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College of Psychology and Community Services

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LaToya Geter

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Walden University
2022

Abstract

Adoptive Parents are Socially Affected by the Behaviors of Adolescents with Reactive Attachment Disorder

by

LaToya Geter

MS, Walden University, 2017

BA, University of Arkansas at Pine Bluff, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

May 2022

Abstract

Research regarding the experiences of adoptive parents in the Midwest has revealed feelings of social isolation. Further research is warranted focusing on social issues adoptive parents of reactive attachment disorder (RAD) youth experience in the South. This could serve as a comparison to the findings from research focused on the Midwest. There is a gap in the research and knowledge regarding the social issues adoptive parents of RAD youth experience in Arkansas. The purpose of this phenomenological study was to explore the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas. Attachment theory was the foundation of attachment behavior, internal working models, and maternal sensitivity, while family systems theory was also signficant to the topic due to the study being conducted to give insight on how a child's beahivor impacts the family system. Phenomenological, intensive interviews were conducted among six adoptive parents of children with RAD. Data were analyzed according to Heidegger's phenomenology and Colaizzi's method. Themes that emerged were focus on mothers living with anxiety and post-traumatic stress disorder (PTSD) lack of understanding of RAD, living with behaviors and symptoms, and social isolation. The study results support the need for mental health and social support services received by parents and give insight into the parents' experiences to the professionals of the fields.

Adoptive Parents and the Behaviors of Adolescents With Reactive Attachment Disorder

by

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MS, Walden University, 2017

BA, University of Arkansas at Pine Bluff, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

May 2022

Dedication

I would like to dedicate my dissertation to my late biological mother, Romunda L. Owens my late maternal grandmother, Betty L. Williams and adoptive parents of adolescents diagnosed with Reactive Attachment Disorder.

Acknowledgments

Thank you to my motivational circle, Christian mother, Vicky Ross Barsh, mother, Annette Williams, sorors, Darrilyn Brittian and LaTasha Rideout, colleagues, Chicketta Jackson, Clarissa Alderman, Carolyn Mills and Dr. Linda Okiror. A special thank you to Deddrick L. McElroy for being my accountability partner.

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Chapter 1: Introduction to the Study

Introduction

Reactive attachment disorder (RAD) is a new diagnosis to the field of mental health (Mikic & Terradas, 2018). The disorder stems from attachment theory (Shi, 2014) and develops from the abuse and neglect by the biological parent (Follan & McNamara, 2014). There is no cure for the disorder (Moran et al., 2017), and clinical mental health treatment is difficult (Shi, 2014). Behaviors of the disorder manifest in adolescence (Moran et al., 2017). Adoptive parents, in particular, struggle with caring for RAD adolescents (Vasquez & Stenland, 2016). The behaviors presented by the youth greatly affect the lives of adoptive parents (Follan & McNamara, 2014).

Problem Statement

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), RAD is an official mental health diagnosis (Mikic & Terradas, 2018). Research on RAD was conducted with a sample size of 60.87% of youth from the United States (Vasileva & Petermann, 2016). The results of the study revealed 43% of the youth included in the study struggled with insecure attachment (Vasileva & Petermann, 2016). Affective behaviors include aggression, verbal threats, self-harming (Vasquez & Miller, 2018), being emotionally withdrawn, and hypervigilant behaviors (Vervoort et al. , 2013). Behaviors associated with the disorder affect adoptive parenting, and there are few resources for the parents (Follan & McNamara, 2014). It is evident the disorder is common among foster care youth and those who have been physically or sexually abused or neglected before the age of 5 years old (Follan &

McNamara, 2014). These behaviors can cause adoptive parents to feel unprepared to parent the child, insecure in their abilities, unprepared for outbursts of emotions (Follan & McNamara, 2014), and socially isolated (Vasquez & Stensland, 2016).

Little research has been conducted on RAD in general (Mikic & Terradas, 2018), but research regarding the experiences of adoptive parents in the Midwest (not specific to RAD; e.g., Vasquez & Stensland, 2016) has revealed feelings of social isolation among adoptive parents. This demonstrates the need to further understand the experiences of adoptive parents with RAD who also face the additional challenge of living in rural communities. Adoptive parents of youth diagnosed with RAD often feel it is difficult for others to understand their challenges (Vasquez & Stensland, 2016). Parents often battle with public criticism from others and struggle to explain why they must cease involvement with social clubs, friends, and networks due to their child's behavior (Vasquez & Stensland, 2016).

According to the Arkansas Department of Human Services and Arkansas Building Effective Services for Trauma, RAD was a new diagnosis among Arkansas youth in 2016 (Arkansas Department of Human Services & Kramer, 2016). In Arkansas, also during this year, 4,880 children were in foster care (Kids Count Data Center, 2018). Fifty-six percent (56%) of those 4,880 Arkansas youth in foster care were listed as *neglected* during the 2016-2017 year (Arkansas Department of Human Services, 2018).

I have found no research specifically on the experience of social isolation of adoptive parents in Southern United States, nor research on adoptive parents of children with RAD and the experiences of social isolation among these parents, specifically.

Further research is warranted focusing on social issues adoptive parents of RAD youth experience in the South. This could serve as a comparison to the findings from research focused on the Midwest. There is a gap in knowledge regarding the social issues adoptive parents of RAD youth experience in Arkansas.

Purpose Statement

The purpose of this phenomenological study was to explore the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas. The population for the study was adoptive parents of adolescents 12-18 years of age. The adoptive parents and adolescents resided in rural areas of Arkansas. Data were collected from interviews with adoptive parents to understand their experience of the child's behavior and the parental feelings of social isolation. The study impacted social change by presenting an understanding of the experience of adoptive parents in a southern region and gives insight into mental health professionals assisting the parents.

Significance

This study had both research and social implications. Research implications are broadening the field and providing further depth to a growing body of literature on the experiences of adoptive parents. More specifically, this study contributed to research on adoptive parents and their feelings of social isolation and adoptive parents of children with RAD.

In addition, this study had implications for the lives and experiences of adoptive parents. This study benefited adoptive parents of RAD youth residing in the state of Arkansas, as well as has the potential to benefit adoptive parents more broadly. It serves

as an original study of the RAD behaviors that cause parents to socially isolate themselves from family, public, and others who do not understand RAD. Exploring both RAD and social isolation among rural families provides new insight into parenting children with RAD and how this affects the lives of adoptive parents. The study supports the need for mental health and social support services received by parents and gives insight into the parents' experiences to the professionals of the fields.

Framework

The theoretical frameworks used for this study consists of attachment theory and family systems theory. Attachment theory was first developed by the work of John Bowlby and Mary Ainsworth (see Bretherton, 1994). Bowlby studied youth in institutions and concluded their behavior of stealing and lack of affection was due to maternal deprivation and separation (Bretherton, 1994). Ainsworth contributed to the theory through various studies. The Ganda Project led to the development of attachment patterns: securely, insecurely, and not attached (Bretherton, 1994). Ainsworth developed mother-infant interaction patterns by studying infants and mothers in the Baltimore Project. The third contributing study was the Strange Situation. Ainsworth concluded infants were more comfortable with the mother in the environment and uncomfortable in the presence of strangers or without the mother (Bretherton, 1994).

The attachment theory posits that mother-child bonding is critical for the child to survive (Karakurt & Silver, 2014). The theory is important to my study as it relates to the child attaching or failing to attach to adoptive parents. Theoretically, failing to attach would cause specific behaviors to transpire. The behaviors may be those that are causing

parents to feel socially isolated. Behaviors include temper tantrums in public environments (Vasquez & Stensland, 2016) or aggressive behavior toward family members. Parents refuse to go out in public due to the child's behavior (Vasquez Stensland, 2016).

Family systems theory focuses on the present or current situation (Helm, 2013) as it pertains to observing the entire family system. The theory expresses when individuals cause issues within their environment, the environment affects the family. The families are triggered by the behaviors of their children, which then has an impact on the environment around them. Although the attachment theory focuses on the past, the family systems theory focuses on the present or the current family system. Each theory serves as a guide to gain an understanding of the behaviors that cause adoptive parents to isolate themselves from family and friends.

Research Question

RQ: What are the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas?

Nature of the Study

I used a qualitative approach to address the research question. An interpretive phenomenology was conducted. The design focused on individuals alone (Rudestam & Newton, 2015). Intensive individual interviews were conducted with adoptive parents of youth diagnosed with RAD. A phenomenology was conducted to gain an understanding of how parents experience social isolation and how their experience originated. Phenomenology studies how people really are (Dziak, 2016). It also studies an

individual's subjective life experience. Phenomenology aims to reveal how a person makes sense of their environment or surroundings (Dziak, 2016). A snowball sampling method was used. Parents recruited with the assistance of other parents or support groups may present confidentiality issues. An appropriate ethical procedure is obtaining informed consent. Individuals with a great understanding present experiences that add a great deal of evidence to the study. Phenomenological studies have small numbers of participants (Rudestam & Newton, 2015). The study included six mothers.

Definitions

Adolescents: Youth ages 12-18 who are diagnosed with RAD.

Adoptive parent: Adopted mother or father who is affected by the behaviors of an adolescent with a mental health disorder (Stellers et al., 2018).

Attachment behavior: Behavior used by a child to become close to or remain close to the properly functioning caregiver for protection (Bowlby, 1982).

Attachment theory: Positive parent-child interaction influences secure attachment from the child to the parent (Stubbs, 2018).

Family systems theory: The behavior of a family member impacts the entire family system (Papero et al., 2018).

Internal working models: Mental models developed during infancy (Bryant, 2016) of the child's view of the caregiver (Stubbs, 2017).

Neglect: Parent failing to meet the basic and emotional needs of child (Barnhart & Jack, 2016) resulting in emotional dysregulation (Lehmann et al., 2018) and RAD (Corval et al., 2018).

Reactive attachment disorder: A mental health disorder that causes an adolescent to be emotionally withdrawn from the primary caregiver (Vasquez & Stensland, 2016).

Assumptions

There are several assumptions that were applied to this study. I assumed all adoptive parents are socially affected by adolescents with RAD. Reasoning for this assumption derives from the purpose of the study. I also assumed that participants' statements were reliable, accurate, and truthful as they described their experiences and perceptions.

Scope and Delimitations

A specific aspect of the research problem that was addressed in the study was the experience of social isolation of adoptive parents in Southern United States. This aspect broadened the scope of the research topic to a specific area of the United States. A second aspect within the problem statement was the experience of adoptive parents of youth with RAD and their experience with social isolation. This aspect gave additional insight into experiences of adoptive parents of adolescents with a mental and behavioral health issue. The World Health Organization defines adolescents as ages 10-19 years old (World Health Organization, 2019). For the purpose of the study, adolescents were 12-18 years old. The populations that are not studied were adoptive parents of youth in urban or developed areas and youth not diagnosed with RAD.

Limitations

A limitation to the study is participant selection. The recruitment of participants was difficult due a limited number of treatment facilities where services for RAD

adolescents are provided. The study risked the recruitment of parents of adolescents who may not be diagnosed with RAD. Adolescents and children may display the symptoms of the disorder. Adolescents may have also had dual diagnosis with RAD, such as autism (McCullough et al., 2014). Similar behaviors may cause parents to experience social isolation. To address this limitation, I directed my focus on the parents of RAD adolescents who do not display the shared behaviors.

In addition, the small sample size of six participants presented as a limitation. The sample size does not represent all adoptive parents of RAD adolescents. Experiences shared may not be a common experience shared among all adoptive parents. The sample size and experiences were only a small representation of the participants.

