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African-American Fathers' Perspectives of Their Sons' Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

Renee Von Raub
Walden University

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Walden University

College of Social and Behavioral Sciences

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Dana Renee Hawthorne Von Raub

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Walden University
2020

Abstract

African-American Fathers' Perspectives of Their Sons' Diagnosis and Treatment of
Attention Deficit Hyperactivity Disorder

by

Dana Renee Hawthorne Von Raub

MS, Florida Atlantic University, 1994

BS, Florida International University, 1985

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

School Psychology

Walden University

January 2020

Abstract

Parents' perspectives about children's Attention Deficit Hyperactivity Disorder (ADHD) diagnosis and treatment are crucial in managing their children's ADHD. While research existed on mothers' perspectives of ADHD treatment, there was little research on the perspectives of African American fathers about their sons' ADHD. The purpose of this qualitative phenomenological study was to explore African Americans fathers' perspectives of their sons' diagnosis and treatment for ADHD. Family systems theory served as the conceptual framework. The research question was designed to explore African American fathers' perspectives and lived experience related to their sons' diagnosis of and treatment for ADHD. Ten biological fathers were recruited for phone interviews. Data were then coded and analyzed using Braun and Clarke's thematic analysis. Nine themes emerged: (a) sought advice; (b) dismissal of symptoms initially; (c) feelings of powerlessness and hopelessness; (d) resources available to me; (e) frustration, shock, and disbelief; (f) my role as a parent; (g) want what is best for my child; (h) successes of treatment plan; and (i) beliefs on medication versus alternative therapies. African American fathers also held beliefs similar to Caucasian fathers found in previous research and initially explained their sons' behavior with a boys will be boys rationale. Further research is recommended on fathers' perspectives of their children's diagnosis and treatment of ADHD within other racial populations. Practical implications include clinicians understanding the role of African American fathers in the treatment of their children diagnosed with ADHD. Social change implications include facilitating culturally sensitive treatment options for African American boys diagnosed with ADHD.

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Dedication

This dissertation is dedicated to my son, Thomas.

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Chapter 1: Introduction to the Study

Introduction

The American Psychiatric Association (APA; 2013) defined attention deficit hyperactivity disorder (ADHD) as a childhood onset neurodevelopmental disorder characterized by inattention, disorganization, and/or hyperactivity-impulsivity. ADHD often overlaps with externalizing disorders, such as oppositional defiant disorder (ODD) and conduct disorder (CD), and may follow into adulthood where it can impair occupational, academic, and social functioning (APA, 2013). Since 2011, over 11% of children have been diagnosed with ADHD (Centers for Disease Control and Prevention [CDC], 2016), making the treatment of ADHD in children a priority for research and practice.

Parents and their decisions are crucial in the treatment of children's neurodevelopmental disorders, such as ADHD (Zhou & Yi, 2014). Singh (2003) found that fathers' perspectives of the clinical evaluation and treatment of their sons' ADHD were important in terms of whether their sons received treatment and the kinds of treatment they received. However, researchers have not focused specifically on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD.

This study adds information on fathers' roles in the treatment of African-American children with ADHD. Chapter 1 contains the Background of the Study, Problem Statement, Purpose of the Study, Research Questions, Conceptual Framework, and Nature of the Study. Also provided in this chapter are definitions, assumptions, scope and delimitations, limitations, significance of the study, and a summary.

Background of the Study

Pediatricians and general practitioners often diagnose ADHD based on behaviors such as overactivity, restlessness and excessive energy, shortened attention span, recklessness, and impulsivity (Sherman, 2015). Boys who exhibit particular learning difficulties and behavioral problems are twice more likely to be diagnosed with ADHD than girls (Visser et al., 2014). Symptoms of ADHD include seeming to not listen, inability to stay on task, losing materials, fidgeting, overactivity, intruding into others' activities, and the inability to wait and stay seated (APA, 2013).

Since 2000, typical drug treatment for children with ADHD has included stimulants such as Daytrana, Focalin XR, Intuniv, Kapway, Methylin, Ritalin LA, Strattera, and Vyvanse (CDC, 2016). Other medications are nonstimulant and include atomoxetine, as well as antidepressants and antihypertensives (Children and Adults with Attention Deficit/Hyperactivity Disorder [CHADD], 2015). Behavioral interventions are also an important form of treatment and include approaches that focus on consistency, positive reinforcement, teaching communication, self-advocacy, and problem-solving skills. Interventions may also include classroom and behavioral accommodations for children with ADHD (CHADD, 2015).

Parents' perspectives and their decisions regarding their children's ADHD treatment are crucial in managing children's neurodevelopmental disorders, such as ADHD (Zhou & Yi, 2014). Mothers and fathers may perceive their children's ADHD and treatment differently (Chen, Seipp, & Johnston, 2008; Gomez, 2010), influencing whether their sons received treatment and the types of treatment they received (Singh,

2003). For example, in a foundational study on fathers and ADHD treatment, Singh (2003) observed a paucity of literature regarding fathers' perspectives of their sons' ADHD treatment in prior research and found that mothers tended to accept drug treatment to help manage their sons' ADHD, while fathers tended to disagree with drug treatment for their sons' ADHD. Singh also found that fathers resisted current medical frameworks for understanding their sons' ADHD behaviors. Fathers' explanations of their sons' ADHD behavior fell within three themes: *boys will be boys rationale*, *lack of motivation*, and *indulgent mothering*.

Parents also have varied understandings regarding the cause of their children's ADHD, which influences parents' coping and treatment choices. Using grounded theory, Harborne, Welpert, and Clare (2004) studied how parents struggled to understand the causes of their children's ADHD. Some parents believed the cause of ADHD was biological, while others believed it was caused by psychological and social factors. Harborne et al. studied nine Caucasian mothers and one father. Parents battled with feelings of blame they perceived from professionals, family members, and friends for their children's behavior, and struggled with the origin of their children's ADHD, which caused them emotional distress. The stated limitation to this study was that it focused only on Caucasian working families and did not include African-American or Hispanic families in the study.

Chen et al. (2008) found that European-Canadian fathers believed ADHD was based on lack of effort, while mothers believed it was based on biological factors. Consequently, mothers believed more in behavioral management for their children than

fathers did. Mothers viewed their children's ADHD by weighing empirical evidence more so than fathers did. Chen et al. also suggested that mothers' and fathers' perspectives of their children's treatment may diverge, creating tension between parents and impacting treatment choices and outcomes.

Gomez (2010) used multiple group confirmatory factor analysis and multiple indicators multiple causes procedures on results of the Disruptive Behavior Rating Scale given to Australian fathers and mothers to rate their children's ADHD behavior. There were inconsistencies between fathers' and mothers' ratings. Gomez stated it is conceivable that mothers and fathers interpret and report ADHD behaviors differently because mothers tend to spend more time in caregiving roles, while fathers tend to spend more time in a playful role. Gomez went on to assert that mother-child interactions are more negative, demanding, and directive than father-child interactions, and that children tend to be more combative with mothers than fathers. ADHD symptoms affected mother-child relationships, while ADHD symptoms do not affect father-child relationships (Gomez, 2008). Finally, the stated limitation of Gomez's study was that this study was considered preliminary and further research was needed to determine why parents had different views of their children's ADHD behavior.

In addition, parents' perceptions of children's ADHD and its treatment may be influenced by parents' race. Pajo and Cohen (2013) reviewed 36 articles about parents' accounts of their children's ADHD. This article discussed the controversy of medicating children for performance enhancers in school, and found that cultural background played an important role in parents medicating their children. The researchers found that

African-American and Hispanic parents tended to not medicate their children. African-American and Iranian parents see ADHD as a lack of parental discipline. Hispanic parents viewed ADHD behavior as normal and were also concerned about the stigma of mental illness for their child. The stated limitation of Pajo and Cohen's study was that the reasons that some parents medicate and others do not medicate needs to be studied.

