specialized in child and family intervention in terms of both professional practice and research emphasis. Throughout the data collection process, the researcher was completing his final year of training as a doctoral intern in an APA accredited counseling psychology program. In addition to professional activities, the researcher's personal life experiences are noteworthy. A parent to a toddler, the researcher celebrated the birth of this second child a month prior to collecting data for the study. To enhance transparency, the researcher identified assumptions regarding the phenomenon under study.

Researcher Assumptions. One identified assumption was that based on the researcher's own clinical experiences of providing counseling services to children and youth, the therapeutic benefits of the child's individual therapy has a positive impact on family relationships. Having observed such impact in the clinical setting and belonging to the mental health profession, the researcher had to explicitly acknowledge the underlying assumption of individual therapy being beneficial for the family system, including the

caregiver-child relationship. After having explicitly acknowledged this assumption, the researcher exerted effort to listen for key words and descriptions from participants that may indicate otherwise in that the child's treatment may not have any impact or had a non-positive impact on the caregiver-child relationship.

The second assumption relates to the researcher's identity as a parent of two young children. The researcher acknowledged that while having a shared identity with participants can facilitate the relationship building process with participants, it was also critical to recognize how the researcher's own experiences of parenting and his own caregiver-child relationship, could unduly affect the research process. For example, when participants described significant interaction with their children, the researcher was mindful to not allow his own caregiver experiences or emotional reactions hinder the process of understanding the participants' experiences. Even in situations when the participants described an experience that many individuals would assume to lead to a certain reaction or response, the researcher asked specific probing questions to capture the participants' individual stories. On-going reflection of this shared identity played a key role in trying to understand how participants were describing their respective caregiver-child relationships.

The third assumption also involves the researcher's own caregiver-child relationship, but from the context of the researcher as a child. The researcher, identifying as Asian and having been raised through Asian parenting practices, had to be mindful to not allow his own interaction with parents (during adolescence) influence the participants' voices in a manner that might not honor their cultural practices and values. A notable example from the data collection phase was when a participant labeled her

communication style with her child as “nagging.” The researcher, based on his own cultural background, internally questioned the usage of the term “nagging” because the communication style described by the participant was one that would be considered acceptable and common in the researcher’s home culture. The researcher was aware of the influential nature of these cultural differences because his assumptions were explicitly acknowledged at the onset of the study. By being aware of how one’s identities and experiences could impact the research process, the researcher was able to continue to focus on honoring each participant’s story.

This process of acknowledging and reflecting on one’s own assumptions continued when the researcher was listening to the audio recordings as well as during the quality checks and throughout the entirety of the data analysis phase. The researcher accomplished this by noting emotional and cognitive responses in reflexive memos as they emerged when interacting with the collected data.

Management of Subjectivity. With the researcher being an instrument for data collection and data analysis, it was vital that the researcher monitored and managed the potential impact of personal biases and assumptions on the study. This was done to avoid imposing the researcher’s own preconceived ideas onto that of the studied phenomenon, in this case, the caregiver-child relationship. In order to do so, the researcher engaged in reflexive journaling about his biases, assumptions experiences, thoughts, feelings, and actions that occurred while conducting the research, as recommended by Morrow (2005). This reflection was done after conducting the interviews, during the quality checks, and throughout the data analysis stage. The intent of self-reflexive journaling was to monitor and make explicit thoughts for any implicit assumptions or biases that may have

impacted the data collection and writing process (Morrow, 2005). By acknowledging that one's assumptions and values could not be eliminated in the study and by engaging in this reflexive practice, the researcher wanted to allow the participants to speak for themselves versus imposing the researcher's values on the participants (Morrow, 2005).

This form of reflexivity is also congruent with the process suggested by Creswell (2013) who states that there are two parts to reflexivity. First, the researcher must acknowledge one's experiences with the phenomenon being studied. The earlier section on researcher assumptions include past experiences from the researcher's professional field and family dynamics that may shape or influence his assumptions and biases. Second, reflexivity involves openly discussing how one's past experiences may potentially impact findings, interpretations, and conclusions of the study (Creswell, 2013). The section on researcher assumptions also provides some examples of how such potential influences might take place and highlights the importance of the researcher managing related personal assumptions.

Participants

The present study sought to understand how caregivers perceive their relationship with their child to have changed due to the mental health treatment received by the child. The target population consisted of caregivers who had been the primary caregiver before, during, and after (if applicable) their child had received mental health treatment. Although the study did not limit participation based on the parent/caregivers' age, the current age of the participants' child had to be between 7-17 years. Recruitment was restricted from caregivers who were currently receiving mental health treatment.

The researcher recruited participants for this study by emailing gatekeepers at private practice clinics, ADHD treatment providers as well as colleagues and clinicians in the researcher's professional network. A total of six participants, comprised of four mothers and two fathers, participated in the study.

Selection Procedures

Two sampling methods were employed to obtain a sample that provided information-rich data, including: purposeful criterion and snowball sampling methods. Participants of this study were initially selected through purposeful criterion sampling (Patton, 2002) based on the following criteria: (a) they identified as the primary caregiver of a child who was currently between the ages of 7-17 years, (b) their child had been or was currently in treatment for ADHD in the form of counseling or psychiatric services. Recruitment was restricted from individuals who had not been the primary caregiver of the child before, during, and after the child's treatment. Furthermore, potential caregiver participants who were currently receiving mental health treatment did not meet criteria for the study as the focus of this study was to explore changes in caregiver-child relationship due to child's mental health treatment. The researcher implemented a screening process, consisting of questions that clarified the age of the potential participant to be above 18 years, the age of the participant's child to be between 7-17 years, whether the potential participant had been the primary caregiver before, during, and after the child's treatment for ADHD, and whether the potential participant was currently receiving mental health treatment. Carrying out this screening procedure ensured the participants fit predetermined criterion characteristics of interest to the study at hand (Patton, 2002).

Further, the researcher utilized purposeful snowball sampling to locate information-rich participants who would be able to share about observed changes in the caregiver-child relationship due to the child's treatment for ADHD symptoms. Snowball sampling occurred by engaging in dialogue with participants, who met the inclusion criteria for the study, if they knew of other caregivers who would meet criteria for the study. In the recruitment process, the researcher also sought assistance from mental health private practices in various states, ADHD treatment centers in the state where researcher was located in, as well as faculty members and former clinical supervisors. Lastly, the researcher sought to recruit participants through snowball sampling by contacting colleagues, some of whom were currently providing counseling services for children diagnosed with ADHD. When seeking assistance through snowball sampling, the researcher shared both the recruitment email and the recruitment flyer.

Sample Size Considerations

In general, sample sizes in qualitative research are smaller because of their distinct traits that separate them from quantitative research (Morrow, 2007; Morrow & Smith, 2000). Qualitative research emphasizes the integrity of the sample via purposeful selection that incorporates a specific rationale for the type of information needed based on the purpose of the study, with careful consideration given to limiting participation based on the number of researchers and the availability of financial resources (Patton, 2002; Sandelowski, 1995). Furthermore, Morrow (2005) stressed that the numerical value of the sample size does not guarantee data adequacy, suggesting that within a qualitative framework, sampling procedures should be determined by quality, length, and depth of interview data which significantly outweigh sample size in terms of relative importance

(Morrow, 2005).

Recent guidelines for reflexive thematic analysis (Braun & Clarke, 2013) categorize suggestions by the type of data collection and the size of the project ('small', 'medium', or 'large'). For small projects, 6–10 participants are recommended for interviews, 2–4 for focus groups, 10–50 for participant-generated text and 10–100 for secondary sources. Braun and Clarke (2013) contend that these sample sizes provide researchers with sufficient data to demonstrate patterns while ensuring there is not too much data to manage effectively and ethically.

In setting the initial parameters of the sample size, the researcher followed the concept of judgment and negotiation (Patton, 2002) which recommend researchers to specify minimum samples based on a phenomenon's expected coverage and then make necessary changes as the study takes shape during data collection. Following these guidelines, the researcher set the minimum sample size to five. Throughout the data collection phase, gathered data was assessed to see whether it was answering the research questions. The researcher determined that the sample size was appropriate given the extensiveness of the data as well as the availability of resources. Lastly, it is important to note that the concept of sample size in qualitative research is not merely fixed on the number of participants, but refers to the total number of data sources which can include interviews (initial and follow-up), focus groups, and observations completed (Sandelowski, 1995).

Demographic Information

The researcher obtained demographic information from participants prior to their initial individual interviews. Five participants' racial backgrounds were White (n=5,

83.3%) and one participant self-identified as Hispanic (*n*=1, 16.7%). Participants' ethnic identities included Caucasian (*n*=4, 66.7%), Mexican American (*n*=1, 16.7%), and German (*n*=1, 16.7%). Participants' ages ranged from 52-64 years, with a mean of 57.7 years. Five participants' ability/disability status were Able-Bodied (*n*=5, 83.3%) and one participant reported having a learning disability (*n*=1, 16.7%). Participants' geographical graphical locations were, Pacific Northwest (*n*=4, 66.7%), Southwest (*n*=1, 16.7%), and Midwest (*n*=1, 16.7%). Additional demographic information in terms of working status, socio-economic status (SES), and religion are provided in the table below.

Table 1

Participant Demographics

Pseudonym	Gender	Working Status	Religion	SES
Ted	Male	Full-time	Roman Catholic	Upper Middle
Rose	Female	Full-time	Catholic	Upper Middle
Lucy	Female	Not working	Christian	Upper Middle
Grace	Female	Full-time	Catholic	Middle Class
Penny	Female	Full-time	Catholic	Middle Class
Kent	Male	Full-time	None	Lower Middle

Demographic Information of Participants' Children

While parent caregivers were the participants in this study, it may be helpful for readers to have some background information about the caregivers' children given that the focus of the study is the caregiver-child relationship. The age of the caregiver

participants' children ranged from 14-17 years, with a mean of 15.8 years. Three of the six children had co-morbid diagnosis, meaning that they were given a diagnosis for another condition. Four children had only received pharmacological intervention (medication) while two children had received individual counseling in the past in addition to medication treatment. Currently, all children were taking medication for ADHD. Additional information regarding the caregivers' children is provided in the table below.