Summary

Although RAD is new to the mental health field, adoptive parents of diagnosed adolescents are affected by the behaviors of the disorder. Research has been conducted in the Midwest area of the United States on the experiences of adoptive parents. There is no research on the experiences of adoptive parents in Southern United States. A phenomenological study of adoptive parents in the southern region gave mental health professionals insight on how to assist parents. The study was based upon the attachment theory and family systems theory. Interviews were conducted to understand the experiences. I assumed statements from the participants were reliable and accurate as I understood there are possible limitations.

Chapter 2: Literature Review

Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), RAD is an official mental health diagnosis (Mikic & Terradas, 2018). Research on RAD was conducted with a sample size of 60.87% of youth from the United States (Vasileva & Petermann, 2016). The results of the study revealed 43% of the youth included in the study struggled with insecure attachment (Vasileva & Petermann, 2016).

The purpose of this phenomenological study was to explore the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas. The population for the study was adoptive parents of adolescents 12-18 years of age. The adoptive parents and adolescents resided in rural areas of Arkansas. Data were collected from interviews with adoptive parents to understand their experience of the child's behavior and the parental feelings of social isolation. The study will impact social change by presenting an understanding of the experience of adoptive parents in a southern region and give insight into mental health professionals assisting the parents.

The current literature gives insight into attachment theory, RAD, family systems theory, and foster care and adoption. The literature expands upon each section. Current literature includes the work of John Bowlby and Mary Ainsworth and their contribution to attachment theory. The symptoms of RAD and the causes such as neglect, maternal childhood maltreatment, and parental stress are present. Literature informs the

relationship of family systems theory and attachment. The literature additionally gives insight into the challenges experienced by foster care and adoptive parents.

Literature Search Strategy

In this literature review, I searched the Walden University Library and Google Scholar. Key search terms used were *attachment theory, family systems theory, foster care, adoption, reactive attachment disorder,* and *neglect.* Combinations of search terms including theorists with associated theory. Other databases used were ProQuest Central, Sage Journals, and Taylor and Francis Online. There was little research surrounding RAD and family systems theory. Due to a small amount of literature, I researched work with the phenomenon completed by theorists John Bowbly and Mary Ainsworth. To find more literature discussing family systems theory, family systems therapy was researched.

Theoretical Framework: Attachment Theory

The attachment theory was developed in the 1950s (Chambers, 2017) by Bowlby and Ainsworth (Ainsworth, 1979; Ainsworth & Bowlby, 1991; Bowlby, 1951). Bowlby theorized that emotional problems originated from the child's experiences with the primary caregiver (Chambers 2017). He began his research in attachment at the London Child Guidance Clinic by conducting a study of 44 juvenile theives and a control group. Bowbly discovered the juvenile theives expereinced mother-child deprevation more than the control group (Ainsworth & Bowlby, 1991). The goal of Bowlby's research was to build a theory of personality. He began to build the theory by observing the children's behavior followed by recording their thougths and feelings (see Bowlby, 1982).

Bowlby contributed to the theory by developing attachment behavior. He defined attachment behavior as a separate behavior from other behaviors (Bowlby, 1982). He concluded attachment behavior was a type of behavior used by a child or person to gain proximity or remain in proximity of an identified individual who is able to function properly (Bowlby, 1982). According to Bowlby, the child's reasoning for displaying attachment behavior is due to seeking protection (Bowlby, 1982). A child may display attachment behavior with multiple individuals (Bowlby, 1982). Bowlby also developed enduring attachment or an attachment bond. A child who has an endure attachment does not attachment to mulitple individuals. The child may have one or two individuals they attach to (Bowlby, 1982).

Bowlby further contributed to the attachment theory by also developing internal working models (IWMs). Intenal working models are mental models of how the child views caregivers and themsevles (Stubbs, 2017). The models originate from early childhood relationships with caregivers (Chambers, 2017). The models may change over the child's life as they are introduced to new relationships (Stubbs, 2017). As the IWMs are forming, children are unaware of the development. Once developed, children are uanware of their thoughts are representations of the IWMs. The thought process is automatic and appears to be normal to the child (Cicchetti & Doyle, 2016). The IWMs are models of self and models of others (Mckewon et al., 2016). IWMs develop during infancy (Bryant, 2016). The infant depends on the caregiver to care for them (Bryant 2016). Attention and proper care from the caregiver leads to appropriate mental health and pyscholocial development of the infant (Bryant, 2016).

A child will develop a positive or negative model of themselves and others. A positive model of self and others are the results of an attentive caregiver (Mckewon et al., 2016). Attentive caregivers are responsive to a child in need (Stubbs, 2016). The use of senstitivity (Bosmans, 2016), warmth, intimacy, and consistency in the parent-infant relationship (Bryant, 2016) when addressing needs contribute to a positive model of self and others. The child will view themselves as worthy and valued (Mckeown et al., 2016). The child will view the care giver as trustworthy (Mckeown et al., 2016) and protective (Bosmans, 2016).

A negative model of self and others is the results of an inattentive (Bryant, 2016) and neglectful (Mckeown et al., 2016) caregiver. The child will develop a negative perspective of themselves. They may feel worthless (Mckeown et al., 2016). The caregiver will be viewed as incapable of providing care (Bryant, 2016) or untrustworthy (Mckeown et al., 2016).

Simiarly, Ainsworth began to conduct research with Bowlby as a member of his research team. She too was interested in the interaction between infants and the mother (Ainsworth & Bowlby,1991) and defined attachment behavior (Ainsworth, 1989). According to Ainsworth, attachment behaviors are signaling behaviors naturally displayed during and beyond infancy to aide in survivng (Ainsworth, 1989).

Ainsworth's contribution to the theory began with three studies where she used direct observation and individual differences as two methods to approach attachment (see Ainsworth, 1989). In the Uganda Study, Ainsworth focused on infants' attachement to their mother by studying general child development emphazing the development of the

mother child bond (Rosmalem et al., 2016). In the Baltimore Study, her focus areas were maternal sensitivity and infant security (Ainsworth & Marvin, 1995). She observed how mothers responded to the infants behavior within the home (Ainworth & Bowbly 1991).

Once the infant reached a year of age, Ainsworth conducted the Strange Situation Procedure (SSP; Ainsworth & Bowlby, 1991). The procedure classifies and measures the child's attachment to the mother. There are eight episodes of the procedure. The infant is placed in a strange environment with the presence of the mother, a stranger then joins, the mother will leave, the mother then returns, the stranger leaves, the mother leaves, the stranger returns, and the mother returns (Rosmalem et al., 2016). During each episode, the child is observed for how they explore the room and the behavior presented when the mother and stranger returns (Rosmalem et al., 2016). The SSP presented three groups of infants. The first group presented positive behavior toward the mother (Rosmalem et al., 2016). The mothers were more responsive to the infants (Ainsworth, 1979). Group 2 was the ambivalent group and Group 3 displayed hostile or indifferent behavior (Rosmalem et al., 2016). The mothers of the groups either presented with an inapproriate response, delayed response, or no response to the infants (Ainsworth, 1979).

Ainsworth's (1979) three studies contributed to the attachment theory by developing the three attachment styles: securely attached, avoidant, and ambivalent. Each study assisted with the development of maternal sensivity. She identified maternal sensitivity and maternal warmth within the theory. Maternal warmth is defined as the charactersisits of the mother, and maternal sensitivity is the appropriate response from the mother (Rosmalem et al., 2016).

The attachment theory is relevant to the study topic. The theory was the foundation of attachment behavior, IWMs, and maternal sensitivity. Adolescents with RADs have negative IWMs of themselves and others and do display attachment behaviors (Lehmann et al., 2018) of the theory toward the primary care giver due to lack of maternaly sensitivity during infancy.

The attachment theory informs positive IWMs are developed by a securely attached child. Isecurely attached children develop a negaitve IWM (Cicchetti & Douglas, 2016). A securely attached child will need to be close to the caregiver at all times (Bosmans, 2016). The child will view the caregiver as safe and secure (Bosmans, 2016). An insecurely attached child will want to be close to caregiver; however, the child will be rejectful of the caregiver (Bosmans, 2016).

The history of the theory surrounds analyzing the relationship between infants and mothers (Simi & Matusitz, 2015) and explaining attachment behavior displayed by the infants (Bowlby, 1982). The theory evolved into explaining the relationship between the parent and the child (Sutton, 2018) and the influence the relationship has on the development of the child's personality (Young et al., 2017). The relationship can result in an attached child or an insecurely attached child (Sutton, 2018). Attachment theory reveals attached children have a positive and interactive relationship with the parent. The children depend on the parent for care and support (Sutton, 2018). The insecurely attached children do not depend on the parent. The relationship between the two is not positive (Sutton, 2018).

Both attached and insecurely attached children have personalities. The personalities are developed according to how the children are treated by the parent (Young et al., 2017). A child will develop a cooperative, dependent, and willing personality if a parent responds in a nurturing manner when feeling threatened or distressed (Young et al., 2017). The attached children will develop dependent personality traits. An insecure attached personality is the result of a parent lacking in caring for their child. The child will not depend on the caregiver when in distress. The child will depend on themselves (Young et al., 2017). The insecurely attached children will develop independent personality traits.

Reactive Attachment Disorder

Infants (Losinski et al., 2016) and children under the age of 5 years old (Follan & McNamara, 2014) living in isolation, abuse, neglect, and unstable homes (Losinski et al.,2016) are at risk of developing RAD. Infants began to show signs of attachment issues at 9 months old (Losinski et al.,2016). If developed in infancy or early childhood, RAD can continue into adolscence and early adulthood (Lehmann et al., 2018).

Children who have RAD are emotionally withdrawn from their caregiver (Bosmans et al., 2018). A child diagnosed with the disorder may have experienced pathogenic care. Pathogenic care is being instituionalized or severly neglected (Corval et al., 2018). Other risks are social neglect, lack of emotional needs such as comfort, simulation, and affection, and constant changes in the primary caregiver, which prevents attachment from occurring (Zimmerman & Iwanski, 2018). Other diagnosing critieron are constant disturbances in social and emotional functioning (Corval et al., 2018). A child

who displays two of the following critieron can be diagnosed with RAD: a lack of social and emoitonal repsonse to others, limited positive affect and frequent times of uexpected irriability, and sadness or fearfulness in situations that do not pose harm (Corval et al., 2018). A child with RAD also displays hyper vigilance and aggression to their own and others' sadness or distress (Zimmerman & Iwanski, 2018). The child struggles with accepting, seeking, and responding to comfort during times of distress (Bosmans et al., 2018).

RAD is diffiult to diagnose (Losinki et al., 2016). Therefore, a child who fits the diagnosis may have received a multi-teiered system of support services. The services are combined of mental health screening, progress monitoring, and interventions (Losinki et al., 2016).

There is currently no evidence-based treatment for RAD. To ease the symptoms, family therapy is recommended for the child and parent(s). Family therapy is designed to assist the parent and child with proper interaction (Losinki et al., 2016). Other approaches to ease the symptoms are goal directed evidence based practics to help prevent specific RAD behavior or a multi-system appraoch. A multi-system approach include combined services for the entire family. The combination of services is known as a family services plan (Losinki et al., 2016).

