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The Lived Experiences of Caregivers of Children with Reactive Attachment Disorder

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This is to certify that the doctoral dissertation by

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Walden University
2020

Abstract

The Lived Experiences of Caregivers of Children with Reactive Attachment Disorder

by

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MS, Capella University, 2013

BS, Park University, 2009

Doctoral Study Submitted in Partial Fulfillment

Of the Requirements for the Degree of

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Abstract

Parents of children with Reactive Attachment Disorder (RAD) encounter challenges in parenting and parent-child relationship development that are not typical to most parental situations. The purpose of the qualitative study was to explore the lived experiences of caregivers of children with RAD, to identify current met and unmet needs, to explore the experiences the caregivers of children with RAD have and the resources available to them. The study included a hermeneutic phenomenological foundation and incorporated the conceptual frameworks of family systems theory and attachment theory. A nonprobability, self-selection sampling strategy was utilized with recruitment through Facebook support groups. Methods included the use of an eligibility survey, semistructured interviews, debriefing form, and in vivo hand coding to analyze data. Themes that impact caregiving of children with RAD were identified as growth, family relationships, experiencing negative feelings, and experiences with supports. The researcher identified subthemes of personal caregiver growth and experiencing growth in the child. In family relationships theme, primary caregiver and sibling relationships were strained while other family relationships are mixed. Caregivers experienced a wide variety of negative emotions. Participants described mixed experiences with resources and reported a need for services. Results will be disseminated to educate health care professionals on the needs and resources most important to caregivers of children with RAD in order to increase support and positive outcomes.

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Dedication

This research study is dedicated to the selfless caregivers and parents raising children with RAD. I see you. I hear you. I am with you.

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Chapter 1: Introduction to the Study

Introduction

This hybrid hermeneutic phenomenological study explored the lived experiences of caregivers of children with Reactive attachment disorder (RAD). Briefly, RAD is described as a diagnosis that identifies a set of symptoms in children resulting from unhealthy or lack of healthy attachment with caregivers or parents, most commonly identified in foster and adopted children (American Psychological Association [APA], 2013). Each year approximately 135,000 children are adopted (Evan B. Donaldson Adoption Institute, 2013). While some adoptions are stepparents, about 59% are adoptions from the foster care system, 26% from other countries, and 15% are voluntary relinquishments of American babies. In a Korean study, Hong et. Al. (2018) estimated that 5.25 children per 100,000 in Korea are diagnosed with RAD. The researchers also determined through data analysis that in more deprived areas, the prevalence of RAD was as much as almost 2% of the population. The DSM-5 (APA, 2013) estimated that in high risk populations, the prevalence may be as high as 10%. With statistics ranging from 2-10% in high risk areas, exploring the experiences of the caregivers of this population is critical to supporting and minimizing the impact of this disorder on the individual with RAD, the family, and the community in which they live in. The exploration of the lived experiences assisted in identifying the current and needed supports for this unique population. The key components of the study are explored to include purpose, problem statement, research questions, framework, and significance. Additionally, the limitations, scope, delimitations, and assumptions will be discussed.

Background

Reactive attachment disorder (RAD) is a diagnosis first identified in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (APA 1980). It is believed that RAD stems from inadequate caregiving in infancy and early childhood (Volkmar, 1997) and an estimated 10% of children who experience adverse attachment develop RAD (Doyle & Cicchetti, 2017). There are two identified clinical patterns: emotionally withdrawn inhibited type and indiscriminately social/disinhibited type (DSM-V, 2013). Researchers have repeatedly supported that RAD is identified in children who are or have been maltreated, institutionalized, or raised in conditions of extreme adversity (Volkmar, 1997). The APA (2013) described RAD as closely matching internalizing disorders where children present with a dampened positive affect. The DSM-V (APA, 2013) reported that children with RAD present with a lack of formation of preferred attachments to caregiving adults. Preferred attachments are defined as the healthy deep connections formed between parent or caregiver and child (APA, 2013).

In diagnosing RAD, clinicians must ensure that a developmental delay is not the sole contributor of symptoms and that criteria for a pervasive developmental disorder is not met (APA, 2013). The child must exhibit disturbances and developmentally inappropriate social relatedness in most settings prior to the age of 5 (APA, 2013). The disturbances may be evident through failure to initiate or developmentally appropriate responses to social interactions represented by hypervigilance, inhabitance, or contradictory responses. Alternatively, disturbances may present through inappropriate selective attachments, such as excessive familiarity with strangers. APA (2013) requires disturbances to be caused by at least one of the following: (a) persistent disregard by parents or caregivers pertaining to basic emotional needs for comfort, stimulation, and affection, (b) persistent neglect of child's physical needs, and (c) repeated changes of primary caregiver that directly prevents the formation of stable attachments.

The causes occurring within the first five years of life have a direct effect on the relational development of children. Erikson's (1950) stages of psychosocial development identify several critical stages that have an impact on a child's healthy development. The first year of life is described as a trust versus mistrust stage which can either instill faith in the environment and those around them or suspicion and fear (Erikson, 1950). This stage is summarized with the basic virtue of hope, hope for the future. The stage of autonomy versus doubt typically occurs in the second year of life and has an impact on a child's sense of control and security within the environment with unhealthy outcomes leading to feelings of shame and self-doubt. Autonomy and doubt relate to a child's ability to pursue desires and exercise determination. Years three through five are identified with the initiative versus guilt stage. Healthy development builds confidence in self-starting activities with a sense of purpose in life and tasks while unhealthy development creates guilt and a sense of inadequacy in being able to be independent. The healthy development of psychosocial stages is largely dependent on the parent and caregiver interactions during the first five years, particularly as related to hope, will, and purpose (Erikson, 1950).

There was little attention or investigation conducted related on RAD over the 20 years following its introduction in the DSM-III. Volkmar (1997) suggested that RAD remained in the DSM through revisions with little empirical support due to the idea that RAD encompassed a unique set of symptoms that were not otherwise explained by other disorders. Boris et al. (1998) conducted the first research study that directly addressed the validity of the criteria for RAD.

Due to the limited literature and popularity about RAD, parents and caregivers of children with special needs are left navigating and learning as they go (Raina et al., 2005). Caregivers of children with special needs are faced with unique parenting experiences (Raina et al., 2005). Decisions about types of treatment and treatment options, the burden of data collecting to justify trying treatments, and commonly relying on external perceptions versus verbal communication are some of the challenges experienced (Kientz et al., 2007). Parents and caregivers of children with special needs often struggle to find balance between meeting children's increased needs for support with the basic needs of daily living (Keenan, Newman, Gray, & Rinehart, 2016; Raina et al., 2005). Leonard, Johnson, and Brust (1993) surveyed caregivers of children with special needs to assess the differences between caregivers managing "OK" and those who reported they needed more help or could not manage for much longer. The caregivers who reported they needed more help were found to have children with more severe impairments, behaviors, and to be functionally dependent. Caregivers were found to be in poorer physical and mental health, have greater time and financial demands, and received less emotional support from those around them. Caregivers who needed more help or who could not manage much longer also reported that special programs offered some assistance but not enough to meet his/her needs.

There are many studies identifying challenges for caregivers of children with mental health disorders. Individuals with schizophrenia are likely to experience an increased emotional attachment with caregivers that can fluctuate with age, but sustains a level of basic attachment, with the emotional attachment having the possibility of being intense in all relationships (Bowen, 1993). The population of individuals with schizophrenia learns to self-manage to basic and casual relationship styles to maintain friend and professional relationships. Additionally, this population tends to operate as an appendage of the family mass needing support and a level of dependence. This situation differs greatly from the distant relationships between caregivers and children with RAD.

Zeanah and Smyke (2008) concluded that high numbers of young children in institutions and foster care settings meet the criteria for RAD. They identified that the beginnings of relational bonding may be present between a few days to several weeks inside of a family environment, however the child will continue to demonstrate significant levels of in discriminant behaviors that signify attachment and relational issues (Zeanah & Smyke, 2008). A challenge found in parenting children with RAD is that closeness and contact does not equate to comfort and security as in typical parent-child attachment (Bretherton, 1992). Rather, child fear is the predominant emotion that typifies the parent-child attachment (Erikson, 1950; Orlans & Levy, 2014). The struggle for parents to connect and form healthy relationships with children with RAD is exhausting as there is often no balance of nurture and corrective guidance that is received without significant adverse behaviors on the part of the child. A study of adopted mothers of children with RAD, reported that parenting was continuously stressful (Wimmer, Vonk, & Reeves, 2010). A qualitative study of 15 parents of children with RAD identified parental challenges as struggles in developing healthy interpersonal and social relationships, strain in the child giving and receiving love, child's lack of empathy, child's chronic lying, and child's stealing (Gallardo, 2016).

Researchers have identified numerous challenges and stresses associated with parenting and caregiving special populations. Children's behaviors are challenging and sometimes unpredictable. While researchers have identified the main stresses and needs for caregivers of many populations of children with special needs, there is a gap in the research when it comes to identifying the lived experiences and needs of caregivers of children with RAD in the United States. It is this gap that leads me to pursue this research study.

Problem Statement

Reactive attachment disorder (RAD) is a condition that affects the relationships, social experiences, and health of those diagnosed (Hanson, & Spratt, 2000). Children diagnosed with RAD experience emotional inhabitants or social disinhibitants that present in challenging behaviors. These behaviors could include being withdrawn, hyper-vigilant, giving contradictory responses, over-friendliness, aggression, dysfunction with peers, and drawn-out attachments (Zeanah & Gleason, 2010; Follan, & McNamara, 2014). Parents of children with RAD encounter challenges in parenting and parent-child relationship development that are not typical to most parental situations (Follan, & McNamara, 2014). For instance, while parenting of most children include hugs, "I love you," cooperative play, cuddling, and mommy and me classes, parents of RAD children experience child detachment, a lack of desire or interest in affection, "I hate you," being asked to leave groups or being too embarrassed to go to mommy and me classes, and a constant struggle to find the technique that "works." Caregivers of children with severe behaviors are found to have poorer physical and mental health, increased time and financial demands, and have diminished emotional support systems (Leonard et al., 1993). Caregivers of children with severe behaviors and increased dependence on others for care reported that current support programs did not offer an adequate amount of support to meet his/her needs (Leonard et al., 1993).

While there are supports and resources such as support groups and support programs, available for parents of children with special needs the experiences of parents of RAD children are uniquely different and available resources may be inadequate to meet the needs of parents whose children are diagnosed with RAD (Keenan, Dillenburger, Doherty, Byrne, & Gallagher, 2010; Palisano et al., 2010). Additionally, there are not resources available in all locales and regions nationwide (Association for Training on Trauma and Attachment in Children, 2015). Identifying themes in parental experiences through semistructured interviews will provide knowledge and direction in designing resources and supports for parents of children with RAD that address the needs and concerns the parents are directly reporting. Mental and medical health professionals, parental support organizations, and other support providers with a desire to meet the support needs of parents of children with RAD can use this knowledge through implementing suggested outcomes.

Purpose

The purpose of this qualitative study was to explore the lived experiences of caregivers of children with RAD, to identify current met and unmet needs, and the experiences the caregivers of children with RAD have with the resources available to them. Caregivers of children with severe behavioral and emotional diagnoses, such as RAD, experience elevated stress levels in parenting, support systems, and finances and report the support programs available are insufficient (Leonard et al., 1993; Smyke, 2015; Spratt, Saylor, & Macias, 2007). The research is a hybrid hermeneutic phenomenological study as it is the most effective method to study the subjectivity of participants with a shared condition (Willis, 2007). The method was selected as the most effective in studying the lived experiences of caregivers of children with RAD and identifying themes of behavior and need through those experiences. The hermeneutic approach allowed for the discovery through revealment and the understanding of the process of a phenomenon. The incorporated family systems and attachment theories provided other lenses to respect the family relationships and attachment challenges associated with this topic and population. The research question was: What are the lived experiences of caregivers of children with Reactive attachment disorder?

Research Questions

Within this research study, I intended to answer the following research question: What are the lived experiences of caregivers of children with reactive attachment disorder? This study has the following subquestions:

- What needs do caregivers of children with reactive attachment disorder experience as met?

- What needs do caregivers of children with reactive attachment disorder experience as unmet?
- How do caregivers of children with reactive attachment disorder experience the resources available to them?

Framework

The Hermeneutic philosophical framework of phenomenological research focuses on being as a state of living and the center of existence (Wilding & Whiteford, 2005). Heidegger (1962) believed that people must examine his/her actions to discover his/her intentions. The Heideggerian phenomenological method allowed for discovery through revealment versus forced activity (Wrathall, 2005). The focus was on the future, with the understanding that the past influenced the present and both will influence how an individual responded to his/her future. Heidegger directed the study of phenomenon to go further than identification. Heidegger suggested that the researcher create an experience through interpretation and critical assessment that goes further than a clear initial meaning. Heidegger believed that experiences and data cannot simply be looked at and bracketed; they must be interpreted and are influenced by the researcher's *Dasein*. The Hermeneutic Circle is a process of understanding and discovery (Heidegger, 1962). The Hermeneutic Circle is based on the circular thinking that it takes an individual to grasp the spirit of the whole group and through the whole group one can learn about the individual (Ast, 1808; Scheiermacher, 1999). Heidegger believed that each individual person has a *Dasein*, the fundamental character of being in the world and being involved and committed to individuals and things. Experiencing outside stimuli has an impact on the individual *Dasein* which alters the understanding of the external stimuli as well, creating a circle of discovery and understanding. By experiencing and learning about other *Daseins*, our own *Dasein* will change. The *Dasein* itself is an issue to interpret and gain understanding in. Each individual person and his/her experiences affect the understanding and interpretation of other experiences and populations. Simply, everyone has biases and beliefs prior to experiencing something. The experiencing and learning about another *Dasein* changes the biases and beliefs of the individual's *Dasein*, which creates a circular pattern of understanding that hypothetically never ends. Hermeneutics is an evolving method based on the lived-in and lived-through moments of participants and the ability to reconstruct the experiences as stories through the view of the researcher (Crowther, Ironside, Spence, & Smythe, 2017).

Using a hermeneutic phenomenological method provided the opportunity to explore the connection the caregivers of children with RAD have with the world and in the world. Participants described his/her lived experiences to explore and expose the thoughts and beliefs that drive behaviors through storytelling (Crowther et al., 2017). The past was explored to understand the future of the population. Without understanding the experiences of the caregivers, there is insufficient information to describe the phenomenon and rejuvenate adequate services.

Conceptual Framework

Within this research, I looked through the conceptual lens of Family Systems and Attachment theories. Including both as considerations in this study allowed for participants to share their experiences and the data to support their experiences through empirically based theory. In this study I asked participants to share their experiences as a caregiver of a child with RAD and describe the needs they have as they relate to caregiving. I will provide a brief description of the connections of each to this study, while a more in-depth summary will be provided in Chapter 2.

Family systems theory incorporates the ideas that the interpersonal relationships within a family unit are impacted by each family members' thoughts, behaviors, and beliefs (Bowen, 1993). This belief relates to the study as it is suggested then that the healthy relationship between a caregiver and a child will impact other children. Additionally, the unhealthy attachment between a child with RAD and the caregiver will impact the other individuals in the house. The complex dynamics of interpersonal relationships within the family system consisting of a child with RAD needs attention and support. In order to accurately address those needs, the needs and experiences must be identified by the caregivers themselves.

Any research study incorporating RAD would be incomplete without the inclusion and lens of attachment theory. Bowlby (1951) identified parenting as an adventure that requires support. Unhealthy parent-child bonds effect the attachment and dependence of children onto the caregiver. Ainsworth et al. (1978) identified mother-child interaction characteristics that impact bonds and development. Overall, Bowlby and Ainsworth et al. explained that unhealthy parent-child bonding results in children searching for safety and security. This seeking for safety and security presents as anxiety, stress, and trauma responses that impact the need for supports both for the children and the caregivers that are raising them.

Nature of Study: Qualitative

The research is a hybrid hermeneutic phenomenological qualitative study with emphasis on attachment and family systems theories as I sought to identify the subjective reality of the studied population. Semistructured interviews were conducted with caregivers of children with RAD over videoconference. A list of predetermined questions was utilized as a guide in the interviews. I asked clarifying open-ended questions to gain insight of lived experiences by the caregivers. Interviews were audio recorded for transcription. All interviews and follow-up interviews were transcribed into Microsoft Word documents and hand coded for themes and analysis. I utilized manual coding with an in vivo technique for my method of analysis to develop theory to the phenomenon of lived experiences for caregivers of children with RAD. In vivo coding is a process of assigning words or short phrases to describe the spoken word of participants (Given, 2008; Saldaña, 2015). I read each transcript entirely and took out unnecessary language. Next I generated initial meaning units by assigning common words or short phrases to sections of the transcripts. I created themes by identifying repeated common words or phrases created in the previous step. I continued to review the transcripts and code to formulate meaning through the themes within. Once I was satisfied that the experiences of the caregivers have been identified in the themes, I generated a summary of the experiences by describing the themes identified and how the experiences correlated with the research question and sub-questions.

Definitions

In all research, it is critical to identify and define key terms to ensure accurate understanding by readers. Additionally, the definitions and terms allow for comparison within research and applying the conclusions. This section will lay out key terms associated with this study and provide the working definitions used throughout literature that will be implemented within this study.

Caregiver: Conceptually defined as a person who provides direct care for another individual (Caregiver, n.d.). Caregiver will be operationally defined as individuals over the age of 18 years that provide primary care for an individual under the age of 18 years.

Child: Can be defined multiple ways, including a person recently born, an individual between infant and youth age, and the son or daughter of a person (Child, n.d.). Child will be operationally defined as an individual between birth and 17 years old.

Reactive attachment disorder: Operationally and conceptually defined as a condition causes difficulty forming lasting relationships, lack of ability to be genuinely affectionate with others, underdeveloped conscious, lack of trust, and an inability to allow others to be in control of them due to abuse and/or neglect occurring during birth to age three (APA, 2013; Thomas, 2017).

Assumptions

Researchers make presumptions when conducting research to create conditions that will yield valid results (Padgett, 2016). The statements made, or assumptions, are presumed to be true, even just for a short time, in order to create the standards and guidelines for comparison. I will describe several assumptions I made while conducting this study.

One assumption was that participants in this study would be honest when answering questions and describing his/her experiences. It is believed that participants will be honest and share his/her perceptions as they believe to be true to contribute to the data. Another assumption is that some participants will drop out of the study throughout the process. While there will be many safeguards and processes in place to prepare the participants for what will be asked of them within the study, it is assumed that some participants will withdraw from the study prior to completion for various reasons. If participants drop out, more participants may be added to the study to reach saturation. It is assumed that children diagnosed with RAD have been neglected or maltreated during the first three years of life. This assumption coincides with the DSM-IV diagnostic criteria (APA, 2015). For the purposes of this study, I assume that caregivers of children with RAD experience a lack of adequate support and resources that impacts the caregivers' health, wellbeing, and the relationship with the child and family. It is also assumed that I will have beliefs, experiences, and biases that influence the lens in which I view the experiences and information shared from participants. The Hermeneutic approach identifies that each individual possesses a *Dasein* that is unique and will continue to develop as the individual has experiences (Heidegger, 1962).

Scope and Delimitations

This study intended to explore the experiences of caregivers of children with RAD. No other populations are incorporated into the study to explore the experiences and possible similarities and differences in the future between caregivers of children with RAD and caregivers of children with other disorders. Transferability of this study is possible through comparison with caregivers of children with other mental health concerns, and caregivers of children with RAD outside of the Unites States and can be explored through future research. Outside researchers and readers are able to read the conclusions of this study and use his/her judgment to explore transferability to other populations.

Two additional theories were considered for application to the study. Attachment theory (Bretherton, 1992) is most often associated with research including RAD. With attachment theory, it is assumed the typical and atypical attachments between parent or caregiver and child are explored and explained. Additionally, family systems theory (Bowen, 1993) was considered for application within the study for its focus on the relationships within the family unit and the impact members have on the family and each other. Both theories describe phenomena that may be involved within this population of caregivers with children with RAD. Attachment theory and family systems theory are not utilized in the direct framework of this research study; both are discussed within Chapter 2 as influencing caregivers and children with RAD.

A delimitation of the study is that participants will all be caregivers of children with RAD. Specific information will be naturally excluded from this study based on the specific traits of the participant. Participants will be able to read, write, speak, and understand English and have access to a computer for video chat. Additionally, participants will be recruited from Facebook support groups for caregivers of RAD which will exclude individuals who do not belong to the support group

Limitations

Due to the use of the hermeneutic approach to research, there are a few common criticisms that may be viewed as limitations. One commonly perceived limitation is that interviewees may not be honest or truthful in the information that is being shared. The hermeneutic approach is intended to explore an individual's lifeworld, which is primarily his/her perceptions of the world around him/her (Heidegger, 1962). This may include prejudices, beliefs, common sense, and other cognitive mechanisms of identity that are not founded on fact, but experience. The purpose of this study is not to determine fact or truth, but to explore and identify the lifeworld perceptions of caregivers of children with RAD to identify needs and resources that are helpful.