Table 2

Participants' Children

Caregiver Pseudonym	Gender	Age	Time of Diagnosis	Start of Treatment	Co-morbid Diagnosis
Ted	Male	16	7th Grade	11th Grade	Learning Disability
Rose	Male	16	5th Grade	5th Grade	None
Lucy	Male	14	2nd Grade	2nd Grade	Depression, Anxiety
Grace	Male	17	7th Grade	7th Grade	Oppositional Defiant Disorder
Penny	Male	16	2nd Grade	3rd Grade	None
Kent	Male	16	5th Grade	5th Grade	None

Data Collection

This study utilized multiple sources of data to increase the rigor of the study. With many dimensions that arise with any qualitative study, it was important to gather multiple sources of data in order to enhance the interpretation of the data being collected (Marshall

& Rossman, 2006). The process of gathering multiple data sources, also referred to triangulation, can improve the depth and quality of the data by having multiple lines of sight on the phenomenon of interest (Morrow & Smith, 2000). Additionally, multiple data sources were helpful in avoiding one-sided, one-dimensional sources of inquiry that could lead to interpretation of data from the lens of the researcher's own assumptions and biases. At the conclusion of the study, a combination of individual interviews, follow-up interviews, participant checks, observations, and memos were used.

Interviews

The researcher utilized in-depth interviews as the primary source of data. In-depth interviews provide an optimal setting to understand the other person's perspective as participants' own worlds and experiences are uncovered and relayed in the interview setting (Marshall & Rossman, 2006; Esterberg, 2002). Marshall and Rossman (2006) assert that this is the data collection approach that allows for the generation of an emic perspective from the study because it facilitates the unfolding of the participant's perspective. By using general topics that guide participants during the initial stage of the interview, the researcher allows this semi-structured approach to take shape based on the participants' responses (Marshall & Rossman, 2006; Esterberg, 2002). It can be compared to a dance where one partner (interviewer) stays carefully attuned to the other's (participant) movements and adjusts accordingly to each turn and as a result, each interview is tailored to the research participant (Esterberg, 2002). Marshall and Rossman (2006) further add that the ability to immediately follow-up and clarify participant responses is what provides researchers with the opportunity to understand the meaning of participants' everyday experiences.

At the same time, it is important to note that conducting in-depth interviews does not come without any challenges. Marshall and Rossman (2006) stress that a limitation in qualitative research interviews is that cooperation between the researcher and participant is essential. It is possible that the comfort level of each participant will vary and as a result, some may not be willing to share the areas of experiences that the researcher is interested in investigating. It was therefore critical for the researcher to begin and end the interview with a briefing and debriefing (Kavale, 2007). During the briefing, the researcher explained the purpose of the interview, which also facilitated in building rapport. At the end of the interview, participants were given an opportunity to provide additional comments. During the debriefing, the researcher also expressed appreciation for the participants' time and reminded them that their participation was valuable. This was a key message the researcher wanted to convey because the communication of respect and the message that participants' views are useful and valuable are one of the most important aspects of an interviewer's approach (Kavale, 2007; Marshall & Rossman, 2006).

It is also possible that some participants may face challenges engaging in the interview due to varying comprehension levels of interview questions. To address these possibilities beforehand, it was important for the researcher to ask simple questions, followed by probing questions intended to extract further descriptions and allow elaboration of emotions and meaning (Kavale, 2007).

Following the general structure as outlined above, the researcher identified a few general topics to assist participants in describing their experiences, but otherwise encouraged the participants to structure their own response. Maxwell (2013) emphasized

the importance of maintaining some level of structure in the data collection process to ensure the comparability of the data among different participants. Therefore, the researcher implemented a consistent set of broad questions during the interviews, while providing participants the opportunity to elaborate on specific aspects of their responses. Accordingly, the probing questions, which are vital in generating in-depth narratives for the participant's experiences (Roulston, 2010), varied for each interview depending on the response from the participant. Examples of the interview questions are provided below:

1. How would you describe your relationship with your child has changed since he/she has received/is receiving mental health treatment?
2. What has been different in your interaction with your child since the beginning of mental health treatment?

Furthermore, participant observation was an integral part of the in-depth interviews. The researcher recorded relevant non-verbal cues in *field notes* throughout the interviews based on what was observed through the available senses and the researcher's intuition. Thus, the notes reflected the researcher's impressions gained during the interaction with the participants (Morrow & Smith, 2000). By staying attuned to the participants' expressions of emotions/affect, the researcher sought clarification of responses when appropriate. Lastly, the researcher used non-verbal language of the participants (e.g., sighing, laughter) to gauge their comfort level which provided the researcher with guidance on the appropriate pacing of the interview.

The researcher conducted six initial individual interviews, with the interviews ranging from approximately 47 minutes to 57 minutes and having a mean of 51.5

minutes. The researcher provided participants with the written consent form via email beforehand, and prior to the start of the interviews, the participants were given the opportunity to ask questions or express concerns about the consent form. Also, at the start of the initial interview, the researcher gathered demographic information and provided participants with the purpose of the study. During the beginning of the interview, the researcher established rapport with the participant, helping them get acclimated to the logistical setting of the interview. According to Marshall and Rossman (2006), the most important aspect of in-depth interviewing is the researcher's attitude, which is evidenced by how the interviewer communicates to the interviewees regarding the high value of their participation. Throughout the interview, the researcher sought clarification, further explanation, and even examples from participants to enhance the understanding of their experiences. The interview protocol ended by debriefing the participants about the next steps of the study which included the transcription process and the possibility of the researcher reaching out to participants for a follow-up interview. During this debriefing process, the researcher also informed participants about the compensation for their valuable participation in the study and confirmed their email address where they would like to receive the gift card. While the researcher offered compensation to all six participants, two participants declined, stating that they were more than happy to be able to contribute to the research study.

Due to logistical barriers of physical distance, the researcher conducted all interviews via phone. Initially, the researcher had intended to conduct in-person interviews to facilitate rapport building with the participants through actual physical interaction and to allow for the inclusion of the observational component of non-verbal

language during the interview (Marshall & Rossman, 2006). However, this was not attainable because all recruited participants were located in various geographical locations. Although phone interviews are less widely used in qualitative research than face to face methods (Novick, 2008), they provide a versatile means of data collection and yield high-quality, meaningful information (Sturges & Hanrahan, 2004). Each interview was digitally audio-recorded and was outsourced to a professional transcription service provider. Once the initial transcriptions were completed, the researcher individually performed a quality check and made corrections to the transcriptions as needed. Upon completion of the quality check, the researcher emailed each participant a copy of the interview transcript that was identified by the participant's chosen pseudonym.

Participant Checks

Throughout the data collection process, the researcher used participant checks to ensure that participants' experiences were being fairly represented (Morrow, 2007). Through the researcher-participant dialogue, the researcher sought for clarification and examples as participants provided accounts of caregiver-child interaction/relationship. The researcher also sent participants a copy of the transcribed interview as they were given the opportunity to add or revise what they had shared in the initial interview.

Follow-Up Interviews

The researcher also had follow-up contact with participants to ask follow-up questions that emerged while listening to audio files as well as during the coding (analysis) and quality check processes. Follow-up interviews took place either through email or phone contact, depending on the participant's preference. This was an important

data collection method because it provided participants with the opportunity to add to what had been shared during the initial interview. Kavale (2007) discusses the importance of asking these "second questions" because there is potential for further description and clarification through the researcher's follow up process.

Memo-Writing

The researcher engaged in memo-writing throughout the research project including the data collection and analysis phase. This facilitated the process of self-reflection by helping the researcher become aware of reactions, make connections within the data, and monitors one's assumptions. In addition to being a holding space for research ideas, Maxwell (2013) describes memos to be very useful because it helps the researcher understand the research topic by thinking about various issues such as but not limited to methodology, ethics, personal reactions, setting, and data. Morrow and Smith (2000) also emphasize the value of memos as they can help researchers keep track of ideas, informal themes, and hunches throughout the course of an investigation.

Data Management

All interviews were conducted and recorded using a digital device, and subsequently sent to a professional transcription provider for verbatim transcription. Participants were asked to review their transcribed interview for accuracy and completeness. A software package for qualitative data analysis, ATLAS.ti (Muhr, 2004) was used to organize and review the data and to develop a conceptual network with easily accessible quotations. This allowed the researcher to review the thematic structure and check the internal consistency of the codes. Previous research has supported the validity of both hand-coded and computer-aided data coding; findings suggest the

relative advantage of computer-aided data analysis, given the approach uncovers material missed by the hand-coded method (Marshall & Friedman, 2012).

Data Analysis

The data from the interviews were analyzed using reflexive thematic analysis (TA) procedures outlined by Braun and Clarke (2006). Thematic analytic method was chosen as it is a versatile, a-theoretical analytical method allowing thematic structures to be generated based on the data rather than preexisting theories (Braun & Clarke, 2006; Bogdan & Biklen, 2003). Theoretically independent, TA does not adhere to any particular theory of language or explanatory framework, and thus, can be applied within a range of theoretical frameworks. As a result, it can be used to analyze a variety of data types and can be applied to produce data-driven or theory-driven analyses. In addition, guidelines regarding participant numbers when utilizing reflexive thematic analysis support its use in studies that may be restricted to a smaller sample sizes (Braun & Clarke, 2013; Fugard & Potts, 2014).