Neglect

Neglect is defined as a parent failing to meet the basic and emotional needs of a child (Barnhart & Jack, 2016). A parent's behavior, a parent's behavior toward the child, and parenting consequences are indicators of neglect (Rebbe, 2018). Neglect is

observable. However, some signs are not observable (Rebbe, 2018). Children who are neglected are affected more mentally and psychologically than those who are physically abused (Rebbe, 2018). Neglected children are often diagonsed with chronic mental health issues and live with ongoing mental health problems (Barnhart & Jack, 2016). Neglect is the main cause of RAD (Corval et al., 2018). RAD is a chronic and ongoing mental health disorder as evident by it transferring into adulthood in some cases (Lehmann et al., 2018). Neglected children suffer from the inability to regulate emotions (Rebbe, 2018). As such, children diagonsed with RAD struggle with emotional dysregulation (Lehmann et al., 2018).

Neglect occurs more in infants and toddlers ages 0-3 years old (Barnhart & Jack, 2016). Infants and toddlers within the age range who are victims of neglect are at risk for developing RAD. Specifically, RAD develops in early childhood before age 5 years old (Follan & McNamara, 2014).

Infants and toddles are at risk for neglect in all homes of different socio-economic statuses (Rebbe, 2018). However, single mothers have been rated at the highest risk of neglecting their chilren (Barnhart & Jack, 2016). Single mothers were rated a high risk due to maternal childhood maltreatment (Enlow et al., 2018), caring for the child alone, and parental stress (Barnhart & Jack, 2016).

Maternal Childhood Maltreatment

Mothers who were neglected in their childhood may suffer from maternal childhood malreatment. The mother is not physically abusive to the child. She displays poor caregiving, inconsistent nurture, decreased involvment with her child, or rejection of

the child (Enlow et al., 2018). The mother may also be triggered by the behaviors of the infant or toddler (Enlow et al., 2018). The baby or toddler crying or displaying a need of help may remind her of neglect she experienced in her childhood. The trigger will cause her to neglect her infant by not responding to the approriate need (Enlow et al., 2018). A mother who experienced childhood maltreatment is at risk of ontogenetic development. Ontogenetic development of parents is defined as the mother implementing the same negative parenting with her child that she experienced in her childhood (Mulder et al., 2018).

Parental Stress

A mother caring for a child without assistance may result in parental stress. Parental depression or stress increases nelgectful behavior from the mother (Barnhart & Jack, 2016). The continuation of parental depression or stress results in parental burnout (Mikolajczak et al., 2018). Parental burnout increases neglect. Charactersitics of paternal burnout are exhaution and emotional distancing from the child (Mikolajczak et al., 2018). There are three dimensions of parental burnout. The dimensions are overwhelming exhaustion due to parental role,

emotional distancing from the child and sense of ineffectiveness in the parental role (Mikolajczak et al., 2018).

Dimension two applies to the dissertation topic. The mothers within the dimension becomes less and less involved with their child and parenting the child as time progesses. The mother does not care for the child with her full ability and potential (Mikolajczak et al., 2018). The behavior of the dimension by the mother places the child

at a risk for attachment issues. Adopted or foster care RAD children struggle with bonding with the adopted primary caregiver because there was no bonding or a lack of bonding with the biologcial primary caregiver within infancy or early childhood. This can be defined as limited opportunities to form attachments (Zimmerman & Iwanski, 2018).

Family Systems

Within the family systems, the family functions as a whole (Papero et al., 2018). Each family member helps others and work together to maintain stability within the family (Sun, 2016). The actions and behavior of one family member impacts the entire family (Papero et al., 2018). Other family members emotions and thoughts are impacted (Sun, 2016). Members in the family are attached to one another (Sun, 2016).

Attachment to the family begins in childhood (Demby et al., 2017).Emotional connections attach family members to one another (Papero et al., 2018). Emotional connections begin in childhood by the child acting together with the family and as an individual (Palombi, 2016). The child first thinks and feels what the family members feel. As he or she grows, the child begins to experince their own emotions along with acting, feeling and thinking for themselves (Palombi, 2016). A child within an adaptive family experinces a family hiearchy and positive interaction. The child will present with positive attachment behaviors. (Demby et al., 2017). A child within a disengaged, enmeshed and chaotic family does not experience family order and witnesses difficulty when the family attempts to connect and interact. (Demby et al., 2017).

The family systems theory is signficant to the topic due to the study being conducted to give insight on how a child's beahivor impacts the family system. Family

systems theory is also similar to the attachment theory (Demby et al., 2017). A child's attachment or security derives from the parent-child attachment as well as mutual relationships within the family (Demby et al., 2017).

Foster Care and Adoption

Foster Care: Foster Parent Challenges

A foster parent is a relative, non-relative or a traditional foster parent (Cooley et al., 2017). Foster parents are expected to provide a secure enviornment while others participate in therapeutic foster homes for children (Cooley et al., 2017). Abused or neglected children may be placed in foster care (Miranda et al., 2019) or a kinship (Cooley et al., 2017). Therefore, there are challenges to fostering children. Challenges include emotional instability. Caring for a child with behavior, emotional or medical needs can lead to distress, guilt, feelings of failure and burnout (Miller et al., 2019).

A second challenge is living with vicarious or secondary trauma. Parents are placed at risk due to caring for a child who experienced trauma (Miller et al., 2019). Parents also struggle with the challenge of moving forward with life after the child leaves their home. Parents struggle emotionally with the absence of the child (Miller et al., 2019).

The types of abuse experinced by foster children prior to placement are physical, sexual, emotional, and verbal. The children also witness domestic violence (Miranda et al., 2019). Physical abuse is defined as purposely harming a child. The harm may result in bruises, fractures or death (Miranda et al., 2019). Examples include punching, beating, kicking, throwing, shaking, stabbing, hitting with an object or burning (Miranda et al.,

2019). Emotional abuse is defined as psychological abuse deriving from neglect of the child's basic needs (Miranda et al., 2019). Abuse, maltreatment and early trauma result in mental health issues. Children in foster care are diagnosed with emotional and behavior problems (Leake et al., 2019). If not diagnosed, many children have un-treated trauma-related mental and behavioral health issues (Leake et al., 2019).

The abuse, maltreatment, behavior and mental health issues of children are stressful for foster parents to manage (Leake et al., 2019). There is a need for more foster parents due to high turn-over rates. Stress leads to foster-care turnover (Leake et al., 2019). Foster parents experince caregiver strain in the form of objective strains or subjective strains (Leake et al., 2019). Examples of objective strains are distruption in family routines or financial issues (Leake et al., 2019). Examples of subjective strains are feelings or emotions a parent may develop about their caregiving abilities. A parent may feel anxious, fatigue or guilty (Leake et al., 2019).

Children in foster care present with various behaviors or problems. Children feel they are not in control and insecure. The child will attempt to gain conrol over the enviornment (Hughes, 2004) by manipulating the foster parent (Miranda et al., 2019). Manipulation is a characteristic of disorganzied attachment. A problem present among foster care children is a disorganized attachment style (Siegel & Hartzell, 2004). The attachment style derives from the child having a difficult time bonding with the foster parent (Miranda et al., 2019). Children presenting with the attachment style feel the foster parent is not nuruturing, inconsistent in care and unsafe (Miranda et al., 2019).

Managing a child's behavior includes particiapting in treatment. Research informs children do not receive treatment until after a long period of residing in foster care (Conn et al., 2016). The child's behavior and mental illness increases over the time period causing the foster parent to seek treatment (Aarons et al., 2010; Conn et al., 2019). Children with disruptive disorders are placed in foster care. These children are more likely to receive mental health services than children who are diagonsed with externalzing behavorial problems (Conn et al., 2016; Wu et al. 1999). Children in foster care may be diagnosed with one psychiatric disorder (Lohr & Jones, 2016). Parents may choose outpatient services for their child (Conn et al., 2016) or psychiatric care (Barnett, et al., 2018). Psyciatric care includes the foster parent consenting for psychotropic mediaction. The medication helps the child focus in the home and school environments. Foster parents have to monitor the side effects of the medications (Barnett et al., 2018). RAD is a psychiatric disorder diagnosed in foster care youth. Changing of multiple caregivers in foster care places the child at risk for RAD (Lohr & Jones, 2016).

Challenges Within The Foster Care System

Foster parents face challenges within the foster care system. Parents feel agencies do not provide adequate assistance, support or information (MacGregor et al., 2006; Thompson & Wojciak, 2017). Parents find it difficult to nativage through the various services offered by agencies (Brown & Bednar, 2004; Cooley et al., 2019). There is a lack of consistent assistance from case workers. Foster parents do not feel valued (Cooley et al.2019; Thompson & Wojciak, 2017). Parents feel they are not valued enough to be

included in the decision making process for the child (Cooley et al., 2019; Sanchirico et al, 1998).

Foster parents face personal challenges when attempting to care for a child. Their lives may be demanding (Cooley et al., 2019; Thompson & Wojciak, 2017) with careers, other children or their biological children. A personal challenge is mental illness. According to Leake et al. (2019), parents have their own unresovled trauma expericences. A third challenge is striving to meet standards. Foster parents are held at a higher standard than biological parents. Foster parents face the challenge of meeting the standards of foster care agencies (Cooley et al., 2019; Miller, 2019).

Adoption

Foster parents may choose to adopt their foster child or children (Moyer & Goldberg, 2017). Other adoptive parents have the opporutnity to specify the type of child they would like to adopt. The most preferred child is characterised as beloning to the same ethnic group as the foster parent and under the age of 3 years old without special needs (Moyer & Goldberg, 2017). The preferance of the foster parent is not always met. The characteristics of children in foster care who are adopted are children of color older than 3 years old. The child has special needs and behavior problems (Moyer & Goldberg, 2017). Adopting a child who does not meet the preferance can cause the adoptive parents stress (Moyer & Goldberg, 2017).

Adoptive parents have stressors just as foster parents. Adoptive parents experience pre-adoption and post-adoption issues or stress. Pre-adoption issues include fertility complications, attachment issues, decline in relationship satisfaction, mental

illness, or an unhealthy relationship with the biological parent (Moyer & Goldberg, 2017).Adopotive parents stress when attempting to care for the child. Older children are difficult to *mold* than younger children (Moyer & Goldberg, 2017). The child's behavior is not the only post-adoption stressor for adoptive parents. Inadequate formal training is a source of stress (Leake et al., 2019).

Adoptive parents feel there is a lack of formal support from professionals when needing assistance with their child (Moyer & Goldberg, 2017). A lack of resources is a major source of stress for adoptive parents (Moyer & Goldberg, 2017). Adoptive parents are in need of assistance with access to behavioral health services for the child and themselves, food, housing, financial assistance and respite care (Leake et al., 2019). Adoptive parents feel there is a lack of informal support. Informal support is the support of friends and family (Moyer & Goldberg, 2017).

Post Adoption Services and Resources

There is a need for relationship and family support for adtoptive families. Many familes experience depression, issues within the partner relationship and coping with issues after officially adopting a child (Foli et al., 2017). Post adoption services are scarce. Families are unaware of the few available services or unable to access services (Miller et al., 2019). Connecting parents with resources is a challenge for public and private agencies (Miller et al., 2019). A post-adoption resource that is used to assist parents with stress are support groups (Miller et al., 2019). Adoptive parents learn coping skills from other adoptive parents (Miller et al., 2019). Adoptive parents learn how to nagivate through life challenges such marital challenges, complicated adoption

experinces, child behavior problems and depression (Miller et al., 2019). Adoptive parents are able to nativate through life challenges due to possessing specific charactersits. The characterisits are being older in age, more established in careers, longer lasting intimate relationships, education and higher socio-economic class (Foli et al., 2017). The parents have also experienced the pre-adoption process and have gained resilience to assist with coping with situations that arise during post adoption (Foli et al., 2017).

Parents who use support groups also use self care strategies. Research informs adoptive paerents engage in moderate self-care. Just as there is a lack of smiliar services, there is a lack of self-care training for adoptive parents (Miller et al., 2019). Self-care strategies can imporve the physical, emotional, mental or spiritual health of parents (Miller et al., 2019).