A strong limitation is bias; participant bias, researcher bias, and personal bias. Participants will have preconceived notions about what they believe I desire to hear or what he/she believes is the "right" answer. It is critical for me to maintain a neutral tone with unbiased verbiage and questions. I have previous professional experience working with families with a member diagnosed with RAD and is a caregiver of a child with RAD. Utilizing supervision and consultation to maintain neutral, address personal biases, and appropriately analyze data will be important for the integrity of the study. Utilizing the hermeneutic approach, it is assumed that I bring personal biases, beliefs, and experiences into learning about experiences and phenomena. There are many ways biases can present through my role as the researcher. When conducting the interviews, I will visually watch my facial expressions and posture through the video chat to ensure neutrality. My tone and inflection will also be important to monitor. I will incorporate my foundational counseling skills of active listening to achieve this. Additionally, to reduce bias through questions, a list of open-ended questions will be predetermined and reviewed by my dissertation committee. Any clarifying questions not predetermined will be open-ended. I will also utilize paraphrasing and summarizing skills to ensure I have understood the information correctly. I will enter this research knowing that there is a risk for confirmation bias, when a researcher forms a hypothesis or belief and uses respondents' information to confirm that belief. To combat confirmation bias, I will continually reevaluate my views and impressions of the participants and the study and continually challenge my preexisting assumptions and hypotheses about the lived experiences of caregivers of children with RAD.

Qualitative studies require a lower number of participants to reach saturation (Maxwell, 2013; Willis, 2007). Due to the low participant count, the study will not be able to generalize to the wider population of caregivers of children with RAD across cultures and countries. With a low number of participants there will not be sufficient representation across cultures, such as race, ethnicity, religion, age, socioeconomic class, education of caregivers, caregivers' knowledge of RAD, amount of time since child was diagnosed, and length of caregiving for the child with RAD. The data, results, and conclusions of this study will be able to provide recommendations for further study to expand knowledge and participant data to apply to wider populations.

Significance

Current research and knowledge are minimal in the lived experiences and needs of caregivers for children diagnosed with RAD. The caregivers interact with countless providers ranging from social workers, teachers, pediatricians, medical experts, and counselors while possibly not getting the support they need from professionals. Within this research, I seek to provide the information needed to explore what resources and needs caregivers might find most beneficial. Counselors must be able to meet clients effectively with understanding, resources, and therapeutic tools. Understanding the lived experiences of caregivers of children with RAD is the first step towards adequate support and reducing stress surrounding caregiving of children with RAD. Improving current support services and forming new supports to directly meet caregivers' needs will reduce stress among the caregivers and improve services provided to children with RAD. The stress experienced by caregivers leads to issues and troubles with finances, increased health and medical concerns, reduced or impacted social support system, and decreased positive interactions with the child. Counselor educators and supervisors are best able to support counselors in furthering the understanding, knowledge, and techniques through his/her own understanding and knowledge of the subjective experiences surrounding caregiving children with RAD. The knowledge can be shared through counselor training programs, counselor supervision, and consultation.

There are many psychosocial, physical, emotional, and financial effects because of parenting stress and challenges when caregivers of children with RAD are not properly supported (Murphy, Christian, Caplin, & Young, 2007). The well-being of caregivers has substantial implications on the overall family well-being as well as direct and indirect implications on the child, such as, poor communication, decrease in loving contact, and emotional or physical abuse (Smithgall, Yang, & Weiner, 2013). In comparison to parents of same-aged children without special needs, parents with children of special needs are found to have higher levels of stress and depression (Miodrag, Burke, Tanner-Smith, & Hodapp, 2015). Additionally, the parents of children with special needs in the same study reported higher physical health problems (Miodrag et al., 2015). Overwhelmed and frustrated caregivers may unintentionally decrease quality of care, become medically sick or psychologically affected, or terminate care of the child to resolve “the problem” (Smithgall et al., 2013). In 2007, Murphy et al. concluded that over 41% of caregivers reported a decline in health over the past year, which they attributed to lack of time, lack of control, and decreased psychosocial energy. In current research, Mcbean and Schlosnagle (2016) additionally found that parent caregivers of children with special needs reported overall poor general health including poor sleep quality and decreased memory. The similarity of results within the two studies nearly a decade apart suggests that parent caregivers continue to receive inadequate supports to cope and manage their role as caregiver. Knowledge and understanding of the lived experiences may decrease the frequency of such results that negatively impact the individuals, families, and communities they live in by development of adequate supports, resources, and tools for caregivers.

Summary

This hybrid hermeneutic phenomenological study was used to explore the lived experiences of caregivers of children with RAD through interviews. Through the use of semistructured interviews, l inquired about the met and unmet needs of caregivers of children with RAD. While the approach had limitations, safeguards and considerations were taken to minimize the impact on the data. Identifying and exploring the lived experiences and met and unmet needs assisted mental health providers and counselor supervisors and educators to better prepare to meet the needs and supports identified by the population. The literature on hermeneutics, RAD, and caregiving are discussed in detail in Chapter 2.

Chapter 2: Literature Review

Introduction

Reactive attachment disorder (RAD) is a child-age condition that primarily affects relationships and social interactions (Hanson, & Spratt, 2000; Mikic & Terradas, 2014; Scott, Stinehart, & Barfield, 2012). Caregivers of children with RAD, much like caregivers of children with other medical and psychiatric diagnoses experience progress and challenges. In this study I sought to learn more about the experiences of caregivers of children with RAD, the met and unmet needs the caregivers have, and about the resources available for the caregivers and his/her families. The intended outcome was to identify strengths in the current supports for caregivers of children with RAD and identify any possible unmet needs to improve resources and supports. A review of available literature identified what is currently known about children with RAD, needs of caregivers, resources available for caregivers, and most specifically the needs and supports for caregivers of children with RAD. In my review of the available literature, I have found that some researchers specify populations as parents and some as caregivers. To include all individuals within, my target population of caregivers, I have explored research to include both. The theoretical framework and conceptual frameworks of hermeneutics, family systems theory, and attachment theory are discussed in detail regarding the application to this study.

Literature Search Strategy

Literature was obtained through local libraries and bookstores and the Walden Library. The Walden Library provided database searches of the following databases:

PsychINFO, PsycARTICLES, PsycTHERAPY, SocINDEX with Full Text, Academic Search Complete, ProQuest Central, SAGE Research Methods Online, and Google Scholar. The following search terms and combinations were utilized in each of the listed databases: phenomenological study, Hermeneutic, RAD caregivers, RAD parents, attachment theory, special needs caregiving, mental health caregiving, family systems theory, Heidegger, Reactive attachment disorder, Reactive attachment disorder parents, Reactive attachment disorder caregivers, Reactive attachment disorder family resources, Reactive attachment disorder

Theoretical Foundation

To learn and explore what caregivers of children with RAD have to share about his/her experiences, an interpretive and open foundation is needed. The term "hermeneutics" means the theory of interpretation or achieving understanding of texts and other phenomena as it pertains to philosophy (Forster, n.d.; Wrathall, 2005). Hermeneutics was initially utilized to interpret the fields of religion, law, and philosophy, often found in biblical texts dating back to ancient Greece (Forster, n.d.; Wrathall, 2005). Early contributors to the evolution over hermeneutics included Ernesti (1707-81), Herder, Schleiermacher in the early 19th century (1999; 1998), Nietzsche (1844-1900), Hegel, and Freud (1856-1939) (Forster, n.d.). When it emerged as a philosophical theory of understanding, many theorists contributed including Heidegger (1927), Gadamer (2004), and Husserl (1928). Husserl (1928) explained philosophy as being a description of experience, yielding the phenomenological slogan "to the things themselves."

Hermeneutic

Ernesti focused on the principles of holism, which posits that interpreting the whole of something requires that the parts are also understood (Forster, n.d.). Ernesti's successors, Herder (Gjesdal, 2007) and Schleiermacher (1998), determined that understanding and interpretation comes in degrees and is not an all or nothing. Furthermore, this developed into the practice that it is possible for a person to interpret the parts with adequacy and in turn apply that understanding to appropriately understand the whole. Once a measure of understanding of the whole is achieved, a person can return focus to the parts and refine his/her understanding which will influence his/her measure of understanding of the whole, and so on (Forster, n.d.). Other additions from Ernesti and Herder were the authorial psychology, or the well-being, state, and linguistic usage of the author or interpreter. This concept suggested that a person linguistic usage will affect the interpretation of words, such as the various interpretations of "in" ("The vegetables are in the garden." Versus "The boy is in trouble.").

In the 20th century, Heidegger (1927) transformed hermeneutics from interpretation to existential understanding which Heidegger described as a way of being versus a way of understanding. Heidegger observed that philosophy has attended to all the beings that can be found in the world yet has failed to ask what being itself is. Heidegger believed that presence does not equate to being, but presence is the interpretation of things as equipment or tools according to a specific system of meaning. Heidegger expressed his argument that through history, Western society has identified

Being as obvious and has neglected to examine what being is. Heidegger (1935) later urged that philosophy retrace its steps to rewrite the history of philosophy.

Husserl (1928) believed that all consciousness is intentional; consciousness is intended toward something and about something. Heidegger (1927) furthered this thought into what he termed existential analysis. Heidegger urged that to properly describe experience, the Being that the description of the experience is most important to must be found and included. This is one of my driving forces for my study and population. This study may provide the caregivers of children with RAD to have a voice and reflect upon his/her experiences.

Heidegger (1927) described a process of exploration and understanding as the Hermeneutic Circle. The Hermeneutic Circle is based on the circular thinking. Circular thinking posits that it takes an individual's exploration to grasp the spirit of the whole group and through the whole group one can learn about the individual (Ast, 1808; Scheiermacher, 1999). Heidegger (as cited in Mootz III, 2017) conceptualized the Hermeneutic Circle as an ontological issue:

> The "circle" in understanding belongs to the structure of meaning, and the latter phenomenon is rooted in the existential constitution of *Dasein*—that is, in the understanding which interprets. An entity for which, as Being-in-the-world, its Being is itself an issue, has, ontologically, a circular structure. (p. 316)

Essentially, the belief is that every individual has a *Dasein* that is unique to them. The *Dasein* is based on an individual's beliefs, experiences, and biases. *Dasein* has been described as the condition of possibility for anything, like a philosophical anthropology

(Heidegger, 1927). When an individual examines the external stimuli or experience the individual views it through his/her *Dasein*. The views and perceptions of the external stimuli may be different for everyone that experiences the external stimuli. Yet, every experience and interaction between an individual and the external stimuli adds knowledge and understanding of the external stimuli. In this case, I have a unique *Dasein* that will impact the views, perceptions, and understanding of the lived experiences of caregivers of children with RAD compared to others that would research this topic. Spence (2017) referred to this experience as discovering how to be hermeneutic through contemplative openness, engaging with preunderstandings through presuppositions interviewing, and word selection that broadens the understanding.

Gadamer (2004), a student of Heidegger (1935), later determined that hermeneutics could be successfully applied to all human activities. Gadamer expressed that the truth comes from understanding our own experiences versus understanding being a methodological process that we follow, such as receiving education. The process of understanding is constantly developing and leads to new perspectives. According to Gadamer, prejudices are unavoidable and an element of our understanding that can be challenging to think outside of. Gadamer suggested understanding our prejudices and how prejudices relate to our understanding is part of a person's historical consciousness and the culture that shaped them. This belief system supports the idea of the hermeneutic circle by supporting that prejudices are an individual's preunderstanding that is necessary to being and are the basis to being able to understand history. Gadamer believed that truth and method are at odds with one another and suggested that hermeneutics explores truths that are otherwise inaccessible by scientific methods.

There are several additional contributors to the beliefs of hermeneutics. Derrida (Forster, n.d.) committed to the belief that there are hidden contradictions within philosophical texts that should be revealed through interpretation, which he termed “deconstruction.” More recently, Austin (1911-1960) and Skinner (1941-present) advanced Herder’s philosophy that linguistic interpretations and psychological interpretations must collaborate to effectively interpret information. Simply stated, understanding words being read or told is as important as comprehending the information and its context. Together these two concepts are critical to adequately interpreting and measuring understanding.

Some Hermeneutic studies utilize interviews to obtain information and data from participants. Chang and Horrocks (2006) conducted a hermeneutic phenomenological study to explore the lived experiences of Chinese family caregivers in Malaysia providing care to relatives with severe and persistent mental illness. The researchers identified the need for this study as other studies on the topic were conducted with methodological flaws, and the bulk of the information was not transferable to Oriental cultures as the research was primarily conducted in Western cultures. This study relates to the heart of phenomenological research and is driven by a fascination and desire for meaning and seeing more (van Manen, 2014). Crowther and Smythe (2016) conducted in-depth interviews to explore the interwoven relationships within the maternity population. Vellone, Piras, Talucci, and Cohen (2008) also utilized interviews within the hermeneutic approach to explore the quality of life of caregivers of individuals with Alzheimer's disease. The study was comprised of a hermeneutic phenomenological design with features of descriptive traits of Husserlian and interpretive traits of Gadamerian. All of the researchers conducted interviews to collect data.

Other Hermeneutic studies utilize documentation and literature to discover themes in conjunction with interviews. Nicholl and Begley (2012) challenged that professionals require a deeper understanding of the experiences of mothers caring for children with complex needs. The researchers utilized a hermeneutic phenomenological method and collected data from 11 diaries and 48 interviews from 17 mothers of children with complex needs in Ireland. Results led to the identification of themes of different environments in which mothers deliver care. The diaries provided insight into the immediate and urgent thoughts mothers had during everyday moments, versus what mothers could recall during the interviews. Diaries and interviews are two ways of collecting hermeneutic data, others include letters, autobiographies, life stories, obituaries, life histories, life experiences, oral histories, and personal histories (Aagaard, 2017; Crowther et al., 2017).

The hermeneutic phenomenological method is most widely used for exploring lived experiences of a population (Maxwell, 2018; Willis, 2007). The theory is best applied to the subject of this study to not assume any information to be true about the caregivers of children with RAD. It is possible to utilize quantitative methods in conjunction with comparable studies on similar populations to create a survey; however, the researcher is hypothesizing the appropriate options of answers rather than allowing the population to speak for themselves. The hermeneutic method provides systems to uncover the underlying elements of experiences and goes beyond the taken-for-granted assumptions (Corbin, Strauss, & Strauss, 2014). Using the hermeneutic method allows for the caregivers of children with RAD to describe in his/her own words the experiences he/she has with seeking and utilizing resources, explain the strengths and weaknesses of resources, and share met and unmet needs in detail. Other research methods do not allow for the amount of rich contextual data and personal narrative of the participants. The quality of the data would not be as rich without the ability for participants to explain the rationale behind thoughts, beliefs, and experiences. The research questions align with the theory as they direct toward exploring the lived experiences, are open-ended, and evoke a conversation versus a simple answer.

True to hermeneutic and phenomenological research, transcripts of interviews or reviews of documents are analyzed for what they are telling, his/her meaning, and themes to interpret and enhance the understanding (Sloan & Bowe, 2014). By isolating the phenomenal themes that emerge from the written interpretations, hermeneutic researchers are rewriting and adding to phenomena. The overall goal is to discover possibilities through the lived experiences to create a closer bond between being and acting when it comes to the population of caregivers of children with RAD (van Manen, 2014).

Conceptual Framework

To best support this research I chose to utilize two frameworks: family systems theory and attachment theory. The belief that every member of the family plays a role in each other member's life and that those relationships and roles are impactful applies to this study. The role of the caregiver and the experiences the caregiver has, positive and negative, will impact the other members of the family. Understanding the experiences and needs of the caregivers and putting effort to support them will have a direct impact on the child with RAD. Additionally, RAD cannot be explored without applying attachment theory.

Family Systems Theory

Bowen's family systems theory describes the effect interfamilial relationships have on individuals and the family unit (Bowen, 1993). The relationships can range from over closeness, where family members can accurately identify thoughts and feelings of another family member, to over distance, where there is a significant lack of connection between family members (Bowen, 1993). The family relationships can be intertwined to the effect that one member of the family could become physically ill because of emotional stress in another family member (Bowen, 1993).

The family systems theory is relative to caregivers of children with RAD as RAD produces an intense amount of emotional stress for the sufferer, as well as the other family members (Smithgall et al, 2013; Wimmer, Vonk, & Reeves, 2010). Bowen's (1993) explored the dynamics of family units including a child with schizophrenia and identified various levels of emotional closeness and attachment. RAD interferes with the development of healthy attachment because of the lack of basic needs and affection during critical developmental stages, which is most impactful on caregivers' ability to feel successful in caregiving duties (Wimmer et al., 2010; Zeanah, & Smyke, 2008). Utilizing the concepts of family systems theory will allow for the inclusion of attachment and relationships within the family system and explain why it is important to understand and address the needs of caregivers to best provide for the RAD population. Karakurt and Silver (2014) discussed the impact of utilizing family systems theory in conjunction with attachment theory to treat sexual abuse survivors. The family systems component blends the dyadic interaction and family context to give a full picture versus an isolated factor. The same can be translated to this study of caregivers of children with RAD. Many studies and interventions focus on the individual directly impacted, family systems theory challenges that this isolates the person and ignores the relationships, supports, and external factors influencing the individual and being influenced by the individual. By exploring the lived experiences of caregivers of children with RAD, I seek to gain insight on the relational influences impacting both the caregivers and the children with RAD via the caregivers' personal stories.

Bowen's family systems theory has been applied by researchers in the studies of a variety of family relationships. Sibling subsystems and relationships have been studied through the lens of family systems (Cridland et al., 2016; Ruff, Durtschi, & Day, 2018; Williams, Riggs, & Kaminski, 2016). The theory has guided the application of family interventions, including home-based family preservation (Barth, 2017). Bowen's theory has influenced the understanding and treatment in romantic relationship distress (Priest, 2015; Rodriguez-Gonzalez et al., 2016; Yektatalab, Seddigh Oskouee, & Sodani, 2017). All types of family relationships were studied through the lens of family systems theory. Sussman (2016) and Cain (2016) applied Bowen's theory to pets in the family unit. Nistor, Papp, Martos, and Molnar (2018) explored belonging within the family unit while maintaining a self-identity which applied both Bowen's theory and attachment theory.

Attachment Theory

Bowlby and Ainsworth (as cited in Bretherton, 1992) founded attachment theory. Through research on hospitalized and institutionalized children separated from his/her parents, Bowlby concluded that healthy mental development is dependent on experiences of warm, intimate, and continuous relationships between a young child and a mother figure that provide mutual enjoyment and satisfaction (Bowlby, 1951; Bretherton, 1992). Bowlby urged society to support parents as parents need support to embark on the adventure that is parenting (Bretherton, 1992). Bowlby proposed that parents, particularly mothers, perform the duties of the ego and super-ego for the child as the child gains self-regulation. Unhealthy mother-child, or parent-child, bonds effect the attachment and dependence of children on the caregiver and negatively impact the psychosocial development. Ainsworth et al. (1978) revealed attributes of mother-child interaction patterns that included feeding situation, face-to-face interaction, crying, infant greeting and following, attachment exploration balance, close bodily contact, approach behavior, and affectionate contact. Ultimately, Bowlby and Ainsworth et al. posited that healthy parent-child bonding equates to security and a foundation for growth where a child feels safe to learn and explore new experiences. Unhealthy attachment during early childhood leaves children searching for safety and security and less likely to explore new experiences and opportunities for further growth.

Attachment theory is a well-researched and applied theory in many areas of social sciences. Researchers have applied the attachment theory lens in studies involving relationship conflict, whether parent-child (Gross, Stern, Brett, & Cassidy, 2017; Jones, Cassidy, & Shaver, 2015), couples (Burgess Moser et al., 2016; Feeney & Karantzas, 2017), or business (Wu & Parker, 2017). The use of attachment theory has branched out to the research of trauma and post-trauma reactions (Bannister et al., 2018; Marshall & Frazier, 2018; Hocking, Simons, & Surette, 2016). Finally, the application of attachment theory has impacted the view of effective substance use addiction treatment to include addressing healthy and unhealthy attachment (Fletcher, Nutton, & Brend, 2015; Parolin & Simonelli, 2016).

Current Literature

In this section I provide current literature on topics addressed in this research study. I begin by identifying the history of RAD. I summarize recent literature on caregivers of children with RAD and caregivers of children with special needs. Finally, I identify areas left to be studied to bridge the gap in research, supported by the current literature.