Thematic data analysis involved these five, non-linear, recursive steps: (a) familiarization with the data; (b) initial code generation involving both semantic and conceptual aspects; (c) searching for themes based on the initial coding; (d) review of the themes; and (e) theme definition and labeling (Braun & Clarke, 2006). In accordance with these iterative steps, regular reviews of data were undertaken by the researcher to check the fit between each theme and transcript extracts.

Trustworthiness

In qualitative research, the term trustworthiness is used to describe the "credibility" and "rigor" of a study. The researcher engaged in a number of activities to enhance trustworthiness.

Triangulation

As outlined in earlier sections, the researcher increased trustworthiness through utilization of multiple sources of data collection, including interviews, observations, participant checks, and memos. This process of using multiple data sources is referred to as triangulation (Merriam, 2009).

Investigator Triangulation

Triangulation can be further enhanced by involving another researcher and this is referred to as *investigator triangulation* (Patton, 2002; Morrow & Smith, 2000). To incorporate investigator triangulation, the researcher involved a fellow researcher during the data analysis stage. In addition to having completed graduate level coursework at a level similar to the researcher, the peer researcher had been involved as a collaborator in multiple qualitative research projects and had completed a qualitative doctoral dissertation. At the time of the study, the peer researcher was a post-doctoral research associate at the University of Oklahoma. To add to the rigor of the study, this peer investigator was asked to review the transcripts and extract dominant themes. The researcher did not share the themes that had been generated in his analysis until their meeting where they both compared their analysis outputs. This cross-checking process allowed the researcher to engage in further reflection and consider alternative explanations that may have been overlooked during the initial analysis phase.

Authenticity Criteria

Among the range of criteria for trustworthiness that have been suggested for use within a constructivist/interpretivist paradigm, Morrow (2005) points to the importance of *authenticity criteria* (Guba & Lincoln, 1989). Authenticity criteria includes *fairness*, *ontological authenticity*, and *catalytic authenticity*.

Fairness. Guba and Lincoln (1989) describe the criteria of fairness to demand that researchers need to solicit and honor different constructions. In this study, fairness was achieved by seeking to recruit a diverse pool of participants. While there is some homogeneity in terms of participants demographics, study findings reflect participants' unique experiences in terms of how they responded to their child's mental health diagnosis/symptoms, which added to the diversity of the perspectives regarding the phenomenon of the caregiver-child relationship. The second aspect of fairness refers to the process of empowering the participants to use their voice and participate in the consensus building process (Guba & Lincoln, 1989). In this regard, there is much effort to balance the power between researcher and participants. In this study, one example of the efforts to achieve balance in power was when the researcher provided participants with various options regarding how their responses may be represented in the final research report, such as whether they consent to being quoted directly. The value of their participation was communicated regardless of the extent of their consent. All participants were given the option to participate; any decision to either accept or withdraw their consent was immediately and fully honored.

Ontological Authenticity. The criteria of ontological authenticity requires that researchers facilitate in elaborating and expanding the constructions of the participants

(Guba & Lincoln, 1989). First, it was critical for the researcher to build rapport with participants from the initial contact, which facilitated the creation of a safe environment for interaction with participants. During the interviews, the researcher reflected the participants' caregiving experience, probing when necessary, to help participants identify the deeper meaning within the context of the caregiver-child relationship.

Catalytic Authenticity. Lastly, the criteria of catalytic authenticity requires that action is stimulated from the research study (Guba & Lincoln, 1989). The researcher has aspirations that findings from this study not only contributes to the body of literature on the caregiver-child relationship within the context of a child's mental health treatment, but also can guide interventions to benefit the caregiver-child relationship. Given the prevalence of mental health symptoms among children/youth and how a child's mental health can disrupt family functioning, the researcher hopes that mental health professionals will gain a deeper understanding of how the caregiver-child relationship can be impacted by the child's mental health treatment.

Ethical Considerations

The researcher received approval from the University of Oklahoma-Norman Campus Institutional Review Board (OU-NC IRB) and followed accepted research protocol procedures. When appropriate, the researcher consulted with staff of OU-NC-IRB for protocol modifications and followed necessary steps to obtain approval for changes. This occurred when the researcher had to seek an alternative transcription service provider after being notified that the Printing, Mailing, and Document Services of University of Oklahoma- Norman campus was no longer offering transcription services to students. The researcher consulted with OU-NC-IRB staff to make sure that the "terms of

service" for the alternative transcription provider were in accordance with the requirements of OU-NC-IRB.

Several measures were put in place to meet ethical obligations to participants. First, to protect participant identities, participants were asked to select a pseudonym to be used in place of their actual names. Once pseudonyms were provided, all research document files stored by the researcher were de-identified. The names of the participants' children in the interview transcripts were also de-identified in the transcription document and instead, were replaced with "child." The consent form, which was provided to participants before the start of the interview, contained several elements to further ensure the protection of the participants. First, participants were given the option to consent to being quoted directly and to consent on having their data be used in the future. Participants could take part in the study regardless of whether or not they provided consent for these two situations. The consent form also speaks to the participants being able to withdraw their consent from the study at any point. An example of when this could happen was if participants were experiencing too much distress as they discussed their caregiver-child relationship. To the extent possible, the researcher was attentive to the verbal and non-verbal language used by the participant to assess for the participant's level of distress. Lastly, the consent form includes the risks and benefits associated with the study and the researcher made sure to provide participants with the opportunity to address any questions before beginning the interview.

Chapter 4: Findings

Data from the interview transcripts were transcribed and analyzed following the procedures for thematic analysis (described in the previous chapter). Findings were

grouped into four main themes: *emotional valence*, *shift in focus of interaction*, *accepting impact of child's mental health symptoms*, and *seeing hope in child*. The findings from each theme are discussed below, supplemented by participants' actual quotes to provide concrete examples of participants' experiences.

Emotional Valence

One of the shared perceived changes that all participants spoke about was the decreased emotional tension when interacting with their child once the child started taking medication for ADHD. During the interviews, participants reflected on the times before their child began treatment and were able to articulate the observed differences in terms of decrease in the intensity of anger and frustration. The decrease in emotional tension was noticed within the academic and household contexts as well in general interaction/conversations with their child.

Academic Context

Three of the six participants discussed their role within their child's academic contexts and spoke about the rising emotional tension when assisting their child with homework. Participants highlighted the difficulty in responding to their child's resistance and inability to focus when engaging with academic work. Rose stated that her son's resistance toward doing homework would at times lead to his expression of out-of-control anger. She stated, "He would just rage. This is when we knew we would have to get some help." For Rose, the situation escalated to a point where she and her husband had to physically restrain their child. Grace also spoke of similar experiences as she described the need to "nag her child" when it came to completing school assignments. For Grace, the nagging was her attempt to "force" her son to do his homework only to have him

respond with anger or to have him “talk back.” Grace further explained that this form of interaction would subsequently turn into “yelling matches” where both she and her son would end up in elevated states of anger.

Emotional tension arising from academic-related interaction was also experienced by Penny, although her experience slightly varied from Rose and Grace. For Penny, she observed that watching her son consistently struggle with focus triggered her own feelings of frustration. She noted, “When he was really little, trying to do homework with him, we'd both end up in tears half the time because he couldn't focus, and I couldn't get through to him.” Penny’s experience highlighted the difficulty she faced in trying to tolerate the frustration resulting from her child’s inability to focus. Since her child began taking medication, Penny stated that there is now “less arguing” and “no more fighting about school.” She added, “What used to be one issue piled up on top of each other just naturally went away.” Penny’s story showed how her son’s treatment led to both a decrease in negative emotional expression and a reduced need for her to address school-related issues.

Rose and Grace also spoke about the changes in their interaction with their respective child in treatment. Since her child has been in treatment, Rose described the progress that she was observing in terms of her child’s increased ability to focus and complete tasks which led to improvement in his grades. This was related to the decreased resistance from her child as it became easier for her to have him complete school tasks. She described the overall change in her interaction with her child as being “steadier and calmer.” For Rose, improvement in academics served as a reminder of the child’s capabilities and was also a contributing factor that alleviated the emotional tension that

they been experiencing. She emphasized, “Anything that makes your child more successful is going to reduce the tension in the house.” For Grace, the notable difference that she observed was the decreased anger she saw in her child. She stated, “I am not having to deal with an angry kid” which then allows her to engage with her child in a more productive conversation about tasks that need to be completed. Both Grace and Rose were able to observe the positive changes of less resistance and anger from their children in response to their initiatives to help their children’s academic tasks.

Household Context

For Ted, the emotional tension that he and his child experienced was in the context of doing household chores. He described the elevated emotions that were observed within himself as well as with his child. He noticed that his child would get “really frustrated with himself” when he was not able to do the things that he was told due to the inattention symptoms. For Ted, seeing that his son could not do what he was asked would cause Ted to experience anger and impatience, eventually leading him to “blow up.” As Ted reflected during the interview, he stated that the root of his anger and impatience was the result of his son “not doing what he was supposed to do”, which ended up creating more work for Ted. Furthermore, Ted spoke about the resentment that he began observing. When asked to elaborate, Ted was unable to clearly state whether the resentment was toward his child, or toward the ADHD. However, what appeared to be certain for Tom was the fact that seeing his child struggle with attention and focus made him think about how unfair it was for his child to be dealing with ADHD. He stated, “I didn’t think it was fair for him to have that; he was such a great kid.” For Ted, seeing his child struggle at home also made him think about the different quality of social

interaction his child was having. He expressed his desire for his son "to be seen by others" and to have meaningful social connections. For Ted, it appeared that what started as emotional tension stemming from his son's inability to follow instructions at home further developed into another emotion (resentment) related to a different domain of his son's functioning.