Summary and Conclusion

Major themes within the literature are attachment, maternal childhood maltreatment, parental stress, foster parent challenges and adoptive parent challenges. The themes expand the literature of attachment theory, the causes of RAD and experiences of foster and adoptive parents.

Within the literature, attachment specifications can be found within the attachment theory. The theory was developed based upon a child's attachment to the primary caregiver. Literature reveals maternal childhood maltreatment leads to attachment issues. Biological mothers may experience parental stress. Parental stress results in neglect. Neglect of the child increases the risk of attachment issues.

The literature concludes attachment theory, associated theorists, adoption and foster care are well known in the discipline of mental health. Literature presenting studies completed by John Bowlby and Mary Ainsworth display knowledge of attachment theory within mental health. Literature provides insight on the impact the adoption process has on the mental state of adoptive parents. Literature also presents challenges experienced by foster parents that causes mental stress.

There is a lack of literature present within RAD and family systems theory. Literature focuses more on attachment. RAD stemmed from the attachment theory. The literature provided for the attachment theory and family systems theory concludes both are similar. Attachment may arise from the child's role within the family and family relationships.

The present study fills the gap by presenting more insight into RAD. Knowledge will be expanded in the discipline by presenting research of experiences of adoptive parents of adolescents residing in southern rural areas who are diagnosed with RAD. A phenomenology will be conducted to understand the experiences of the parents to properly address the gap in literature and expand knowledge within the field of mental health.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological study was to explore the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas. The population for the study was adoptive parents of adolescents 12-18 years of age. The adoptive parents and adolescents resided in rural areas of Arkansas. Data were collected from interviews with adoptive parents to understand their experience of the child's behavior and the parental feelings of social isolation. The study impacted social change by presenting an understanding of the experience of adoptive parents in a southern region and give insight to mental health professionals assisting the parents.

Research Design and Rationale

The research question is what are the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas? The central concepts of the study were RAD and social isolation. RAD is a mental health disorder diagnosed in children who are emotionally withdrawn from the primary caregiver (Bosmans et al., 2018). According to Vasquez and Stensland (2016), social isolation is experienced by parents who care for adolescents diagnosed with RAD.

A phenomenological study was conducted. Phenomenology was appropriate to coincide with the research question. A phenomenological study focuses specifically on the lived experiences of individuals within a population. Phenomenology is used to recover the lived experience by encouraging participants to reflect on what the original experience was like (Van Manen, 2017). Participants reflect on their everyday or

ordinary life experiences and how the phenomenon under study has affected their daily lives, understandings, and mental processes. The chosen tradition is designed to bring awareness to lived experiences of a specific phenomenon (Van Manen, 2017). The specific phenomenon is presented by the researcher in the form of a narrative or story given by the participant through interviews. These narratives or stories are defined as phenomenological examples (Van Manen, 2017).

Role of the Researcher

While conducting the research, I served as an interviewer and observer, as well as the data collection instrument. Interpretative phenomenology was my chosen approach. I served as an interpreter of the impact adolescents diagnosed with RAD have on adopted parents. Researchers of interpretative phenomenology set aside their personal beliefs about a phenomena and present actual observations of participants (Allan & Eatough, 2016). To be an effective and ethical researcher of phenomenology, I managed my own bias by placing aside observations I witnessed in the profession as a residential treatment counselor for RAD adolescents. I did not apply information from parent experiences I was informed of as a residential treatment counselor.

Phenomenological researchers understand their role is to observe everyday life of participants as they experience a phenomenon (Van Manen, 2017). The researcher focuses on what the lived experience is like (Van Manen, 2017). Phenomenological studies focus on original experiences and what is possibly missing from the experience (Van Manen, 2017). As a phenomenological researcher, I interpreted original experiences

and questioned what was missing or what has faded (Van Manen, 2017) from the experience.

Methodology

Participant Selection Logic

Snowball sampling was used to select participants. Snowball sampling is used to find hidden or difficult to find populations (Etikan et al., 2015). Using this approach, I relied on participants to recommend other potential and qualified participants. Snowball sampling is a form of non-probability sampling. Non-probability sampling techniques enable the researcher to select participants of the study criteria (Etikan et al., 2015). The first participants were recruited from a rural area. Business owners were asked to place a flyer for the study in their establishment. Each participant was encouraged to reach out to another participant to participate in the study. I asked participants for the contact information for other potential participants and to reach out to prospective participants. The goal of the method was to implement linear snowball sampling (Etikan et al., 2015) by gaining one new family from a previous family (Kirchherr & Charles, 2018). A snowball sampling method is appropriate due to parents of mentally ill children serving as a resource and support for one another. Parents of a child with a mental illness are familiar with other parents who have a child with the same disorder. The population is considered a difficult to reach population. Thus, I employed snowball sampling because it is commonly used for populations classified as difficult to reach (Kirchherr & Charles, 2018).

The population of the study was adoptive parents of adolescents diagnosed with RAD residing in rural areas. Rural areas were identified as small cities or towns 30 miles from a major city. Participants were solicited upon referral. After receiving the referral from a previous participant, the participant was contacted and required to give consent. Participants were selected if they had a spouse residing the home. A spouse is defined as a mother or father. The child of the mother and father must be an adolescent. An adolescent for this particular study is defined as a 12-18-year-old male or female. The adolescent must be diagnosed with RAD or have received treatment for the disorder within their adolescent years. The sample had six participants. Phenomenological studies have small numbers of participants (Rudestam & Newton, 2015). The study included six mothers, married and single. Each mother was interviewed separately to gain insight of their personal lived experience. Although I focused on mothers, both mothers and fathers are affected by behaviors of RAD youth (Vasquez & Stenland, 2016).

Participants were recruited through flyers explaining the study. I met with rural community businesses and establishments to place flyers. Participants were encouraged to respond via email if they wanted to participate in the study. A specific email was created for the study to prevent irrelevant emails from interfering with the study. Email was the main source of communication between researcher and participants to avoid personal contact information being released. I used email to schedule interviews, conduct transcript reviews, and study results. For this particular study, the relationship between saturation and the sample size was influenced by the accounts of lived experiences given by the participants.

Instrumentation

To ensure content validity in the interview questions, I asked a colleague who provides therapy to RAD youth and families of RAD youth to provide expert feedback on the content of the questions. The colleague has been a licensed professional counselor for 4 years. I provided interview questions and asked for the colleague to return feedback, comments, and suggestions in 1 week. I then incorporated their feedback into the interview questions.

Multiple interviews did not take place. Subsequent interviews would have been conducted if new experiences were revealed to give each participant an opportunity to share their experience of similar accounts. I led the initial interviews and recorded them via audio-tape. Interpretative phenomenologists write about the experiences they observe. This is known as reflexive journaling (Alan & Eatough, 2016). I used a journal to write about each experience to further interpret the lived experiences of participants.

Other sources for data included fact sheets of child neglect and trauma published by the United States Department of Health and Human Services and published research exploring the experiences of adoptive parents caring for children with a mental illness. The fact sheets were used to gain information to develop interview questions. The trauma fact sheet presented signs of trauma youth ages 12-18 present with. One sign is being overwhelmed with emotions (Child Welfare Information Gateway, 2014). RAD youth present with overwhelming episodes of irritability (Corval et al., 2018) and emotional problems (Zimmerman & Iwanski, 2018). An example interview question for a parent is, “What is the experience like for you when your child is irritable?”

The four models of saturation are theoretical saturation, inductive thematic saturation, priori thematic saturation, and data saturation (Saunders et al., 2017). The appropriate model of saturation for the study was data saturation. Data saturation is defined as collecting new data that is repetitive of previous data (Saunders et al., 2017). Data saturation was reached upon participants disclosing similar experiences of social isolation.

Interviews were transcribed in naturalized transcription. Naturalized transcription is more than just words. It includes the nonverbal body language of the interviewee (Azevedo et al., 2017) along with pauses or other expressions (McGrath et al., 2019). Naturalized transcription was performed by following six steps. The first step was prepping for transcription. During this step, I created extra copies of the recorded interview (Azevedo et al., 2017) in case the original copy was lost or misplaced. Step 2 is organizing field notes through reading and analysis. I listened to the recording at least twice for effective analysis (Azevedo et al., 2017). Researchers of interpretive phenomenology will analyze the journal of observations instead of field notes. Step 3 was the actual transcription of the recording. I focused on writing exactly what was said by the interview (Azevedo et al., 2017). Step 4 was the editing stage. During this stage, I added corrections such a punctuation marks (Azevedo et al., 2017). I reviewed the transcription in Step 5. The goal was for the recording and transcription to be identical (Azevedo et al., 2017). Step 6 involved creating multiple versions of the transcription due to possible issues arising (Azevedo et al., 2017)

Data Analysis Plan

Each interview transcript was coded according to Heidegger's phenomenology concepts. A specific software was not needed to perform the coding. Heidegger's phenomenology is used to describe the meaning of being in the world. The phenomenological method is used to answer the question, "What does it mean to be?" (Kelly et al., 2016). The codes from interview transcripts were connected to the research question. The codes described what the lived experience of an adoptive parent of an adolescent with RAD is like. Each of the concepts were then analyzed according to Colaizzi's method of data analysis. Colaizzi's method is a qualitative method used to describe the experiences of participants. The method requires validation of data from participant feedback (Wirihana et al., 2018).

The method includes the following steps: reading the transcript multiple times, extracting significant statements that can be applied to the phenomenon, discovering meanings from each statement, placing the meanings into theme clusters and themes, developing an exhaustive description of the phenomenon, developing a fundamental description of the structure of the phenomenon, and validating participation (Wirihana et al., 2018). In the first step, I reviewed the transcript of the participant interviews for 2 days. This step enabled me to obtain thorough knowledge of the phenomenon and assure participants gave appropriate responses (Wirihana et al., 2018). Step 2 is significant to the study as I extracted statements from the transcript. Each statement was identified by the participant number and location within the interview transcript (Wirihana et al., 2018). I formulated a meaning for all extracted statements in Step 3. In Step 4, all similar significant statements and their meanings were grouped into theme clusters.

Themes were also established during this step according to the theme clusters (Wirihana et al., 2018).

In Step 5, I developed a description of the significant meanings, theme clusters, and themes (Wirihana et al., 2018). All findings were placed into one description. Step 6 involved removing repetitive and unused descriptions. During the final step, participants were sent the findings. Participants were sent their transcript and given the opportunity to validate the transcript. Findings were revised at this to match the participant's actual experience. Each participant was given the opportunity to comment on their experience (Wirihana et al., 2018). This step addressed and solved discrepant findings.

Issues of Trustworthiness

Credibility

A study is credible when the analyzed data are a representation of the participants (Hadi & Closs, 2016). Triangulation was implemented to enhance the credibility. Triangulation is the implementation of two related data collection methods within a study (Hadi & Closs, 2016). The two data collection methods that were used in the study are Heidegger's phenomenology and Colaizzi's methods. The main purpose of Heidegger's phenomenology is to shed light into the everyday lives of individuals within a specific phenomenon (Kelly et al., 2016). To accomplish this goal, data are interpreted and includes the concepts of Heidegger's phenomenology participants lived experiences, everyday ordinariness, Dasein or the living being, being in the world, being with, encounters with entities, temporality, and participants with structure (Kelly et al., 2016).