Chang, Chiu, Wu, and Gau (2013) observed that Western fathers had less father-child interactions with children diagnosed with ADHD than Western fathers with children not diagnosed with ADHD. Similarly the researchers studied father-child interactions in Chinese fathers and found children in China with ADHD received less affection and care from their fathers than children without ADHD. Chinese children diagnosed with ADHD also experienced a more authoritarian style of parenting and more overprotection from their fathers than children without ADHD. Chinese children with ADHD reported they received less family support than those without ADHD. Chinese children also reported negatively on child-father relations than fathers reported. Chang et al. concluded that ADHD negatively affected father-child relations and fathering parenting styles. In addition, the researchers recommended the need for clinical interventions to improve father-child interactions for children diagnosed with ADHD, as well as more study of diverse ethnic populations.

Although work on fathers' perspectives regarding the diagnosis and treatment of their children's ADHD is emerging, research was limited in scope, especially in relation to diverse populations such as African-American fathers. In addition, while there was much research on mothers' perspectives of children's ADHD diagnosis and treatment,

research on fathers' perspectives continues to lag. The present study was designed to help add to research regarding African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD; thereby helping African-American boys diagnosed with ADHD receive proper treatment.

Problem Statement

Boys who exhibit particular learning difficulties and behavioral problems are twice more likely to be diagnosed with ADHD than girls (Visser et al., 2014). Parents and their decisions regarding their children's ADHD treatment are crucial in treating and managing children's neurodevelopmental disorders such as ADHD (Zhou & Yi, 2014). There was little research on fathers' perspectives of the symptoms, diagnosis, and treatment of their sons' ADHD (Chang et al., 2013). However, father involvement generally can lead to enhanced well-being, social competence, and cognitive development of their children (Chang et al., 2013). Although research on fathers' perspective of their sons' ADHD diagnosis and treatment is beginning to emerge, past studies have been restricted to mostly Caucasian populations (Chang et al., 2013; Pajo & Cohen, 2013; Singh, 2003). The literature reflected the lack of diversity in study samples and the need to study ethnically diverse groups, including African-Americans. In order to better understand fathers' perspectives regarding symptoms, diagnosis, and treatment of their sons' ADHD in ethnically diverse populations, the present study focused on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD using Singh's (2003) findings as a base. Finally, findings from this study may lead to a better understanding for practitioners of the role of African-American fathers in their

sons' diagnosis and treatment of ADHD, thereby leading to enhanced interventions for African-American boys.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore African-Americans fathers' perspectives of their sons' diagnosis and treatment for ADHD. Singh (2003) found that fathers' perspectives of their sons' diagnosis and treatment for ADHD was important in Caucasian populations. This study is important because there is limited prior research on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD. Findings from this study could help explain the roles African-American fathers play in their sons' diagnosis and treatment of ADHD. The study will add to Singh's (2003) research regarding Caucasian fathers' perspectives and Chang et al.'s (2013) study of Chinese fathers with children diagnosed with ADHD. In addition, this research will add to literature regarding the treatment of ADHD in children generally, and the study could also lead to social change by informing treatment approaches of ADHD in African-American populations. Exploring African-American fathers' perspectives of their sons' diagnosis and treatment for ADHD will lead to information regarding what both hinders and facilitates ADHD treatment for children.

Research Questions

The overarching research question guiding this study was,

RQ: What are African-American fathers' perspectives and lived experiences related to their sons' diagnosis of and treatment for ADHD?

SQ1: How do African-American fathers interpret and make decisions regarding their sons' ADHD behaviors?

SQ2: How do African-American fathers experience and perceive their sons' ADHD diagnosis?

SQ3: How do African-American fathers experience and perceive their sons' ADHD treatment?

Conceptual Framework

Family systems theory (M. Bowen, 1978) served as the conceptual framework for the study. M. Bowen (1978) theorized that human behavior could be understood in the context of the family unit by applying systems thinking in order to examine and explain the complex interactions and emotional connections of family members. The interdependent nature of family interactions and emotions greatly influences human development, so much so that M. Bowen observed that it seems as if family members are living under the same *emotional skin*. M. Bowen's (1978) family systems theory, which is a theory of human behavior that emphasizes the family as a unit, implies what one does within the family affects the family as a whole. Consequently, changes in the emotional states and functioning of one family member affects the emotional states and functioning of other family members (Ng & Smith, 2006). Family relationships are reciprocal and undergo continual evolution as relational units (e.g., father-mother, mother-child, and father-child) interact within the community unit (e.g., the family as a whole; M. Bowen, 1978).

Parents must make decisions about their children's treatment of ADHD. However, research indicates that parents do not always agree on the cause or treatment for their children's ADHD, which can influence the type of treatment parents choose for their children, as well as cause emotional stress and tension between parents (Pajo & Cohen, 2013). For example, Chen et al. (2008) found that fathers believed ADHD was based on lack of effort, while mothers believed it is based on biological factors. Consequently, mothers believed more in behavioral management for their children than fathers did. Harborne et al. (2004) found that some parents believed the cause of ADHD was biological, while others believed it was caused by psychological and social factors. Additionally, parents battled with feelings of blame they perceived from professionals, family members, and friends for their children's behavior, and struggled with the origin of their children's ADHD, which caused them emotional distress. Consequently, family systems theory was an appropriate framework to examine fathers' perspectives of their sons' diagnosis and treatment of ADHD because the theory allows for understanding how family dynamics can affect and can be affected by fathers' perspectives of ADHD, including its diagnosis and treatment.

Nature of the Study

The study was a qualitative phenomenological approach to explore the lived experiences and perspectives of African-American fathers related to their sons' diagnosis and treatment of ADHD. The qualitative methodology was selected to align with Singh's (2003) research exploring the perspectives of Caucasian fathers related to their sons' ADHD diagnosis and treatment. Within the current study, I focused on the experiences of

African-American fathers and selected a phenomenological design instead of the grounded theory approach used in the Singh's study. Because there was a paucity of research related to the unique perspectives of African-American fathers regarding their sons' ADHD diagnosis and treatment, I centered the present study on exploring lived experiences and not formulating a theory related to the phenomenon.

A qualitative methodology was selected because there was little research related to African-American fathers' perspectives of their sons' ADHD diagnosis and treatment. Qualitative methods are best suited when little is known regarding the phenomenon under investigation (Creswell, 2009). The phenomenological approach is used to explore the lived experiences and perspectives of participants to gather data related to the phenomenon (Tracy, 2013). I used the phenomenological design to explore African-American fathers' lived experiences and perspectives related to their sons' diagnosis and treatment for ADHD. I conducted semistructured interviews using an interview protocol I developed called, Von Raub's Interview Questions and Prompts Protocol. The data collection procedure included obtaining informed consent from participants. Participants were African-American fathers with sons who had been diagnosed with ADHD. The main inclusion criteria for interviews were that fathers must be African American, must have a biological son 18 years or younger diagnosed with ADHD, and must live with the son.

Participants were recruited through flyers placed in several Central Florida locations, including the Sweet Center in Winter Haven, Florida; Peace River in Central Florida; and local hospitals. Ten participants were recruited for this study using Qualtrics,

a company that identifies potential research participants. Data collection and analysis occurred simultaneously by reflecting on the data and finding emerging categories with examples from the data.

Definitions

Attention deficit hyperactivity disorder (ADHD): A neurodevelopmental disorder defined by impaired levels of disorganization, inattention, impulsivity, or hyperactivity. ADHD frequently overlaps with CD and/or ODD. In adulthood, ADHD often impairs academic, occupational, and social functioning (APA, 2013).