History of Reactive Attachment Disorder

Attachment has been described many ways within various human development stages, each identifying components of attachment that result in healthy or unhealthy human development. Freud’s psychosexual stages of development identify personality differences in children and adults based on infant and child needs being met by the caregiver, often mother. For example, the oral stage describes infants nursing; if those needs are met the child is said to be optimistic and loving while children who are not fed and nursed adequately are pessimistic and full of suspicion (Stevenson, 1996).

Additionally, in the anal stage the child is said to have the capability of excreting bodily functions based on social pressures from caregivers. Freud's stages, particularly those representing early childhood, describe the importance of healthy attachment and parenting to decrease maladaptive behaviors.

Erikson (1950) described the impact of external factors, including parents, on the development of an individual's personality within his psychosocial stages of development. While Freud emphasized the importance of nursing in infancy, Erikson placed importance on the touch and visual contact between the infant and his/her caregiver. When a child is properly cared for and held, the child will be optimistic, confident, secure, and trusting. An absence of trusting connection with the caregiver through touch and visual contact yields a child who will develop a general mistrust of the world and feel unworthy and unsafe. Additionally, Erikson identified a stage of autonomy versus shame in which a child can develop self-esteem and pride when well-cared for. However, shame and low self-esteem can build through an inability to learn skills or the absence of proper care to foster learning.

Mahler (1968) focused on the first three years of childhood and the development within the mother-infant relationship. This research seemingly bridged the gap between Freud and Erikson. Mahler described infancy in multiple stages, versus one as Freud and Erikson had. In the first month the infant is selfish while identifying the mother not as an external source, but intrinsic to the infant. From one to five months of age, the infant views the mother or primary caregiver as the source of needs-satisfaction (Mahler, 1952). Physiological needs begin to mesh with psychological desires and a basis for future relationships and interactions is formed. To develop in a healthy manner in this stage, it is critical that the mother or caregiver can adapt to the infant's changing needs. Mahler (1952) described the development up to age two as separation-individuation in four sub-stages: differentiation/hatching, practicing, and rapprochement. In this stage, the infant becomes more aware of external processes, while relying on a main caregiver for safety and reassurance. While the infant continues to develop, the primary caregiver is looked to for support and shared experiences. Stern (1985) advanced Mahler's work by exploring the interpersonal world of an infant. Stern identified four senses of self that began in infancy and continue to impact individuals into adulthood; the four senses of self are emergent, core, subjective, and verbal. If at any time throughout the sensitive periods of development of senses of self a child is impacted by trauma or abuse, the child is at a higher risk of having significant impacts later in life. In situations where the primary caregiver is absent, constantly changes, or is not adequate there is severe impairment in the development of individuality, relationships, and self-esteem. For example, during the core self-development a child creates generalized representations of caregivers by determining whether the child can depend on the caregiver for basic needs and healthy attachment. Stern believed that disruptions in this stage of self-development could result in significant pathology related to attachment and/or borderline personality disorder. Stern (2009) divulged into the importance of the mother-child relationship for healthy interpersonal skills, sense of self development, and ability to self-manage issues and conflict throughout the lifetime. This research mirrors what is seen in reactive attachment disorder and supports the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders.

Reactive attachment disorder (RAD) is a diagnosis first identified in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III, 1980). Despite diagnostic criteria being revised in the DSM-III-R (APA, 1987) and the DSM-IV (APA, 1994), the disorder was given little attention for nearly 20 years (Zeanah, & Gleason, 2010). It was hypothesized that RAD remained in the DSM-IV merely due to its unique set of symptoms not otherwise covered by other disorders (Volkmar, 1997). The diagnosis includes components of maltreatment and inappropriate social relating prior to the age of 5 (Chaffin et al., 2006). The disorder shares overlapping symptoms with PTSD, oppositional defiant disorder, conduct disorder, and anxiety disorder and is often confused with several neuropsychological disorders such as autism spectrum disorder, childhood schizophrenia, and pervasive development disorder (Chaffin et al., 2006). The similarity of symptomology with other disorders creates a unique challenge in accurately diagnosing RAD, but also in determining if there are multiple diagnoses.

The DSM-5 (APA, 2013) identifies RAD as a stressor-related disorder occurring prior to age 5 caused by a lack of adequate caregiving. Children must be of at least a 9-month-old developmental level. The criteria have been criticized for having a large focus on atypical social behaviors, such as inappropriate speech, irritability, social withdrawal, and hyperactivity or noncompliance (Aman, Singh, & Stewart, 1985) versus focusing more on atypical attachment behaviors, such as non-attachment to primary caregiver and attachment to strangers. With the primary predictors of diagnosis of RAD being a lack of healthy attachment with parents and a history of maltreatment, there is a large population of children diagnosed with RAD that are adopted or in the foster system.

There is evidence in descriptive studies of institutionalized children beginning in the mid- 20th century that detail behaviors similar to those outlined in the DSM-IV criteria (Goldfarb, 1945; Levy, 1947; Provence & Lipton, 1962; Spitz, 1945; Wolkind, 1974). The majority of children raised, or partially raised, in institutional settings with all basic needs adequately met and acceptable caregiver-child ratios exhibited a lack of willing attachment to caregivers due to caregivers being discouraged not to form attachments with the children (Tizard, 1977).

Over 213,000 children were internationally adopted into the United States from 1999 to 2009 (Garvin, Tarullo, Van Ryzin, & Gunnar, 2012). In 2014, the United States saw a record low in over thirty years with 6,441 international adoptions (Rodden, 2018). In recent years, the majority of children adopted into the United States were from China and Ethiopia. Others in included Ukraine, Haiti, and South Korea. Historically, prior to adoption bans and suspensions, American parents adopted largely from Russia (Rodden, 2018). A significant number of children have been adopted from institutions and orphanages in Russia, Romania, and Asia. Children adopted from foreign countries have an increased association with having social delays, fetal alcohol syndrome, aggressive behavior, and relational issues (Gunnar & Van Dulmen, 2007). The children in intercountry adoptions are a part of a high-risk group.

Hillen and Gafson (2015) researched preplacement and placement factors related to mental health conditions including attachment disorders. Identified risk factors included sudden placement moves, multiple placement moves, and child-caregiver alienation, which all relate to a disruption in healthy attachment. Foreign orphanages and child residential facilities are notorious for sudden and rapid placements without explanation to children, movement between multiple placements, and a lack of sufficient caregiver attention due to high child to caregiver ratios.

Caregivers of Children with RAD

Researchers have utilized hermeneutic studies to explore caregivers of children with RAD (Smyke, 2015; Smithgall, Yang, & Weiner, 2013; Zeanah, & Smyke, 2008). Follan and McNamara (2014) conducted a hermeneutic phenomenological study to gain insight on the experiences of adoptive parents caring for children with RAD that help them make sense of his/her life-worlds. The researchers included the use of semistructured interviews with eight adoptive parents of children with RAD; the theme of adoptive parents of children with RAD was found to be that parents felt grossly unprepared for the challenges of parenting this population despite the rigorous assessment and training process to support adopters. Research by Smyke (2015) corroborated that parents feel they were grossly unprepared for the challenges in parenting children with RAD. Participants described feelings of exhaustion, fragility, shock, surprise, sense of unrelenting burden, and unpreparedness for the intensity of challenging behaviors of his/her children with RAD (Follan & McNamara, 2014). Overall, four themes continued through the deduced meanings: being profoundly unprepared being insecure in self, being assailed by unexpected emotions, and being committed (Follan & McNamara, 2014). Feelings of failure and disappointment and confusion related to the unpredictability of his/her children with RAD's inappropriate attachments to others were shared throughout. Caregivers of children with RAD express intense worry, anxiety, and stress surrounding parenting and caregiving his/her children (Fallon & McNamara, 2014). The data provided an obvious fragility in the relationships between the children with RAD and his/her adoptive parents (Fallon & McNamara, 2014).

Parents of children with RAD reported significantly more child behavioral problems than parents of children not diagnosed with RAD (Hall & Geher, 2003). Taft, Ramsay, and Schlein (2015) conducted semistructured individual interviews and discussions at group support meetings provided data to conclude with narrative themes. Two narrative themes emerged from the transcripts: (a) inappropriate and unpredictable behaviors and (b) threatening behaviors. Taft, Ramsay, and Schlein (2015) gave a voice to what caregivers of children with RAD experience in the home with his/her children through stories and narratives. This study provided valuable narratives to give insight to what parents of children with RAD experience and the challenging situations they are faced with.

Adopted mothers of adopted children diagnosed with RAD reported feeling unsupported by mental health professionals, and society in general (Zeanah, Chesher, & Boris, 2016). Parents of children with RAD described being significantly unprepared to parent his/her children, feeling insecure in his/her parenting, being overwhelmed with unexpected emotions, and being "committed" (Follan & McNamara, 2014). Follan and

McNamara (2014) concluded that the parent-child relationship is a committed one prone to chronic destabilization.

Mothers of adopted children with RAD disclosed in interviews and narratives how his/her health has been compromised due to the stresses of raising his/her children with RAD (Zeanah, Chesher, & Boris, 2016). Physical and mental health is directly correlated to stress levels; increased chronic stress levels are linked to diminished physical and mental health (Lovallo, 2015). Caregivers reporting an impact on his/her own health is a critical element to consider when exploring lived experiences and exploring supports and resources. Sleep deprivation, above typical parental or caregiver sleep loss was noted and directly impacts a caregiver's mental and physical health (Wright et al., 2017).

There are recommended treatments and interventions to support caregivers of children with RAD, including a handbook of all recommended interventions (Dozier et al., 2017). Intensive attachment-based interventions have yielded results that increase pro-social and attachment behaviors and decrease violent and self-injurious behaviors (Purvis, McKenzie, Becker Razuri, Cross, & Buckwalter, 2014). Attachment-based family therapy focuses on the instinctive desire for meaningful relationships through a structured path that addresses family conflict (Diamond, Russon, & Levy, 2016). Additionally, providing daily routines and structured activities in both institutions and homes lead to increased pro-social behavior (Soares, Belsky, Oliveira, Silva, Marques, Baptista, & Martins, 2014; Thomas, 2017). Numerous researchers have produced studies that indicate that sensitivity coaching and training to promote warm, responsive interactions increase attachment behavior (Soares et al., 2014; Thomas, 2017; Wright et al., 2017). Recommendations of structure, clear expectations, and warm, sensitive, and caring interactions may seem simple; however, guidance and support for caregivers to provide these responses consistently is warranted (Smyke, 2015; Wright et al., 2017). Video-feedback interventions provide support to encourage positive parenting (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2017). Follan and McNamara (2014) recommended early involvement of mental health professionals with expertise in early neglect and separation of children and biological parent.

Caregivers of Children with Disabilities or Special Needs

Studies that target caregivers of children with special needs or disabilities may include caregivers of children with RAD without specifically identifying the population. When looking at the broad population of caregivers of children with special needs there is more information known or presented. Caregivers of children with special needs experience complex and lifelong challenges including decision making of therapies, services, doctors, and medication regimens (Kientz, Hayes, Westeyn, Starner, & Abowd, 2007). On average, family caregivers provided over 5 hours of care per week to children with special needs (Romley, Shah, Chung, Elliott, Vestal, & Schuster, 2017). Children with more significant needs required upwards of 21 hours per week in direct family-provided care. Caregivers who also coordinated health care outside of the home spent an average of approximately 4 hours a week on those activities. The monetary equivalent of the services and care being provided by the parent caregivers is a minimum of $2100 for unskilled minimum wage support staff and $6400 for skilled support staff per child per year (Kientz et al., 2007).

There is an increasing amount of research in regard to parents of children with ASD. Parents of children with ASD describe increased stress and high anxiety related to attachment with his/her child (Keenan et al., 2016; Burke & Heller, 2016). Teague, Newman, Tonge, and Gray (2018) reported that caregivers of children with ASD described less closeness, more conflict in relationships, and increased attachment behaviors compared to parents of children with other developmental disabilities. Through research aimed at caregivers of children with ASD, Burke and Heller (2016) concluded that greater futures planning, and community involvement led to increased self-efficacy and satisfaction in caregiving. Parents of children with special needs report increased depressive symptomology, in addition to stigma, self-esteem, and social support were contributing factors to increased depressive symptoms (Cantwell, Muldoon, & Gallagher, 2015).

The pressure of making major decisions, possibly frequently, is a heavy burden causing stress financially and psychologically. Leonard, Johnson, and Brust (1993) sent questionnaires to caregivers of children with disabilities to compare the characteristics of caregivers who reported to be “OK” and caregivers who reported to be “not OK,” also described as not being able to manage any longer. The questionnaires allowed caregivers to self-rate on predetermined aspects of life including finances, physical and mental health, emotional support, and effectiveness of available resources by selecting one of the provided responses. Most caregivers who identified as “not OK” reported having children who were severely impaired and functionally dependent. The caregivers reported as “not OK” were identified as having decreased physical and mental health, increased demands placed on his/her time and finances and dwindled emotional support from family and friends. Caregivers who reported as “not OK” also described assistance programs as not providing enough support to meet his/her needs. Parents who self-identified as “not ok” are likely responding to high levels of parental stress. Increased levels of parental stress are correlated to caregiving for children with medical special needs, low IQ or impaired cognition, and behavioral problems (Spratt, Saylor, & Macias, 2007).

Another questionnaire study conducted by Murphy, Christian, Caplin, and Young (2007) explored the health of caregivers of children with disabilities in urban, suburban, and rural regions of Utah. However, the researchers followed up with focus groups to add themes and patterns of information to supplement the statistics of the questionnaire. Through the questionnaire, the researchers found that over 40% of caregivers reported a decline in health over the past year. This decline was attributed to a shortage of time, absence of control, and reduced psychosocial energy. Murphy et al. (2007) and Mcbean and Schlosnagle (2016) concluded that caregivers of children with disabilities explained negative physical, emotional, and functional health due to long-term, informal caregiving. Particularly, parent caregivers of children with special needs reported poor sleep quality, declined memory, and overall poor general health compared to parents of children with typical development (Mcbean & Schlosnagle, 2016). Similarly, Miodrag, Burke, Tanner-Smith, and Hodapp (2014) further studied caregiver health through stress by conducting a meta-analysis of eligible studies that administered the Parent Stress Index (PSI) Health Sub-domain to parents of same-aged children without disabilities and parents of same-aged children with disabilities and chronic health conditions. The researchers described higher PSI health problem scores among parents of children with disabilities and chronic health conditions.

Parent caregivers of children with special needs described needing “help getting information and services for the child, help coping with the child, help getting childcare, and help with finances” (Tan, 2015). The highest scores were indicated by parents with increased financial burdens and employment problems. Parent caregivers report increased stress involving financial issues and employment (Romley et al., 2017). Parent caregivers described higher concerns about experienced financial concerns, reducing work hours, stopping working, or deterring from employment changes to avoid risking health care insurance lapse all as worries directly linked to his/her child’s condition.

Raina et al. (2015) described a conceptual model of the caregiving process of children. The model diagrams an intertwining web of internal and external factors influenced by background and context (socioeconomic status), child characteristics (function and child behavior), caregiver strain (caregiving demands and perception of formal care), intrapsychic (self-perception), factors coping factors (social support, family function, and stress management), and outcomes (psychological health and physical health). Through studying this model, the researchers determined that the psychological and physical health of caregivers was greatly impacted by child behavior and caregiving demands, with child behavior being the most impactful factor that predicts caregiver psychological well-being. This web of factors Nicholl and Begley (2012) identified three environments identified by mothers caring for children with complex needs: the world inside the home, the world outside the home, and a "going-between" world. The conclusions of this study suggest that mothers of children with complex needs have increased environments to navigate and juggle which cause stress and anxiety.

Lindo, et al. (2016) reviewed interventions geared at managing stress levels in parents of children with developmental disabilities. Truete and Hiebert-Murphy (as cited in Lindo et al., 2016) identified that increased stress negatively impacts a parent's well-being. In their review, Lindo et al. (2016) concluded that stress management techniques improved the overall well-being and decreased stress in parents of children with developmental disabilities. Telehealth services such as education, consultation, social support, problem solving and decision-making training has been identified by caregivers as supportive and beneficial in addressing caregiver needs (Chi & Demiris, 2014). In-person (Brand, Barry, & Gallagher, 2014) and internet support groups (Parker Oliver et al., 2017) for caregivers have been identifies as helping to address the social isolation of family caregivers and exploring benefit seeking and quality of life to address stress management.

Mindfulness is a concept over 2,500 years old that is continuously evolving (Black, 2011). One of the most popular definitions of mindfulness in Western society is by Kabat-Zinn (Black, 2011) who stated, "paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally" (p. 1). Mindfulness practices have been applied to various populations to successfully decrease stress and anxiety while increasing awareness and rationality. Germer (2016; 2009) describes discovering self-compassion through being kind to yourself, listening to your body, and inviting in difficult emotions. Further, he determines that there is a critical step in finding balance between caring for ourselves and caring for others. This is a balance that seems to be challenging for many parents and caregivers, especially those with children that have increased needs. Mindfulness training was determined to decrease stress, improve judgment and rationality, and increase awareness of surroundings and mental processes in caregivers of children with special needs (Benn, Akiva, Arel, & Roeser, 2012). Caregivers studied reported increased empathy, self-compassion, and personal growth following a five-week mindfulness training program. The improved mindfulness of caregivers is suggested to improve the overall connection and relationship with the child with special needs as well as the whole family.

What Remains to be Studied

Mikic and Terradas (2014) identified the need for more research to increase the overall understanding of RAD and the impacts of the disorder on relationships. Additionally, research with high quality results are limited and are centered greatly around relationships with mothers versus caregivers in general or including fathers (Wright et al., 2017).

There is little qualitative research completed about children with severe emotional and behavioral issues (Schlein, Taft, & Tucker-Blackwell, 2013) and significantly less experiential research on children with RAD (Minnis et al., 2009). While Taft, Ramsay, and Schlein (2015) provided narrative stories from parents of children with RAD, this is only a starting point of gaining more insight and understanding into the lived experiences of caregivers of children with RAD and what supports, if any, may be beneficial to them. Fallon and McNamara (2014) identified a need for proactive support for adoptive parents of children with RAD. The researchers suggested that support start in the early stages of adoption to provide education, advice, and support on the challenges of parenting children with RAD rather than waiting for adoptive parents to reach out for support at a distant point in the future, often when adoptive parents are barely getting by. What the ideal supports and resources in the adoption situation are is yet to be studied. Researchers and professionals can speculate and make assumptions on what adoptive parents of children with RAD would need or desire, however, the most beneficial information and ideas will come from the population itself.

One common trend in the published research is the importance of adoption agencies, foster care programs, and other organizations to be up front with parents and caregivers about the possibility of attachment disorder and provide education to parents and caregivers to identify early signs (Smyke, 2015). However, there is little support that this is best practice or implemented with consistency by organizations. Further research may include analysis of protocols and processes of adoption and foster agencies in preparing parents and caregivers for the possibility of the child having a RAD diagnosis and providing resources and support up front.

Murphy et al. (2007) suggested that caregivers of children with disabilities hold important insights pertaining to the negative and positive influences caregiving has on his/her health. Exploring interventions that specifically address issues of impacts on health, stress, and support have the prospective to positively impact the caregiver. Miodrag et al. (2014) and Spratt, Saylor, and Macias (2007) agreed by concluding that health professionals must recognize the need for health prevention and intervention for the at-risk population of parents of children with disabilities. With seven years between the studies, the same issue is still present: there is little to no consistent intervention and support provided to families and parents of children with special needs by mental health and medical providers, who are the first or most direct line of support to this population. Future studies might focus on caretaker-focused intervention, such as parents' coping skills, and multifaceted interventions for families specific to the unique symptoms of the child with special needs (Spratt, Saylor, & Macias, 2007).

Summary and Conclusions

I completed a literature search to collect the available information on the topics related to this study including hermeneutics, Attachment theory, family systems theory, reactive attachment disorder, and caregivers. In this study, I utilized a hermeneutic approach in order to interpret and understand the lived experiences of caregivers of children with RAD. Due to a lack of substantial research on the needs and strengths of this population, it was critical that the caregivers are given a voice to share his/her experiences without boundaries. Utilizing hermeneutics allowed for themes to be extracted out of the interviews to provide feedback from the caregivers of children with RAD.

Family systems theory and attachment theory are utilized within the theoretical scope of this study. The experiences of the caregivers and the impact it has on the family, caregiver, and child with RAD and the roles the family members play supports the use of family systems theory. Additionally, one naturally cannot study RAD without including attachment disorder. The healthy or unhealthy attachments made between caregiver and child with RAD not only impact this relationship, but the other relationships within the family unit. A dual theory approach to this study seemed the most fitting and appropriate.

Studies of caregivers of children with special needs, including RAD, have identified that caregivers of children with special needs encounter heightened stress and relational issues (citations). Further, studies suggest that caregivers of children with special needs have a decreased sense of self and adequacy as a parent or caregiver. While the impact being made on the caregiver has been studied, there is a lack of information specifically addressing the strengths and needs of caregivers of children with RAD and what supports, if any, this population views as necessary to be successful in his/her role.