Transferability

Transferability is defined as being able to apply the results of a study to other populations (Hadi & Closs, 2016). Thick description was implemented to display transferability. The inclusion and exclusion criteria (Hadi & Closs, 2016) of the study were available prior to the study. Participants were the adopted parents of an adolescent diagnosed with RAD. The adolescents were 12-18 years of age. Participants were married or single, residing in the same home with the child. Participants resided within in a rural area. Exclusion criteria are parents of adolescents ages 17 and under who do not reside in rural areas of Arkansas. Within the results of the study, there is a description of the setting of each interview, sample characteristics of participants, and data collection and analysis methods (Hadi & Closs, 2016)

Dependability

A study becomes dependable when researchers can depend on the study and appropriate implementation of research methods to perform a replica study (Hadi & Closs, 2016). Dependability relies on the documentation of sources and techniques of data collection and analysis methods (Hadi & Closs, 2016). Documentation was a detailed description of the steps of Heidegger's phenomenology and Colaizzi's method applied to the study. The detailed documentation is defined as audit trails (Hadi & Closs, 2016). Audit trails enable readers to determine the quality, transferability, and worth of the study (Hadi & Closs, 2016).

Confirmability

Confirmability is established upon auditors reaching an agreement on the meaning, relevance and accuracy of data from a study (Hadi & Closs, 2016). Reflexivity and review of data by auditors will be used to establish confirmability. Before the start of the study, researchers should address the influences of the development of research questions (Kelly et al., 2016). I addressed the influences of the development of the research questions by informing participants of the purpose of the study. The conduction of interviews should not just include analyzing the experiences of participants. Past experiences of the researcher within the phenomenon should be recognized to avoid a biased analyzation of experiences (Kelly et al., 2016). Reflexivity involves the researcher acknowledging their own bias and how personal beliefs and past training have influenced research results (Hadi & Closs, 2016). I addressed my past experiences of working with RAD youth and families as a residential treatment counselor. I addressed my own bias and personal beliefs by ensuring each do not influence the analysis of the interviews.

Ethical Procedures

As the researcher, I interacted with participants in an empathic manner to ensure participants were comfortable during the study. I informed the participants of their rights prior to conducting interviews. Consent forms were signed before the conduction of interviews. Participants were required to sign the consent form with an electronic signature.

Ethical concerns related to recruitment materials are verbiage on flyers. Verbiage should not be misleading or offensive. The plan to ensure verbiage is not misleading is to

use simple wording and short phrases or statements. To ensure verbiage was not offensive, the purpose of the study was placed on the flyer along with implications of social change.

Ethical concerns related to data collection are interview locations, participants refusing to participate and early withdrawal from the study. Interview locations should be in a private location where participants are comfortable and safe. Locations should be professional such as conference room or meeting room. If a participant refuses to participate, recruitment for other participants will continue. Early withdrawal from the study will be addressed by recruiting more participants during the recruitment phase of the study. Extra participants were asked to join the study if others withdraw early.

Data was treated as anonymous. Study results reveal participants as mother or by initials. I have access to the data. Transcription of interviews and study results are stored on a hard drive. Data was destroyed at the completion of the study after participants have validated their responses.

Summary and Conclusion

A phenomenology was conducted. The researcher explored the daily, lived experiences of adoptive parents of adolescents with RAD living in rural areas through appropriate qualitative instruments, methods and sampling. Fact sheets published by the United States Department of Health and Human Services were used to develop interview questions. Other qualitative instruments were a pilot study and interviews of participants. A pilot study was conducted prior to the study by sending interview questions to an expert who has experience serving families of adolescents diagnosed with RAD.

The sampling method of snowballing enabled the researcher to select participants within the criteria of the study. I then interviewed the participants. Each recorded interview was transcribed. Reflexive journaling took place to give more insight into the participants experiences. Transcribed interviews were coded and placed into themes according to Heidegger's Phenomenology and Colaizzi's Methods. The two methods made the study credible and dependable. The study is transferable as it can be applied to other populations that do not include adolescents in a different southern area. Confirmability was established by informing the participants of the study prior to their participation. I also addressed my own bias as a previous residential treatment counselor who served adolescents diagnosed with RAD.

Ethical procedures included empathetic interactions with the participants throughout the study. Verbiage on flyers were not misleading or offensive. Participants were encouraged to participate in interviews held via zoom in a comfortable environment of their choice. Data was treated as anonymous and participants were identified by their initials with a number or mother.

Chapter 4: Results

Introduction

This chapter will present the results of the study and answer the research question. In this phenomenological analysis, I present the lived experiences of adoptive parents of adolescence with RAD. The parents gave detailed insight into their experience of how they are mentally affected by their children's behavior. More insight was given into their experience of seeking treatment for their child, living with specific behavior and symptoms of RAD, and experiencing social isolation. There will be four major themes and associated subthemes presented within this chapter.

The results serve as a recommended guide for social change in terms of research and practice regarding this topic. These results will provide mental health and human services professionals with scholarly evidence of mental health issues being faced in southern areas of the United States. Phenomenology adds new information to literature as it pertains to RAD. Adoptive parents are more than socially isolated.

Pilot Study

A pilot study was applicable for this research. Interview questions were sent to a licensed professional counselor for review prior to the study. The counselor had experience in servicing families of youth diagnosed with RAD. The counselor conducts a private practice in the rural southern area of Valdosta, Georgia. Therefore, the counselor gave me insight on the appropriateness of each interview question. The counselor-informed researcher questions were appropriate to ask parents. The counselor encouraged me to remain within the realm of studying the lived experiences of the parents and to

avoid venturing into the diagnosis. Through this pilot study, I learned guidance from a licensed professional can increase validity of the study.

Setting

The research study was conducted virtually due to the COVID-19 pandemic. The study consisted of virtual Zoom interviews and phone interviews. I conducted the interviews in an office space free of additional sounds and distractions. Each participant was encouraged to participate at their convenience in a comfortable environment of their choice.

Demographics

The six participants in the research study were White, adoptive mothers of adolescents. Married and single mothers participated. Each mother lived in a rural city in Arkansas. Each mother confirmed their child was diagnosed with RAD. Each participant was identified by a letter and number combination. The participants were not compensated for their participation. Each consented electronically via a consent form prior to interviewing, expressing an understanding of voluntary participation. See Table 1 for participant demographic information.

Participant 1

Participant LS1 was a married mother. She was a Caucasian woman who adopted two adolescent boys, ages 15 and 16. The mother was an experienced foster parent. She and her husband fostered 70 or more children over 10 years.

Participant 2

Participant PH2 was a married mother with a husband. She was a Caucasian woman who was unable to have children. She decided at a young age to adopt. She and her husband experienced unsuccessful adoptions. After 10 years of waiting for a child, she and her husband received their first child. She was the adopted mother of two adolescent boys ages 16 and 17.

Participant 3

Participant CW3 was a Caucasian single self-employed mother. She was a foster mother who fostered 50 children. She became an adopted mother. She is the adopted mother of one adolescent boy, age 17.

Participant 4

Participant SG4 was a Caucasian married mother. She did not intentionally want to adopt a child. She was the family member of the adolescent male. She did not want the child to be placed back into foster care. The adolescent was a 13-year-old male.

Participant 5

Participant CS5 was a Caucasian married mother. She was unable to conceive a child due to infertility. She decided to adopt a child through an agency. The adolescent was a 12-year-old boy.

Participant 6

Participant CL6 was an employed Caucasian single mother. She never wanted birth children. She decided to adopt. She terminated the adoption of her 16 year old adolescent daughter.

Table 1

Participant Demographic Information

Participant	Sex	Ethnic background	Married	Single	Relationship to adolescent	Sex of adolescent	Age of adolescent
LS1	Female	White	X		Adoptive mother	Boy(s)	16 and 15
PH2	Female	White	X		Adoptive mother	Boy (s)	16 and 17
CW3	Female	White		X	Adoptive mother	Boy	17
SG4	Female	White	X		Relative/adoptive guardian	Boy	13
CS5	Female	White	X		Adoptive mother	Boy	12
CL6	Female	White		X	Adoptive mother	Girl	16

Data Collection

The proposed sample size of the study was 10 participants, with data saturation being the final determinant of sample size. Originally, I planned to focus on families, meaning participants would be one of two married individuals. During the recruitment phase of the study, I began to receive responses from single mothers who wanted to participate and who had experiences to share. A variation in the study was changing the selection of participants. Even though I had initially planned on couples as my unit of analysis, the number of single mothers who reached out led me to reassess the need for couples. I discussed this change with my committee, and we decided that it made sense to pivot to looking at parents individually. After that decision was made and approved by my committee, I submitted an Institutional Review Board (IRB) addendum form to gain

IRB approval to make this adjustment to my population and sample. This change was then reflected in my purpose and RQ, where I removed the emphasis on families.

After completing the interview process and several interviews, the final number of participants was six. I reached data saturation at six participants. Data saturation in qualitative studies means that the information received from participants begins to repeat in terms of ideas, concepts, and answers (Saunders et al., 2017). A researcher knows when saturation has occurred because there is no new information being reported from additional participants (Saunders et al., 2017). The final number was appropriate due to a phenomenology being a small study requiring five to 10 participants (Rudestam & Newton, 2015).

Data were collected via a desktop computer, Zoom video recording, and telephone. There were 21 interview questions (see Appendix). Interviews ranged from 15 minutes to 2 hours. The duration of the interview depended on the participant. Interviews were recorded via Zoom and telephone recording systems. Each interview was stored on an external flash drive. I transcribed each interview into a Word document that could then be coded. I transcribed each interview using Microsoft transcription. I conducted quality checks of the transcripts by uploading the recorded audio of each interview into Microsoft office. I then listened to each audio recording and ensured it matched the final transcript. I also kept a reflexive journal and created Word files of my journal notes that could be reviewed and coded alongside my transcription data.

Data Analysis

Data were analyzed according to Colaizzi's method (Hadi & Closs, 2016). Qualitative software is not necessary to conduct Colaizzi's method. A Microsoft Word document was used to create a table. The table was used to formulate codes. There were five columns.

Column 1 served as the "location of the significant" statement. Significant statements were taken from participants' responses to interview questions. Under Column 1, the participant, interview question, and location of statement within the transcript were listed. An example is LS1, IQ1, pg. 2.

The next column served as a placement for the statement. Under the column, each significant statement related to the interview question given by the participant was listed. An example is interview Question 7, which asked, "What was the experience like seeking treatment for your child?" A significant statement given by participant related to the question was listed in the chart.

Column 3 recorded the "formulated meaning." The formulated meaning defines the significant statement. As the researcher, I reviewed the significant statement to develop a meaning.

The fourth column contained theme clusters. In order to develop a theme cluster, I reviewed the significant statement and formulated meaning to find a theme cluster for both. I discovered the common theme within both. The fifth column listed "themes." A theme was developed by reviewing the significant statement, formulated meaning, and theme cluster to find one common aspect across all columns.

The table of Colaizzi's method was recorded in the order of the interview questions. Each question received a section within the table with the significant statement of each participant, the formulated meaning, theme cluster, and theme. After analyzing one interview question given by the participant across each column, I moved forward to the next participant. Each interview question was analyzed separately. After finishing analyzing all participants' according to the one interview question, I moved forward to the next interview question, repeating the steps above.

Codes derived from the participants' responses. The most common responses among the interviews were recorded as codes. Codes were used to create themes and sub-themes. To uncover codes, interview transcripts were reviewed multiple times. I focused on the participants' responses to each question. Repetitive words, statements, or ideas for each interview were recorded. The recorded words and statements became codes. Each code was placed into a category. Themes were developed to answer the research question. Each theme was developed by combining the codes and categories to interpret the lived experiences of the participants. See Table 2 for a discussion of codes, categories, and themes.