General Interaction

In the interviews, participants also spoke about observed changes in emotional tension that were not tied to specific situations/contexts, but more within the day to day interaction with their child. Lucy shared her observation that since beginning treatment and when taking his medication, her son presents in a "delightful" manner. She described a conversation with him when he is on his medications as, "Hi mom, I love you." She added that when he is on medication, "You can talk to him." This was in high contrast to when the medication wears off where Lucy described her son as "Mr. Snapping Turtle." For Lucy, benefits of medication were clear because her son is (and has been) only being medicated for a certain time during the day and therefore, she is able to see the shifts in their interaction from unpleasant and grumpy (before medication and after medication wears off) to a more pleasant and agreeable form of interaction (when medication effects are still observable). Ted also commented on how his interactions with his son changed following treatment in terms of emotional expression on a more routine level. He shared that since being on treatment, he has observed his son to be "witty" and that he "says one of the funniest one-liners" he has ever heard. Ted noted that his son sharing a joke positively impacts the entire family as all of them "burst out laughing." In terms of the caregiver-child relationship, Ted stated, "My relationship with him is so much improved,

because I can laugh with him." For both Lucy and Ted, their child's treatment appeared to impact the caregiver-child relationship in a manner that helped facilitate the expression of laugher and affection which in turn, led them to perceive a more positive form of interaction.

Shift in Focus of Interaction

As participants described their relationship and interaction with their child before and after beginning treatment, they pointed out a shift in the focus of their interaction. This shift was observed within conversations between caregiver and child as well as in the caregiver's perspective toward their child. The sub-themes below (*decreased emphasis on child's deficits* and *fostering child's sense of responsibility*) illustrate these shifts that participants shared.

Decreased Emphasis on Child's Deficits

Penny shared her observations about shifts that were taking place in the interactions with her son. She stated that in the past, before the child started taking ADHD medication, she and her son spent considerable time addressing behavioral issues at school. With much of the focus being on what her son was doing wrong at school, conversations then centered on Penny trying to gather additional information surrounding notable incidents in her son's day-to-day functioning at school. Some of the questions she would ask her child were: "Why? What was going through your mind when it happened? What can we do to make sure that you handle it differently next time?" These questions illustrate Penny's desires and efforts to better understand the contributing factors that led to those incidents which then further developed into a discussion on how to avoid similar incidents in the future. With her son being in treatment, Penny described the differences

in their conversations, as they began talking about her son's accomplishments and talents, as well as identifying ways to increase his tools to attain academic and social success. Penny's conversations and interactions before and after treatment were, in a way, both future-oriented. However, the conversations that took place after treatment had more of a strength-based theme whereas in the past, much of the focus was on the child's deficits which naturally required the implementation of a problem-solving approach.

Furthermore, the shift in conversations for Penny and her child also illustrates the contrasts of a reactive versus a proactive stance. Whereas much of their dialogue prior to treatment would be a reaction to her child's behavioral incidents at school, the dialogue and interaction that they shared since beginning treatment took more of a proactive stance. There was less of a need to "respond" to incidents. This provided space for the dyad to talk about how they could shape future interaction, in a manner that would facilitate the growth and success of the child.

In a way, Kent's experiences resembled that of Penny in the sense that he was constantly reacting to his child's events at school. Before his child started taking the medication, Kent stated that he would often get a call from the school about his son's behavioral incidents (e.g., being disruptive in class, not getting classwork done, saying inappropriate things to other students). This put Kent in the position of what he described as a "constant disciplinarian." Once his child began taking medication, Kent stated, "I no longer had to be the constant disciplinarian because he was not getting into trouble." For Kent, this meant that he didn't have to be "on his child" the minute he got home. Kent further stated that not having to discipline his child "gave some relief" to the relationship.

As Kent looked back on the earlier signs of change, he was able to recall that on the days that he did get a call from school, he would realize that he had forgotten to give his child the medication. Thus, medication significantly helped address the child's behavior at school which in turn, meant less "behavior-related conversations" for Kent and his child.

Rose's responses also demonstrated the shift in the interactions with her son. In relation to the earlier theme, she had shared that her concern for her son's academics/career led her to worry about the struggles that he may face in the future. Since her son has been in treatment, Rose talked about how being less concerned about her son's future has allowed them to engage in more day-to-day interactions. She gave examples of cooking together with her son, watching a show as a reward for completing homework, and having conversations in the car. Similar to the experience of change that Penny shared, the interaction between Rose and her son before treatment was focused on things that could go wrong. Her son receiving treatment allowed them to be more present in the moment by engaging in regular, and meaningful activities. Ted also looked back on a recent conversation that stood in high contrast to before treatment. What he described was a negotiation of responsibilities with his son and he emphasized that this was one of the few times that his son's ADHD or learning disability symptoms were not part of their conversation.

Fostering Child's Sense of Responsibility

As participants described the shifts in the focus of the caregiver-child interaction, they also spoke about the increased sense of responsibility that they were observing in their child. What they were observing was in response to the parent providing the child with the opportunity to be more responsible. The example that Grace shared was in

relation to the phone data plans as she described her current process of giving her son the data up-front and making him ration it. She added that her child now manages it on his own rather than Grace saying, “If you do X, you get Z.” She explained that before treatment, setting these conditions was not effective. When reflecting on this change, there was laughter as Grace described how she uses positive motivation when interacting with her son. She stated, “It (treatment) has given me the opportunity to be able to try different things without having to force things.” It appeared that seeing her son demonstrate a higher level of responsibility has made things easier for Grace, as compared to the past.

Ted was also able to identify similar shifts toward an increased responsibility of his son in his caregiver-child relationship. Within the specific context of car maintenance at home, Ted shared how his son currently takes the initiative to identify problems and take steps toward problem resolution all on his own. Ted explained, “I would never let him do that before” as he talked about the increased trust that he now had in his son. When asked how he felt about seeing his son carry out such responsibilities for the first time, Ted stated, “I relaxed. I’m more relaxed that he’s going to be okay.” Since his son began treatment, what Ted noticed was that his son was “not scared” to volunteer ideas and take initiative. While treatment helped the child take the initial steps toward embracing a bigger range of responsibilities, it is significant to recognize Ted’s supportive response that allowed the shift to take place. Ted elaborated on this shift by further discussing the mutual dependence that he was observing. He stated that whereas in the past, his son was dependent on him, Ted is also now able to depend on his son. Observing the increased sense of ownership and accountability from his son, he used the

word “partnership” to describe the bi-directional nature of their current relationship. As Ted spoke about the observed transformation in the caregiver-child relationship, the researcher sensed joy, hope, and confidence about the kind of relationship he was currently sharing with his son.

Accepting Impact of Child’s Mental Health Symptoms

This research study sought to gain a deeper understanding of how caregivers perceive their relationship to have changed with their child’s mental health treatment. While previous sections illustrated the perceived changes reported by participants, the researcher observed during the interviews that participants also spoke about aspects of the caregiver-child relationship that have yet to change in their accounts of on-going challenges. It was important for the researcher to bring to light caregiver participants’ voices regarding these on-going struggles. More importantly, caregivers talked about the process of coming to acceptance regarding the impact of ADHD symptoms on the child and the caregiver-child relationship. The sub-themes of *embracing and adapting to unchanging elements* and *stepping back and allowing child to be* describe caregivers coming to acceptance about situations that are unlikely to change within the caregiver-child relationship.

Embracing and Adapting to Unchanging Elements

As participants described their current interaction and relationship with their child, they spoke about the on-going communication challenges that have continued from the past. Rose stated that she still observes the anger and obstinence in her child from time to time and recognizes the need for her to take a step back. She noted her effort in trying to be more intentional to be less emotional in order to reduce the tension in the

interaction with her son. At the same time, she was open to the fact that her son may not respond in the most desirable manner. She mentioned, “But sometimes he just gets real mad and stomps off. He goes around the block a little bit and kind of blows off some steam that way. And that's okay, too.” Lucy echoed similar challenges when communicating with her son, describing the lack of response or willingness in their conversation. As Lucy spoke about the communication barriers, she identified herself as the “daily disciplinarian” which potentially leads to more negative interactions with her son. Furthermore, she explained that in the more important matters, she involves her husband to help facilitate conversations with her son. This demonstrated her ability to understand the extent of her influence when interacting with her son as well as her willingness to seek alternative approaches. Lucy was referring to the fact that she knew when she was unlikely to have any significant influence when interacting with her son and in those situations, asked her husband to intervene.

Penny’s story illustrated a similar acceptance component and her efforts to take further steps forward in adapting to the situation on hand. She shared her acknowledgment that her son is likey to respond to her with more sensitivity than other kids, including her other child. Thus, she pointed out that she tries to be more intentional about how she communicates with him, demonstrating her willingness to tailor her communication style to meet her son’s needs. At the same time, she was also well-aware of the toll that this was taking on her. She stated,

> Sometimes it's just a little exhausting, sometimes because it does take a lot more forethought and whatever we say, he's going to be a lot more sensitive than most kids are. So I try to take a deep breath and think a little bit more about what I'm

going to say to him before I say it, because I know that it's going to impact him more than it would his brother.

These stories capture the multi-faceted nature of the participants' acceptance regarding some of the unchanging elements of the caregiver-relationship. They seemed to be well aware that some of their current interactions still maintain some of the same relational dynamics from the past. More importantly, they appeared willing to acknowledge that some things may not change and accepted their lack of control in these situations. Lastly, they highlighted that because there was some acceptance of the fact that some interactions may not change, they needed to adapt accordingly whether that involved "stepping back", involving the other caregiver/parent, or exerting effort to communciate in a different manner. Their stories demonstrate a process of acceptance that involved engaging in self-reflection about their lack of control but also their desire to make things better, which was then channeled into future action steps.