Chapter 3: Research Methodology

Introduction

This study explored the lived experiences of caregivers of children of RAD and identified positive supports and reported needs. Based on the lack of available literature, caregivers of children with RAD are underrepresented among the caregivers of children with special needs. This chapter details the research design and my rationale for selecting a hermeneutic qualitative method. My role as the researcher is critical in the hermeneutic method and is discussed in detail. Additionally, the process and steps of the study ware detailed. The steps include participant selection utilizing several sampling techniques, instrumentation, procedures for recruitment, participation, and data collection. I describe my data analysis plan for hand coding using Seidman's (2015) three-interview structure. Finally, I account for any issues of trustworthiness and discuss ethical procedures implemented.

Research Design and Rationale

To understand the needs and experiences of caregivers of children with RAD, the information must come from the caregivers themselves. The qualitative methodology gives voice to individuals to facilitate learning (Creswell, 2013). There are many qualitative methods that are all adaptable to increase responsiveness of participants (Maxwell, 2013). I utilized the literature and the research questions in order to select my qualitative methodology. I selected phenomenology for this study. I briefly overview the history of phenomenology and how the methodology was selected for this study.

In the early 20th century, Husserl (1928) aimed to give meaning and understanding to lived experiences through language. The focus of phenomenological research is not to interpret the data through the researcher's lens, but to clearly and concisely describe the experience (Forster, n.d.; Wrathall, 2005). This original form of phenomenology gave life experiences descriptors that could be easily compared, grouped, and explored further through other forms of research (Frankfurt-Nachmias & Nachmias, 2008). Heidegger (2005), a student of Husserl, branched off from Husserl and created his own philosophy, now known as hermeneutic. He believed that it was impossible to separate the researcher's views and interpretations from the life experiences being studied (McConnell-Henry, Champan, & Francis, 2009). Within hermeneutic methods, researchers contribute to defining the meanings within life experiences and meaning is viewed as contextual, emergent, and always developing (Sloan & Bowe, 2014). Heidegger believed that each person is always in the world with others in the circumstances of existence. This state of being-there was termed *Dasein*. Each person is *Dasein* in one's own existence, and by doing so Heidegger believed it is impossible to bracket our experiences from other's and the world. Due to this belief, Heidegger created the term Hermeneutic Circle, a revisionary process to come to an understanding of the world to get to the essence of a phenomenon without suspending our own judgements and biases. Individuals have predetermined knowledge, which Heidegger termed foreconception. Through learning and experiencing, individuals revise these prejudices and biases which leads to deeper understanding. Data analysis utilizes the process of the Hermeneutic Circle in which the researcher views the data through different lenses and compares the whole data to the parts of the data and then back to the whole (Gadamer, 2004).

I chose the hermeneutic phenomenology method for this study. The research method allows for exploration of life experiences through the participants' own words. I have a total of three lenses in which the data was interpreted: hermeneutic which includes my preunderstanding, attachment theory, and family systems theory.

I chose the hermeneutic approach to account for any beliefs, views, and impressions I brought to this study through my personal background and experiences which are the lens in which I view and interpret the life experiences of the participants within the study (Maxwell, 2013; Willis, 2007). Along with the hermeneutic approach, I incorporated family systems and attachment theories as lenses. By looking through the family systems lens, I maintained the beliefs that all of the relationships in the family is impacted by the behaviors of other members of the family. This belief is important as caregivers are impacted by the behaviors of the child with RAD and also commonly concerned with the impact those behaviors and their own reactions have on the others in the family. I needed to be considerate and aware of the other stresses that may come up within the interviews and that above all, many participants are members of families and concerned with the whole family and the impacts of RAD. When discussing and researching RAD, it is difficult to not look through an attachment theory lens. The consideration of attachment theory gave me the perspective of the focus being on the emotional relationship between the caregiver and the child with RAD and the caregiving role being extremely difficult with maladaptive attachment behaviors within the child with RAD. Ultimately, each of the lenses I looked through gave me a different piece of understanding of the lived experiences of the caregivers of a child with RAD. The hermeneutic lens provided the openness to explore and preunderstanding of what I brought to the research study in my roles as interviewer and researcher. Family systems brought the lens of family relationship dynamics and the impact individuals have on each other. Finally, attachment theory provided the lens of maladaptive nurturing in childhood that significantly impacts the attachment to other caregivers.

Participants in this study were able to describe his/her life experiences raising children with RAD to assist in formulating a deeper understanding of the emerging phenomenon. I chose a series of open questions that allowed for participants to share experiences and opinions that were both positive and negative, as well as express opinions on what works well and what may be needed for the participants to feel better equipped or more supported in raising his/her children with RAD. Flexible questions were utilized in order to meet the needs of both the participant and the researcher (Janesick, 2015; Maxwell, 2013). By leaving questions open and broad, the participant had the freedom to share any thoughts, opinions, and experiences that may be relevant. Additionally, through open, flexible questions I provided less direction to the participants in order to have less influence on the specific experiences shared.

This hermeneutic phenomenological study was utilized to explore the experiences caregivers of children with RAD have with caregiving and the resources available to them. The research method allowed for research questions to be formulated to align with experience narratives of the participants. Within this research study, I intended to answer the following research question: What are the lived experiences of caregivers of children with Reactive attachment disorder? Additionally, I asked the following subsequent sub-questions:

- What needs do caregivers of children with Reactive attachment disorder experience as met?
- What needs do caregivers of children with Reactive attachment disorder experience as unmet?
- How do caregivers of children with Reactive attachment disorder experience the resources available to them?

Thus, the experiential aims of the semistructured interview through the phenomenological approach were appropriate for the study. The data collection methods of semistructured interviews are designed to uncover and gain insight into the caregivers' experiences and perceptions through his/her own words while allowing themes to emerge for further understanding, guidance, and research around needs and resources.

I considered other qualitative methodologies prior to selecting the hermeneutic phenomenological approach. Grounded theory utilizes methodical gathering and analysis of data to create theories (Charmaz, 2014). Grounded theory would have allowed a theory to emerge from the information, however, my research question seeks to hear the experiences of caregivers in order to better understand the lived experiences. A case study analyzes an individual, group, or situation in great detail over a period of time (Meyer, 2015; Yin, 2015). A case study was a possibility, however, the likelihood of multiple sources of information for each participant was unlikely as well as did not correlate with the research questions seeking the lived experiences of the phenomenon

(Creswell, 2013). Additionally, case studies are conducted over time. With the reported stress and demands on a special needs parent, it was not in the best interest of the population to add a lengthy and in-depth responsibility on them. Obtaining multiple sources of information from participants, such as medical records, treatment records, CPS records, school records, and statements from others are time consuming, invasive, and would not meet the desired outcome of this study in exploring the lived experiences in the caregivers' words. Ethnography is the study of a culture of a defined group in which the most common data collection is observation (Hammersley & Atkinson, 2007). I did not consider ethnography due to the lack of cultural sharing and the time and proximity required to conduct effective ethnography. While there were many qualitative approaches to consider for this study, I chose the hermeneutic phenomenological approach as the most appropriate for this study. Future studies may utilize other approaches to allow for expanded information and knowledge to the topic and field.

Role of the Researcher

The role of the researcher should be clearly outlined and described to provide transparency for the study, as well as the ability to replicate the study in the future (Creswell, 2013; Karagiozis, 2018). The researcher should disclose his/her personal and professional views, any assumptions they have about the research process, and his/her role as a participant. The views, beliefs, and experiences of the researcher can impact the study as well as those of the participants. Coinciding with hermeneutic phenomenology beliefs, the researcher brings his/her own beliefs and experiences to the current experience of the research study (Finlay, 2009; Sloan & Bowe, 2014). Gadamer (as cited in Spence, 2017) challenged Hermeneutic researchers to embrace the prejudices that they bring into the experience and not discredit them as all negative. I disclose my views on caregiving, resources for caregivers of children with RAD, and children with RAD.

I am a White, middle-age woman who has worked with children and families for 15 years. I am a licensed professional counselor who is a mental health supervisor and clinic director of multiple outpatient and community-based clinics for a variety of mental health concerns including children with RAD and his/her families. I am a caregiver of a child with RAD. From my experiences as a professional in mental health and my support of consumers, both children with RAD and his/her families, that there are many challenges to effective treatment and support. Both my personal and professional experiences lead me to have prejudices or biases relating to caregivers of children with RAD. I believe as though there are barriers and gaps to the support of caregivers for children with RAD, an invisible illness. By invisible illness, I mean that there are no visible disabilities or physical deformities that others can observe. Typically, in my experience, there is more grace and understanding given to caregivers of children with a visible disability, such as Cerebral Palsy and Down Syndrome. My experiences have created a belief that there is a lack of understanding of RAD and the struggles of caregivers of children with RAD by not only the general public, but also by teachers, medical professionals, and mental health professionals. The perceptions and beliefs that are held in my role of caregiver for a child with RAD and the needs that might be met or unmet affect the interpretation of the data. I detailed this set of biases and beliefs in my journal prior to starting data collection. I sought consultation from my Committee Chair to maintain objectivity when conducting semistructured interviews. I kept a running journal to record my thoughts and reflections as I proceed through the study. Journal writing is a reliable research tool utilized in humanities studies (Janesick, 2015). The act of journaling provides personal and professional development to enhance the researcher, who is the main research instrument. This tool allowed me to assess and interpret my thoughts and opinions as I followed through the hermeneutic phenomenological process. I journaled in order to properly document and explore personal biases and anticipated projections and maintain focus on the data. This process allowed me to constantly replace my current conceptions with more suitable ones by reflecting throughout the process (Gadamer, 2004). The hermeneutic circle is found in the journaling process through the revision of personal biases as the personal biases direct the questions that cause thought revision. Projections will surface, at times not in congruence with one another. Through time and continued research, the goal is for the projections to come together to form an agreement of meaning (Gadamer, 2004).

In my role as researcher, I observed and interviewed participants and interpreted and analyzed the data (Fink, 2000). Staying true to the hermeneutic phenomenological approach, I analyzed the spoken word of the participants (Janesick, 2015). In the past 6 years, I have professionally interviewed and assessed individuals which provides me with experience in interviewing with compassion. I am also trained in Motivational Interviewing.

As one of my tasks, I transcribed the recorded interviews verbatim into written transcripts. I performed data analysis of the written transcripts to identify the similarities and differences between the responses to the questions (Clark & Veale, 2018; Crowther et al., 2017). The transcripts became a series of stories rich in context to increase understanding (Crowther et al., 2017). The study provided a participants' view of his/her experiences as a caregiver of a child with RAD, as well as his/her experiences with supports and resources and what could be done to improve experiences and supports. I utilized the hermeneutic methodology to give voice to the commonalities and differences in the experiences of the caregivers of children with RAD (Sloan, & Bowe, 2014).

Safety, security, and protection of participants is a primary focus in this study. I did not have any professional or personal relationship with any of the participants (Karagiozis, 2018). To reduce the possibility of a potential participant who has a current relationship with me, I recruited participants through social media outlets that I do not have close connections. The study did not utilize incentives. To abstain from causing harm, participants were able to withdraw from the study at any time without consequence. The selected interview questions allowed participants to answer the questions without providing any identifying information about themselves or his/her families. I assigned pseudonyms to participants who agreed to participate in the study (Creswell, 2013; Saunders, Kitzinger, & Kitzinger, 2015). All collected material and data were treated as confidential throughout the study. Methods for maintaining confidentiality are discussed in the next section, Methodology.

Participants were asked to participate in two interviews. The first was to answer the predetermined interview questions. The second was to review the written transcript of his/her interview and assure accuracy to the information. Participants would also be able to clarify information and experiences in the second interview, as desired.

Methodology

To fully understand this current study, I describe in depth the context. The logic and process of participant selection is provided in detail. The instruments being used are described and provided. I describe in detailed steps the process of participant selection data collection, and data analysis. Finally, issues of trustworthiness and validity of this study are analyzed.

Participant Selection Logic

A nonprobability, self-selection sampling strategy will be used. Nonprobability sampling is particularly useful in exploratory research to explore possible problems or issues (Brick, 2015; Creswell, 2013). Nonprobability sampling is often used when a list of members of the target population cannot be accessed. With the frequency in diagnosis of RAD unknown and the often-hidden suffering of individuals and loved ones of mental health issues, it is difficult to access a list of individuals that would meet the requirements of the target population. I considered contacting agencies that would have a higher likelihood of interaction with caregivers of children with RAD, such as foster care systems, adoption agencies, county mental health systems, and RAD treatment agencies. However, that connection would create extra layers of confidential information and permissions for access, as well as would assume that members of the target population have had access to or maintained connection to those resources. I determined that placing posts in Facebook groups known for RAD support would be more inclusive by not assuming individuals have access to local resources. The nonconfrontational method of posting in the groups removes the possibility of participants feeling persuaded to do something they would rather not do (Fenner et al., 2012; Seidman, 2015). Additionally, the use of the nonprobability sampling through Facebook groups did not intentionally target individuals of same geographical areas, treatment resources, and other similarities and aims to obtain a more diverse participant pool and population. I was purposeful in the eligibility criteria and screening survey of potential participants in order to elicit participation from individuals who match the target population (Seidman, 2015).

The Facebook groups had voluntary membership and allowed all levels of engagement, such as those who were actively vocal and sharing and posting and those who simply read and did not post. I chose the self-selection sampling strategy because I sought participants who will be open and share his/her experiences in detail. Asking others to share the intimate experiences they have with his/her loved one and caring for his/her loved ones is sensitive in nature. I am aware that this study asked the participants to be vulnerable by sharing personal experiences. By asking participants to volunteer to participate, I hoped to recruit participants who were seeking the opportunity to share his/her experiences and would commit to the study through its entirety, while respecting the safety and support of the Facebook groups. The safeguards and protections for participants are described in the Ethical Procedures section.

Participants would be at least 18 years old and the primary or joint caregiver of a child under the age of 18 years old who has been diagnosed with RAD. The age criterion is based upon the assumption that legal guardians must be at least 18 years old.

Participants must be a resident of the United States of America for the past five years. I chose to focus on residents of the USA as there is a gap in the research pertaining to the experiences of caregivers of children with RAD in the USA. Research is present for caregivers of children with RAD in eastern hemisphere countries (Follan & McNamara, 2014; Nicholl, & Begley, 2012; Zeanah, Chesher, & Boris, 2016). The five-year time frame is given to ensure caregivers have had the opportunity and exposure to potential or available supports around caregiving for a child with RAD. In addition, I want to provide nationwide results to further the understanding for the profession. There are no restrictions or exclusions based on gender, religion, race, ethnicity, sexual orientation, or any other demographical information because the key variable being analyzed is that they are a caregiver of a child with RAD. Americans and caregivers of children with RAD may have a broad range of backgrounds and all experiences are important to be shared. Interested participants will complete an online survey to determine eligibility based on the criteria; See Appendix A (Palinkas et al., 2015). If eligible, participants were directed to input his/her email address for me to contact them. The use of the eligibility survey is purposeful sampling to ensure that the volunteer participants meet the criteria of the study (Palinkas et al., 2015).

The research description (Appendix B) and link to the eligibility survey (Appendix A) was posted and shared in the groups “reactive attachment disorder,” “Surviving reactive attachment disorder,” and “reactive attachment disorder (RAD) Parent Support Group” on Facebook. The preselected Facebook groups require a membership screening process and are moderated by a team 24/7. Through reading descriptions of the groups and membership summaries, there are members from around the world that are individuals with RAD, caregivers or loved ones of individuals with RAD, and a small percentage of professionals involved with RAD research and care. Interested parties read and agreed to the research consent and completed the eligibility survey via Survey Monkey (2018) (see Appendix A). The email addresses were pulled from the survey results and placed into a Microsoft Word document saved to a password protected folder on my password protected MacBook. Each eligible participant was contacted by email describing the study, the next steps, and asked to set up a first interview. I sent all participants a consent form and offered to review and answer any questions(see Appendix C) (Padgett, 2016). I continued this process until I had saturation.

It was estimated that ten participants would be sufficient to reach saturation (Seidman, 2015). Saturation would be evident by the emergence of themes. The number of children diagnosed with RAD in the United States is unknown, however it is predicted that as many as 8 out of every 10 children who have experienced trauma in early childhood meet the criteria for RAD (Health Services Funding, 2018). There are reported to be over 3 million maltreatment cases reported to Child Protective Services nationwide each year, and likely at least that many that go unreported (Health Services Funding, 2018). The number of members, which are international, of the Facebook support groups for RAD range from 800 to 1500 (Facebook, 2018).

Instrumentation

I utilized myself as the main research instrument. Additionally, I utilized the eligibility survey (see Appendix A), the interview guide (see Appendix D), and the study debriefing form (see Appendix E). I utilized Zoom video conferencing, HIPPA compliant version, to conduct and record all interviews.

Eligibility survey. The eligibility survey was created via Survey Monkey (2018) and was shared on the three Facebook groups with a message of introduction. The survey provided information about the purpose of the study and asked questions to screen potential participants for eligibility according to the requirement criteria for participation (Appendix A). Seidman (2015) identified the importance of purposefully selecting participants that meet the criteria for the population. Participants meeting the criteria was a vital step for validity of this study. Upon meeting the eligibility criteria via the survey, potential participants were informed that they met the criteria and were asked for his/her email address in order for me to set-up an interview. I emailed each eligible individual with the study process and asked them to set up a time and date for the first interview. If any eligible participants chose to opt out, I moved to the next eligible participant on the list.

Semistructured interview and follow-up interview. I served as the basic instrument, the main researcher who interviewed all participants in two interviews each (Creswell, 2013; Janesick, 2015). I created the interview questions based on the research question and the literature review. The interview questions (see Appendix D) were created to increase validity by focusing all interviews of the study towards the same topics (Creswell, 2013; Janesick, 2015). The use of predetermined interview questions increased the consistency of the study and the researcher to ensure the adequate and relevant data was collected to identify themes (Janesick, 2015).

Data collection from semistructured interviews was completed through computer video teleconference recording using Zoom (2018). Video conferencing allowed for flexibility of location and time available but reducing travel time to locations and allows for participants from across the nation. Zoom is a video conferencing program that allows an individual to have a private conferencing room. The Zoom program is easily utilized on computers, laptops, smart phones, and tablets. Additionally, Zoom allowed for administrators of the meeting room to encrypt the connection for added protection and HIPPA compliance. All participants were explained that his/her contact information will be securely electronically stored, and a pseudonym assigned to each participant to save all documents and recordings (Appendix F). All documents and recordings were contained on my personal laptop secured with a password in a password-protected folder.

I facilitated semistructured interviews with each participant and offered one follow-up interview for the purposes of reviewing the interview transcript, clarifying misunderstandings, and gaining missing information. The predetermined questions I created for the interview are found in Appendix D and are structured around the research question and sub-questions. Additional questions were asked to clarify responses or obtain more information about specific experiences. I transcribed each interview within three days following the interview to increase repetition of data (Janesick, 2015; Seidman, 2015). Between three and seven days following the initial structured interview, I attempted to conduct a debriefing interview with each participant to review the transcript from the initial interview. The purpose of this debriefing interview was for participant to ensure the information was accurate, to add detail or information that may have been missed, and to clarify any information. None of the seven participants accepted this offer.

To review, I recruited participants through Facebook groups and utilization of a Survey Monkey eligibility survey. I collected the data over Zoom video conferencing utilizing semistructured interview questions. I also acted as the transcriber of the interviews and do so within 3 days of the interview. With respect to this process, I reviewed concerns with validity and truthfulness pertaining to his/her use in this qualitative study. I had committee members review my instruments and evaluate his/her validity and reliability (Creswell, 2013; Janesick, 2015).

Procedures for Recruitment, Participation, and Data Collection

In this section I detail the steps I took in regard to the recruitment and participation for this study. These steps commenced following IRB approval.

Step 1: Obtaining participants. I selected the specific Facebook groups based on the topic of the group, the descriptions of the groups as a space for support and information for RAD, membership being open to individuals located in the United States, and member size. I contacted each group's administrator via Facebook Messenger to explain the purpose and desire of the study and asked for permission to post the invitation to participate (Appendix B) in the study and the link to the eligibility survey in the Facebook group (Appendix A).

Step 2: Initial contact with potential participants and consent. Upon approval and acceptance by Facebook group administrators, I posted a brief description of the purpose of my study (Appendix B) and asked for interested individuals to click the Survey Monkey link to complete an eligibility survey (Appendix A). When the potential participant clicked on the survey link, the first thing they saw was the Participant Consent Form (Appendix C) and were asked to click that they consent. The individuals were then directed through a series of criteria questions. If potential participants met the criterion to participate in the study, he/she will be asked to provide his/her name email address. Once contact information was received from potential participants, I moved on to Step 3.