Table 2

Codes, Categories, and Themes

Code	Category	Theme
Anxiety	Mother's mental health	1. Adoptive mothers of children with RAD live with anxiety and PTSD a. Mothers attend therapy
PTSD	Mother's mental health	
Mental health professionals	Lack of understanding	2. Living with a lack of understanding or information about RAD a. lack of understanding/treatment from mental health professionals b. lack of understanding from educational officials
Educational officials	Lack of understanding	
Lying	RAD behaviors/symptoms	1. Parents live with RAD behaviors and symptoms
Manipulation	RAD behaviors/symptoms	
Destroying items	RAD behaviors/symptoms	
Superficially charming	RAD behaviors/symptoms	
Aggressive toward mother	RAD behaviors/symptoms	
Purposely releasing of bowels	RAD behaviors/symptoms	

No bonding	RAD behaviors/symptoms	
Staring at others	RAD behaviors/symptoms	
Stealing	RAD behaviors/symptoms	
Running away	RAD behaviors/symptoms	
Hoarding food	RAD behaviors/symptoms	
Releasing in air vents	RAD behaviors/symptoms	
Assaulting children	RAD behaviors/symptoms	
Constant chaos	RAD behaviors/symptoms	
Aggressive toward children	RAD behaviors/symptoms	
Non-existent	Parent's social life	1. Parents experience social isolation a. Family isolation b. Personal isolation c. No community resources d. Social media interaction
Zero	Parent's social life	
Social media	Parent's social life	

Results

Theme 1: Mothers Live With Anxiety and PTSD

Mothers who care for adolescence experience anxiety and PTSD from various situations such as physical abuse from the child, phone calls from school officials, seeking treatment or attempting to redirect the child's behaviors in a public setting. Participant, PH2 expressed they experience "PTSD over the school ringtone. LS1 shared an experience of their child's physical abuse:

> “I was having a lot of um, nightmares and panic attacks and just the flashbacks of him. Kind of coming at me in attack mode. And it did subside 'cause he was gone for about 8 months, and so that gave me time to really just focus on myself for a little bit and get some therapy and try to work on healing.”

When the child is in the home, parents find it difficult to control their anxiety or remain calm. CS5 shared an experience of “staying calm as best as we can” and “just trying not to reacts when he reacts.” Parents struggle with maintaining a calm demeanor when being attacked. Anxiety decreases when the child is not in the home. When the child is away at treatment, parents are able to work on their anxiety and healing. To cope with anxiety and PTSD, mothers attend therapy. Mothers also take medication to assist with their mental health, LS1 shared, "I'm on some meds for anxiety." Another method of coping with anxiety for mothers is allowing the father to handle the child while taking a break from the child. Mothers experience anxiety outside of the home as well. While in a public setting, such as a restaurant or grocery store, when the child begins to present with

negative behavior, according to CW3, she would "pack up all the food and we would walk out of the restaurant and leave." SG4 shared an experience of feeling PTSD symptoms while being out in public with her child. Her thoughts consume her. She begins to think if she and her family are being punished for caring for the child.

A parent's experience of being informed of their child's behavior results in PTSD. Parents receive many calls of behaviors presented by a child with RAD. The ringing of the phone is a trigger for parents. PH2 shared an experience of setting the "Lion King" movie theme song as the ringtone. If she would hear the song today, she would be triggered. Ph2 expressed, "Oh I had the ringtone as The Lion King, and now if I hear that song it just triggers me. Cause I had so many calls. Had lots of calls with the 16 and the 17 year old and then our 21 year old. Those are the three that I had all the calls."

For CW3, Seeing the telephone number belonging to the school was a trigger. She expressed,

> I, I don't even know how to describe the trauma reaction I started having when I would see the schools number come up on my phone. And it it is just that has been a nonstop ordeal. Uhm, now he's to the point. Now that the school he's in now. Uhm, they almost kicked him out of his special Ed classroom. I mean they, he was there maybe a month, maybe two months, and he had actually just been switched to this school because of his behavior at the school before this.

Parents of multiple children diagnosed with RAD experienced receiving school calls simultaneously. PH2 shared a moment of breaking down and crying on the phone to school officials. PH2 shared,

> Then one time I had the principal to call me with one child and the counselor beeped in on the other line with another child and I broke down and started crying and after that they genuinely started handling everything.

Seeking treatment for RAD causes PTSD for parents. Making the constant effort to find treatment and services are not available causes the parent stress. A source of PTSD is trying to find professionals who understand RAD to better help the parent understand. CW3 explained the process as hitting one brick wall after another brick wall. She expressed,

> I was lucky that I had the one counselor, you know, give him the diagnosis and then I was able to find another local counselor that that was aware of it and diagnosed him also. And really, it was very helpful, but getting him the actual help that he needed was just it was brick wall. After brick wall I was told at one point that he had to go acute at least three times before they would approve treatment and I said, well, that's no problem. He goes acute all the time. I just usually call. Uh, a friend of the family. Another foster parent, you know that that can come over and help me handle it. Or I call the police and just their presence calms him down.

Mothers of adolescence with RAD experience traumatic situations that result in anxiety and PTSD. Direct and indirect actions of the adolescence trigger the anxiety and PTSD.

Therefore, mothers are always anxious or triggered when their child's behavior is toward them or when they are being informed by someone.

Theme 2: Lived With a Lack of Understanding or Information About RAD

When seeking treatment for their adolescent, parents experience mental health therapist who is not knowledgeable about RAD. CW3 experienced "the lack of understanding for trauma in general, but especially RAD."

CW3 shared more of her experience as,

> I'm telling you he has had so many bad counseling experiences and that has been, just mortifying. There was there was one counselor that that suggested that he just needed to do an apology session with a child that he had offended and I tried to explain to her. I said you don't understand he can apologize all day long but there's no remorse, none. Not at all. And you know the whole reason for you helping him is is to help him dig deep enough to to find the empathy for other human beings. But if he doesn't truly have that. That's not going to accomplish anything. It was just that, that's been the biggest struggle. Lack of expertise among the experts.

Professionals were formally educated. However, parents felt professionals lacked experience beyond their education. Parents shared their experience of finding an experienced RAD therapist. Participant CS5 shared,

> It's really hard to find a therapist that knows what reactive attachment disorder is beyond textbook. It needs to be completely out of the box thinking you cannot

> approach this child with the typical behavior charts and chore charts and star systems and reward system, you can't do that.
>
> They don't care, so you know it's it's finding a therapist. That actually gets it sees it. Recognizes it and knows what to do with it, because that's the biggest problem that we found was just, you know, beyond textbook, they don't know what to do.

There were some therapists who lacked understanding or information about RAD but was willing to try to learn about the disorder to assist the parents. A mother shared her experience of a therapist attempting to treat her children. According to PH2,

> The last therapist that they had that came to our home here, he didn't know about RAD, but he was learning. He was letting me teach him and he even came in one day and he said.
>
> You know, I thought you were really out there with a lot of the stuff you were saying, he said but a friend of mine that's a social worker, she started telling me all this the same stuff that you've told me and she even gave me this website.

Parents traveled 2-3 hours away from their homes to seek treatment for their children. There were no mental health professionals in communities where parents reside to receive assistance. CL6 shared, “There was nobody in our area that had the the knowledge to be able to care, care for her to treat her so we had to travel. You know, three hours, 2 1/2 hours just to get treatment.”

Similarly, LS1 shared their experience of finding a therapist who was able to properly assist. "Until just recently that we found maybe a therapist or two and that I didn't have to go in and explain my kids to somebody like they finally got it." L1 also

shared, “But we drove to Little Rock basically every day for about two years. I mean not every day, but every week for about 2 1/2 years and there was a lot of traveling and a lot of expense.” CW3 shared her experience of traveling to a residential treatment facility for her adopted son. CW3 expressed,

> It was very exhausting for me as a parent because I had to, you know, either take my other two kids with me or get a a babysitter, but I had to go up there.I would say one to three times a week and it was an hour and a half away, so I would usually have to take a day off of work.

Educational officials such as teachers, principals, and counselors inform parents of behaviors presented by an adolescent in the school environment. Upon attempting to explain the behaviors, parents experience educational officials who are unaware or do not understand RAD. Parents live as RAD advocates and educators.

Parents experienced educational meetings with school staff and officials for their adolescents to explain RAD behaviors and find a solution for their students. Parents express their experience as an educational moment, CS5 expressed, "I educate them the best I can. And give them things that they need to go look at." "I spend a lot of time teaching and training about trauma."

While some parents educated school administrators and teachers, others struggled with explaining their child's behavior. PH2 expressed, "In the beginning, it was hard, but then as the school let me educate them," and SG4 shared, "they just couldn't see what we were seeing at home." CL6 shared an experience of being blamed by school officials for

not feeding her child due to her child's ability to manipulate school teachers into believing the mother was starving the child. CL6 shared that her daughter,

> would always claim to be starving like I never fed her and so like we came up with a plan before school before she went to school in order to curb that. That way, like I brought a package of huge package of crackers just to leave at school for her to be fed that way, she knew that me and the teacher were on the same page and that she couldn't triangulate between us, but she still found a way.

Mothers experienced educational and mental health professionals who did no understand RAD. Although the experience was exhausting and sometimes a struggle, parents continued to educate school officials and mental health professionals about RAD. Due to the lack of understanding, parents also searched for knowledgeable professionals to help their children in other areas outside of their hometown.

Theme 3: Parents Live With RAD Behaviors and Symptoms

Parents live with the following common RAD behaviors and symptoms, manipulation, destroying items, superficially charming, constant chaos, aggressive behavior toward children, aggressive behavior toward the mother, assaulting children, releasing in air vents, purposely releasing of bowels, hoarding food, staring at others, stealing, running away, and failing to bond.

Adolescents lie to and manipulate family members, teachers, and mental health professionals. Parents experience teachers and treatment facility staff who believe the child and not the parent. According to LS1, "Sometimes it feels very judgmental, and you could be judged as parents for your kid's behavior."

Parents live with their children destroying items in the home and items received during holidays such as birthdays. CS5 expressed, "I mean, it could be his favorite toy when he gave it to him, and a week later, he has completely destroyed it." Children appear to be superficially charming toward school officials and family members. CL6 shared their child was

> Really good at charming people into thinking that you know, like she's not got all these issues that she had. And so that was probably my biggest struggle
> It’s like I always had to be like this bad guy and I never got to, you know. Like I don't know I just always had to implement these rules and be the bad guy and. and there just seemed to be like very little respect for the fact that, she has all this documented issues.

Parents live in constant chaos created by their children. The child may create chaos during holidays, in public settings, or in the home. A mother shared her experience with her child during holidays. According to PH2,

> Holidays were always extremely difficult. A lot of chaos. We could not tell our kids that we were going to celebrate something until we got there. If we were going somewhere because they would absolutely start acting out before we left to where I would just be so frazzled that I just didn't even want to go period, and then they always acted out real bad afterwards.

Children also cause chaos among their siblings. CW3 shared, "Just always creating chaos, always breaking things. Always just stirring the pot with all the other children."

Within the home, the adolescents present with aggressive behavior toward other children. CW3 experienced their child being "aggressive towards the other children and in unhealthy violent ways." Other children have been assaulted by adolescents and physically attacked in residential treatment facilities. A parent shared experiences of being informed by the treatment facility of their child attacking roommates.