Conduct disorder (CD): A type of disorder that involves behavioral patterns that violate rules and societal norms (APA, 2013).

Hyperactivity-impulsivity): Entails fidgeting, an inability to stay seated, an inability to wait, intruding into other people's activities, and overactivity (APA, 2013).

Inattention and disorganization: Entails the inability to stay on task, to keep materials, and to listen (APA, 2013).

Oppositional defiant disorder (ODD): A disorder that involves patterns of the following: angry or irritable mood, argumentative or defiant behavior, and vindictiveness lasting at least 6 months and with at least one individual other than a sibling (APA, 2013).

Assumptions

In the present qualitative study, I assumed that participants would provide honest and forthright responses to interview questions and would not deliberately give misleading answers. I constructed an environment to encourage candid and honest

responses by selecting a comfortable and private location to conduct the interviews. Because the purpose of the study was to gain insights regarding the unique perspectives of African-American fathers related to their sons' ADHD diagnosis and treatment, I assumed the best population to speak with was African-American fathers. A third assumption of this qualitative study was that a phenomenological approach was the most appropriate to collect rich, in-depth information and explore the perceptions and experiences of the lived experiences of African-American fathers regarding their sons' diagnosis and treatment of ADHD.

Scope and Delimitations

The scope of this qualitative study involved African-American fathers with sons who had been diagnosed with ADHD. The study focused on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD, and no other population was studied. Because the study involved in-depth exploration of the unique perspectives and experiences of African-American fathers, the findings do not transfer to other populations. Qualitative phenomenological research is designed for in-depth exploration of people's perspectives and experiences, and such research is not expected to produce statistical transferability to other populations.

In addition, I considered using ecological theories, such as Bronfenbrenner's (2005) ecological systems theory as the conceptual framework for the study. Although ecological theories allow researchers to understand individual actions and development in relation to family settings, ecological theories also involve a much wider social and cultural population than was necessary for the purpose of this study. Because the study

focused on perceptions related specifically to family dynamics and the family unit, family systems theory (M. Bowen, 1978) served as the conceptual framework for the study.

Fathers' perceptions of their sons' ADHD treatment can be influenced by family dynamics, such as mothers' perspectives (Chen et al., 2008; Gomez, 2010). Therefore, family systems theory was appropriate to examine and explain the complex interactions and emotional connections of family members that may play a role in fathers' perceptions of their sons' ADHD treatment.

Limitations

My unique position with data collection, analysis, and reporting may have posed a limitation to the study, because biases can influence findings. However, my biases were addressed through journaling. Through journaling, I considered my own biases to ensure they were set aside prior to data collection and analysis. I also used member checking within the study. By allowing the participants to confirm the accuracy of the findings, trustworthiness of the data was further ensured.

Significance of the Study

The original contribution of this study could be important to research in psychology. Typically, fathers' roles in their sons' diagnosis and treatment of ADHD were not mentioned in the literature. Father involvement has had positive influence on children's well-being and social competence, both of which are important to the functioning of children with ADHD (Chang et al., 2013).

Findings from this study have implications for practice, research, and social change. This research could help clinicians better understand the role of African-

American fathers in the treatment of their children diagnosed with ADHD, and could help clinicians devise intervention approaches accordingly. In addition, because the role of African-American fathers in the treatment of their sons diagnosed with ADHD is largely unknown and underrepresented in the literature, the findings will add to the literature regarding racial and gendered dimensions of treatment for children with ADHD. Finally, the research could support positive social change by facilitating enhanced treatment options for African-American boys diagnosed with ADHD.

Summary

Effective intervention for childhood ADHD remains a challenge for practitioners, making the treatment of ADHD in children a priority for research and practice. Parents and their decisions regarding their children's ADHD treatment are important for the treatment of children's neurodevelopmental disorders, such as ADHD (Zhou & Yi, 2014). However, mother and fathers may perceive their children's ADHD and its treatment differently (Chen et al., 2008; Gomez, 2010), and these differences may influence whether or not their children receive treatment or not and the type of treatment they receive (Singh, 2003). In addition, perceptions and treatment of children's ADHD can be influenced by race (Chang et al., 2013; Singh, 2003). Yet, research on fathers' perceptions regarding their children's ADHD treatment among diverse populations is only beginning to emerge. To add to the literature on the role of fathers in their children's treatment, this study was designed to explore African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD. This study added to the existing literature to help inform treatment for African-American boys diagnosed with ADHD. Chapter 2

contains the literature search strategy used for the study, as well as synthesis and analysis of reviewed literature.

Chapter 2: Literature Review

The purpose of this qualitative phenomenological study was to explore African-American fathers' perspectives of their sons' diagnosis and treatment for ADHD. Although research on fathers' perspective of their sons' ADHD diagnosis and treatment is beginning to emerge, past studies have been restricted to Caucasian populations (see Chang et al., 2013; Pajo & Cohen, 2013; Singh, 2003). The literature reflected the lack of diversity in study samples and the need to study ethnically diverse groups, including African-Americans.

The five major sections of Chapter 2 are the introduction, literature search strategy, conceptual framework, literature review, and summary. The introduction section includes the problem, purpose, and synopsis of current literature. The Literature Search Strategy section includes the list of databases, key terms, a description of the iterative search process, and methods used to locate current research. The Conceptual Framework section includes the phenomenon, synthesis of key theories, definitions key to research, and how current research applies to the framework. The Literature Review section includes studies related to the scope of the study, the ways researchers have approached the problem, justification of selected concepts, a review of what is known, and synthesis of related studies. The Summary section includes a summary of the major themes and a transition to Chapter 3.

Literature Search Strategy

A comprehensive search for literature from databases accessed through Walden University's online library portal was conducted. The PRISMA flow diagram (2015) was

used to guide systematic screening of articles to be included and excluded. Databases searched were Academic Search Complete, CINAHL, Cochrane, EBSCO ebooks, LexisNexis Academic, MEDLINE, ProQuest Central, PsycARTICLES, PsycINFO, PubMed, SAGE Premier, ScienceDirect, and SocIndex. Google Scholar was also used for relevant literature using search terms, which were *attention deficit hyperactivity disorder, children's ADHD intervention, parents' perspectives of treatment, parents' perspectives of diagnosis, fathers' perspectives of diagnosis, fathers' perspectives of treatment, African-American fathers, African-American sons, and family systems theory.*

Conceptual Framework

M. Bowen's (1978) family systems theory is a theory of human behavior that emphasizes the family as one unit. Change that affects one member affects all members of the family. This theory emphasizes the family as a whole is greater than its parts. M. Bowen's family systems theory holds that eight interlocking forces shape family functioning: differentiation of self, emotional cutoff, family projection processes, multigenerational transmission processes, nuclear family emotional systems, sibling positions, societal emotional processes, and triangles.

Differentiation of self is related to the ability to engage in conscious effortful control of behavior (M. Bowen, 1978). A person with good self-differentiation is able to stay calm during criticism, rejection, or conflict (M. Bowen, 1978). A person with poor self-differentiation is one who depends on others for acceptance and approval (M. Bowen, 1978). Emotional cutoff occurs when a family member moves away geographically in order to avoid unresolved emotions with parents or other family

members. This does not solve the problem, as the individuals who move away often see the problem with parents or other family members rather than with themselves (M. Bowen, 1978).

The family projection process occurs through parents, who can pass emotional problems to children by focusing on their children's problem during infancy, causing major symptoms during adolescence (M. Bowen, 1978). Multigenerational transmission processes are supportive or detrimental family traditions and ideals that occur and are passed on over multiple generations (M. Bowen, 1978). Nuclear family emotional systems refer to relationship patterns that govern where problems develop in a family (M. Bowen, 1978).