Step 3: Second contact. I emailed each eligible participant to schedule the semistructured interview via Zoom. I assigned an identification code to the participant's email address to use throughout the study to protect the participant's identity and confidentiality.

Step 4: Data collection (interviews). I conducted the responsive interviews as mutually scheduled via Zoom video conferencing and recording (Rubin & Rubin, 2011). Interviews conducted over the internet allow for a feeling of comfort, added privacy, and flexibility within a participant's life, particularly when studying individuals on sensitive personal topics (Rubin & Rubin, 2012). Additionally, participants had the option to opt to have the video component off to hide his/her emotional reactions and adding a level of privacy (Rubin & Rubin, 2012). I began with a brief overview of the nature of the study. I utilized the responsive interview questions (Appendix D) to answer the question of the study and gain insight on the lived experiences related to caregiving children of RAD

(Seidman, 2015). I audio recorded the sessions and took handwritten notes to document any nonverbal communication or thoughts or reactions throughout the interview. The audio recording and notes were labeled with the participant's identification code. It was projected that interviews will last between 30 and 60 minutes each. Seidman (2013) discussed the importance of letting the participant guide and recreate his/her experiences in his/her dialogue based on his/her process versus a predetermined amount of time.

Step 5: Interview debriefing (debriefing form). Prior to the interview, I emailed each participant a debriefing form (Appendix E). At the end of the interview I reviewed the form with the participant and asked the participant to acknowledge the information verbally. The debriefing form will have a 24-hour emergency mental health phone number and a statement reminding participants that any mental health or medical care sought will be at the participant's expense.

Step 6: Follow-up with participants to review transcripts. I emailed the transcription of the initial interview for the participant to review and asked to schedule a second interview time and date three to seven days after the initial interview to increase engagement and allow time for participants to process his/her thoughts (Seidman, 2015). This provided the participant with an opportunity to confirm the text based on the audio recording, discuss any salient responses, and provide partial trends identified for the participants' feedback and thoughts (Seidman, 2013). This interview is the final step in Seidman's (2013) three-interview model and asked participants to reflect on the meaning of his/her experiences as a caregiver of a child with RAD. Seidman's model is three-interviews, which is condensed into two in order to be respectful of time of the participants and that Seidman's first and second interviews are combined into the first interview. The first two interviews are those in which the researcher gains information on the topic and the details of those experiences. This interview would be audio recorded. During this interview, participants would have the opportunity to suggest changes or provide additional opinions.

Step 7: Data analysis. This step is described in detail in the next section, Data Analysis Plan, of this document.

Step 8: Dissemination of results of the study. The debriefing form (Appendix E) includes a statement asking if participants would like to be informed of the final results and if they would like them mailed or emailed. Participants who selected to be provided the results, will be sent the results. Additionally, the results will be shared in each of the three Facebook groups by sharing the final pdf document of the study.

Data Analysis Plan

Data analysis and interpretation within qualitative research is largely based on the meaning that the words cultivate into a description (Creswell, 2013; Frankfort-Nachmias & Nachmias, 2008). Hermeneutic phenomenology, the qualitative design for this study, emphasizes the designing of the meaning of words by the participants and researcher (Finlay, 2009; Sloan & Bowe, 2014). In this study, I merged the spoken words of participants, the nonverbal communication of participants, and my thoughts to create the data that was used for analysis and interpretation. I used two cycle coding methods as described by Saldaña (2015). I utilized manual coding through employing the in vivo coding to attune to participants' perspectives and pattern coding to identify meaningful themes and opinions of the participants to reach a final interpretation. In vivo coding is described as the process of assigning a word or short phrase taken from a selection of a transcript or other selection of data based on participants' spoken word (Given, 2008; Saldaña, 2015). I utilized the following steps in my data analysis process.

The data analysis process is spiral in nature as I reviewed the whole transcript, identified codes and themes, and then continued to go back and forth between the whole and parts as more data is introduced (Heidegger, 2005). The process was a constant revision with the understanding of the phenomenon of being a caregiver of a child with RAD being shaped by the data introduced and the personal experiences of myself as the researcher. Each revision brought forward new meaning and understanding as I viewed the transcripts and data through one of the three lenses each time.

Step 1: Reading and deleting unnecessary language. I read through the entirety of each interview transcript, interview notes, and my research journal. During this process I removed any repetitive statements and filler words, such as "uh," "um," "well," and "you know." This process weeded out the words and statements with no purpose of meaning in the lived experiences. For example, a participant stated "Um, actually now my son is 23 and I really didn't experience anything positive until really, really recently." I removed "um."

Step 2: Generate preliminary meaning units. I read through each interview as they were completed keeping in mind the purpose of giving voice to the experiences of caregivers of children with RAD. I began to identify key features or traits of the phenomenon of being a caregiver of a child with RAD. I reviewed past interviews as needed to review for themes that emerge from the interviews and assess for saturation. I also reflected on my research journal notes to incorporate the thoughts, ideas, and beliefs I noted before, during, and after the interviews. The first meaning unit describes Participant 2's view of the positive experiences of being a caregiver of a child with RAD and the second meaning unit is experiencing negative feelings due to being a caregiver of a child with RAD. First, participant stated she has learned a lot, prioritized self-care, and strengthened her religion. Second, participant felt judged, misunderstood, and finds herself tirelessly advocating.

Step 3: Generate final meaning units. I read through each interview three times, reading each time using one of the three lenses (hermeneutic, attachment, and family systems). I revisited the key features and traits from each participant interview and interview question. I created themes that were informed by my understanding of the descriptions of the participant's experiences. Each lens brought forward different themes and codes based on the view in which I had with the transcript, research notes, and journal. The hermeneutic lens focused on meaning in the lived experiences. The attachment lens focused on the relationships between caregiver and child. Finally, the family systems lens sought themes and codes pertaining to family roles and family dynamics. This cycled in nature as each review and lens brought forward new meaning and then integrate with the meaning of another lens and review. I read through the transcriptions and notes and identified significant and relevant words, phrases, and statements through in vivo hand coding (Saldana, 2015). I utilized the constant comparative method of analysis to develop theory to the phenomenon of lived experiences for caregivers of children with RAD. The constant comparative method is a process of analysis that guides data collection and analysis to gain initial understanding of a phenomenon and further the emergence of a theory (Chamaz, 2014; Glaser & Strauss, 2000). As Chamaz suggested, I began with descriptive codes and worked them into inferential codes. Themes began to emerge from codes, and I compared themes against each other to develop a final interpretation (Saldaña, 2015).

Participant 6

Preliminary meaning unit 1: Participant had no outlets for self-care.

Preliminary meaning unit 2: Participant could not obtain necessary treatment services in a timely manner for their child.

Final meaning unit: Caregivers of children with RAD are lacking various supports.

Step 4: Themes. I organized specific experiences thematically in relation to family systems and attachment theory. I showcased each participant's experiences by using direct quotes from the interviews.

Growth

P2

"I have learned a lot about attachment…I have learned a lot about parenting."

> It has forced me to have to think about how I am going to take care of myself, so I don't become overwhelmed with her. So, I have had to do a lot of self-care. At some points it has pushed me closer to my religion because I felt like I didn't have a whole lot of people there to support me.

P5

I started going to the ATTACH (Association for Training on Trauma and Attachment in Children) conferences. Because the ATTACH conferences are in different parts of the country, they try to rotate where they are. And it's like 3 days of conferences with the people that are on the cutting edge of everything. And then the parents-they would actually set it up where there were things for the parents to do in the evenings.

"And of course, getting all of the books, and I've gone and heard Dan Hughes speak a lot."

P7

"It has caused me to become a more patient person… and a better parent to my other children."

Step 5: General narratives. I summarized the data and experiences of the themes that emerge from the participants (Sloan & Bowe, 2014). The frequency in which each theme is identified will be shared within a data chart for easy reference. For the description and summary, narratives were organized by "most" meaning saturated theme, "many" meaning 50% theme, and "some" meaning it was relevant but not saturated. A general narrative was formed as a compilation of the situated narratives from the participants' experiences to represent the experiences as a whole for the population.

Theme: Family Relationships

All participants experienced unhealthy primary parent-child bonding. All caregivers with more than one child, experienced unhealthy sibling bonding among the child with RAD and their siblings. Most participants witnessed bonding between the child with RAD and family members other than the primary caregiver and siblings.

Step 6: Generate general description. The end result was a combination of all themes together to form a phenomenon. The phenomenon that came forth was the result of looking at the themes and general narratives through the lenses of attachment and family systems.

An example of this is: In general, caregivers of children with RAD experience few positive moments in their caregiving role. These individuals experience strained and unhealthy family bonding throughout the majority of the relationships within their family unit that impacts the function and overall health of their family. Caregivers of children with RAD are overwhelmed with negative feelings that impact their relationships with themselves and others in their family.

Discrepant Cases, Negative Cases, or Disconfirming Evidence

All data was included in the analysis, with no data excluded for not falling within the majority themes. I searched all data for disproved themes or themes that did not fit within the emerged categories (Creswell, 2013). Discrepant data was included to identify and explore all reported experiences of caregivers of children with RAD and noted as discrepant or disconfirming. As I aimed to investigate all experiences caregivers of children of RAD have related to needs and resources, exclusion of any data would not provide an accurate depiction of the wide range of experiences of the population.

Issues of Trustworthiness

To establish trustworthiness, I utilized the tools of validity, reliability, and confirmability (Creswell, 2013). Establishing trustworthiness required a rigorous protocol to address multiple areas involving trustworthiness in research (Amankwaa, 2016). These tools are described next.

Validity

It is critical to consider validity in the framework of trustworthiness in research. To assure validity, I utilized multiple data sources including participants' spoken words, participants' nonverbal communication through my observations, and field notes. I intended on implementing the triangulation strategy with multiple sources (Amankwaa, 2016; Creswell, 2013). I intended to use the debriefing form to check for accuracy of information. No participants followed through with utilizing it. This process of checking for accuracy of transcripts is known as member checking, a method to ensure trustworthiness in which the data is shared with the members who originally provided the data (Chang, 2014). Member checking gives voice, creates active participation, and acknowledges the importance of the researcher and participants working together to create understanding. I did utilize my committee chair for checking transcripts for errors and identifying themes from a non-data collection participant. Additionally, I have discussed openly the bias I bring to this study.

Reliability

To have a reliable study, the researcher must have a consistency and continuity of the process (Creswell, 2013). I clearly described the steps I took to acquire the data and documented my steps as the researcher in my field journal. I built in steps to check the transcripts for mistakes, either on my part or that of the participants (Amankwaa, 2016). I also outlined my steps in data analysis and interpretation.

Confirmability

Confirmability is also termed external reliability and focuses on a neutral study (Bloomberg & Volpe, 2018). I intended to achieve confirmability through many actions and steps. First, I outlined with transparency the research steps that were conducted. Along with following this process, I conducted an audit trail to document what was completed throughout the research (Amankwaa, 2015). An audit trail also addresses credibility (Cope, 2014). The audit trail is located in my field journal. The checking of interview transcripts for accuracy by the participants holds accountability and accuracy of the interpretation of body language and experiences.

I previously disclosed the biases that I bring to this study. My efforts to maintain a neutral study continued through documentation in my field journal. My journaling included my open and honest accounts of the study throughout the research process, personal thoughts and biases, and the rationale for any decisions I made (Amankwaa, 2015).

Ethical Procedures

This section will address each ethical consideration for this study, to include access to participants, data collections, treatment of data, protections of confidential data, and incentives.

Access to the participants. Prior to conducting the study, I completed the Walden University IRB form and received approval. Internet-based research studies have the same guidelines and protections to human subjects as other research (Gupta, 2017; Harriman & Patel, 2014; Sugiura, Wiles, & Pope, 2017). The IRB board reviewed the processes and ensured that all actions and steps are ethical and within the proper research protocol. I utilized Facebook groups to access participants; however, no information was collected from Facebook for the use of data or data analysis in this study (Gupta, 2017; Harriman & Patel, 2014; Sugiura, Wiles, & Pope, 2017).

Recruitment. I recruited caregivers of children with RAD through Facebook groups. Interested participants were asked to review a statement explaining the study and took a brief survey enduring potential participants meet criteria for participation. I explained the purpose and nature of the study to all potential participants through the invitation posting in the designated Facebook groups. The rights of the participants were outlined in the informed consent form (see Appendix C).

Data-collection activities. No data was collected via Facebook (Gupta, 2017; Harriman & Patel, 2014; Sugiura, Wiles, & Pope, 2017). The participants completed the informed consent form (see Appendix C), which outlined the participant's right to withdraw or refuse participation in the study at any point in the process without penalty. Additionally, the consent form reviewed the data collection process. To maintain confidentiality of participants, I assigned each participant an identification code.

Treatment of data. All information provided by participants, to include names, contact information, and responses to interview questions, remained confidential unless required by law (i.e. Child abuse, elder abuse, danger to self/others). Permission would need to be granted from the IRB entities to release any information.

Protections for confidential data. The audio recordings, consent forms, debriefing forms, and transcripts were kept in a locked cabinet in my locked file room at 1234 Main St, Green Bay, WI 54302. I stored electronic documents (Word and Excel) that included the transcripts, journals, and reports, in a password protected folder on my password protected laptop. I kept the master code sheet in a separate locked cabinet in a separate locked office. I ensured that I would only be able to link participants to the study and this information would be kept confidential and not be shared with anyone. After 5 years post dissertation publication, I will destroy all raw study data, to remain in compliance with Walden University guidelines. In the case of a need to transfer any data, I will utilize standard privacy envelopes.

Incentives. I offered no incentives to participation.

Summary

In this chapter I have detailed the methodology of this study. This qualitative, hermeneutic study was led by myself. My role as researcher has been a participatory role within the research as implementing hermeneutic methodology suggests that the researcher's beliefs and thoughts impact the narratives and themes that emerge. The sampling methods and instrumentation tools, including myself, consents, semistructured interviews, and de-briefing forms were explained and are provided in the Appendices. I outlined and described the procedures for recruitment, participation, and data collection. A two-cycle coding method was utilized to hand code the verbatim transcripts to allow for themes and phenomena to emerge from the rich contextual data (Saldaña, 2015). Finally, I addressed the issues of trustworthiness, validity, and ethical procedures implemented in this study. In Chapter 4, I detail the data collection process and the results.

Chapter 4: Results

Introduction

The purpose of this hermeneutic phenomenological study was to explore the lived experiences of caregivers of children with RAD to identify supports and needs. The research question that was explored is: What are the lived experiences of caregivers of children with Reactive attachment disorder? Sub-questions were utilized within the semistructured interviews to gain participants' insight on experiences with met and unmet needs, resources, bonding, and family relationships. In this chapter, I describe the setting and demographics of the research participants. I detail the data collection and data analysis processes. Finally, I provide evidence of trustworthiness within my research process.

Sampling Strategy

Seven caregivers of children with RAD participated in this study. I used purposeful sampling to recruit individuals who met all the inclusion criteria for participations. Criteria for inclusion included being a caregiver of a child with RAD at least 50% of the time, being 18 years or older in age, and having lived in the United States for the past five years. I assigned each participant's email address an ID code (see Appendix G) to protect the identity of all participants. Real names were not collected. Participants reviewed and acknowledged the consent form prior to moving forward to the eligibility survey. As outlined in Chapter 3, I conducted interviews in accordance with the methodology.

Setting

The setting of the interviews was as convenient as possible, via Zoom video chat. Some participants had difficulty signing onto the encrypted Zoom chat room, which was remedied quickly, all under 10 minutes. For some it was a download of an application and for others it was providing time for the site to load and then click through to connect. No participants utilized the video option, choosing to not be shown on video. When scheduling interviews, many participants provided narrow windows of times, either while children were at school or after they were in bed. Typical windows of availability for interviews were during regular school hours or after bedtime, such as after 9:00 pm in their respective time zones. Children could be heard in the background during several interviews, indicating that participants were multitasking their home duties and their desire to participate in the study. There were at least two eligible participants who dropped out due to not having the time or having urgent family matters to attend to. For example, one potential participant never followed through with the interview due to her husband being in the hospital for emergency surgery and not having anyone for child-care or respite.

Demographics

All participants completed the eligibility survey. All participants were confirmed to be over the age of 18. Participants were parents or caregivers of children with Reactive attachment disorder; 2 participants' children are over the age of 18 years and 5 participants have children under the age of 18 years at the time of the interviews. All participants provided at least 50% of care to the child with RAD. Participants also have all lived within the United States for the past 5 years. All participants were female. There were no age, race, ethnicity, religion, or sexual orientation data collected intentionally. There were no demographic questions asked in the eligibility survey (see Appendix A) or the interview questions (see Appendix D). I did not ask any participant directly for any demographic data. All demographic data was provided voluntarily by the participant through the interview process.

Participant 1: Participant 1 is a female from a Jewish family. She reported being a single-parent and schoolteacher; who adopted her son when he was 4 years old. She lives in the New England States.

Participant 2: Participant 2 is a female. She was a single parent when she adopted her daughter and is now married. She adopted her daughter when she was 6 years old and resides in Atlanta.

Participant 3: Participant 3 is a Hispanic female who has 3 children with RAD. She resides in the Las Vegas area. She is divorced and recommitted. She is a member of the LGBTQ community.

Participant 4: Participant 4 is a married female who adopted her daughter at 2.5 years old from Washington state. They currently reside in Florida.

Participant 5: Participant 5 is a married female who adopted her child when 3 years and 9 months old from a Russian orphanage. She worked in human and social services and resides in rural Pennsylvania

Participant 6: Participant 6 is a married female. She is the biological grandma who gained care of child at age 3. She has previously raised 2 children. She resides in Alabama.

Participant 7: Participant 7 is a divorced female. She lives in a multiple child household in the San Diego area.

Data Collection

I was able to complete and record seven semistructured interviews. I opened every interview with a recap of the purpose, a review of the process, and asked the participant if s/he had any questions for me. This helped refresh and prepare the participant for what the interview was going to entail and allow for rapport building to begin. I recorded each interview using Zoom. Interviews lasted between 20 and 55 minutes. The recordings began when I asked the first interview question. Participants were able to discontinue the interview at any time or decline to answer any question asked.

The semistructured interview questions (see Appendix D) provided open-ended questions to seek answers to the research question. Some questions were asked out of order or adjusted as participants naturally led to those topics. All interviews took place via Zoom video chat and were recorded. The audio was saved, and I transcribed them within 3 days of the interview. The transcript was provided to the participant via email to review and offer changes or additions. With the transcripts, I asked participants to review the transcript for any errors or information the participants would like to elaborate on or change and also to set up a second interview to discuss any changes or additions (see

Appendix E). I did not receive any return correspondence from any of the participants who completed an initial interview. I sent each participant two email reminders one week apart. This was not anticipated during the initial research plan creation.

None of the participants accepted the offer to turn on the video option in Zoom to allow me to see them. Several participants stated that they did not know how to turn on the video, one shared she did not have a camera on her device, and the remaining participants stated they did not want to be seen on video and felt self-conscious. Due to challenges with technology I was not able to collect data around body language and non-verbal communication. Seven interviews were conducted over the course of 8 weeks, with one interview occurring per week. There was a break of a week between interview six and interview seven due to scheduling conflicts. Interviews lasted between 20 minutes and 6 seconds to 54 minutes and 16 seconds. The average length was 36 minutes; this is much lower than the projected 60 to 90 minutes. The decrease in time may be due to many factors, one being time available and another being limited number of things to say about themselves and the needs as a parent or caregiver versus experiences of their child with RAD. Many interviewees focused heavily on experiences of their child with RAD's symptoms and challenges. The questions asked focused on the experiences that the caregiver has and about themselves.

Data Analysis

Hermeneutic phenomenological studies allow for the exploration of experiential data through the identification of themes (Saldaña, 2015). I utilized in vivo hand coding to analyze the data. This process required six distinct steps. The first step was simple; while the remaining steps were circular and took time.

My first step was to read the transcripts and cross out any unnecessary language in the transcript that has no purpose or meaning. This included repetitive statements and filler words, such as “uh,” “um,” “well,” and “you know.”

The second step was to read each transcript with the purpose of giving voice to the caregivers of children with RAD. I identified key features or traits of the phenomenon. After finishing a few transcripts, I would circle back around to the first interview transcript. I would also circle back to other transcripts when a theme would emerge to see if I had missed the same theme in previous interviews or similar content that could be connected. My process included underlining, circling, or highlighting words, phrases, and statements, as well as, writing themes or traits in the margins to paraphrase the important content.