In addition to the acceptance of the communication aspect of the caregiver-child relationship, one participant spoke about her struggle in coping with her child's behavioral symptoms. Lucy provided a clear example of the daily exchange with regard to the child's behavior at home. She mentioned, "He has to lay on the floor, I don't know why. He's 14 years old, he still lies on the floor." She reflected back on the past where she was more directive in setting rules around the house and at times, being more proactive in providing structure. This was no longer the case as Lucy recognized that her son may not be able to meet some of her expectations and desires. Her statements of "It's never going to happen" and "A lot of the mom stuff, I've let go of" captured the sense of her acceptance that some of the struggles and challenges she was currently facing were

likely to continue into the future.

Stepping Back and Allowing Child to Be

During the interview, Penny reflected on how she initially responded to her child's ADHD diagnosis. She clearly remembered her efforts to research extensively about ADHD as well her involvement in a support group for parents of ADHD children. The desire to acquire knowledge in order to help her child was captured in her statement, "I'm going to arm myself with probably too much information and I'm going to figure this out and try to help him (child) as much as I can." Once her child began treatment, she described her role for the next few years to vacillate between getting closely involved, even referring to herself as a "helicopter parent", and taking a step back as a result of negotiating her role with her son. Her current perspective reflected increased willingness to take a step back when interacting with her son, giving him room to make mistakes along the way. She stated,

> Sometimes you have to just let them be them and let it be, and the good thing is that at this age, most of the decisions that do end up being what you'd classify as a failure or not successful are pretty benign, because they're not out in the real world yet and on their own. It's about making those mistakes now under the protective environment of living at home and being a minor and having parents that are looking out for you, because when you get out in the real world, some of those mistakes could be a little bit more impactful.

Penny's willingness to take a step back may be related to how Penny currently views her child's ADHD diagnosis. She stated, "It's just a little bit of a challenge that he has to face, that he has to manage his life differently than other people in order to succeed." These

statements reflect her acknowledgement that unique challenges will be inevitable for her son.

As Grace described her interaction and relationship with her child since treatment, she also spoke about the current struggles as she stated “I still have to get on his case to get things done.” As she further elaborated on her son’s struggle with focus, she also acknowledged that she can only do so much if the desire to change doesn’t come from her son. She spoke about her son’s tendency to not take initiative as being part of his ADHD symtomology and behavior and noted, “If he is not willing to get help, there’s not much I can do. Similar to what Penny had shared, Grace was willing to accept that there were certain aspects of the caregiver-child relationship that may not change, no matter how strong her desire.

Within the sub-theme of *stepping back and allowing child to be*, two participants also spoke about coming to acceptance regarding previous expectations toward their child’s level of functioning in the social domain. Penny reflected on her previous bias that because she and her husband had large groups of friends during their childhood/adolescence, she had likewise wanted the same for her child. She came to recognition that her child may not necessarily want this and stated that her child’s happiness is what is truly important. She mentioned, “That's just not him, and that's been our own bias that we've had to get over, that it's okay if he only has one or two friends. If he is happy, that's all that matters.” For Penny, it seemed that she was willing to have her child define his own standard of what consitutes happiness and meaning whereas in the past, she had allowed her own “definition of happiness” to exert more influence in her son’s life.

In relation to the social domain of her son's functioning, Rose spoke about her fear that her son might not fit in among his peers. She elaborated that this fear led to her taking a more protective stance toward her son because she was worried that other kids "might not be able to pick up on her son's social cues." During the interview, Rose stated that she is stepping away from being too protective and instead, is challenging herself to strive toward "finding a balance between coddling and saying you (child) are responsible." She stated, "It's a fine line between 'you need to modify your behavior' and yet, being his advocate when you need to be his advocate." Ultimately, she appeared willing to accept the possibility that her son may not fit in as she noted, "I don't want him to feel like he doesn't quite fit, but I think that is the case, actually. And it may just be that way." Similar to Penny, Rose reflected on the process of wanting something for her child and then facing the realization that some of her desires may not actualize.

Seeing Hope in Child

The theme of *seeing hope in child* was generated as participants reflected on the caregiver-child relationship before and after their child began treatment for ADHD. With their child in treatment, participants talked about being hopeful for the future most notably because of the potential they were seeing in their child.

As Rose reflected on the relationship with her son since he began receiving treatment, she not only talked about seeing her child's potential, but also observed her son internalize some of his abilities that he himself was noticing. There was a sense of excitement and hope as Rose stated that her child was beginning to see himself as someone who could write. She mentioned,

When he says that about himself and he internalizes, "yes, I can write," that's...I

> don't think he'd be able to focus as well as he could without the medication. That's positive that he's identifying himself as someone who can write and who can think, using words like ineffable. The other day, he used the word ineffable when talking about God. I was like, wow, that's hopeful.

These words captured the experience of a parent bearing witness to seeing her child acquire and develop a skill. She saw that her son was able to write better because of the improved ability to focus. Yet, there was more that took place given the deeper, significant meaning of "writing" due to Rose belonging to a family of writers. In the interview, Rose also expressed assurance for her child's overall future. In contrast to having been worried about her son's future, she expressed confidence about his ability to "rise to the occasion when he needs to." There was firm conviction in her voice as she stated, "I'm very hopeful for the future. He'll be absolutely fine. And he'll be good at whatever he decides to do, any job."

Ted also articulated the potential that he is currently seeing in his child. Previously, Ted stated that he only felt proud of his son after he had "solved a problem." Observing improvement in focus and seeing positive changes in his son's daily routine, Ted noted that he is feeling proud of his son every day. He added that he is no longer concerned about his child's career. Similar to Rose, this was in contrast to the past where Ted had been concerned about his son's ability to pursue a career and whether he would be able to pursue his dreams.

Penny also mentioned hope toward the future as she reflected on the treatment-seeking process. For Penny, actively engaging in the treatment process provided clarity about the ways in which she could support her son. More importantly, she recognized that

her son's ADHD symptoms were what made him special. She shared,

> But once we got more answers, we realized that there really is no "normal", and he was going to be fine, as long as we addressed it, supported him and got rid of any preconceived notions about the definition of "normal." I am so thankful now that we accepted it early, did our research, consulted the experts, and acquired lots of "tools in our toolbox" to help him. I think early intervention is so important.

During the interview, Lucy expressed happiness for the changes she was seeing in her child since taking medication. She noted, "His teachers tell me he's so nice, he's so funny, the kids in the class laugh and he's hilarious." At the same time, because her son was taking medication only for the duration that he was in school, Lucy had not observed these traits in her caregiver-child interaction. She stated,

> But you [individuals at child's school] see a different kid than we do, he's a medicated kid, and he is wonderful when he is medicated. But we get the hangover kid [laughter], when he is grumpy and the meds have worn off.

As she talked from her position of not being able to observe changes firsthand, Lucy still expressed hope for the future, stating that she is hopeful for the day when she can see the traits in her son that others are currently seeing. However, the source of hope was not from treatment but rather, an increase in her child's level of maturity. She added, "Hopefully, he gets to the next stage of maturity, we'll be able to enjoy what other people seem to enjoy about him."

It is important to distinguish the hope that Lucy described from the hope that other participants spoke of. For other participants, progress from treatment and

observable changes within the caregiver-child interaction gave them hope about the child's future. For Lucy who was not experiencing as much change and progress, hope for her child was rooted in her desire that her son would reach a higher level of maturity and that she wanted her son to "outgrow" the symptoms. This form of hope was also expressed by Kent. He, too, had been seeing some benefits from the child's medication treatment. Yet, he wanted to believe that his son would no longer need medication as he grew older. Just like Lucy, Kent appeared to be counting on his son to gain maturity so that he might cope with his symptoms more effectively in the future without the need for medication.

In summary, the themes described above capture caregivers' perception of observed changes in their interaction and relationship with their child. The themes showed that negative emotional expression from both caregivers and children lessened in intensity as medication treatment helped improve child's behavior in various contexts. Thus, with less of a need for caregivers to focus on the child's ADHD symptoms, there was shift in the focus of the caregiver-child interactions where caregivers began observing a more holistic identity of their child, one that was less deficit-centered and also validating of the child's increased sense of responsibility. Through this process, caregivers also moved toward acceptance in terms of acknowledging the unchanging aspects of their child's behavior and its implications for the child's future. The clarity that they gained in terms of what it might mean for their child to continue experiencing ADHD symptoms also helped caregivers manage some of the previous expectations for their child. Eventually, as caregivers became more informed about the ADHD diagnosis and treatment and began worrying less about their child's future, there was a sense of

hope for the child's future and for the caregiver-child relationship.

Chapter 5: Discussion

The objective of this qualitative investigation was to gain a deeper understanding of how caregivers perceive the caregiver-child relationship to have changed due to the child's mental health treatment. To meet this objective, individual interview data were analyzed utilizing reflexive thematic analysis. This analysis produced key themes pertaining to caretakers' lived experience of relational change secondary to their child's mental health treatment. In the sections below, each theme is discussed in relation to previous research. In the context of study limitations, the chapter concludes with a discussion of the findings' implications for informing future clinical practice and for furthering continued empirical research.

Emotional Valence

For the participants, there were observable changes once their child began treatment for ADHD. It seemed that with the decreased level of negative emotions, it was easier for caregivers to take on the parenting role, indicated by the decreased level of distress within the home, academic, general interaction contexts. These findings were consistent with previous research that has demonstrated high parenting stress associated with child's emotional problems (Muñoz-Silva, Lago-Urbano, Sanchez-Garcia, & Carmona-Márquez, 2017). The importance of treatment was highlighted when caregivers expressed their sense of ease that resulted from not having to interact with an angry child. The statement from one participant, "All of those things that used to pile up on top of each other just naturally went away" may be a representative statement for this theme. When treatment (ADHD medication) helped alleviate the intensity of emotions,

parents saw the caregiver-child relationship from a more optimistic perspective. The emotional tension experienced by both the caregiver and the child can be perceived to be a natural and expected outcome of the child's ADHD symptoms which had served as a barrier to an optimal caregiver-child relationship.