Sibling positioning refers to the idea that the oldest sibling is usually a leader and the youngest is usually a follower, which can be used to predict marriages and divorces (M. Bowen, 1978). Societal emotional processes occur as families experience chronic and sustained stress, causing families to regress to lower levels of functioning. This can also be seen in society; the more society experiences stress, such as overpopulation and unemployment, the more it regresses to a lower level of functioning (M. Bowen, 1978). Finally, Triangles are relationships involving three people wherein conflict exists between 2 of the 3 people involved. Relational dyads shift between the three, leaving one as an outsider at any given time. A typical triangle is between a mother, father, and child (M. Bowen, 1978).

Researchers can use these eight areas to help understand phenomena as they relate to the dynamics of family functioning. Family systems theory is therefore a suitable

foundation for exploring fathers' perspectives of their sons' diagnosis and treatment of ADHD. The theory allows for understanding of how family dynamics can affect and can be affected by fathers' perspectives of ADHD.

Support for Family Systems Theory

Haefner (2014) used family systems theory to examine family dynamics in relation to a child's behavioral problems at school. The family included a 7-year-old child and the child's mother and father. Haefner conducted a single-case study to examine the child's behavioral problems in school, including bringing a knife to school for protection. The mother raised the child during the child's first 7 years as a single parent, and then married the child's father. Following the marriage, the child began acting out and having behavioral problems in school. M. Bowen's theory suggests the child was confused with family roles because, for the first 7 years of the child's life, the central relationship was child-mother. The child was then involved in a child-mother-father relationship, and meaningful interaction between child and mother now centered largely around behavioral corrections for misbehavior (Haefner, 2014). The family went into counseling together to focus on the family, using M. Bowen's theory, instead of focusing solely on the child's misbehavior in school. Haefner concluded that family systems theory helped explain the child's behavior resulting from family dynamics and not stemming solely from the child.

Ng and Smith (2006) sought to show a relationship between Bowlby's attachment theory and M. Bowen's intergenerational family systems theory. The attachment theory assessment contains four attachment styles: dismissive attachment, fearful attachment, preoccupied attachment, and secure attachment (Bowlby, 1958). Dismissiveness is

defined by high avoidance and low anxiety, fearful attachment is defined by high avoidance and high anxiety, preoccupied attachment is defined by low avoidance and high anxiety, and secure attachment is defined by low anxiety and low avoidance (Bowlby, 1958). The intergenerational family systems theory assessment contains eight scales: intergenerational fusion, intergenerational intimacy, intergenerational intimidation, intergenerational triangulation, nuclear family triangulation, personal authority, spousal fusion, and spousal intimacy. Ng and Smith examined the relationship between intergenerational family systems theory and attachment theory, and found linkage between the two theories. The most significant areas were in terms of spousal relationships and parent relationships with children.

M. Bowen (1978) said how well a child functions as an adult through life and how well the child's own nuclear family functions are influenced by lack of differentiation between parents and children, as well as unresolved attachment. Differentiation emphasizes the distinction between emotional and intellectual processes and one's ability to manage individuality and togetherness within a relationship system (Kerr & Bowen, 1988). Differentiation refers to the ability to experience autonomy from others and intimacy with others. When this differentiation occurs, individuals can relate to parents as peers with equal power (Ng & Smith, 2006).

M. Bowen (1978) said that ability to control one's behavior is related to self-differentiation. Ng and Smith (2006) found that individuals with less anxiety experienced more intimacy with spouses, more personal authority, and less triangulation in the nuclear family. Individuals with higher levels of anxiety experienced less intimacy with spouses,

less personal authority, and more triangulation in the family (Ng & Smith, 2006). In addition, individuals who were less avoidant experienced less triangulation with their children and spouses along with higher degrees of intimacy with their spouses.

Individuals with higher levels of avoidance were less securely attached, experienced discomfort with closeness, and avoided closeness in relationships (Bowlby, 1988).

Using family systems theory (M. Bowen, 1978), Palkovitz and Trask (2014) explored the differences in mothering and fathering in a qualitative study from a feminist perspective. Family systems theory supports the idea that since mothers and fathers engage in different roles and rules, they are therefore essentially different. Feminist theory also supports the idea that men and women are different and that they represent differences in roles and power. Family systems theory is often used as a mainstay in family studies programs. However, it has not been used for empirical studies of fathering. The tenet of feminism is that women and men have different experiences in society, which would stand to also support that mothers and fathers also have different experiences parenting. This also supports the corollary that men and women influence their children in different ways, such as in children's development and well-being.

Palkovitz and Trask (2014) found that fathers' parenting is distant, while that of mothers is more proximate than fathers. The researchers also found that fathers tended to use physical engagement with infants and young children, while mothers tended to take a more caretaking role. Fathers' stimulating play helps build child-father bonds (Palkovitz & Trask, 2014). According to Palkovitz and Trask, fathering behavior was also influenced by marital quality. In their study, fathers defined good parenting as helping

mothers with childcare, spending time with children, and participating in family life and mothers viewed good parenting as providing structure, reliability, and discipline. Further, fathers saw work outside the home as helping with childcare through the provision of economic support and mothers saw working outside the home as time spent away from the child.

M. Bowen's (1978) family systems holds that the family is a dynamic, interrelated whole and that change affecting one member can also affect or result from the relationships among family members. In the present study, African-American fathers' perspectives on their sons' ADHD diagnosis and treatment involved family dynamics, including not only father-son relationships, but a combination of other family relationships as well. Family systems theory was an appropriate theory because the topic included multigenerational father-son relationships. I captured information on the different parenting styles between mothering and fathering to understand the lived experiences of mothers and fathers and the distinctions they bring to the development of children in unique family settings.

ADHD and *Diagnostic and Statistical Manual of Mental Disorders* Criteria

ADHD is a childhood onset neurodevelopmental disorder characterized in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; APA, 2013) by the criteria of disorganization, inattention, and/or hyperactivity-. ADHD may overlap with externalizing disorders (e.g., ODDs and CDs) and may persist into adulthood, where it can interfere with academic, occupational, and social functioning (APA, 2013). Symptoms of ADHD include inability to stay on task, seeming to not listen, losing

materials, fidgeting, overactivity, the inability to wait, intruding into other's activities, and the inability to stay seated (APA, 2013).

Gender Differences and Diagnosis

Over 11% of children have been diagnosed with ADHD (CDC, 2016), with boys exhibiting comorbid learning difficulties and behavioral problems being twice more likely to be diagnosed with ADHD than girls (Visser et al., 2014). General practitioners and pediatricians often diagnose ADHD based on behaviors, including overactivity, restlessness and excessive energy, shortened attention span, recklessness, and impulsivity (Sherman, 2015). The treatment of ADHD in children, especially boys, remains a research priority.

Treatment

Treatment for ADHD in children has included both drug-based and behavioral interventions. Typical drug treatments include the use of stimulants, such as Focalin, Daytrana, XR, Intuniv, Kapway, Methylin, Strattera, Ritalin LA, and Vyvanse (CDC, 2016). Drug treatments also include the use of antidepressants and antihypertensives, as well as nonstimulants, such as atomoxetine (CHADD, 2015). Additionally, behavioral intervention represents an important form of treatment, and typically involves approaches that focus on consistency, positive reinforcement, teaching effective communication, self-advocacy, and problem-solving skills. Interventions for children with ADHD may also involve classroom and in-school behavioral accommodations (CHADD, 2015).