In Step 3, the process was a spiral process. I started with the first interview transcript and then moved progressively through the transcripts. I reviewed the key features and traits from each interview question for each participant. I created themes of meaning based on my understanding of the description of the participant’s experiences. Each lens contributed to the themes and codes. The hermeneutic lens focused on meaning in the lived experiences. The attachment lens focused on the relationships between caregiver and child. Finally, the family systems lens sought themes and codes pertaining to family roles and family dynamics. I read through the transcriptions and notes and identified significant and relevant words, phrases, and statements through in vivo hand coding (Saldana, 2015). I utilized the constant comparative method of analysis to develop theory to the phenomenon of lived experiences for caregivers of children with RAD.

Once all transcripts had been analyzed sufficiently with codes identified in Step 4, I organized all codes by question in an excel document and sorted by code in each column. This allowed me to see how frequently each code had emerged within the transcripts. Code clusters were translated and grouped into emerging themes. I took quoted excerpts from the interviews that showcased the experiences and placed them under each question. Four main themes emerged: growth, family relationships, caregiver feelings, and supports. Growth emerged with subthemes of personal growth of the caregiver and of the child's growth. A theme of family relationships was identified with three subthemes: primary parent-child bonding, sibling bonding, and bonding with other family members. Caregivers experienced negative feelings were identified throughout the interviews. The subthemes that emerged were: experiencing feeling unsupported, experiencing judgement, experiencing feeling misunderstood, experiencing loneliness, experiencing exhaustion, experiencing hypervigilance, experiencing isolation, experiencing frustration, experiencing feeling scared, experiencing blame, experiencing helplessness, experiencing feeling unprepared, and experiencing other negative feelings. The final theme of experiences with supports includes the subthemes of mixed experiences with organized resources, mixed experiences with education systems, experiencing a need for attachment and trauma trained providers.

I summarized the data and experiences, including the quoted excerpts. I organized the situated narratives by all, many, and some and began to formulate general narratives. Finally, I was able to compile all of the general narratives into a general description of the phenomenon.

Discrepant cases were identified as cases that fell outside of the perimeters. Two cases fell outside of the other five as the children with RAD were over the age of 18 years and no longer living at home. The cases were still included in the data analysis as the themes that were shared coincided with themes of the other five participants.

Results

In this study, I strived to present the voices of caregivers of children with RAD as they disclosed their experiences in caregiving. I have identified four main themes: growth, family relationships, difficult emotions, and support. The themes were determined through imploring the hermeneutic circle within data analysis. I describe and give examples of each theme and the sub-themes.

Theme 1: Growth

Growth can be defined as "the process of developing or maturing physically, mentally, or spiritually" (Oxford Dictionaries, 2020). In this section, I identified areas of relational, mental, and spiritual growth in participants' stories. This first theme had the fewest amount of data of all the themes. Participants frequently stuttered or paused longer prior to answering any question about positive experiences in caregiving or parenting their child with RAD. All positive experiences shared were minimal and pragmatic. Positive experiences are defined as moments or interactions within the relationship that fed the connection or bond between the parties. Positive experiences are important in parenting and bonding as they strengthen that bond and healthy attachment. When asked to share positive experiences in parenting, Participant 4 replied "…that's an interesting question because most people don't think of any positives." Participant 6 stated "you know being a RAD parent, it's kinda hard to pick out anything positive." However, identifying positives in parenting/caregiving a child with RAD was the purpose behind the research question. As I read through the experiences over and over again and focused on positives, two main subthemes emerged. The subthemes were centered around the growth in themselves as a person and caregiver and the child's growth.

Subtheme 1: Personal growth. Personal growth is defined as physically, mentally, and spiritually maturing (Oxford Dictionaries, 2020) of the person or self. Participants shared that they have found personal growth through caregiving or parenting a child with RAD. Participants described learning how to be a better parent, therapeutic parenting, prioritizing self-care, and becoming a better advocate. This subtheme was found in all of the seven interviews in some part. Participant 2 stated "I have learned a lot about attachment…I have learned a lot about parenting." This indicated mental growth. Participant 2 added:

> It has forced me to have to think about how I am going to take care of myself so I don't become overwhelmed with her. So, I have had to do a lot of self-care. At some points it has pushed me closer to my religion because I felt like I didn't have a whole lot of people there to support me.

Participant 2 described mental and spiritual growth. Participant 5 shared learning through reading books, attending conferences, leading support groups, and phone calls with experts. Participant 7 detailed “it has caused me to become a more patient person… and a better parent to my other children.” This statement also indicated growth mentally. All participants reported advocacy and case management for their child with RAD being a main role and daily task. The skills needed to advocate for the child and case manage suggest spiritual and mental growth. They were able to identify how they have grown and developed in a better way as a person and parent.

Subtheme 2: Child’s growth. Child’s growth is defined as the physical, emotional, mental, and spiritual maturation (Oxford, 2020) of the child. All seven participants largely deemed experiences as positive when focused on the personal growth or healing of the child with RAD. Positive experiences ranged from children making progress with providers, bonding with family members, displaying kindness and caring, and making progress towards healing from trauma. These positive experiences represented the child making progress and growth, which was rewarding to the participants to experience. Participant 1 shared “I really didn’t experience anything positive until really, really recently.” She reported that her son was then 23. Participant 3 explained that “the ones that have healed, they are great kids.” Participant 5 shared that seeing the child overcome and heal were positive experiences. Participant 6 described:

> She had in discriminant friendliness, which I realize is not a good thing. But to see this little girl smile at everybody and run up to people and hug them and love

> on them, sometimes you know that's the people that really needed that and maybe wasn't getting it anywhere else.

These were all experiences of growth within their child that the participants were proud of and shared as positive experiences in the caregiving process.

Theme 2: Family Relationships

There are a variety of relationships within the family unit. There are the relationships between the primary caregiver and the child (possibly mom or dad), caregiver and other children, between children in the home, between children and a non-primary caregiver (maybe other parent, step-parent, nanny), and the relationships of the family members within a household with extended family members, such as aunts, uncles, cousins, and grandparents. The family relationships are important as they drive the status of the environment and the systems within the family (Bowen, 1993). The status of the relationships and those experiences also impact the bonds between family members (Bowlby, 1951; Ainsworth et al. 1978). Participants shared an overwhelming amount of difficult experiences that all related to a lack of bonding due to the child's behaviors and symptoms and the impact those experiences had on the family members. All participants related experiences of difficult and atypical parent-child relationships. Participants 2, 3, 4, 5, and 6 shared experiences of the child testing and manipulating relationships within the home.

Subtheme 1: Strained primary parent-child bonding. Parent-child bonding is relational connections that occur between the primary caregiver and the child. All seven participants described experiences related to a lack of bonding, or lack of healthy bonding. All participants described the challenges of bonding with their child with RAD in various ways. Participant 1 described "when he was little, he was affectionate toward me…Um and even now he's a little bit warmer with me. But not like say my nephew would be to his mother." Participant 2 shared "it is like bonding with a brick wall." Participant 6 described herself as a "vessel for meeting needs" to her child with RAD. Participant 4 reported that her daughter with RAD prefers that she be the only one to meet her needs. These excerpts from their experiences describe a broad spectrum ranging from all to almost nothing in regard to the connections that have been developed in parent-child relationships. These examples were shared as challenges and unmet needs within their caregiving experience.

Several participants described all of their child with RAD's anger and aggression being directed at them. Participant 2 explained the challenges about her children with RADs' anger saying, "even if it is about someone else it's directed towards me." Many participants explained a constant state of catering to the child with RAD over basic expectations or normal routines in an attempt to maintain the peace or decrease the negative impact on the whole home. These bonding experiences are describing the mother as the primary caregiver. Participants 5 and 6 did describe the honeymoon period after taking the child in as mostly positive. Additionally, participants reported moments of typical parent-child love that are rare but rewarding. Participant 3 stated "You know that parent-child love, that respect, everything is there, just moments, it's just moments that they have." Participant 5 described the good times in the beginning during the honeymoon helping make the hard times that came after "easier to deal with."

Participant 6 explained that the bonding from her child to her is the same as a chair to her, which was explained from a therapist. Participant 7 shared "if I go out of town and I leave her with a relative, when I come back it's a nightmare or she will do something stupid like overdose, so I have to come back." Participants shared these experiences as challenges in parenting/caregiving a child with RAD.

Subtheme 2: Experiencing one-sided sibling bonding. Relational connections that occur between siblings are defined in this study as experiences of sibling bonding. Sibling bonding is described as being one directional, meaning that the siblings cater to and accommodate for the child with RAD. Participant 4 explained how siblings in the home accommodate in order to keep the peace. Participant 7 described her child with RAD "being mean and just hateful" towards her sibling, often intentionally saying very mean things about sensitive, personal topics. Participant 7 also shared:

> Having a kid with RAD is not just the kid with RAD is affected and the parents are affected, the whole family is affected. Living in a very dysfunctional and chaotic state and it effects my other children. So, I really really really need family therapy and I have requested this many times over a couple years and they still have not provided me with that. And more recently they have acted like they are going to and then they don't.

Participant 4 described experiences where the child with RAD lied and stated a sibling hurt her. Participant 3 explained that her other children have felt a need to protect the participant from the child with RAD's aggression and violence. Participants shared these experiences as challenges and unmet needs in caregiving their child with RAD.

Subtheme 3: Bonding with other family members. In this subtheme I identified relational experiences between the child with RAD and members of the family that are not the primary caregiver or any siblings. Examples of these family members included another caregiver, grandparents, aunts, uncles, dogs, and spouses or significant others of the primary caregiver. Participants described children with RAD seeking out extended family relationships and wanting to impress those individuals, such as uncles and grandparents. Participant 1 shared that her child with RAD would tell exaggerated stories like, "I hit 50 home runs in my game, and he may have not have hit any you know but 'I hit 50 home runs' " to impress grandpa. This was a situation where the child was attempting to connect but doing so in a possibly unhealthy way. The spouses or significant others of the primary caregiver are described to have good connections when it is on the child's terms. When asked about her daughter's bond with the participant's husband, Participant 2 stated that her daughter does "choose him over me most times." Participant 3 shared that her children with RAD "love my mom. They don't act out for my mom." These were examples of positive interactions and relational experiences with family members.

Oppositely, the child with RAD was also described to ignore, avoid, reject, or test the other parent constantly. Participant 4 shared a story in which she went out with another one of her children and her husband was left to care for the child with RAD and feed her. The child refused to eat for dad and reported "you have to feed me mommy that's how this works" when the participant returned home. Participant 6 shared that for almost 10 years she would have stated that their child with RAD was completely bonded with the participant’s husband, however that has declined and the child’s intentional harm to all family members has balanced out. These situations are unhealthy relationships within the family unit and cause strain on not only that relationship but on the other relationships within the family system.

Theme 3: Experiencing Negative Feelings

Participants described an abundance of varying feelings throughout the interviews. I did not directly ask about feelings in the interviews. However, throughout the interviews, each participant described negative feelings. No positive feelings were directly expressed, except for love and commitment towards their child with RAD. Positive feelings are defined as feelings where there is a lack of pain, discomfort, or negativity (Changing Minds, 2020). Feelings ranged from judged, blamed, exhausted, scared, fearful, unsupported, rejected, alone, and misunderstood. A complete chart of feelings and data can be found in Table 1. Participant 2 shared “I really thought I was prepared to be a parent when I took her in, I found out I wasn’t.” Participant 6 explained:

> If I told somebody today that my child had leukemia, there would be people knocking down our door demanding to help. If I said my child has a malignant brain tumor. People would be begging us to help us. Those things might kill my child. My child has a very serious, chronic illness that can not only kill her but others around her, and no one can help us.

The lack of positive feelings experienced is indicative of the challenges and unmet needs caregivers are experiencing in raising their child with RAD. The feelings directly connected to unmet needs identified in the other themes, including bonding relationships and supports.

Subtheme 1: Experiencing feeling unsupported. To be unsupported, is to be lacking or appearing to lack assistance or help (Meriam-Webster, n.d.). All seven participants interviewed shared feelings of being unsupported in parenting their child with RAD. Participant 1 stated “No. I had no support.” Participant 2 stated “I felt like I didn’t have the support that I needed to navigate the challenges that I’ve had with her.” Participant 3 shared crying to a psychiatrist begging for resources. Participant 4 described situations of not finding the professional support, well-trained individuals, or schools that were understanding and knowledgeable leaving her to decide upon homeschooling as the solution and no therapist. Participant 5 shared “the biggest need I had was for support from people who understood.” Participant 6 discussed I detail the challenges of adopting a family member’s child privately and not going through the state or county system process of foster care and adoption as there were no supports offered through private adoption. Participant 7 described:

> It’s not like your kid has diabetes or something where there are a lot of doctors that understand it and classes where they can train parents on, and even though you might be stressed out and concerned because it is your child’s health, at least you have support where I think with RAD you are desperately trying to find support for your kid.

Subtheme 2. Experiencing judgement. In this study, feeling judged is defined as someone who feels others have formed an authoritative opinion of them (Meriam-

Webster, n.d.). All of the interviewees identified feelings of being judged related to their parenting or caregiving by friends, other parents, and people in public. This included reported feelings of being unconventional in their parenting techniques. Participant 1 described how others would judge her as a parent based on her son's rude or inappropriate behavior and their lack of connection or bond. Participant 2 stated "they don't understand that you can't parent a child with reactive attachment disorder in the same way that you can parent a child who does not have reactive attachment disorder." Additionally, Participant 2 described some parenting techniques that if shared with others she felt judged for being "cold or mean," although it was in the best interest and care of her child with RAD. Participant 3 reported false allegations of neglect or abuse. Participant 4 shared an experience being at the store with her children, including her child with RAD in which "this lady though, the looks that she gave me, she literally pulled her children away from me like I had leprosy" when her child with RAD was struggling and she was using unique parenting techniques that work for her child. Participant 5 detailed times in which her son would be hospitalized, and the hospital social worker would not return their calls or provide information because he believed the son's issues were from poor parenting. Participant 6 shared judgements from the school:

> One of the other things that is really difficult when raising RADs is the schools. They are absolutely precious when they are at school. They are the most charming person in the world and have that charming way about them. And (daughter) by everyone's standards was the cutest, sweetest child. They just didn't see her at home. So when I would go to school to see about extra precautions to make sure

> she didn't run away or cut herself or make sure she doesn't do this or doesn't do that, I actually had a school try to report me that I was trying to make (daughter) look sick, like I was trying to make it like something was wrong with her. Because they could just not imagine that there was anything wrong with this child so young.

Participant 7 described people in the community being rude or dismissive due to a lack of understanding of RAD.

Subtheme 3. Feeling misunderstood. To be misunderstood is to be "not sympathetically appreciated" or "wrongly or imperfectly understood" (Meriam-Webster, n.d.). All participants reported feeling misunderstood by providers, school faculty, family members, and others. Participant 1 responded "no" when asked if she felt other parents understood what she was going through. She elaborated "a couple only because they were teachers or counselors or therapists or something along those lines so they could understand it. But the outside world had no idea and a lot of people I didn't even tell." Participant 2 shared that the general public does not understand invisible illnesses like RAD and even medical doctors have not understood her reasoning of sitting in and speaking for her daughter who is chronologically 16 or 17, but emotionally between 3 and 5 years old. Participant 3 described experiences with others not understanding the intensity of the situations and behaviors she experiences with her children with RAD. Participant 4 shared:

> She is bad for me because she trusts me and she knows I am not going to beat her, and she doesn't know that about others, so she uses up all of her nice at school

> and comes home and lets it all hang out. And I am her safe place and there is a huge gap in teacher's understanding that.

Participant 5 reflected:

> If I ever shared stories about my son, they would normalize, and they would downplay it. There was one time he went into a rage over not wanting to brush his teeth. And it was like a 45-minute rage. And I just said to my co-workers, colleagues, oh it was such a rough night last night. He got into such a snit over brushing his teeth. 'Oh yea, all kids do that, don't worry about it, you're a new parent.' And I wasn't a new parent at that point, but you know. But basically 'you don't have the parenting experience to understand it' was the message I got. And I just snapped at her and said, 'oh going into a 45 min rage, taking out the TV and needing to be restrained, that's what normal kids do when they don't want to brush their teeth?'

Participant 6 shared that:

> When I would go to school to see about extra precautions to make sure she didn't run away or cut herself or make sure she doesn't do this or doesn't do that, I actually had a school try to report me... Because they could just not imagine that there was anything wrong with this child so young.

Participant 7 described her experience as "not just like raising a difficult child, it is raising the most difficult children" and "a lot of these people don't understand, and you would think that they would."

Subtheme 4. Experiencing loneliness. To be alone is to be separated from others (Meriam-Webster, n.d.). Six participants stated feeling alone. Participant 1 shared that she had no social outlets and "couldn't make plans," aside from work. Participant 2 described being pushed closer to religion and God to rely upon due to a lack of people to support her. Participants 4 and 5 described having supportive spouses that would help, but still feeling alone in parenting due to the high and constant needs. Participant 6 shared alienating herself from others to avoid having to answer questions about her daughter. Participant 7 reported:

> You know I think I dated like once or twice in the past 2 years and I can't do it because my daughter won't let it happen. She threatens people she makes it so I cannot do that. So that affects my relationships with people as well.

Subtheme 5. Experiencing exhaustion. To be exhausted is to be "completely or almost completely depleted of resources or energy" (Meriam-Webster, n.d.). For participants in this study, this meant many things were exhausted, both resources and the abilities of themselves as caregivers. Six out of seven participants shared experiences of being exhausted. Participant 1 shared how simple tasks of taking technology away as a consequence would lead to lengthy outbursts and confusion:

> Say I wanted to take his computer away because he was on it for a long enough time and he would say 'no it's my computer you can't have it.' And I'd say 'I am only going to put it in my room. You can see where it is, and you can get it in the morning.' 'Nope. It's my computer and I want it now.' You know he didn't realize he was going to get it back. Nobody was saying it wasn't his computer."

Participant 3 described the exhaustion of repeatedly reviewing rules and expectations for years and being patient through all of the anger outbursts stating “Like it’s exhausting, but it’s more like, ‘seriously we are doing this again? I’m not doing this again’-type of situation.” Participant 4 described having to be:

> on her like white on rice. I have to watch her every second or if she doesn’t get the attention she needs from me, there is limit to what she will do to get the attention that she needs from me and she will continue to escalate until I step in. That is challenging because number one that means that I don’t get a break and number two it means that if I need to do something (outside of the house and her) that there is going to be a price to pay for me doing that.

Participant 5 described the rigorous schedule of services and the amount of travel required to access those resources and supports with the amount of planning, taking time off of work, balancing FMLA and paid time off, educating herself and performing therapeutic parenting as getting “so exhausting.” Participant 6 relayed that during a recent hospitalization of their child with RAD, her and her husband realized that was the first time they had been alone in ten years. Participant 7 explained “she demands me to be there with her 24/7 and it’s exhausting.”

Subtheme 6. Experiencing hypervigilance. Hypervigilance is defined as being “highly or abnormally alert to potential danger or threat” (Merriam-Webster, n.d.). Five participants described the need or urge to be hypervigilant. Participant 1 reported “you are on guard 24/7…because you don’t know what is going to happen next.” Participant 3 described needing to stay connected to service providers and share everything and have service providers double check everything due to her children's attention seeking behavior. One example was one of her children with RAD telling the service provider that they did not have any socks, which then the provider took the child to the store and bought them socks instead of working on the goals and tasks outlined for the service time. In reality, the child had socks and did not need socks, but quickly led to service providers questioning the parenting of the participant. Participant 4 shared experiences of her child waking up and smearing paint all over the carpets of two rooms, smeared body powder all over the bathroom and her husband's keyboard. Participant 5 reported having to lock up items and search rooms and belongings in order to keep everyone safe. Participant 6 described her daughter eating dog treats, raw meat, tainting food and putting it back in the refrigerator or freezer, and attempting to poison the pets and her. Further, Participant 6 discussed needing to lock every pantry, refrigerator, and room in the house aside from the child's bedroom and bathroom in order to keep everyone in the house safe.

Subtheme 7. Experiencing isolation. Isolation for participants was described through being hidden, secluded, or sheltered from the outside world, community, or others (Merriam-Webster, n.d.). Five participants shared experiences and moments throughout caregiving that led them to feeling isolated. Participant 1 shared not having any outlets for connection and the inability to make plans for vacation or dates because no one else could watch her son. Participant 2 described feeling isolated from other parents of children with RAD that are "in the trenches just like I am" outside of the Facebook support groups. Participant 4 stated that when sharing challenges with her child that other parents will normalize the behaviors and say things like "all kids do that," which isolates her from other parents who do not understand that children with RAD take typical child behaviors to another level. An example provided by Participant 4 was that all kids play in their diaper, but "not coat their entire body in it like lotion, coat the entire bedroom in it, grind it into the carpet, stuff it into toys, and then not notice that it stinks." Participant 6 described that people avoid them like they have the plague, because mental health still has such a stigma compared to medical conditions. Participant 7 shared a situation of distancing from:

> Some of the other people around me. Like they don't want their kids to come over because of the way she acts, and they are worried that she will hurt them, which is not going to happen, I would never let that happen, but they have those thoughts in their head. So, they don't want their kids to come over and play with my kids. So, it does effect relationships and make things really hard.