Mothers are the main target for adolescents. Adolescents display aggression toward their mothers. Fathers do not leave the mother at home alone with the adolescent due to their behaviors. Mothers live with being verbally and physically attacked by their children. LS1 shared an experience of being verbally attacked, "So if I am alone with him, or if I'm in a car where I can't obviously stop and get out, that's when he kind of gets into that attack mode." Mothers are hit and kicked. CL6 expressed her daughter, hit, kicked, and bit her. Mothers live with bruises inflicted by their children years ago.

A common behavior presented by adolescents is purposely releasing urine and waste. Parents have found bags of waste in the closet. CW3 shared an experience of finding waste as, “one time he got mad at me and he was in his room for a long time. And weeks later I was cleaning his room and I found a bag of poop he had pooped in a Walmart sack and thrown in the back of his closet.” The child will release into the air vents of the home. CS5 expressed her son, was “pooping in my air vents on the floor.”

A child will also release in new clothing. Adolescents may display this behavior at 16 years old. CL6 shared the experience of her sixteen year old adopted daughter, “Yeah, she's 16, but she pooped her pants three times last week. Just because she was

mad and they would be like oh okay. You know my kid did that too or my kid just peed down the vent. She used to pee on her carpet and down the fence."

Parents live with their children hoarding food. Children will eat from the trash CL6 shared an experience with her child during the holiday. "She might get in the trash and eat something out of the trash." SG4 and CS5 also expressed their adopted sons were hoarders.

While in public settings, the adolescent may be seen standing and staring at others. Parents attempt to redirect the abnormal behavior. Parents also live with children who steal items. Running away from home is a common behavior displayed by adolescents. Parents live with children who have attempted to run away more than once. CL6 shared, "She had attempted to run away a couple of times." Parents live with children who run away as a method to receive attention. LS1 experienced," he ran away once and then came back and then that didn't get enough of a reaction so he ran away again and then the cops had to bring him back. And so when they brought him back, he didn't like that."

The behaviors and symptoms of RAD create a different life for parents. Parents are blamed for their children's behavior. Mothers are the main target for the adolescents. Parents experience the behaviors and symptoms during holidays and within public settings. All behaviors and symptoms of RAD are difficult for parents to live with.

Theme 4: Parents Experience Social Isolation

Family Isolation

Parents live a life of social isolation. Family members do not understand RAD. PH2 expressed, "My husband has lost his family. His whole family." While driving to a

family members home for Thanksgiving, the child used profanity and screamed. Upon arriving at the home, the grandmother offered the child pie. The mother did not allow the child to have pie. The grandmother blamed the mother for the child's behavior due to not understanding RAD.

Parents attempt to educate their families. LS1 shared her experience of educating her father:

> He would just get really mad at the kids when they were younger and just blow up and kind of get mad at them and there were a lot of times when I just couldn't even bring the kids over to the house because he was hateful like he was mean to me mean to them. I would just avoid going there because I thought we don't need this. The kids don't need this. You know whatever, and I've spent a lot of time educating him and helping him understand why they have those behaviors where the trauma comes from Family members are supportive while others are not.

CW3 suffers from social isolation due to the death of her mother, who was her support system. She expressed,

> I don't really have any family. When my mother was alive, she died two years ago and when she was alive she totally understood it. She saw it every time she came to visit. She really helped me a lot. You know she lived in a different state but she would come visit for two months a year and I don't even know how to describe what a big cheerleader and how much help she was. She really got it. Other than that she passed away two years ago, which is just a huge loss and I just don't really have any other family.

Family members are sympathetic to RAD. According to SG4 "They're all very sympathetic and think it's horrible what his mom did to him."

Personal Isolation

Parents experience personal isolation. Their child's behavior prevents trips to the store for necessities. Parents sneak out of the home at night to purchase items while the child is sleeping. CL6 shared her experience as,

> There was a point in time when after she went to bed that my other daughter would keep an eye on her. Well, I mean she was in her room but she would just make sure that you know like she didn't get up at night or whatever and I would be able to leave. But I would only go grocery shopping like that was my social life was to go grocery shopping by myself.

Parents do not live a life of dating or participating in extracurricular activities. Parents fear their child will ruin their relationships with others. CL6 shared her experience of dating while her daughter was in her care:

> Like I even started dating after she left. Well, it was like right before she left I started dating and you know, like now I'm engaged to be married and it's like crazy. Because I couldn't imagine like. On my wedding day. Like how stressful that would be to have to deal with. Making sure she didn't. You know, like that she was doing what she's supposed to be doing and not hurting someone or hurting herself.

Parents do not attempt to invite individuals to their homes. LS1 shared an experience of personal isolation: "You can't invite people over because you don't ever

know when they're gonna be losing it." Parents do not have many friends. PH2 shared, "As far as like having friends over like we used to or going to peoples houses like we used to hang out with friends. All of that was non-existent anymore." PH2, CW3, SG4,CS5, and CL6 all described their social life using the words "zero," "non-existent."

No Community Resources

Parents live in areas where there are no community resources to assist their children according to CW3 and SG4. Therefore, parents have resulted in starting support groups for families. LS1 shared,

> I'm just kind of the trailblazer for our area. We have the oldest kids.in our network. At least people that I know in our network in our area because we have all the teenagers and that I know of at least with RAD in our area. And so when we're looking for resources I'm usually the one that's out there looking and searching and trying to figure out what's available because there really is nothing. And so I'm just trying to figure out where do I go next? What's out there, who may have some training in it.

PH2 shared, “as far as I know there's not anything anywhere as far as people who will you know, come together to help like give you respite.”

Social Media Interaction

Social media has been an outlet for parents. It has assisted with coping with social isolation. Parents have joined Facebook groups that have been instrumental in helping. SL1 shared, “there's also a lot of stuff on social media that I follow some RAD groups and some of them are supportive, some of them not so much.”

SG4 shared her experience of the social media pages. "I don't post on there a lot. Hardly ever, but I do read a lot of their posts." CL6 shared her experience as, “we had a like a RAD moms group that I was involved with from the families that went to that camp that I was telling you about the bonding camp…So, we all like got a Facebook group and we kept in touch and so.”

The Facebook pages assist the parents with gaining a sense of not being alone. CS5 described social media pages help her with knowing others who are experiencing the same issues with their children exist. She described her experience as,

> I think that it's helpful to know that you're not alone. I think that those kind of groups they can either get you down, lift you up, whatever it is. It depends on how you want to look at it. You know, I don't think that on those groups that there's anybody out there that's saying anything negative. They're all going, oh girl, been there, you know, been there just hang in there it'll be ok, this too shall pass and so that's good to know that you have. People out there even though you don't physically know them.

CW3 described her experience as, “I have found some Facebook pages that are geared around RAD and it has absolutely been. I don't even know how to describe it. You feel like you're on an island all alone with a crowd of people on shore watching you starve to death and die. And suddenly there's other people on the island with you.”

Mothers of adolescence with RAD experience social isolation. Their life surrounds the child due to not having any friends or family visit their home. Parents are unable to experience life outside of the home due to difficulty in finding an individual to

care for their child while away. Family members do not understand the disorder, therefore parents do not receive much assistance from family. Mothers experience personal isolation. Their personal or intimate lives are impacted. Parents are unable to date or develop relationships with others due to a fear of their child's behavior impacting the relationship. There are no community resources to assist parents with their children or their issues that have stemmed from caring for a child with RAD. Social isolation has led mothers to reach out for help via social media. Social media has been an outlet for mothers and help cope with feeling alone. Interacting with others on social media has been helpful for mothers caring for their child and coping with isolation.

Evidence of Trustworthiness

Credibility

Triangulation was implemented within the study. The two methods implemented in the study were Heidegger's Phenomenology and Colaizzi's Methods. The main purpose of Heidegger's Phenomenology is to shed light on the everyday lives of individuals within a specific phenomenon (Kelly, Millar & Dowling, 2016). The specific phenomenon of the study was RAD (RAD). The implementation of Heidegger's Phenomenology presented the everyday lives of mothers living with adolescents with RAD. Colaizzi's Method assisted with presenting an in-depth interpretation of the mothers' lived experiences through significant interview statements, formulated meanings of the statements, codes, theme clusters (categories), and themes.

Transferability

Adjustments were made to transferability. The adjustments were due to the recruitment of participants. While recruiting participants, the researcher discovered there were single mothers who were adoptive parents. Therefore, adjustments were made to the inclusion and exclusion criteria. Single mothers were no longer excluded from the study but were included with married parents. Within the results of the study, there will still be a description of the setting of each interview, sample characteristics of participants, and data collection and analysis methods (Hadi & Closs, 2016)

Dependability

The implementation of audit trails is used to identify the steps of the research study. The first step was to place the research study flyer on social media to recruit participants. Once participants expressed interest, consent to participate in the study was obtained via email. A consent form was sent to the participants, and the participants replied to the email giving consent. Phone interviews and zoom interviews took place according to the availability of the participants. Each interview was audio recorded. During each interview, the researcher conducted reflexive journaling. After the completion of the interviews, each interview was transcribed. Transcriptions and audio recordings were saved to a flash drive.

Colaizzi's Method was implemented after transcription of interviews for coding. Significant statements were recorded on a chart from each participant for all interview questions. Each significant statement was defined to formulate a meaning. The formulation of a meaning, cluster themes, or categories assisted with the establishment of

themes. Themes were also established according to Heidegger's Phenomenology. Before themes were established, the researcher chose a key goal and tenant of Heidegger's Phenomenology to reveal a theme that interpreted the lived experiences of adoptive parents of adolescents with RAD. A key goal of Heidegger's Phenomenology is to give insight into the everyday existence of human beings (Kelly, Millar & Dowling, 2016). A key tenant is "being in the world" (Kelly, Millar & Dowling, 2016). Therefore, themes would represent the everyday existences of adoptive parents or human beings and their lived experiences of being in the world with others or adolescents with RAD.

Confirmability

I implemented confirmability by not allowing my previous professional experience as a residential treatment counselor to influence the conduction of the study as well as data analysis. While conducting the study, I made sure to review the transcriptions thoroughly for symptoms that I did not experience as a residential treatment counselor. As the researcher, throughout the interviews, I ensured I was clear and concise about the purpose of the study. I removed my professional experience and bias from my thoughts and solely focused on the experiences of the participants.

Summary

In this chapter, I presented how the study benefited from a pilot study. The setting of the study informed how each participant was able to participate at their own level of comfort and convenience. The demographics and descriptions of each participant gave more insight into the lived experiences of the participants. Capturing the lived experiences through transcription of interviews and Colaizzi’s Method resulted in codes,

categories and themes. Within the chapter each code and category and are presented along with four major themes. Each theme is supported by narratives given by each participant. The narratives presented the lived experiences of adoptive parents of adolescence with RAD.

Evidence of Trustworthiness was presented in this chapter. Credibility was achieved through triangulation, by using the two methods of Heidegger's Phenomenology and Colaizzi's Methods. Adjustments were made to transferability by including both married and single mothers in the study. Dependability is presented in steps that can be used again to duplicate the study. Confirmability was implemented by removing professional bias as a previous residential treatment counselor while analyzing data.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the research study was to conduct a phenomenological analysis to explore the daily lived experiences of adoptive parents of adolescents with RAD living in rural areas. The population for the study was adoptive parents of adolescents 12-18 years of age. The adoptive parents and adolescents resided in rural areas of Arkansas. Data were collected from interviews with adoptive parents to understand their experience of the child's behavior and the parental feelings of social isolation. The study impacts social change by presenting an understanding of the experience of adoptive parents in a southern region and gives insight into how mental health professionals can assist the parents.