Parents and ADHD Diagnosis and Treatment

Parents' perspectives and their decisions regarding their children's ADHD diagnosis treatment are important, and research indicates that mother and fathers may perceive their children's ADHD and its treatment differently (Sherman, 2015; Zhou & Yi, 2014). These differences can influence whether their children receive treatment and the types of treatment they receive (Sherman, 2015; Zhou & Yi, 2014).

Researchers have studied both parents' perspectives of treatment and diagnosis of their children with ADHD. For example, in their qualitative study, Coletti et al. (2012) explored parents' perspectives of initiating medication treatment for their children's ADHD. Although treating children with medication is accepted, it can be contentious because medication is sometimes considered a quick fix for a potentially overdiagnosed condition (Sherman, 2015). In addition, adherence to medication is also important. Coletti et al. sought information from 27 parents (six fathers and 21 mothers) to guide the development of a provider-delivered intervention to improve adherence to medication regimes for their children with ADHD. The researchers used grounded theory and inductive analysis to reveal three themes important to the study of ADHD medication adherence in children: defining adherence, identifying attitudes that promote or interfere with adherence, and identifying parent perceptions of medical providers.

Parents do not always adhere to medication regimes. Interestingly, when parents were asked if they adhered to medication regimens, they answered that they did adhere (Coletti et al., 2012). However, after further probing, it was discovered that on occasion they did not adhere to the medical treatment (Coletti et al., 2012). For example, parents

missed dosages because they unintentionally forgot; or, it was the weekend and parents felt the medication was not needed, so they did not give their children the required medication. Coletti et al. (2012) also found that although parents adhered to medication regimens early in treatment, parents often deviated from adherence, citing reasons such as the irregular schedules of weekends or unintentionally forgetting.

In addition, parents' attitudes can be barriers to pursuing stimulant treatment, and include perceptions about medication side-effects, such as tics and reduced appetite. Parents said "My fear is that he would kind of 'zombie out.'" "I didn't want to take the sparkle away from her." "We like him the way he is. I love his personality. when he takes the [medication] all of a sudden he becomes very serious and he's focused but I don't like it as much." (Coletti et al., 2012; Sherman, 2015). Coletti et al. (2012) found that parents' perceptions of medical providers were positive when parents were involved with health-care professionals in shared decision-making processes regarding treatment. Parents also felt that using a chronic illness metaphor was effective in explaining the need for medication to treat ADHD. For example, "If your child has a chronic illness such as diabetes, you would give your child insulin. It is the same for ADHD. Your child has a chronic illness and needs medication" (Coletti et al., 2012, p. 230). Parents feared the stigma of an ADHD diagnosis for their children and of their children needing medication, which aligns with previous research (DosReis et al., 2010). Although Coletti et al.'s study was important for exploring parents' perspectives on medication treatment and adherence; the researchers did not examine the differences in the perspectives of fathers

and mothers, reinforcing the need for this study. Additionally, the researchers did not focus on race in relation to treatment.

Researchers have studied disparities among ethnic minorities utilizing health services for ADHD, which has implications for diagnosis and treatment decisions (Berger-Jenkins et al., 2012). Berger-Jenkins et al.'s (2012) study included 70 parents of children or adolescents diagnosed with ADHD, of which 34% were Black non-Hispanic people and 57% were Hispanic people. None of the children or adolescents were receiving psychological treatment or medication. This significant lack of participation in mental health care was due to inaccuracies in parent knowledge about ADHD etiology and interventions, such as Ritalin. Berger-Jenkins et al. recommended educational interventions for teachers, health-care providers, and the public concerning misconceptions of ADHD, with a special emphasis on treatment and etiology. Educational interventions should aim at improving knowledge, attitudes, and behaviors surrounding ADHD treatment' in addition, educational interventions should be evaluated for their long-term effectiveness (Berger-Jenkins et al., 2012). Berger-Jenkins et al.'s study helped to shed light on the continued misinformation about ADHD and the implications misinformation has for diagnosis and treatment decisions in minorities. Future researchers can build upon this study by continuing research on ways to provide accurate information about ADHD to children, parents, teachers, pediatricians, and health-care professionals.

Studies have also included a focus on the attitudes of parents concerning their children's ADHD and treatment in conjunction with the attitudes of a wide range of

stakeholders. These stakeholders included adolescents, children, health-care professionals, parents, and teachers. Moldavsky and Sayal (2013), for example, conducted a literature review of key studies on the knowledge and attitudes of various stakeholders toward ADHD and its treatment in children. Moldavsky and Sayal grouped articles into four main groups: parents' and young people's perceptions of ADHD stigma, stakeholders working together on the diagnosis and treatment of ADHD, attitudes and general knowledge towards ADHD, and professional health-care interventions to provide accurate knowledge about ADHD.

Examining the perceptions of various stakeholders was important because ADHD is a common disorder, the diagnosis and treatment of which are often contentious (Moldavsky & Sayal, 2013; Sherman, 2015). This contentiousness can have negative implications for families, teachers, and health-care providers in achieving shared goals (Moldavsky & Sayal, 2013). Parents and their children diagnosed with ADHD often report stigmatizing experiences stemming from misconceptions about ADHD (Moldavsky & Sayal, 2013). Additionally, Moldavsky and Sayal concluded that health-care providers and parents may have different views about their roles in the shared decision-making process while working together on the diagnosis and treatment of children with ADHD. All stakeholders should support the principles of information-sharing and working together. However, Moldavsky and Sayal did not focus specifically on the perceptions of fathers, which is consistent with most of the literature on parents' perspectives of their children's ADHD and treatment.

Decisions about treatment for children with ADHD are often complicated and may pose challenges for parents. To understand these challenges, Pajo and Cohen (2013) conducted a literature review to examine the issues associated with parents' decisions regarding treatment for their ADHD children. Pajo and Cohen analyzed 36 peer-review articles published between 1996-2008. The central construct was parents' perspectives of their child's diagnosis and treatment of ADHD. Pajo and Cohen found that parents in 27 studies thought of ADHD as a valid disorder. Twenty-two studies indicated parental views on ADHD adhered to a biomedical view. Eight studies indicated that parents saw ADHD as a controversy (Pajo & Cohen, 2013).

From their review and analysis of the literature, Pajo and Cohen (2013) also discovered seven themes related to parents' perspectives of their children's diagnosis and treatment of ADHD. Parents are often unaware of problems prior to school years, and it is not until children begin attending school regularly that difficulties begin to appear; teachers are often the ones to notify parents of these difficulties at school (Pajo & Cohen, 2013). After that, parents often experience a grieving process because they believe their child is no longer considered normal. Additionally, schools often pressure parents for medication information for children with ADHD, which can make parents feel as if there is not enough time to decide on medications. Pajo and Cohen also found that fathers are less willing than mothers ascribe a medical cause to the ADHD behaviors in their children; this finding aligns with the foundational findings of Singh (2003), who found that fathers resisted current medical frameworks for understanding their sons' ADHD behaviors. Furthermore, living with a child with ADHD involves constant chaos,

disruptions, and stress. Major challenges include getting children for school in the morning and completing homework at night (Pajo & Cohen, 2013).

Pajo and Cohen (2013) also found that relationships between teachers and parents can be problematic, and sometimes fraught with suspicion and turbulence. Additionally, parents may have animosity toward doctors because parents see doctors as judgmental toward their parenting (Pajo & Cohen, 2013). Parents often perceive doctors as wanting only to prescribe medication, and not help their children beyond prescribing medications (Pajo & Cohen, 2013). Parents may also feel that doctors lack interest in understanding family situations, as they only take a few minutes to come to their diagnosis of ADHD (Pajo & Cohen, 2013). The decision to medicate their children is also a source of confusion for parents. While medication can lead to improved grades, increased self-esteem, and less aggression, parents often remain resistant and suspicious of medicating their children (Pajo & Cohen, 2013). Negative effects of using performance-enhancing drugs can be sleep problems, stomachaches, loss of appetite, sore eyes, twitchiness, zombie effect, and increased hyperactivity from missed medication. Parents, however, may tolerate these side effects if they see significant academic progress and improvement in their children (Pajo & Cohen, 2013).