Subtheme 8. Experiencing frustration. Frustration is defined through feelings of "discouragement, anger and annoyance because of unresolved or unfulfilled goals, desires, or needs" (Meriam-Webster, n.d.). In this study, participants reported levels of frustration around many unmet goals, desires, or needs related to their children with RAD. Five participants stated feeling frustrated. Participant 1 relayed the frustration of things in the house being broken, no respect towards her regardless of her parenting style, and the battles over consequences, boundaries, and limits. Participant 3 expressed frustration about only being able to find parent support groups online and most services and facilities excluding RAD from their treatment array. Participant 4 expressed frustration over the lack of organized information available for RAD, to include trained providers, facilities, interventions, books, resources, supports, and available assistance. Participant 6 shared frustration in finding out that once her daughter needed serious help, that the state controlled all of the residential treatment placements and needed to follow a lengthy process to get help. Participant 7 described frustration with her child not wanting to be picked up and not meeting her milestones and a pediatrician accounting it to a difference in temperament, as well as, not getting the supports or help that has been offered, available, or professionals who understand also causing feelings of frustration.

Subtheme 9. Experiencing feeling scared. Scared is described as being "thrown into or being in a state of fear, fright, or panic" (Meriam-Webster, n.d.). Five out of seven participants reported feelings of being scared. Participant 1 shared concerns for her son's risk of harming himself or completing suicide. Other feelings of being scared were in reference to their safety or safety of others in their home. Participant 5 described experiences where "he would make me public enemy number one and he would have told them what a horrible worthless mother I am and (the police and Child Protection Services) didn't understand RAD enough and they would have taken him." Participant 3 shared similar experiences and stated "I record every single bruise because I was terrified. I am still terrified of losing my other kids." Participant 7 stated "most people don't have to deal with children that try to start their house on fire or jump out of the car numerous times." Participants 3, 5, and 6 described experiences of violence and aggression in which they were scared for their own safety and needed to involve police on multiple occasions. More specifically, participant 6 detailed experiences of her child hurting her, her husband, the pets, other animals, eating uncooked meat or inedible items, and tainting food and putting it back in the refrigerator.

Subtheme 10. Experiencing blame. To be blamed is "to be held responsible or to find fault with" (Meriam-Webster, n.d.). Many participants shared feelings of responsibility or perceived fault. Four out of seven participants shared feeling blamed. Participant 2 shared that she wished she could tell others "don't blame us, they came broken." Participant 3 shared an experience where her child with RAD would tell workers that mom was not providing for her basic needs and the workers would blame the behaviors the child had on mom. Participant 5 described a social worker not calling her back for 2 days while her son, as a minor, was hospitalized due to the belief that the "parent is at fault for everything." Participant 6 shared experiences with professionals telling her not to ask her child with RAD questions because that is a known trigger and "you are setting them up to lie to you." This was another example of feeling blamed for her child's behaviors.

Subtheme 11. Experiencing helplessness. Meriam-Webster (n.d.) defines helpless in several ways applicable in this study; "lacking protection or support" and "an inability to act or react." Four participants expressed feeling helpless in their role as caregiver. Participant 2 stated "it feels like no matter what I do I can't meet her needs." Participant 3, among other participants, described devoting an abundance of time to seeking out services to benefit her children with RAD and that most times she does not get a call back or are told there are no openings. Participant 6 shared that to reduce fear and safety concerns with her child equates to giving her exactly what she wants and that since she and the world are not like that, she fears the risk of violence and aggression. Participant 7 explained that she loves her kid and her kid:

> Doesn't treat you really nice and nobody else does either and nobody knows how to help you. I would call CPS, the social workers that placed her in my home every day and tell them something's wrong. And they would be like 'ok you are getting the extra money because she has issues.' But what am I supposed to do with it? That doesn't help me. It was, it was really frustrating to not get the help where I needed it and from the people that were supposed to be helping me. And then when I finally did figure out, she was adopted later, and then I thought great now I will be able to figure this stuff out on my own and get some actual help. And I was so wrong.

Subtheme 12. Experiencing feeling unprepared. For this study, unprepared can be described as an immense or increased feeling of not being prepared for parenting that goes above and beyond the typical level of unpreparedness all parents feel in regard to child-rearing their children. Four participants described being unprepared. Participant 2 stated that she thought she was prepared for being a parent and found out she was extremely unprepared for parenting the child she adopted. Participant 3 reported being told that one of her children with RAD "only needed therapy, a [service worker], and love," however, she feels the issues were downplayed at the beginning by the county placing the child in order for her to take the child. Participant 3 described feeling unprepared for the behaviors, needs, and issues that arose and how to deal with them. Participant 6 reported not knowing what was available for supports and information, the processes for getting supports, or that having a private adoption hindered the process in getting support when needed. Participant 7 stated:

> I did not understand a lot of the issues that she had when she was younger, like I said, there are a lot of things I would go back and do completely different… And you know they just put her in my home and didn't offer me any support from the beginning. They didn't even offer me any information or anything.

Subtheme 13. Experiencing other negative feelings. There were other feelings that were identified by two or three participants, which is below the majority, however, are still noteworthy. Three out of seven participants identified feeling trapped, targeted, fearful, and like a failure. Two out of seven participants identified each of the following feelings: rejected, unloved, unappreciated, and selfless. Participant 2 explained:

> I really went into this relationship that if I just bring her into my home and I just love her and I give her all of these things and give her a safe environment, that she'll snap out of it.

Table 1

Participant Feelings on Caregiving a Child with RAD

	Participant						
Feeling	1	2	3	4	5	6	7
unsupported	x	x	x	x	x	x	x
judged	x	x	x	x	x	x	x
misunderstood	x	x	x	x	x	x	x
alone	x	x		x	x	x	x
exhausted	x		x	x	x	x	x
hypervigilant	x		x	x	x	x	
isolated	x	x		x		x	x
frustrated	x		x	x		x	x
scared	x		x		x	x	x
blamed		x	x		x	x	
helpless		x	x			x	x
unprepared		x	x			x	x
failure		x		x			x
fear			x		x	x	
targeted				x	x	x	
trapped	x			x		x	
selfless				x			x
unappreciated	x					x	
unloved	x					x	
rejected						x	x

Theme 4: Experiences with Supports

The theme of supports resounded throughout the interviews. Discussion and situations of supports being met and unmet needs were shared throughout each question of the interview. I identified supports having the following subthemes: resources, education, and attachment and trauma trained providers. The supports being met or unmet needs are displayed in Tables 2 and 3.

Subtheme 1: Mixed experiences with organized resources. I termed this subtheme "organized resources" to include all services and supports that are structured, scheduled, or readily available to be used. Needed support and resources were plentiful when listed and discussed (see Table 3). The unmet needs related to this subtheme included: local support groups, financial and insurance assistance, organized information about resources being provided, local resources, social and self-care support, community education, parent and family-specific support, legislative change, prevention and early intervention, and timely services. All participants stated a need for timely services; participants detailed the work in advocating, finding, and obtaining services to be lengthy. All seven participants expressed unmet needs of organized information, local resources, and social and self-care support. Participant 1 shared that she needed timely resources, local supports, and social outlets while her son was growing up. Participant 4 remarked that other illnesses and diagnoses have national organizations that have websites, funding, information and training, and recommended treatments and providers, but not RAD. Participants 2, 3, and 7 specifically disclosed that although they are in or near a large metropolitan city, that there are limited resources and supports available. Participant 4 expressed a desire for a national RAD organization that includes listings of trained doctors, therapists, programs, and resources in a centralized location. Four out of seven participants shared a need for local support groups, community education, parent and family-specific support, and prevention and early intervention. Participant 5 reported a lack of organized and consistent local support groups and stated that the support groups are often left to "already exhausted parents to lead and run." Participant 6 asked for all adoption and foster situations to be assigned a case worker, as many private adoptions do not get assigned case workers which would help with resources, rights, and support during the process; and for the school counselors and staff to screen for early-intervention opportunities that lead to RAD in children, such as incarcerated parents, kinship guardianships, and other adverse childhood experiences (ACES).

Five out of seven participants shared experiences where resources that were received were very helpful (see Table 2). Participant 2 shared online support groups as the only met need, 2 other participants also listed support groups as positive resources. Other resources mentioned included co-parent, friends, and church family support (two out of seven), financial assistance (one out of seven), ATTACH conferences and workshops (one out of seven), attachment parenting books (one out of seven), good insurance (one out of seven), parent retreats (one out of seven), and schooling support and understanding (two out of seven).

Subtheme 2: Mixed experiences with education systems. The education of others about issues related to RAD and trauma were indicated in unmet and met needs. Four out of seven participants talked about the need for school faculty who are trained in the field of trauma and attachment (see Table 3). Participants discussed the importance of all faculty members including the teachers, assistants, special education teachers and staff, principals, and school district leadership being trained in the field of trauma and attachment. Participant 5 suggested five-minute materials, power points, videos, or brochures for teachers and school staff to review to gain education quickly and efficiently. Several participants discussed the decision to homeschool rather than continue to struggle with schools not meeting the needs of the child with RAD. Participant 2 expressed a need for "therapeutic schools" as a solution to the challenges faced in public school systems and the denial of enrollment for children with RAD in many private schools due to the behaviors and safety risks.

Subtheme 3: Experiencing a need for attachment and trauma trained providers. All seven participants detailed a need for attachment and trauma trained providers in general, including speech therapists, psychologists, psychiatrists, and pediatricians (see Table 3). Participant 2 stated that she:

> Struggled to find therapists that are qualified and well-trained, who could treat this effectively. I've struggled to find other professionals, but medical doctors who will understand that my child is emotionally 3 or 5 years old although chronologically she maybe 16.

Participant 3 reported that doctors "put a patch on it" and don't help address the root issues. All seven participants expressed an unmet need for respite providers. Six participants reported a need for specifically trained therapists. Most participants specifically named attachment parenting, combined attachment and trauma therapy, and dialectic behavioral therapy (DBT) as highly sought-after specialties that are not always found. One participant shared that therapists that advertise or list being trained in attachment and trauma struggle to effectively address the RAD. Three participants stated a need for RAD-specific treatment centers. Participant 2 shared that many treatment programs do not accept the RAD diagnosis, although the programs advertise that the presenting symptoms are treated within their program. Participant 2 added that many programs available are costly and unattainable for most families with a child with RAD.

Five out of seven participants shared met needs related to attachment and trauma trained providers (see Table 2). All five participants described the positives of having a therapist who was experienced and knowledgeable in trauma and attachment. Participant 1 reported a good therapist was the only met need throughout the entire time caregiving. Participant 1 also shared an experience with a psychiatrist who "in front of my son said, 'you two are never going to get along, why don't you just get rid of him?'" Participant 4 explained how therapeutic advice from an attachment parenting therapist when her child was young was helpful to her for years and years.

Table 2
Supports Received

	Participant						
	1	2	3	4	5	6	7
Support Groups	x	x			x		x
Supportive People				x	x		
School				x			x
Financial/Insurance				x		x	
Conferences/Workshops					x		
Books					x		
Therapists	x			x	x	x	x
Doctors & Other							x
Programs	x					x	

Table 3

Unmet Support Needs

	Participant						
	1	2	3	4	5	6	7
Local Support Groups	x	x	x				x
Financial/Insurance		x	x	x			
Organized Information	x		x	x	x	x	x
Local Resources	x		x	x	x	x	x
Social/Self-care	x		x	x	x	x	x
Community Education			x		x	x	x
Parent & Family-Specific Support	x			x	x		x
Legislative Change				x		x	
Prevention/Early-Intervention			x		x	x	x
Timely Services	x	x	x	x	x	x	x
Therapeutic Schools		x					
Trained School Faculty	x		x	x	x	x	x
Treatment Centers		x	x			x	
Respite	x	x	x	x	x	x	x
Therapists	x	x	x	x	x	x	x
Doctors and Other Providers	x	x	x	x	x	x	x

General Narratives

All participants experienced unhealthy primary parent-child bonding. All participants who had more than one child, identified experiences with unhealthy sibling bonding. All participants experienced feeling unsupported, judgement, and feeling misunderstood. All participants experienced at least one other negative feeling associated with caregiving their child with RAD. All participants reported mixed experiences with organized resources. All participants shared mixed experiences with education systems. All participants experienced a need for attachment and trauma trained professionals.

Most participants described experiences of bonding within other family relationships. Most participants shared experiences of seeing personal growth in their children with RAD. Most participants experienced loneliness, exhaustion, isolation, frustration, and feeling scared. Many participants experienced blame, helplessness, and feeling unprepared. Some participants identified personal growth.

Table 4

Summary of Themes

	Participant						
	1	2	3	4	5	6	7
Growth							
Personal Growth		x			x		x
Child's Growth	x		x	x	x	x	
Family Relationships							
Unhealthy Primary Parent-Child Bonding	x	x	x	x	x	x	x
Experiencing Unhealthy Sibling Bonding	NA	NA	x	x	NA	NA	x
Bonding with Other Family Members	x	x	x	x		x	
Experiencing Negative Feelings							
Experiencing Feeling Unsupported	x	x	x	x	x	x	x
Experiencing Judgement	x	x	x	x	x	x	x
Experiencing Feeling Misunderstood	x	x	x	x	x	x	x
Experiencing Loneliness	x	x		x	x	x	x
Experiencing Exhaustion	x		x	x	x	x	x
Experiencing Hypervigilance	x		x	x	x	x	
Experiencing Isolation	x	x		x		x	x
Experiencing Frustration	x		x	x		x	x
Experiencing Feeling Scared	x		x		x	x	x
Experiencing Blame		x	x		x	x	
Experiencing Helplessness		x	x			x	x
Experiencing Feeling Unprepared		x	x			x	x
Experiencing Other Negative Feelings	x	x	x	x	x	x	x
Experiences with Supports							
Mixed Experiences with organized resources	x	x	x	x	x	x	x
Mixed Experiences with Education Systems	x	x	x	x	x	x	x
Experiencing a Need for Attachment and Trauma Trained Providers	x	x	x	x	x	x	x

General Description

Caregivers of children with RAD identify a few met needs and an abundance of needs in order to feel they are adequately providing for their child with RAD. Caregivers of children with RAD experience seldom positive moments in their caregiving role.

Among positives, they find pride in the work they have done to better themselves as individuals and caregivers. These activities and experiences include gaining further knowledge and experience in parenting or mental health, consciously practicing self-care, and finding a closer religious connection. Other positive experiences are centered around seeing growth and healing in their child with RAD. Caregivers of children with RAD experience strained and unhealthy family bonding throughout the majority of the relationships within their family unit which impacts the function and overall health of their family. Caregivers of children with RAD are overwhelmed with negative feelings that impact their relationships with themselves and others in their family. Additionally, caregivers of children with RAD describe positive experiences with the resources they have been able to obtain for their child and their family. However, most caregivers of children with RAD describe a lack of knowledge and access to organized resources, support for their child with RAD through education systems, and barriers and lack of access to trauma and attachment trained providers.

Discrepant Cases

Participants 1 and 5 are two possible discrepant cases. Both participants have children who no longer live at home and are over the age of 18. The first question of the eligibility survey asks if the potential participant is a parent or guardian of a child (under the age of 18) diagnosed with RAD. Both participants said yes in order to continue the survey, however, in the interview it was disclosed that the children were over the age of 18. I included both interviews in the data analysis as they identified themes that mimicked those of the other participants. Something interesting to note is that both participants' interviews had similar themes to the other five participants, despite a decade or more difference in caregiving or parenting timeframes. This suggests that the themes are not new, but longstanding.

Evidence of Trustworthiness

Throughout the study I employed numerous processes to establish trustworthiness (Amankwaa, 2016). The processes previously detailed for data collection and data analysis were applied to the tools of validity, reliability, and confirmability.

Validity

Validity, or credibility, was established by clearly identifying and following procedures for data collection and data analysis. I audio-recorded each interview and then transcribed each interview verbatim. This process allowed for immersion in the data and experiences of the participants. I provided each participant with a copy of the interview transcription within 3 days of the interview and asked for the participant to review the transcript and provide feedback on any changes, which is known as member checking (Chang, 2014). I made no changes to the transcripts aside from ignoring filler words like "uummm." I used direct quotations when appropriate to convey the thoughts and feelings of the participants to ensure integrity of the data.

Reliability

I practiced consistency and continuity of the process throughout data collection. I followed my clearly described steps to data collection. I re-read and reviewed transcripts for mistakes and offered each participant the opportunity to review and correct the transcripts by emailing the transcript (Amankwaa, 2016). I followed the steps outlined for data analysis and interpretation.

Confirmability

I reflected upon my role throughout the study to incorporate confirmability. I had to acknowledge the impact that my experiences as a caregiver of a child with RAD and a therapist who has treated children and families with RAD for many years brought to the study. I discovered that the participants were much like myself as a caregiver of a child with RAD, desperate for support, relief, and understanding (Amankwaa, 2015). I also found that the participants were very similar to the families of children with RAD I had provided therapy for in the past who were begging for resources, support, and anything that would help. Client families of children with RAD that I have served often seek family therapy as a last resort and have reported to me statements such as "this is my last attempt," "I can't do this much longer," "I have failed parenting," and "how do I keep my family safe and love this child?" These are very powerful statements for parents to make.

Summary

This chapter provided an account of a hermeneutic phenomenological analysis with the purpose of understanding the lived experiences of caregivers of children with RAD. The study had one main research question that guided eight interview questions which were asked to each participant. From the seven individual interviews, four main themes emerged. The fours themes were growth, bonding, feelings, and supports.

The first theme identified was that of growth. The two subthemes emerged of personal growth and child growth. Participants identified personal growth and development through caregiving their child with RAD. Participants also identified growth within their children as being very rewarding.

Family relationships emerged as a second theme. This involved primary parent-child bonding, sibling bonding, and bonding with other family members. Primary parent-child bonding is described as having positive and loving moments with an overwhelming amount of strain to cater to the child and meet their needs. Sibling relationships are strained with siblings often being the target of hurt. Other family member relationships vary, from extended family members having typical bonds and non-primary parents struggling to connect.

The third theme was negative feelings identified by caregivers. Participants identified various feelings related to being a caregiver of a child with RAD. The feelings most frequently described by participants include unsupported, unconventional, judged, isolated, hypervigilant, and exhausted.

The final theme that emerged was of supports with the three subthemes of organized resources, education, and attachment and trauma trained providers. Six participants identified met needs within those three subthemes. All seven participants stated unmet needs of respite, trained therapists, trained doctors and other providers, and timely services. Six out of seven participants identified trained school faculty, social and self-care opportunities, local resources, and organized information on resources and supports.

In Chapter 5, I will present, discuss, and evaluate the findings from the study. In addition, I will review the limitations of the study. Finally, I will present the implications for positive social change from the study and suggestions for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the study was to explore the experiences of caregivers of children with RAD in the United States. Results demonstrated that participants identified few positive experiences and an abundance of unmet needs. All seven participants identified that the current supports and services were insufficient for themselves, their child with RAD, and their families. Specifically, participants labeled an abundance of feelings associated with caregiving for a child with RAD, none of which are feelings of love, support, or healthy attachment. Feelings described by participants included fear, alone, judged, unsupported, and failure. Participants shared some positive experiences with providers, schools, and support groups that were helpful. All participants identified with the theme of unmet needs, including support and resources, education, and attachment and trauma trained providers.

Results from this research added an essential component to the existing body of literature: the voice of the caregiver of a child with RAD. The following discussion reviews the findings from the results described in Chapter 4 and compares those results to previous research found in the peer-reviewed literature described in Chapter 2.

Interpretation of Findings

A limited amount of research regarding caregivers of children with special needs has not specifically focused on caregivers of children with RAD in the United States. Previous studies found that adoptive parents of children with RAD felt unprepared for the challenges of parenting a child with RAD (Follan & McNamara, 2014; Smyke, 2015).

This study aligned with that theme and delved deeper into the reasons for feeling unprepared, amongst other feelings. Through the interviews, I found that parents felt unprepared due to a lack of support and resources, as well as feeling judged by others and as though they cannot be like other parents (unconventional). Participants described feeling unlike other parents they know due to the parenting techniques and interventions they must use out of safety for their child and family. Participants detailed not being able to leave teenage children with RAD unsupervised for any period of time, having key locks to all doors and cabinets except for the child's bedroom and bathroom, locking closets, and using techniques to mimic earlier stages of nurture and bonding. Throughout the interviews of this study, participants identified and shared feelings related to parenting/caregiving a child with RAD. Feelings such as failure, hypervigilance, exhaustion, and unprepared were also found in other studies involving parents of children with RAD (Follan & McNamara, 2014).