Shift in Focus of Interaction

With the reduced expressions of negative emotions such as frustration and anger (as described in the theme, *emotional valence*) between caregivers and their children, it can be expected that there was more room for the caregiver and child to have positive interactions. The theme, *shift in focus of interaction* illustrates that with the child receiving medication treatment, the focal points of the caregiver-child relationship began to shift from ADHD-related concerns to strength-based traits and qualities of the child that may not have been given as much attention in the past. With less emphasis on deficits related to ADHD symptomology, participants described the changes in the nature and process of the caregiver-child interactions. There were clear differences in the exchange of words to one another and how the dyad was going about their daily interactions. It seemed that some of the traits and qualities being recognized by the caregivers may not have been as readily observable or even recognized in the past. With caregivers noticing these differences subsequent to the onset of treatment, it appeared that in addition to treatment helping the child cope with ADHD functions, treatment was indirectly facilitating the caregiver-child communication and interaction. By observing these different traits and qualities in their children, caregiver participants appeared to be learning something new about their child which in turn, was strengthening the relational connection with their child.

Within this theme, it is important to recognize the variance among participants in the different ways they were perceiving and engaging with their child. On one end, the researcher observed a participant expressing her excitement because she no longer had negative interactions resulting from homework-related matters This opened her eyes to many of her child's strengths. Another participant saw the caregiver-child relationship transforming into what was described as a "partnership" after seeing the child's ability to manage daily tasks more effectively. On the other end, one participant didn't express the same level of excitement nor describe the same magnitude of observed change, but still reported feeling encouraged given that treatment was helping her child be more responsible.

From these findings, it can also be inferred that caregivers' perception of their child began to change due to child's mental health progress, further leading caregivers to redefine the identity of the child. Within the context of family mental health, perceptions toward family members can be shaped by their mental health symptoms. In a study of father caregivers whose children were diagnosed with schizophrenia, participants talked about the sense of loss that they experienced due to their child's diagnosis and symptoms (Wiens & Deniluk, 2009). Among the five specific losses experienced by caregivers, two types of losses reflected the caregivers' perception of their child: loss of who their child once was and loss of their child's potential. Although the study involved a more severe mental health condition, other studies that included various other mental health conditions support similar findings in terms of caregivers perceiving their child's mental health illness as losing a part of their child (Macgregor, 1994; Richardson et al., 2013).

When considering how participants spoke about seeing their child in a different light, one can also infer the possibility that caregivers may not be able access a holistic view of their child without effective mental health treatment. For the participants in this study, untreated ADHD-related symptoms might have been a barrier that prevented them from seeing certain aspects and traits of their child, particularly those that are strength-based. Instead, findings from this study showed that seeking mental health treatment led to increased recognition of their child's strengths, which then promoted a higher quality of caregiver-child interaction.

Accepting Impact of Child's Mental Health Symptoms

All participants were clearly able to describe how treatment was positively impacting the functioning of the child. Furthermore, they knew what this meant in terms of their relationship and interaction with the child. Participants seemed to have gained a sense of clarity about what to expect and what not to expect when interacting with their child. While it is important to consider other factors (e.g., caregiver personality, time, child's development), it can be inferred from this study that the child's mental health treatment helps caregivers gain a better understanding of the mental health condition. This leads to clarity in expectations toward the child, leading to acceptance and subsequently, fostering more positive caregiver-child interactions.

Acceptance and ACT

The concept of acceptance in mental health challenges the traditional medical model of illness and helps individuals find meaning in life by encouraging them to solidify an identity that is not defined by the diagnosis or symptoms and instead, identifies and builds on their strengths (Ridgway, 2001; Davidson & Roe, 2007).

Through this perspective, an individual is able to re-focus on their strengths, fostering a sense of hope and empowerment. One framework in psychotherapy treatment that incorporates acceptance is the Acceptance and Commitment Therapy (ACT). Within ACT, there are six core processes, one of which is acceptance (Hayes et., 2004). It is important to not misinterpret acceptance as tolerance or resignation and instead, to see it from the viewpoint of "to take what is offered" (Hayes et al., 2004).

At the caregiver level, some studies on severe mental health conditions and development disorders have shown the positive impact of psychological acceptance from caregivers as evidenced in the improvement of caregiver functioning (Weiss et al., 2012; Dorian, Garcia, Lopez, & Hernandez, 2008). Conceptually, psychological acceptance is closely related to *parent empowerment*, a psychological process that involves an individual's active attempts to change or eliminate stress events by directing efforts toward problem-focused coping (Gutiérrez, 1994). According to Gutiérrez (1994), these proactive attempts to seek knowledge and skills to address the stressors is in contrast to how one may respond with avoidance. The stories of the participants in this study demonstrated that the process of coming to acceptance with the child's mental health diagnosis and symptoms provides clarity in terms of their caregiver roles, further allowing the caregiver and child to have higher quality of interactions. They acknowledged their lack of control when it came to how ADHD symptoms were influencing their child's functioning but were able to come to realization that stepping back from previously set expectations was beneficial for the caregiver-child relationship. At the same time, they utilized the gained clarity to proactively identify ways to improve their child's functioning as well as the caregiver-child relationship.

Seeing Hope in Child

Four of the six participants in this study expressed hope for the future that seemed to be rooted in the benefits of the child's treatment. For these four participants, the perceived changes reflected in the abovementioned themes may be the building blocks that constitute their sense of hope within this theme. With their child receiving treatment, participants were observing decreased negative emotional expression. At the same time, they were noticing increased expression of positive emotions. By moving away from their child's deficits and instead, focusing on their child's strengths, they began to see their child differently. Within this process, they came to a clear understanding of how to navigate and adapt to the child's mental health symptoms which also meant they needed to let go of unrealistic expectations. Going through this process allowed them to see what the realistic future might hold within the caregiver-child interaction. Here, we recognize that the level of hope varies for each participant and it is possible that the extent of perceived positive change shapes an individual's hope for the future. In this regard, it would make sense that the hope described by Kent and Lucy was not rooted in the treatment of the child's symptoms but rather, the maturity level of their children. Despite their recognition that their child was benefiting from receiving treatment, the extent of change did not apppear sufficient enough for both Kent and Lucy to believe that treatment can continue to help in the future.

The complexity of hope was explored in a qualitative study that examined the caregivers' understanding of hope when attending to the mental health needs of family members (Bland & Darlington, 2002). Family members described hope as being temporal in nature, drew connection between hope and loss, while also identifying

various sources of hope such as family and friends, religious beliefs, and positive attitude (Bland & Darlington, 2002). Family member participants varied in the way they defined and sought hope in their caregiving roles. Thus, it is important to recognize that although treatment can lead to improvement in functioning, the impact of progress on caregivers' perception of treatment will be unique to their experiences.

Thematic Findings and Family Functioning

McMaster Model of Family Functioning

An overview of the McMaster Model, as described in the literature review, offers a framework for interpreting study results within the context of a well-established and empirically validated family systems model. The McMaster Model was selected due to its assumption that the underlying function of family is to provide appropriate environmental conditions for all members to fully and holistically develop. In order for this to occur, the family system must effectively complete a series of tasks, including basic tasks (e.g., meeting material needs), development tasks (eg., adapting and promoting growth and development of members) and crisis tasks (e.g., dealing with all types of family emergencies).

Consistent with the model, as the child developed, family task demands, and expectations became increasingly challenging. Inevitably, behaviors and consequences secondary to ADHD placed increasingly novel and stressful demands on the child, and thus, family system itself. Ultimately, this compromised members' ability to effectively complete both developmental and crisis tasks needed to appropriately meet the child's needs, further affecting multiple aspects of family functioning.

Thus, in the context of the McMaster Model, these caregivers initially struggled in their perceived ability to provide their child with the appropriate environmental conditions. In turn, this hindered their child's ability to continue holistic development (including physical, psychological, social, and cognitive). As a result, consistent with the family systems perspective, the caregiver's own ability to continue development was also stymied. The caregiver-child relationship then became a symptom of compromised family functioning. Ultimately, participants' experienced improvement within each theme only after they were able to access needed mental health intervention on their child's behalf. Once able to effectively address their child's unique behavioral, expressive and learning needs, overall family functioning increased, and caretakers experienced improvement across all themes. In this next section, findings from each theme will be briefly discussed as it relates to the increased family function within core dimensions of the model.

Problem-Solving. Findings from the study showed that participants' ability to resolve problems with their child was enhanced because they no longer had to focus on the child's deficits or problematic behavior. In fact, the ability to recognize their child's strengths facilitated the process of problem-solving because it provided the dyad with another internal resource. Seeing the child as being more responsible is a concrete example that demonstrated enhanced problem-solving skills between the dyad. Furthermore, the theme of acceptance is also relevant to this dimension as participants were more willing to let go of concerns that they might not have let go of in the past which alleviated the level of stress in problem-solving situations.

Communication. It was evident from the descriptions of caregivers that the quality of communication was enhanced with the child's treatment. This was possible because both the caregiver and child were not as frustrated or angry as they had been prior to treatment. Reduction in child's symptoms also provided the caregiver and child to engage in a dialogue on a wide array of topics whereas in the past, there was a focus on deficits (e.g., behavioral issues at school) within the caregiver-child communication.

Roles. The clarity that caregivers gained through acceptance was instrumental in modifying previously set expectations for the child in the home. With the child's treatment, participants became more flexible regarding expected behavior from their child. This was in stark contrast to the past where disagreement among rules and expectations would naturally escalate to an argument or conflict.

Affective Responsiveness. As participants described the range of affect in the caregiver-child relationship, it was evident that caregivers had more reasons to be excited and happy compared to when the child was not in treatment. One contributing factor was that, following the child's treatment, caregiver-child interaction led to caregivers' gaining increased awareness of their child's traits and qualities that instilled joy, hope, and excitement about the child's future.