Pajo and Cohen's (2013) article, like others (see Coletti et al., 2012; Sherman, 2015), shows that parents' perspectives of treatment and diagnosis of their children with ADHD are important and can influence treatment decisions. However, as in other studies, father's perspectives were largely not examined. Pajo and Cohen recommended that future research might include understanding parents' concepts of their children's

problematic behaviors and how these concepts relate to wider features of economic, educational, family, and social life.

Researchers have also studied parents' perspectives on ADHD, in conjunction with children's perspectives, to gain an understanding of family dynamics in managing ADHD and the implications this may have for practitioners. For example, Wong and Goh (2014) conducted a qualitative study using in-depth semistructured interviews with parents and their children with ADHD. During data collection, researchers observed exchanges between parents and children. The sample size consisted of five family units, including eight parents (fathers and mothers) and five male children, aged 9 and 10, from Singapore. Four themes emerged from the research: children's responses to parents' parenting methods, parents' strategies to manage stress, positive child-parent relationships despite ADHD disability, and stressful moments in child-parent dynamics (Wong & Goh, 2014).

Parents reported stressful moments, specifically when they tried to get children to do their homework or to manage their children's unruly behavior (Wong & Goh, 2014). Parents used nagging, scolding, threatening, hitting, and watching over children to ensure their children's compliance and to manage stressful moments. Parents also expressed feelings of weariness, powerlessness, and uncertainty. Parents reported that children often ignored them to avoid parents' instructions. However, parents expressed that they could gain compliance by using incentives, threats, and physical punishments. Interestingly, no parents viewed their parent-child relationship as strained (Wong & Goh, 2014).

Children, on the other hand, reported compliance and noncompliance was based on their mood. Children also reported that they complied if an incentive was offered, such as more play time or their parents buying them a present (Wong & Goh, 2014). Children also reported that taking medication helped them behave better, helped them become smarter, and helped them listen to their parents. Children usually negotiated until terms were in their favor or parents used threats or physical punishment. Children reported that when they did not want to comply with their parents' requests, they used crying, fake crying, tantrums, and whining. Despite stressful moments, parents and children reported their relationships were generally positive, and they often shared moments together that were pleasant, such as playing sports or games. Parents expressed that their children brought laughter and joy to the family (Wong & Goh, 2014).

Although Wong and Goh's (2014) study was qualitative and included fathers' perspectives of their sons' ADHD behaviors, it did not focus solely on fathers nor on their perspectives of diagnosis and treatment. This study provided useful information for practitioners to keep in mind that children and parents both have the power to create positive and negative moments when living with ADHD. Additionally, children with ADHD are active agents, not passive recipients. Parents can also help their children by recognizing their children's talents, possibilities, visions, and hopes (Wong & Goh, 2014).

Sollie, Morch, and Larsson (2016) also studied parents' perspectives of ADHD in relation to family dynamics and demographic variables. In their quantitative study, including 214 Norwegian children and their parents, fathers made up only 5.1% of the

study population. Sollie et al. found that parents of boys less than 13 years of age experienced more stress than did parents of boys 13 or older. Parents with children diagnosed with ADHD and ODD symptoms in the clinical range experienced significantly more parent and family dysfunctions than those of children with ADHD only. Furthermore, fathers experienced significantly less child involvement, less parental efficacy, and parenting stress than mothers (Sollie et al., 2016). Sollie et al. recommended that parenting programs should be designed to include ways to enhance father involvement and parenting strategies for fathers. Future research might also include longitudinal studies designed to investigate the family dynamics that underlie the relationships between parents and their children with ADHD over time (Sollie et al., 2016).

Researchers have found it important to understand parents' perspectives toward ADHD in relation to children's perspective and in relation to pediatricians' perspectives as well. In a quantitative study, Efron et al. (2016) examined pediatric practices and parent perspectives regarding ADHD diagnoses in children. The researchers used Conners 3 ADHD Index and the Strengths and Difficulties Questionnaire. The sample population was from Western Australia and Victoria, Australia, and included 137 patients (77% boys), their parents, and 24 participating pediatricians. The number of fathers was unknown. Efron et al. found that Australian pediatricians' management and diagnostic practices were consistent with international guidelines and that pediatricians underidentified externalizing, such as sleeping problems, compared to parental reports. In addition, the researchers found that 1 in 7 parents did not agree with their children's

ADHD diagnosis. This partially aligns with the findings of Singh (2003) and Pajo and Cohen (2013), who found that fathers specifically disagreed with ADHD diagnoses for their children. Efron et al. did not describe the study population in detail, such as the number of fathers and number of mothers, and did not focus on fathers' perspectives. The researchers recommended future research on how pediatricians and parents can work collaboratively in the ADHD diagnosis process.

The decision to medicate children with stimulant medication for ADHD is a serious concern for parents (Sherman, 2015). Hansen and Hansen (2016) explored parents' perceptions and experiences concerning decisions to use stimulant medication to treat their children's ADHD. Hansen and Hansen conducted a phenomenological qualitative study using semistructured interviews with both mothers and fathers. The researchers found that parents struggled with the decision to use stimulant drugs because of their potential long-term side effects. Additionally, several themes emerged surrounding medication therapy: balancing side effects and improvements in academic performance, balancing side effects and functional improvements, concerns about lifelong medication, side-effect costs, dilemmas after medication termination, improving the atmosphere at home, role of medication in the children's futures, preparing to cope without medication, and stimulants as a postsecondary aid (Hansen & Hansen, 2006).

Parents' desire to balance medication side effects with improvements in academic performance partially supported the findings of previous studies (see Pajo & Cohen, 2013; Singh, 2003). Singh (2003), for example, found that mothers tended to accept drug treatment to help manage their sons' ADHD more readily than fathers did. Pajo and

Cohen (2013) found that an important role in parents' decisions to medicate their children for ADHD was cultural background. African-American and Hispanic parents tended to not medicate their children, attributing ADHD to nonmedical causes. African-American parents saw ADHD as stemming from a lack of parental discipline, while Hispanic parents viewed ADHD as being within the bounds of normal behavior and were concerned about the stigma of their children being diagnosed with a mental illness (Pajo & Cohen, 2013). This study on African-American fathers' views of the diagnosis and treatments of their sons' ADHD supported the findings of Hansen and Hansen (2016), Pajo and Cohen, and Singh.

Mothers and ADHD Diagnosis and Treatment

Research on parents' perceptions of diagnosis and treatment of children with ADHD has largely focused on mothers. In an early qualitative study of parental schemes for managing children with ADHD, Bull and Whelan (2006) used semistructured interviews, which included phenomenological and interpretative analysis to identify the schemas that guided mothers' management practices. The sample size included 10 Australian mothers who lived in the metropolitan area of Sydney. The purpose of the study was to answer the following research questions: What are parents' understandings of the nature of ADHD? What are the perceptions of mothers' and fathers' roles? and What are beliefs regarding effective management practices? However, no fathers participated in this research. Eight themes emerged on ADHD management from the data: aspirations, authority, community support, differences, management, medication, mothering, and fathers.