The conceptional framework for this study consisted of both attachment theory and family systems theory. Attachment theory concepts were found throughout with the strained and complex relationships between the primary caregiver and the child with RAD. This was obvious in the data that came through with the child prioritizing their needs being met by the primary caregiver and simultaneously directing anger and aggression to push them away. Examples of this include making false reports of abuse and neglect and physically harming or threatening the primary caregiver. In regard to family systems, all participants described how the relationships with the child with RAD impact the other members of the family. Siblings are subject to abuse and pushed aside due to the needs of the child with RAD. Other parents and family members are ignored. In addition, participants identified needs for family members to receive supports to heal, not just the child with RAD. Families relayed needs for family and individual therapy, sibling support, and family resources to relieve the stress and strain.

Research involving the support of parents of children with RAD has resulted in the identification of parents not feeling supported by mental health professionals and society in general (Zeanah, Chesher, & Boris, 2016). Further, Follan and McNamara (2014) identified the importance of mental health professionals with expertise in early neglect and separation of children and biological parent providing early intervention. Results from participants support the previous findings. Participants reported a lack of guidance and resources from case workers, schools, therapists, and other primary care providers. The caregivers disclosed the lack of solutions and the long waits for services, if you can find the services needed. Many participants identified needing to advocate and constantly do research to find services and solutions because none are being provided to them. This leads to the caregivers feeling alone, exhausted, frustrated, tired, unprepared, unsupported, and tired.

Physical and mental health is directly correlated to stress levels; increased chronic stress levels are linked to diminished physical and mental health in caregivers (Lovallo, 2015; Wright et al., 2017; Zeanah, Chesher, & Boris, 2016). The participants in this study described emotions and feelings that are associated with chronic stress. Participants disclosed in the interviews a lack of control in their own lives. This presented itself in many ways. Many participants shared an inability to make plans for themselves, go on dates, have friends and a personal social life, or even leaving the home to provide self-care for themselves. Participants expressed experiencing fear due to retaliation or manipulation that would impact their relationships, employment, and personal feelings when engaging in any activity that did not center around the child with RAD.

Information about recommended treatments and interventions to support caregivers of children with RAD have been published (Dozier et al., 2017). Among suggested treatments are intensive attachment-based interventions, attachment-based family therapy, and positive parenting (Diamond, Russon, & Levy, 2016; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2017; Purvis et al., 2014). Caregivers in this study who have experienced these treatment modalities described the modalities as positive experiences for them and their family. However, most of the participants reported not being able to find attachment-based providers who are trained and experienced. A lack of trained providers in the recommended treatment modalities has a critical and dire impact on the progress towards positive outcomes for caregivers of children with RAD.

An abundance of research described the value in providing daily routines, structured activities, clear expectations, and warm, responsive interactions in all settings and environments (Soares et al., 2014; Thomas, 2017; Wright et al., 2017). Participants described experiences that validate the successes in following the recommended interventions. However, most participants shared a lack of support by schools, providers, and even family members that act as a barrier in providing the necessary consistency.

Research emphasizes the importance of caregivers receiving the guidance and support to provide the responses consistently in order to be effective (Smyke, 2015; Wright et al., 2017). Caregivers who are providing the recommended interventions without the support and collaborative team modality, describe loneliness, exhaustion, isolation, failure, hypervigilance, trapped, unloved, unappreciated, and helpless, among other feelings. This suggests that most participants, and caregivers of children with RAD, do not have the support and guidance available to them to provide the evidence-based treatments and interventions for their children with RAD.

Limitations of the Study

In Chapter 1, I discussed the possibility of participants not being truthful as a potential limitation. After hearing the distress, exhaustion, and pleas for help from the participants during the interviews, I believe this to not be a limitation of this study. Participants were asked to share about his/her lived experiences as a caregiver of a child with RAD. Regardless of the full accuracy of the information, the perceptions of the participant about his/her experiences are his/her reality (Heidegger, 1962).

No data was specifically collected regarding gender, race, ethnicity, religion, socioeconomic class, or other demographical information. All of the participants referred to themselves as the “mother” or female primary caregiver for the child with RAD. The study may not be generalizable to all genders, races, ethnicity, or other demographics. Additionally, cities or areas of the United States where the families are located was disclosed during most interviews, but not all interviews. There was a variety in locations, with none identified as being the same. However, the data may not be generalizable to all caregivers of children with RAD within all areas of the United States.

Recommendations

During this hermeneutic study I asked caregivers of children with RAD to share their experiences in caregiving (positive and negative), experiences with resources, met and unmet needs, experiences with bonding with their child with RAD, and the relationships among their family members and the child with RAD. Through data analysis, I was able to identify themes and subthemes related to those topics. Further research is recommended in exploring those themes in more detail. Further research in these areas has the potential to provide more specific answers on the unmet needs of this population to improve their quality of life and that of those around them.

One of the areas for future study is to pursue the barriers caregivers of children with RAD have to obtaining resources and services for themselves and the children they care for. Future researchers should include barriers to caregivers utilizing parent or family specific supports, such as, respite, support groups. social outings, conferences, books, trainings, and therapy. Future research should include quantitative research on the number of mental health providers who are trauma and attachment trained and who are ethically competent in treating children and families with RAD. It would be helpful to know a general estimation of how many mental health providers report to be trauma and attachment trained. Additionally, it would be helpful to have a concrete understanding of what being trauma and attachment trained means to those individuals and what being ethically competent in the expertise means. Other mental health specialties identify what education, experience, and ongoing training is necessary to be deemed ethically competent. Many participants reported finding mental health professionals who self-identified as trauma and attachment trained, however they lacked the experience and competencies to support them efficiently. Future research should also include qualitative and quantitative studies on the education currently provided and needed for all school faculty to be trained in supporting children and families with RAD. By knowing what education and training for attachment and trauma is currently available or provided and where, could lead to standardizing training and education to school faculty in all schools. This could reduce the barriers to education for children with RAD and increase the collaboration and support for them within typical education settings.

Another area for further study is to compare the feelings identified by caregivers of RAD to other parents and caregivers. The feelings identified by caregivers of RAD could also be used by most parents or other caregivers. Future research could identify and compare the frequency of occurrence of identified feelings of caregivers of children with RAD to the frequency of occurrence for parents of typical children and caregivers of children with other disorders.

Additionally, an area for future study would be to explore the experiences of siblings of children with RAD. Research could identify the unique experiences and compare to siblings of typical children and other children with special needs. Future studies could give voice to the sibling population.

As a recommendation for action, results from this study indicated that there are available resources and support available to caregivers of children with RAD in the

United States. Findings suggested that participants were overall are underserved and under supported. Therefore, I recommend actions to improve the resources and support to caregivers of children with RAD include the following:

- Brochures and organized handouts of the local, state, and national resources, services, and supports should be provided to caregivers of children with RAD, or a potential diagnosis of RAD, by providers and organizations (such as foster care agencies, adoption agencies, CASA, and mental health providers) upon first contact.
- Attachment and trauma trainings that specifically address treatment and intervention for children, caregivers, and families with RAD at state and national conferences for mental health and medical providers.
- Establish in-service and training programs that are concise and effective on the topics of RAD, attachment, and trauma in children for educators and school faculty.
- Foster care and adoption agencies should work collaboratively with human service and mental health programs specific to trauma and attachment to assure consistent programming is offered to those in need of services.
- Disseminate current and future findings through conferences, presentations, and publications that target mental health providers, stakeholders, and policy makers to enhance the continued and collective

efforts to increase the services and supports available to caregivers of children with RAD.

Implications for Positive Social Change

It is known that caregiving is a selfless job. Further, parents and caregivers of children with RAD experience parenthood and parent-child bonding different than other parents. Children with RAD can be described as “broken,” “wanting others to hurt like they hurt,” and “untreatable.” The behaviors associated with RAD not only impact the safety and well-being of the child and family, but the community around them. Most caregivers associate a decrease in stress and concerns with the child with RAD’s needs being met and the level of support and resources being received. Increasing support in a few targeted areas has the potential to reduce stress and fear in caregivers, which will in turn increase the support for the child with RAD and the rest of the family. The findings of this study point to the need for more support for caregivers of children with RAD in several areas.

Caregivers described the never-ending, and all consuming, responsibility of not only being parent and provider, but case manager and advocate. Caregivers spend countless hours researching treatments, interventions, programs, supports, providers, policies, rights, and more. This is time away from the other duties of the family, his/her job, and time to take care of his/herself. Caregivers of children with RAD are pleading for an organized database of available resources, information, and providers who specialize in RAD, attachment and trauma, and families. While organizing such information would be timely, it would cut down on the repetitive searching of hundreds and thousands of caregivers across the nation. Currently, caregivers are depending on google searches, word of mouth, and fate to steer them in the right direction towards help for their children and their families.

Education is a powerful tool. Education for the community at large on RAD would create a community of acceptance and support, which caregivers and families of children with RAD are desperately seeking. RAD is an invisible disease compared to diagnoses that have physical attributes. Lack of education for communities impacts the children, caregivers, and families negatively, often isolating and ostracizing them. Commonly mentioned by participants was the additional need for education and training for school systems from the top down. Awareness and understanding in the school systems will provide early intervention, modeling of acceptance to others, and provide children and families a collaborative ally. It is no secret that teachers often spend as much or more awake time with children as parents do, based on a typical parent 40-hour work week and 35-hour school week. This partnership is critical.

Trained providers in trauma and attachment were described as being a needle in a haystack by caregivers of children with RAD. Children with RAD and their families deserve appropriate treatment that meets their needs effectively. This requires general providers who are trained and knowledgeable in trauma and attachment, as well as, mental health providers that are trained and experienced in trauma and attachment. Participants described the challenge in finding specialized providers for mental health in their community, or even region of their state. Participants also stated that other providers often do not understand the child with RAD or their symptoms, which can hinder progress and even be damaging. For example, untrained pediatricians have stated to participants that it may be the child's personality as not being affectionate or liking touch so the caregiver of the child with RAD should refrain from physical touch. Researchers have identified that refraining from physical touch further solidifies the negative thoughts and beliefs of the child about safety with caregivers (Narvaez et al., 2019). Alternatively, many children with RAD who become hospitalized for mental health issues will be restrained by staff in an effort to calm or control them. This form of physical touch reaffirms that caregivers are not safe. Pediatricians, occupational and speech therapists, dentists, nurses, emergency room staff, and crisis center staff are among those who interact with children with RAD and need the training to be confident and competent in their services with them.

Ultimately, the goal is to provide support to others to live a happy, successful life. Currently, caregivers of children with RAD are struggling to identify happy moments and successes. The caregivers of children with RAD are exhausted, tired, scared, and on the verge of burnout. For caregivers of children with RAD that burnout, attachment parenting becomes less of a practice and more of an idea. Children with RAD increase behaviors and often show signs of being unsafe in the current environment. Reaching this point inevitably lands children who believe they are unlovable outside of a home environment and placed in group homes, treatment programs, high level mental health facilities, or in the justice system. I believe this is not only a failure to the children and families, but to our community and society as a whole.

Conclusion

Caregivers of children with RAD are an underserved and often unidentified population of caregivers. The present study provided critical information regarding the experiences of caregivers of children with RAD in parenting, access and use of resources, needs, and bonding within the family unit. While there are evidence-based treatments and interventions available, results from the study suggest that access to these resources is limited and the availability is minimal, even in metropolitan areas. A lack of resources and support available to caregivers has stemmed a population of caregivers who are misunderstood, unsupported, exhausted, and feel like failures to their children with RAD and themselves. The availability and access to resources must be addressed nationally to better serve the caregivers and their families. Additionally, education on RAD and attachment issues to mental health providers, educators, primary care providers, and the community is necessary to increase awareness, advocacy, and understanding. Providers and educators are a critical component and support to the success of treatment for RAD by working collaboratively with the family to provide consistent, evidence-based interventions. These gaps in services and supports lead to children with RAD being removed from their families, again, and placed in facilities or treatment programs that do not provide the evidence-based, family, and attachment therapies suggested for positive outcomes. Caregivers and parents are then left broken and feeling as though they have failed their children. Often, the cycle will continue again with children with RAD who have not healed. Children with RAD who have not healed, pose a higher safety risk to themselves and others due to their lack of trust and relational attachment and are at an increased risk of unhealthy relationships, unplanned pregnancies, violence, and substance use. These behaviors continue the cycle of RAD. Addressing the unmet needs of caregivers of children with RAD, as described early in Chapter 5, may reduce costly and damaging inpatient treatment, police and crisis involvement, cost of emergency alternative school opportunities, and violent and aggressive behaviors towards themselves and others around them. Providing increased support and resources to those who care for and teach children with RAD will not only provide positive social change for the family unit, but for the community at large.

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Appendix A: Participant Eligibility Survey

My name is Abby Baumgart, and I am a doctoral candidate at Walden University. I am inviting you to be a part of a study to explore, with you, your perceptions of the resources and supports available to you and desired as a caregiver of a child with Reactive attachment disorder (RAD). You may find this study interesting as you have the opportunity to voice your experiences as a caregiver and your opinion not only of current resources and supports, but what you believe is necessary to support you and others with similar experiences in raising a child with RAD.

In order to participate, the following criteria must be met:

1. A parent or caregiver of a child with Reactive attachment disorder.
2. At least 18 years old.
3. Lived in the United States with your child with Reactive attachment disorder for the past 5 years.
4. Provide at least 50% of care for the child with RAD.
5. Be willing to share your experiences as a parent of caregiver.

Your participation in this study is completely voluntary. You are free to refuse to participate, and if you choose to participate, are free to leave the study at any time without any negative consequences. In this study, you will participate in 2 online video conferencing sessions with the researcher lasting up to 90 minutes each, approximately a week apart. The interviews will be completed in English, so you must be comfortable reading and speaking English. The first interview will be audio-recorded and transcribed with your permission and will be kept strictly confidential. This means that I will be the only one who will have access to the audio recordings, and they will be kept in a secure, password-protected file. The researcher will assign a confidential ID to you so that your name is not identified on any research data collected, including written or audio-recordings.

1. Are you a parent or guardian of a child (under the age of 18) diagnosed with Reactive attachment disorder?
    a. Yes
    b. No
2. Are you at least 18 years old?
    a. Yes; enter birth year ______
    b. No
3. Have you and your child with RAD lived in the United States for the past 5 years?
    a. Yes
    b. No
4. Do you provide 50% or more care for the child with Reactive attachment disorder?
    a. Yes
    b. No
5. Are you willing to share some of your experiences and insight about caregiving for a child with Reactive attachment disorder?
    a. Yes
    b. No

If all questions are yes, the following will prompt:

"You meet the criteria to participate in this study. If you would like to share your experiences as a caregiver of a child with Reactive attachment disorder, please share your first name and email address and I will contact you shortly to get the process started.
First Name:
Email Address:"

If any question is no, the following will prompt:

"Thank you for your time and interest. You do not meet the criteria for this study."

Appendix B: Study Invitation Posting

My name is Abby Baumgart, and I am a doctoral candidate at Walden University. I am inviting you to be a part of a study to explore, with you, your perceptions of the resources and supports available to you and desired as a caregiver of a child with Reactive attachment disorder (RAD). You may find this study interesting as you have the opportunity to voice your experiences as a caregiver and your opinion not only of current resources and supports, but what you believe is necessary to support you and others with similar experiences in raising a child with RAD.

Your participation in this study is completely voluntary. You are free to refuse to participate, and if you choose to participate, are free to leave the study at any time without any negative consequences. In this study, you will participate in 2 online video conferencing sessions with the researcher lasting up to 90 minutes each, approximately a week apart. The interviews will be completed in English, so you must be comfortable reading and speaking English. The first interview will be audio-recorded and transcribed with your permission and will be kept strictly confidential. This means that I will be the only one who will have access to the audio recordings, and they will be kept in a secure, password-protected file. I will assign a confidential ID to you so that your name is not identified on any research data collected, including written or audio-recordings.

Thank you for your time and consideration.
Sincerely,
Abby Baumgart
PhD. Candidate
Walden University

Appendix C: Participant Consent Form

You are invited to take part in a research study about the experiences caregivers of children with Reactive attachment disorder have as caregivers. The researcher is inviting adult caregivers of children with Reactive attachment disorder to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Abby Baumgart, who is a doctoral student at Walden University.

To be eligible, participants must:
- Be 18 years of age or older.
- Provide at least 50% of the care of a child with RAD.
- Have lived in the United States with a child with RAD for the last 5 years.

Background Information:
The purpose of this study is to explore the lived experiences of caregivers of children with Reactive attachment disorder (RAD) and their opinions of resources and supports available to them.

Procedures:
If you agree to be in this study, you will be asked to:
- Complete a brief 5-minute survey to make sure you meet the criteria to participate.
- Meet with the researcher via video chat for an interview lasting about 90 minutes.
- Review a transcript of your first interview to check for accuracy lasting about 45 minutes.
- Meet with the researcher via video chat again one week later for approximately 30 minutes to correct or add any other information missed from the first interview.

Here are some sample questions:
- What are some of the positive experiences you have parenting/caregiving for your child with RAD?
- What are some challenges you have as a caregiver for a child with RAD?

You can decline to answer any question asked.

Voluntary Nature of the Study:
This study is voluntary. You are free to accept or turn down the invitation. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress and becoming upset. Being in this study would not pose risk to your safety or wellbeing.

If at any time you are struggling with your mental wellness and would like support, the following resources are suggested:
~Call 211 to get local resources for you
~Your county Crisis line
~Hope Line text 741-741
~National Help Line 1-800-662-HELP (4357)

The benefits of this study are broad. With the contributions of participants, the results of this study will be able to inform mental health providers, pediatricians, foster care and adoption agencies, schools, and more on the needs of caregivers of children with RAD.

Payment:
There is no payment or compensation provided for this research study.

Privacy:
Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by utilizing data encryption, use of codes in place of names, and storing email addresses separately from the data. Data will be kept for a period of at least 5 years, as required by the university. Confidentiality may be broken when information is shared that falls under mandated reporting laws, which may include intended suicide or homicide, child abuse, or elder abuse.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via e-mail at abby.baumgart@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university at 612-312-1210. Walden University's approval number for this study is **08-28-19-0456696** and it expires on **August 27, 2020.**

Please print or save this consent form for your records.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by clicking "accept."

Appendix D: Interview Guide

Interview questions to explore the experiences and opinions of caregivers of children with RAD.

Participant ID: ________________________________ Date: ___________

Introduction.

1. What are some of the positive experiences you have parenting/caregiving for your child with RAD?
2. What are some of the challenges you have parenting/caregiving your child with RAD?
3. What are the needs that you have as a caregiver for a child with RAD that are being met?
4. What are the needs that you have as a caregiver for a child with RAD that are not being met?
5. What are the resources that are available to you as a caregiver of a child with RAD? And what are your experiences with these resources?
6. What are the experiences that you have had in bonding with your child with RAD?
7. Give me some experiences within your family/household relating to relationships among the household members?
8. Is there anything else you would like to share?

Appendix E: Interview Debriefing Reminder

You participated in this study entitles, "Lived Experiences of Caregivers of Children with RAD." You were asked to participate in an audio-recorded interview that would last around 90 minutes and participate in a debriefing about the study.

You were informed that the purpose of this study was to explore the lived experiences of caregivers of children with Reactive attachment disorder (RAD) and his/her opinions of resources and supports available to them. You are in a special position to give voice to caregivers of children with RAD.

I did tell you everything about the purpose of the study. If you have any questions, you may contact me, Abby Baumgart at abby.baumgart@waldenu.edu, or Dr. Dorothy Scotten at Dorothy.scotten@mail.waldenu.edu. If you would like to talk privately about your rights as a participant, you can call the Walden University Participant Advocate who can discuss this with you at 1-800-925-3368 or by email at irb@waldenu.edu.

Together we scheduled a follow-up interview listed below. The transcript of the first interview will be emailed to you within 72 hours of the interview. I ask that you please review that transcript for any errors, edits, and information to be added. We will discuss any at the below date and time:

Next meeting: Date: _____________ Time: ________________

Virtual Meeting Room Link: ____

Thank you for your willingness to participate in this study, it is greatly appreciated. Would you like to know the results and be kept informed about this research study?

- ○ No
- ○ Yes, how can we contact you?
  - ○ Email: _______________________________

Referral Information:
If at any time you are struggling with your mental wellness and would like support, the following resources are suggested:
~Call 211 to get local resources for you
~Your county Crisis line
~Hope Line text 741-741
~National Help Line 1-800-662-HELP (4357)

Appendix F:

Debriefing Interview Questions

1. Did you have the opportunity to review the transcript of your initial interview?
2. Are there any errors or items that need to be corrected in the transcript?
3. Do you have any other information you would like to add?

Appendix G: Master Code Sheet

Interviews

(This sheet is filed separate from all documentation)

e-mail address	**ID Number**