The research question was, what are the lived experiences of adoptive parents of adolescence with RAD? After completing the study, the key findings to answer the question are adoptive parents experience and live with mental health issues due to their child's behavior. Adoptive parents live with common RAD behaviors and symptoms. Adoptive parents experience a lack of understanding from mental health professionals when attempting to seek treatment for their children. Adoptive parents experience school staff and officials who do not understand RAD. Parents experience social isolation.

Interpretation of the Findings

This section will describe how the findings confirm and extend the knowledge of the peer-reviewed literature discussed. Literature informs infants (Losinski et al., 2016) and children under the age of 5 years old (Follan & McNamara, 2014) living in isolation,

abuse, neglect, and unstable homes (Losinski et al., 2016) are at risk of developing RAD. The research study confirms the literature. Through reflexive journaling (Alan & Eatough, 2016), I found adoptive parents began caring for their children during the ages of 17 months old, two and half years old, three years old, and five years old. The research study extends upon the literature. Specific RAD behaviors also manifest at younger ages. Participants revealed behaviors manifest at the age of 3 years old such as eating bugs and explosive behavior. Behaviors also began at 5 years old.

Foster Parent Challenges

Prior to adoption, research participants were foster parents. The literature reveals foster parent challenges. Caring for a child with behavioral, emotional, or medical needs can lead to distress, guilt, feelings of failure, and burnout (Miller et al., 2019). The research study confirms the literature. Participants within the study live with distress, as evident by attending therapy due to suffering from anxiety and PTSD as a result of caring for a child with behavior needs. Participants experienced burnout, as evident by sharing their experience of disrupting adoptions.

Child's Behavior/Mental Illness and Services

Literature reveals the child's behavior and mental illness increases over the time period, causing the foster parent to seek treatment (Aarons et al., 2010; Conn et al., 2019). The research study confirms the literature. Adoptive parents expressed children began to display behavior issues as early as 5 years old. The continuation of the behavior caused the parent to seek treatment. A participant shared their experience of 8 years of behavior and mental issues displayed by their child that required treatment.

According to the literature, parents may choose outpatient services for their child (Conn et al., 2016) or psychiatric care (Barnett et al., 2018). Due to living with a RAD child, research participants chose outpatient services such as family therapy, individual therapy, and school-based therapy. Participants chose psychiatric care for their children, such as inpatient and residential programs. Parents shared experiences with allowing children to attend a diagnostic program.

Pre and Post Adoption Challenges

The research study confirms challenges with pre and postadoption presented in the literature. Pre-adoption issues include fertility complications (Moyer & Goldberg, 2017). Mothers within the study chose adoption due to infertility. Literature informs a lack of resources is a major source of stress for adoptive parents (Moyer & Goldberg, 2017). Adoptive parents are in need of assistance with access to behavioral health services for the child and themselves and respite care (Leake et al., 2019). The research study confirms a need for access to behavioral health services for the child and parent, as evident by no community resources for RAD, inexperienced mental health professionals, and professionals who lack knowledge. Adoptive parents travel lengthy distances of 2-3 hours away from their home to receive services for their children. My reflexive journaling revealed parents travel for weekend respite care for themselves and other children within the home.

Literature states adoptive parents feel there is a lack of informal support. Informal support is the support of friends and family (Moyer & Goldberg, 2017). The research study confirms the literature by giving insight into social isolation. Adoptive parents

experience family isolation. Family members lack an understanding of RAD. Family members are more at risk of being manipulated by the child. Mothers within the research study shared experiences of family conflicts and disruptions due to RAD behavior.

According to the literature, post-adoption services are scarce. Families are unaware of the few available services or unable to access services (Miller et al., 2019). The research study confirms the literature. Participants referred to post-adoption services as "frustrating." Participants expressed feeling "helpless" after finalizing adoptions. A post-adoption resource that is used to assist parents with stress is support groups (Miller et al., 2019). Adoptive parents learn coping skills from other adoptive parents (Miller et al., 2019). The research study extends upon the literature. Parents are unable to access support groups established by agencies or offered within the community. Therefore, research participants have created support groups in religious organizations within their communities for adoptive parents. The research study confirms there is a lack of self-care training for adoptive parents (Miller et al., 2019). Participants within the study shared experiences of not partaking in self-care or struggling with self-care.

Theoretical Framework and Key Findings

Attachment Theory

The attachment theory stemmed from the work of John Bowlby. When conducting his research in the attachment at the London Child Guidance Clinic, he studied 44 juvenile thieves and a control group. Bowlby discovered the juvenile thieves experienced mother-child deprivation more than the control group (Ainsworth & Bowlby, 1991). Adoptive parents within the research study live with adolescents who display the

common behavior of “stealing.” Bowlby’s study and the research study give insight into the behavior of RAD adolescents that has been displayed over the years.

Bowlby also developed enduring attachment or an attachment bond. A child who has an enduring attachment does not attach to multiple individuals. The child may have one or two individuals they attach to (Bowlby, 1982). Adoptive parents within the research study shared an experience of “no bonding” with their children. The children may bond with biological siblings or adoptive grandparents. Mothers experienced a trauma bond between adopted children. The research study presents John Bowlby’s term of enduring attachment is prevalent in the present day.

Adolescents with RADs have negative IWMs of themselves and others and do display attachment behaviors (Lehmann et al., 2018) of the theory toward the primary caregiver due to lack of maternal sensitivity during infancy. A common RAD behavior found in the research study is “aggressive toward mother.” During the early stages of life, the child did not receive maternal sensitivity from the biological mother. The child did not develop a positive IWM for the mother. The negative IWM for the mother is inflicted upon the adoptive mother in the form of aggressive behavior.

Family Systems Theory

The family systems theory was significant due to the study being conducted to give insight into how a child’s behavior impacts the family system. A major key finding of the study is parents experience social isolation. Family isolation is included in social isolation. Mothers within the study expressed a lack of understanding of RAD among their family members. The mothers struggled with explaining RAD to their family

members. Several family members supported their redirection of the behavior of their children, while others did not. Lack of understanding and support caused a negative impact on the family. The behaviors of the RAD children cause division between adoptive maternal and paternal families. Spending time with families during holidays is difficult. Behaviors of the child such as eating from the trash can, sexually predatory behavior, or stealing money may cause conflict. Other children have a better relationship with grandparents. Grandparents assist parents with deescalating children. Some children do not have a bond with family members. A participant of the research study shared an experience of disrupting an adoption with the support of family for disruption due to the negative impact the child's behavior had on the entire family.

Limitations of Study

Limitations of trustworthiness that arose within the research study were geographic region selection, diverse participant pool, and the age and gender of children. The research study was limited to one southern state. Additional southern states were not included in the study. Participants were limited to rural areas of the chosen southern state. Participants from more established and resourceful residential areas were not included in the study. The participants were limited to Caucasian women. The study was limited to adoptive parents of adolescents. Adoptive parents of youth under the age of 12 years old were not included. After the completion of the study, five of the six participants of the adoptive mothers were guardians of adolescent males. One participant was a mother of an adolescent female.

Recommendations

Recommendations for further research that are grounded in the limitations of the current study are to conduct a research study including more than one southern state. Further research may be conducted in another southern state. More research within the state of Arkansas may be conducted, expanding on key findings extending current literature, participant selection, area selection, methodology, and theoretical framework.

Research recommendations on the findings expanding on the literature include conducting research on the lived experiences of adoptive parents caring for children with RAD under the age of 12 years old. The recommended age range for future research is 17 months old to 5 years old, according to research findings. Specification of child's gender is a recommendation due to adoptive parents caring for a high percentage of male children and a lower percentage of females within the current study.

Research recommendations on the key findings within the theoretical framework include researching the lived experiences of adoptive parents of RAD children who present with the prominent behavior of stealing. Additional research on the lived experience of an adoptive parent lacking a relationship with their child is appropriate, along with more research of the lived experiences of adoptive mothers due to lack of maternal sensitivity from biological mothers. More research on RAD behaviors impacting the entire family system would provide in-depth insight into the lived experiences of families.

Implications

The research study impacts individuals, families, professionals, and society. The potential for positive social change includes providing insight into the lives of parents who struggle with caring for their child diagnosed with RAD. This positive social change extends beyond the individual. The purpose of the study was to give insight into the lived experiences of adoptive parents. The study provides additional insight into how the entire family system is impacted by the behaviors of children with RAD.

This study also impacts the professional field of mental health by providing scholarly evidence for the establishment and expansion of community resources within rural areas. The research study presents a need for new resources for families and individuals caring for a child with RAD.

The purpose of the study was to focus on social change within the mental field profession. After the completion of the study, the educational field is an additional focal point of social change. This study provides insight into educational assistance for parents, the formal introduction of RAD to educators, and the implementation of services within the educational field for students with RAD.

Methodological implications of social change include the continuation of an interpretive phenomenology for further research. Conducting an interpretive phenomenology allowed me to learn more details of the lived experiences that warrant additional research to add to scholarly literature. Adding to the literature presents more need for social change within the mental health field to better assist adoptive parents living with children with RAD.

Recommendations for practice within the mental health and educational fields include the implementation of awareness initiatives for RAD. Initiatives include creating foundations to assist adoptive parents with finances for treatment for their child. Participants within the study expressed traveling long distances for treatments and difficulty paying for treatment not covered by insurance. Initiatives and practices include parents and school officials joining to begin conversations about their experiences of the child with RAD to increase an understanding of RAD. Formal training for educational professionals could be provided by experienced and knowledgeable mental health professionals of RAD.

Conclusion

The research study was conducted to address a gap in the research and knowledge regarding the social issues adoptive parents of RAD youth experience in Arkansas. The purpose of the phenomenological study was to explore the daily lived experiences of adoptive parents of adolescents with RAD living in rural areas.

The key findings of the research study enhanced the significance of the study and provided more implications for social change. The significance of the study was to contribute to research on adoptive parents and their feelings of social isolation and adoptive parents of children with RAD. Adoptive parents are socially affected by the behaviors of adolescents diagnosed with RAD. Adoptive parents experience different types of social isolation. Adoptive parents are socially isolated from family and friends. The parents experience community resource isolation, as there are no services to provide

assistance. Their only form of social interaction to ease social and community isolation is social media.

The study was significant, as it set out to provide the lived experiences of adoptive parents of adolescents with RAD. Not only are adoptive parents socially isolated, but they also live with anxiety and PTSD due to their child's behavior. Adoptive parents live a life of constant advocating for change in the mental health field and educating professionals on RAD.

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Appendix: Interview Questions

1. Would you mind sharing why you chose to be an adoptive parent?
2. Describe the feelings you experienced when your child arrived in the home for the first time.
3. Describe your feelings when you were informed your child was diagnosed with reactive attachment disorder
4. Tell me about the first time witnessing abnormal behavior from your child.
5. Tell me more about the RAD behaviors/symptoms your child displays.
6. Describe how you cope with the negative behaviors presented by your child.
7. What was the experience like when seeking treatment for your child?
8. Describe your child's treatment history.
9. What was your experience like with your child's treatment history?
10. What was the experience like bonding with your child?
11. Describe the experience of holidays or birthdays with your child.
12. Describe bonding between your child and other family members or siblings.
13. What is your experience like of being informed of your child's behavior by school officials?
14. What is the experience like when you try to explain the behaviors your child displays to school officials?
15. Tell me about your experience of informing family members of your child's RAD.
16. Describe the experience of taking your child into public places such as a store.

17. What feelings do you experience when your child presents with negative behaviors in public settings?
18. Tell me about your social life as a parent of a child with RAD?
19. What was your experience with community resources for parents of RAD youth?
20. If you are involved in a social network or support group for RAD parents, what is the experience like?
21. Is there anything else you would like to tell me about your experience as parent of a child with RAD?