The themes of Bull and Whelan's (2006) study are summarized as follows. Mothers believed their children with ADHD were different from their peers without ADHD because of the disruptive behaviors that required unusual levels of accommodations. Mothers also held aspirations and expectations that their children would overcome abnormalities and become capable, responsible, and happy adults, while realizing that their children's conditions might limit these expectations. Additionally, medication schemas held by mothers included believing medication was vital to the management of ADHD, while realizing it was not a cure. However, some mothers were torn between the benefits of medication and its side-effects, which support previous research (see Hansen & Hansen, 2016; Pajo & Cohen, 2013; Singh, 2003).

Mothers also largely believed in limited management techniques and that there were no effective overall management techniques to manage children completely with ADHD (Bull & Whelan, 2006). Contingency management was mostly used, but was difficult to implement and had limited effectiveness. Some mothers expressed that fathers' control was more effective than their own control. However, mothers preferred attempting to reason with their children as method of control rather than more punitive methods used by fathers. Mothers also reported that using strict parental authority was not appropriate for controlling their children with ADHD. Mothers felt that responsibility for child management was theirs and that fathers should follow mothers' principles and directions. However, one mother believed managing a child with ADHD could be successfully achieved if fathers and mothers shared management responsibilities through a unified, consistent, and planned management approach. In addition, high parental

expectations held by mothers included strong commitment to providing the best parenting for their children despite difficulties. Lastly, mothers reported experiencing a lack of community support and that support focused solely on child management courses, and did not include emotional support (Bull & Whelan, 2006). A key finding of Bull and Whelan's (2006) study, as it relates to the present study, was that mothers believed fathers should play a subordinate role to mothers' roles, and that fathers should follow mothers' leads concerning child management. This idea may be an indicator as to why fathers did not participate in this study. The differences in the feelings about mothers' and fathers' roles in managing their children with ADHD are clearly an area for further research.

Research has also included adolescents' perspectives and mothers' perspectives on willingness to use self-management for ADHD. In their mixed-methods study, Bussing, Koro, Gurnani, Garvan, and Mason (2016) sought to understand both adolescents' and mothers' perceptions of ADHD self-management care in a sample size of 161 mothers located in North Florida. Mothers who had adolescents in an ADHD high-risk group represented 67.7%, and mothers who had adolescents in a ADHD low-risk group represented 32.9%. In addition, 72% were White mothers, and 28% were African-American mothers. Also included in this study were 148 adolescents between the ages of 14 to 19 who were previously diagnosed with ADHD and were considered high risk. For the qualitative component of the study, the researchers focused on six self-management intervention constructs, including increased activity outlets, dietary

restrictions, family rules, homework help, prayer, and sleep regulation (Bussing et al., 2016).

The dual-perspective focus of the study indicated that there were significant discrepancies between mothers' and adolescents' willingness to use common self-management strategies for ADHD. The only intervention adolescents were willing to follow was increasing activity outlets. The only race or gender difference in self-management perspectives included African-Americans' willingness to use prayer in self-management care (Bussing et al., 2016). Bussing et al. concluded that it is important to involve adolescents with ADHD in developing self-management practices so that adolescents will be more interested in following self-management practices. Bussing et al.'s (2016) study highlighted that family dynamics play a central role in the treatment and management of ADHD. Furthermore, the study was also an example of research focusing on mothers' roles in the treatment and management of ADHD instead of fathers'.

Fathers and ADHD Diagnosis and Treatment

Research shows that mothers believe they should take the lead in management of their children's ADHD, including making decisions about treatment, and that fathers should play a subordinate role to mothers (Bull & Whelan, 2006). Additionally, an overwhelming amount of past research focuses on mothers, but not fathers in relation to the diagnosis and treatment of children's ADHD (Chang et al., 2013). However, fathers are becoming increasingly involved in the management of their children's medical

conditions (Roy, 2014) and, in recent years, research on fathers' roles of their children's ADHD diagnosis and treatment has begun to emerge.

Singh (2003), for example, conducted early foundational research in the form of a qualitative study on fathers' perspectives of their sons' diagnosis and drug treatment for ADHD. Noting the limited amount of research on fathers' perspectives, Singh conducted in-depth interviews with 22 fathers and 39 mothers. Singh found that mothers tended to accept drug treatment to help manage their sons' ADHD, while fathers disagreed with drug treatment for their sons' ADHD. Fathers disagreed with drug treatment because fathers resisted current medical understanding of their sons' ADHD behaviors. Fathers' explanations of their sons' ADHD behavior fell within three categories: a *boys will be boys* rationale (p. 316), lack of motivation, and indulgent mothering. The conclusions of this study were divided into two categories related to fathers' beliefs about the medical nature of their children's ADHD: tolerant nonbelievers and reluctant believers. Fathers' resistance to treatment using stimulants and fathers' resistance to their son's diagnosis of ADHD were consistent across both categories. The study was important and foundational for understanding fathers' perspectives of their sons' diagnosis and treatment of ADHD. Singh's study was also important for understanding that fathers' perspectives often occur in relation to mothers' perspectives.

Although Singh (2003) made an important original contribution to the existing body of literature on ADHD treatment in children, the study was limited to a Caucasian population. However, Singh helped to lay a foundation for future research on fathers' perspectives, including African-American fathers' perspectives of their sons' diagnosis

and treatment of ADHD. Although Singh's results may not generalize to other cultural or socio-demographic populations, the study could be used as a guide for the study of fathers in other populations.

Early research has also shown that fathers were far less studied in pediatric psychology than mothers were, and fathers continue to be underrepresented in clinical, pediatric, and health-related research (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). Phares et al. (2005) conducted a review of the literature to examine the role of fathers in pediatric psychology. Phares et al. reviewed a total of 577 articles on the topic of child psychopathology. They found that only 1% included fathers only; 26% included both mothers and fathers studied separately; 25% included mothers and fathers, but not studied separately; and 48% of studies included mothers only. Even Singh's (2003) foundational study did not include a population of fathers only. Phares et al. concluded that research on pediatric psychology lagged behind clinical pediatric research in the analysis of maternal and paternal effects separately. Pediatric psychology also lacked inclusion of fathers in family-based interventions. Other findings included that fathers' low levels of encouragement were associated with maladaptive daily coping for boys and poor peer relationships for girls. Additionally, greater symptomatology in the children was related to mothers' overinvolvement and fathers' critical comments (Phares et al., 2005).

Phares et al. (2005) recommended that researchers conduct parallel examinations into both maternal and paternal processes involved in pediatric psychology. Additionally, fathers may participate more in research when fathers' involvement in children's lives is

highlighted. Father research participation can be facilitated also by conducting phone interviews, interviews in the home, free transportation to interviews, free childcare, and by contacting fathers directly. Phares et al.'s study helped to explain why there is limited research on the topic of fathers' perspectives of their children's diagnosis and treatment of ADHD.

More recent studies on fathers and their children with ADHD have focused on father-child relationships and fathers' parenting strategies among adolescents and children. In a quantitative study, Chang et al. (2013) examined father-child relationships and fathers' parenting among children and adolescents in Chinese families. The study sample included 296 males with ADHD between the ages of 11 and 18. The research questions focused on the differences in father-child interactions in children with ADHD and in those without. Chang et al. interpreted findings within a cultural framework of Confucian traditions, which have high academic performance expectations of children. Because ADHD affects individuals' attention levels that can adversely influence academic performance, children diagnosed with ADHD often struggle to perform academically (Chang et al., 2013). This struggle can lead to increased authoritarian control from fathers, overprotection from fathers, and increased tensions in father-child interactions (Chang et al., 2013). Chang et al.'s study represented an important contribution to the study of fathers' perspective of their children's ADHD diagnosis and treatment in culturally diverse populations.