Affective Involvement. Observing the various ways in which treatment was impacting their child's functioning facilitated the acceptance of the child's mental health concerns, which then helped caregivers re-define their child's identity. With a more holistic identity of their child, participants gained clarity about the child's potential for the future. As a result, it became easier for caregivers to be involved and engage with

their child. It is also important to note the optimism and hope that caregivers expressed as they observed their increased level of engagement with their child.

Behavioral Control. The combination of acceptance from caregivers along with seeing progress in their child's mental health symptoms shaped caregivers' perspectives toward rules and standards at home. While they still had their aspirational family rules and expectations, participants had a clear understanding that a degree of flexibility was also needed as they became more aware of what they could or could not expect from their child. Thus, the standards of "acceptable behavior" seemed more fluid than before.

Summary. In sum, these core components of the McMaster Model of family functioning relate directly to this study's thematic findings. Embracing a systems theory approach in terms of its description of structure, organization, and transactional patterns, families range in functioning along a continuum from healthy to severely pathological (Epstein, Bishop, & Levin, 2007). Commensurate with the thematic findings of the current study, the model's core components place considerable importance on affective dimensions as experienced by family members. In addition to its theoretical and conceptual foundation, the model offers practitioners multiple options for assessment and evaluation of family functioning. It also provides a well-established treatment approach grounded in both efficacy and effectiveness research (Epstein, Bishop, & Levin, 2007). Relational changes experienced by caregivers following their child's treatment reflect the model's potential for addressing the difficulties that families may experience when coping with mental health concerns.

Implications for Practice (Intervention)

Findings from this study suggest the importance of helping caregivers of children experiencing mental health symptoms become aware of their perception of their child. It was powerful to hear caregivers talk about how their newly defined perception of their child was positively influencing the caregiver-child relationship. With this positive outcome as the objective, it may be beneficial to help caregivers gain a more holistic identity of their child, one that is more encompassing of their strengths. This might be accomplished within the context of caregiver support groups, family therapy, or consultations with the child's mental health treatment provider. An example is a guided exercise or intervention to help caregivers explore and expand their current perception/identity of the child. Given the increased stress and responsibilities associated with parenting a child with mental health concerns (Mayberry & Heflinger, 2013), it may be challenging for parents to accomplish this on their own and thus, they would benefit from external resources for support and intervention.

Findings from the theme of *accepting impact of child's mental health symptoms* add to existing literature about the positive impact that acceptance can have on mental health, particularly within the context of the caregiver-child relationship. At the same time, there is a need to acknowledge how mental health stigma can be a significant barrier because it fosters a sense of hopelessness (Davidson & Roe, 2007; Roe & Kravetz, 2003). This suggests the importance of addressing stigma in the greater society given its influence at multiple levels (Wahl, 2012; Delaney, 2012; Hinshaw, 2005).

Specific to the role of caregivers, efforts from different stakeholders are needed to help educate caregivers about mental health and to challenge the stigma and

stereotypes that may have been passed down from previous generations or internalized from inaccurate sources. One potential avenue is for school districts to have partnership with local mental health practitioners in the community. Caregivers can greatly benefit from seminars and Q&A sessions led by mental health professionals where they can acquire information about mental health in terms of symptom recognition and treatment options. These seminars and Q&A sessions may closely resemble psycho-educational interventions. These types of interventions help patients and family members gain knowledge about mental health concerns and provide supportive and cognitive behavior therapy to help with adjustment to mental health symptoms, and facilitate problem solving skills (Hazel et al., 2004; Navidian, Kermansaravi, & Rigi, 2012). Existing research supports the efficacy of psycho-educational interventions as they help reduce caregiver burden (Luciano et al., 2012). Furthermore, the need for this kind of partnership may be greater in communities that have reduced access to services. In addition, research has shown that families with ethnic/racial minority status may be less willing to seek help from mental health professionals (Bussing et., 2005; McKay & Bannon, 2004), highlighting the need for dissemination of accurate information regarding mental health. As such, the barrier of stigma accentuates that on-going efforts are needed to dismantle the destructive influences of stigma. While there is potential for progress when mental health professionals and organizations take a proactive approach to helping caregivers gain a more accurate understanding of mental health concerns, such efforts need to be reciprocated by school administrators by allocating adequate time and resources to allow such partnership to develop. With their existing connection with caregivers, the school systems have access to a potential audience for psychoeducational

interventions and therefore, can play a pivotal role in addressing mental health stigma by serving as a bridge between caregivers and mental health providers.

Implications for Research

The participant sample in this study does not represent diversity in terms of cultural identities. Therefore, a follow-up study that is cross-cultural may glean light on how caregivers from different cultural backgrounds perceive changes in the caregiver-child relationship due to child's mental health treatment. In this study, a primary concern among caregivers regarding their child's ADHD symptoms was related to impaired academic functioning. In a mixed-methods study, Bussing et al. (2005) demonstrated that how caregivers perceive and respond to a child's ADHD symptoms may vary depending on the caregiver's race and child's gender. Such findings speak to how caregivers from different cultural groups may vary in terms of what they find most concerning about their child's ADHD symptoms. If those cultural variables are taken into consideration, we can also anticipate that caregivers' perception of changes in the caregiver-child relationship may also vary depending on cultural background. The findings from those future studies can guide culturally sensitive interventions for family members and more importantly, give voice to the caregiver participants so that their caregiving experiences can be validated.

Although it may not have been explicitly reflected in the themes, participants' interaction with their partner/spouse appeared to be a significant factor within the process of navigating the help-seeking process and responding to the child's symptoms at home. Given that all participants were married and living with their spouse, a follow-up study that compares the experiences of single parents with married parents will be

beneficial. The general caregiving experiences of single parents have been under investigated (Brown et al., 2008) although the risk of parental stress is higher for single parents compared to married parents (Mullins et al., 2011). Therefore, a qualitative study that compares the experiences of single parents and married parents may reveal the unique perspectives of single parents regarding perceived changes in the caregiver-child relationship due to the child's mental health treatment.

This qualitative investigation was conducted to more deeply understand the lived experience of caregivers. From the perspective of participant caregivers, the study emphasized changes in the caregiver-child relationship subsequent to the child's mental health treatment. Grounded in a constructivism-interpretive paradigm based on a phenomenological epistemology, individual interview data were collected and analyzed utilizing reflexive thematic analysis. This analysis generated four key thematic findings discussed in relation to previous research. Through the valued perspectives of caregiver participants, it is hoped that the study's clinical practice and empirical research implications might offer a meaningful contribution to an area of inquiry previously understudied.

Limitations

The researcher acknowledges several limitations to this study. The first limitation relates to the participant sample. In this study, all of the participants identified their socio-economic status to be above lower middle class. One observation the researcher made throughout the data collection process was the caregiver participants' emphasis on their child's school performance. It was interesting to note that for majority of the participants, their initial response to the question, "How would you describe your

relationship with your child?" was closely related to the child's functioning at school. Based on these observations, it would be interesting to see how much emphasis caregivers from different socio-economic statuses place on the child's academic functioning when asked about the caregiver-child relationship.

The second limitation relates to the co-morbid diagnosis for three of the six participants' children. Even though caregivers reported ADHD symptoms to be their child's main presenting concerns, the complexities in symptom presentation when there is more than one mental health diagnosis may have been one of the factors that led to some of the different caregiving experiences. This might explain why some of the caregivers' children were less responsive to the medication treatment and furthermore, caregivers being less cognizant of change in the caregiver-child relationship. Therefore, a future study that screens out co-morbid diagnosis of participants' children may glean findings that represent more of the common experiences for caregivers of children diagnosed with a single mental health condition.

Lastly, within this study's sample, there was considerable variance in the "time since diagnosis" and "length of treatment" among the caregivers' children. The researcher observed that some participants were not able to recall as much detail regarding changes in caregiver-child interaction due to treatment. A follow-up study that is more stringent in terms of "when a child received diagnosis" and "duration of treatment" will lead to a more homogenous sample and will likely lead to more dense findings as participants may be able to recall past experiences with less difficulty.

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APPENDIX A

Figure 1. Theoretical Framework

PHILISOPHICAL PARDIGM	***Ontological Assumptions***	***Epistemological Stance***	***Theoretical Perspective***	***Methodology***	***Method***
	The study of "being or reality"- the fundamental nature of things	**The study of how people know about reality**	**A world view, a general perspective, a way of framing and breaking down complexity of the real world**	**The way the plan of action is to be approached: construct development and exploration of relationship between them**	**Tools by which data are collected an analyzed**
	What is reality?	How can one know reality	Which approach does one use to know something?	How does one go about finding out?	What techniques/strategies are used to find out?
Constructivist / Interpretive	There is no single reality or truth. Reality is fundamentally shaped/created by individuals as observers.	Therefore, reality needs to be interpreted. It is used to discover the underlying meaning of events and activities	Interpretivism (reality needs to be interpreted) Phenomenology (reality consist of objects and events, "phenomena" as they are perceived or understood in the human consciousness	Phenomenological research methodology The direct investigation and description of phenomena as consciously experienced, without regard to a priori theoretically-based causal explanation and as free as possible from unexamined preconceptions or presupposition	Reflexive Thematic Analysis A reflexive process designed to illuminate meaning.

Note. Figure adapted from Crotty (1998), Foundations of social research: Meaning and Perspective in the Research Process. p.256.

APPENDIX B

Demographics Questionnaire

Instructions: Please provide your self-identification in regard to the below identities and statuses.

What is your racial identity? _____

What is your ethnic identity? _____

What is your age? _____

Are you working? If yes, full-time or part-time? _____

What is your religious and/or spiritual affiliation? _____

What is your ability or disability status(es)? _____

What is your highest educational degree? _____

What is your socioeconomic status? _____

Please provide a pseudonym for us to use in place of your name: _____



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APPENDIX C

RECRUITMENT FLYER

WANTED: Research Participants

- Has your child received or is receiving ADHD treatment?
- Do you want to talk about your experience?

You are invited to participate in this research project if you are:

(a) the current parent or primary caregiver of a child or youth ages 7-17 who has received or is receiving ADHD treatment in the form of counseling or psychiatric medication;

(b) have resided with the child before, during and after the child has received or is receiving mental health treatment;

If you agree to participate, you will be asked to:

- Take part in an initial individual, audio recorded interview of up to 60-90 minutes
- Take part in an individual, audio recorded follow-up interview of up to 20 minutes

You will receive compensation for your participation in the form of a $25 Amazon giftcard.

If you are interested in this study, or have questions, please contact Hyung Seo at hyungseo@ou.edu or (267)-231-0971. This study is being supervised by faculty sponsor, Dr. Paula McWhirter (paulamcwhirter@ou.edu).

By requesting more information about this study, you are not obligated to participate in this or any study.

APPENDIX D

IRB APPROVAL LETTER

The UNIVERSITY of OKLAHOMA

Institutional Review Board for the Protection of Human Subjects

Approval of Initial Submission – Exempt from IRB Review – AP01

Date: November 04, 2019 **IRB#:** 11358

Principal Investigator: **Approval Date:** 11/04/2019
Hyung S Seo

Exempt Category: 2

Study Title: Perceived Change in the Caregiver-Child Relationship Due to Mental Health Treatment

On behalf of the Institutional Review Board (IRB), I have reviewed the above-referenced research study and determined that it meets the criteria for exemption from IRB review. To view the documents approved for this submission, open this study from the *My Studies* option, go to *Submission History*, go to *Completed Submissions* tab and then click the *Details* icon.

As principal investigator of this research study, you are responsible to:

- Conduct the research study in a manner consistent with the requirements of the IRB and federal regulations 45 CFR 46.
- Request approval from the IRB prior to implementing any/all modifications as changes could affect the exempt status determination.
- Maintain accurate and complete study records for evaluation by the HRPP Quality Improvement Program and, if applicable, inspection by regulatory agencies and/or the study sponsor.
- Notify the IRB at the completion of the project.

If you have questions about this notification or using iRIS, contact the IRB @ 405-325-8110 or irb@ou.edu.

Cordially,

Fred Beard, Ph.D.
Vice Chair, Institutional Review Board

APPENDIX E

SCREENING FORM

Screening Document

"Thank you for agreeing to participate in this research project. Your participation will be valuable in understanding the perceived changes in the parent-child relationship due to the received mental health treatment by the child. This screening process is to ensure that you fit within the criteria for our sample of interest for this study.

Clarify the following questions:

1. Are you the parent or primary caregiver of a child or youth who is currently between the ages of 7-17 years?
- If yes, move on to question 2.
- If no, stop the screening protocol, thank the participant for their time, and dismiss them from the study.

2. Are you above the age of 18?
- If yes, move on to question 3.
- If no, stop the screening protocol, thank the participant for their time, and dismiss them from the study.

3. Has your child received mental health treatment for ADHD in the form of counseling or psychiatric medication?
- If yes, move on to question 4.
- If no, stop the screening protocol, thank the participant for their time, and dismiss them from the study.

4. Did you reside with the child before, during and after your child received mental health treatment?
- If yes, move on to question 5.
- If no, stop the screening protocol, thank the participant for their time, and dismiss them from the study.

5. Have you ever received mental health treatment in the form of counseling or psychiatric medication?
- If yes, stop the screening protocol, thank the participant for their time, and dismiss them from the study.
- If no, move on to next step.

** Determine if the participant has met the inclusion and exclusion criteria.
If YES: Read the Consent Script
If NO: Inform the participant that they do not meet the inclusion and exclusion criteria



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APPENDIX F

CONSENT FORM (PAGE 1)

Signed Consent to Participate in Research

Would you like to be involved in research?
I am Hyung Seo, a doctoral candidate in University of Oklahoma's Counseling Psychology program and I invite you to participate in my research project entitled Perceived Changes in the Parent-Child Relationship due to Child's Mental Health Treatment. This research is being conducted through the University of Oklahoma. You were selected as a possible participant because you are the parent/caregiver of a child who has received mental health treatment in the form of counseling or psychiatric medication for ADHD. You must be at least 18 years of age to participate in this study.

Please read this document and contact me to ask any questions that you may have BEFORE agreeing to take part in my research.

What is the purpose of this research? The purpose of this research is to examine how parents perceive their relationship with their child to have changed as a result of mental health treatment for their child.

How many participants will be in this research? Up to 20 people will take part in this research.

What will I be asked to do? If you agree to be in this research, you will be asked to participate in the following:

- Initial individual interviews: You will be asked to participate in one initial individual interview (held either in person at a location agreed by the researcher and participants, or by phone). The purpose of the initial individual interview is to gather initial data regarding the participants' perceived change in their relationship with their child as a result of the child's mental health treatment. The initial individual interview will be digitally audio recorded for transcription.

- Follow-up individual interviews: You will be asked to participate in one follow-up/ clarification individual interview (held either in person at a location chosen by the participants or by phone). The purpose of the follow-up interviews is to clarify or deepen the information gleaned from the initial interviews. Follow-up interviews will be digitally audio recorded for transcription.

How long will this take?
Your participation will take up to 60 - 90 minutes for the initial Interview.
Your participation will take up to 20 minutes for the follow-up interview.

What are the risks and/or benefits if I participate?
The risks are similar to those you experience when discussing personal information with others. It is possible that the interviews may remind cause emotional or psychological distress

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APPENDIX F

CONSENT FORM (PAGE 2)

particularly if the mental health treatment for your child has not led to positive results. Distress may include feeling upset or discomfort, such as tearfulness, sadness or depression. The researcher will not serve as a counselor or therapist. However, the researcher will provide you with resources appropriate to your level of distress. If you become distressed to the point in which you decide and/or the researcher agree that further participation would not be in your best interest, your engagement in the study would be discontinued, your consent to previous participation would be revisited, and if your consent is withdrawn, all of your collected information would be redacted from the study.

Indications that you may be feeling too distressed to participate may include, but are not limited to: uncontrollable tearfulness or feeling such physical or psychological discomfort that you do not wish to participate any longer. The researcher cannot promise any direct benefit for taking part in this study. However, you may experience the benefit of having an opportunity to talk openly about perceived changes in your relationship with your child as a result of his/her mental health treatment.

What do I do if I am injured? If you are injured during your participation, report this to a researcher immediately. Emergency medical treatment is available. However, you or your insurance company will be expected to pay the usual charge from this treatment. The University of Oklahoma Norman Campus has set aside no funds to compensate you in the event of injury.

Will I be compensated for participating? You will be reimbursed for your time and participation in the form of a $25 Amazon gift card.

Who will see my information? In research reports, there will be no information that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers and the OU Institutional Review Board will have access to the records. Audio transcripts may be shared with OU Printing Services who will transcribe them. If you choose to transmit any study information over email, please note that email is not a secure form of communication.
You have the right to access the research data that has been collected about you as a part of this research. However, you may not have access to this information until the entire research has completely finished and you consent to this temporary restriction.
Finally, state law requires reporting information about suspected or known sexual, physical or other abuse of a child (if applicable, or older person), or a subject's threats of violence to self or others. If any member of the research team is given such information, he or she will make a report to the appropriate authorities.

Do I have to participate? No. If you do not participate, you will not be penalized or lose benefits or services unrelated to the research. If you decide to participate, you don't have to answer any question and can stop participating at any time.



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APPENDIX F

CONSENT FORM (PAGE 3)

Will my identity be anonymous or confidential? Your name will not be retained or linked with your responses unless you specifically agree to be identified. The data you provide will be retained in confidential form. Please check all of the options that you agree to:

I agree to being quoted directly. ___ Yes ___ No
I agree to have my name reported with quoted material. ___Yes ___ No
I agree for the researcher to use my data in future studies. ___Yes ___ No

What will happen to my data in the future?
After removing all identifiers, we might share your data with other researchers or use it in future research without obtaining additional consent from you.

Audio Recording of Research Activities To assist with accurate recording of your responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. However, if you do not agree to audio-recording, you cannot participate in this research. Audio files will be retained indefinitely to ensure accuracy of data.
I consent to audio recording. ___Yes ___ No

Who do I contact with questions, concerns or complaints? If you have questions, concerns or complaints about the research or have experienced a research-related injury, contact me at 267-231-0971 or hyungseo@ou.edu. You may also contact the faculty sponsor, Dr. Paula McWhirter (paulamcwhirter@ou.edu) or the University of Oklahoma- Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

You will be given a copy of this document for your records. By providing information to the researcher(s), I am agreeing to participate in this research.

Participant Signature	Print Name	Date
Signature of Researcher Obtaining Signature	Print Name	Date

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APPENDIX G

INTERVIEW GUIDE QUESTIONS

Possible interview guide questions

(follow-up questions will be adaptable and flexible per nature of qualitative interviews)

- In what ways do you think the child's symptoms impact the caregiver-child relationship?
- What was most difficult about responding to the child's symptoms?
- How was the decision-making process in terms of seeking treatment?
- How would you describe the caregiver-child relationship before child began receiving treatment?
- How would you describe the current caregiver-child relationship?
- If there is any observed change within the caregiver-child relationship, what do you attribute those changes to?

Possible topics that may emerge during the interview

- Caregiver's expectations toward treatment
- Caregiver's level of hope toward future
- Impact of child's symptoms on caregiver's daily functioning
- Changes in the child's functioning with treatment
- Any significant events through the course of child's treatment

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