Fathers with an ADHD diagnosis may feel differently about treatment for their children with ADHD than fathers without ADHD. In a quantitative study, Romirowsky

and Chronis-Tuscano (2013) used a cross-sectional study design to examine correlations between children's conduct problems, fathers' adult ADHD, and father involvement among 37 biological fathers and their children with ADHD. The researchers used linear regression analysis and found positive correlations between fathers having adult ADHD, father involvement, and children's conduct problems. For example, children were likely to exhibit conduct behavior problems if their biological fathers had adult ADHD and were involved in their children's lives (Romirovsky & Chronis-Tuscano, 2013). Because child conduct problems for childhood ADHD were significantly positively related to paternal ADHD symptoms, it may follow that ADHD diagnoses in fathers may influence how fathers perceive diagnosis and treatment for their sons' ADHD. However, more research in this area is needed.

Having a son diagnosed with mental illness can change a father's view of mental illness. Morris (2014) conducted a case study using a constructionist perspective to explore one father's perceptions of mental illness after his son's diagnosis of ADHD. Five central themes emerged from semi-structured interviews: alienation from peers, ambivalence, how mental illness works, conflict with mental healthcare and school system stigmatization, and discovery of new peers and mental healthcare specialists. Morris's (2014) study was important for exploring fathers' perceptions of mental illness after diagnosis and adding to the literature from fathers' perspectives. However, although the study provided an in-depth exploration of a father's perceptions of mental illness, because it was a case study of one Caucasian father, generalizability of findings to other

populations is difficult. Nonetheless, fathers' perceptions of ADHD may change after their children are diagnosed with ADHD.

Parents, Race, and ADHD

Research on the connections between race and parental perspectives on ADHD is beginning to emerge. Recently, for example, researchers have focused on parental strain in relation to race in parents of children with ADHD (Hinojosa et al., 2012) and assessed differences in ratings by mothers and teachers of African-American children's ADHD-related behavior (Linton, 2015). Additionally, researchers have investigated the connections between ADHD symptoms and demographic variables, such as ethnicity, gender, and socioeconomic status (SES; Martel, 2015). Recent research has also revealed that the underdiagnosis of ADHD in African-American children can lead to a lack of treatment and the overrepresentation of African-Americans in the criminal justice system (Moody, 2016).

Parental strain in caring for children with ADHD can have implications for how parents view ADHD management and treatment. To examine the ethnic and racial variations in parental strain for African-American, Latino, and non-Latino White parents of children with ADHD and other comorbid diagnoses, Hinojosa et al. (2012) conducted a quantitative study using multivariate regression analysis. The sample size consisted of 5,397 children with current diagnoses of ADHD and other comorbid conditions. Hinojosa et al. observed that children with ADHD are at risk for entering the juvenile justice system, for having a low quality of life, and for poor school performance. Additionally, children with ADHD are at elevated risk for a number of behavioral and comorbid mental

health disorders. For example, half of children diagnosed with ADHD are also diagnosed with anxiety, autism, CDs, or depression (Hinojosa et al., 2012). Hinojosa et al. found that parents of children diagnosed with ADHD and other comorbid conditions had strain that varied by race. ADHD has a greater impact on minority families, including Latino and African-American families. Latino and African-American families were less likely to engage in treatment and were more likely to have severe symptomatology and psychiatric comorbid conditions than non-Latino White families were. Parental strain was also found to manifest as high levels of care burden, increased depressive symptoms, uncertainty, poor health, and poor quality of life (Hinojosa et al., 2012).

Hinojosa et al.'s (2012) findings showed that African-American parents of children with ADHD experienced more strain than their White counterparts did. However, African-American parents were also found to have better social support networks than White parents. Hinojosa et al. recommended more research on understanding parental strain for racially diverse parents of children with ADHD, in order to develop interventions tailored to reduce parental strain in these populations. Hinojosa et al.'s article is relevant to the study because parental strain varies by race and may have implications for how African-American fathers, for example, perceive of treatment for their children with ADHD.

ADHD may be over diagnosed in African-American children, which may be connected to how African-American parents understand their children's externalizing behavior. Additionally, African-American children who receive special education services may be disproportionately diagnosed with disabilities. Linton (2015) examined

the differential ratings of specific behaviors of African-American children with ADHD by parents, children, and teachers in special education. Linton conducted a quantitative study and used analysis of variance and *t* tests for data analysis. The sample size included 126 African-American children, mothers, and teachers. The variables included parents', children's, and teachers' ratings of externalizing and internalizing behaviors. Linton observed a cultural mismatch, wherein White teachers may be more likely to refer African-American children for disability assessments. Linton hypothesized that teachers would have higher ratings of all externalizing behaviors than children, and that children's ratings of all internalizing behaviors would be higher than their mothers' and teachers' ratings.

Linton (2015) found differences between mothers', children's, and teachers' ratings of externalizing and internalizing behaviors. African-American children rated themselves higher for internalizing behaviors, such as headaches, stomachaches, and sleeping problems. Teachers rated African-American children higher for externalizing behaviors, such as hyperactivity, oppositional, and conduct behaviors. Additionally, the study showed that children from lower socioeconomic backgrounds compared to children from high socioeconomic backgrounds were more likely to report internalizing behaviors. White children scored lower in internalizing behaviors than parents and teachers, as opposed to African-American children who scored higher on internalizing behaviors than parents and teachers.

Linton (2015) recommended that professionals conducting assessments of children receive training on the ADHD diagnostic criteria. African-American children

from lower socioeconomic backgrounds need improved interventions to improve internalizing behaviors. Although Linton's study was important for focusing on African-American mothers' and children's perceptions of ADHD, African-American fathers' perspectives of their children's internalizing and externalizing behaviors were not included. A lack of focus on fathers' perspectives is consistent throughout much of the existing literature on parents of children with ADHD. Linton's research informs the present study by shedding light on the difficulties African fathers may experience during their sons' diagnosis phase of ADHD, which can have implications for how fathers may view diagnosis and treatment. Future researchers can build upon Linton's study by studying African-American father's perspectives of their children's externalizing and internalizing behaviors.

Ethnicity, sex, and SES can be important predictors of symptoms of ADHD, which can influence perceptions of ADHD diagnosis and treatment. Therefore, Martel (2015) examined the connections between ethnicity, sex, SES, and ADHD symptoms in children. Martel conducted a quantitative study using analysis of variance and multivariate analysis of variance for data analysis. The sample included 109 children, 3- to 6-yearsold, and their caregivers. In total, 28% were African-American children, while 9 out of 18 were African-American children with ADHD, and 64% were male. The number of fathers, however, was unknown. Martel found that African-American males were at high risk for ADHD symptoms. African-Americans families with low SES were at risk for high negative affect, which may increase the risk of ADHD symptoms. Negative affect may make African-Americans susceptible to negative environmental

conditions, such as deviant peer influences, poor parental monitoring, and dangerous neighborhoods (Belsky & Pluess, 2009). Lower SES was associated with higher negative affect, hyperactive impulse, inattentive ADHD symptoms, and poor executive function (Martel, 2015). Negative affect was higher in ethnic minorities diagnosed with ADHD and ODD than within other groups. In addition, effortful control was lower in ethnic minorities diagnosed with ADHD and ODD compared to other groups. African-American males, compared to White males, exhibited more hyperactive-impulse and inattentive ADHD symptoms (Martel, 2015).

Information on the connection between the propensity for being diagnosed with ADHD, sex, ethnicity, and SES is relevant to the present study because such information helps in understanding the role of sociodemographic variables during diagnosis and treatment phases. Understanding the role of sociodemographic variables during diagnosis and treatment phases can help researchers and practitioners focus on identifying children and developing interventions that will be effective in assisting children in managing their ADHD symptoms. Martel (2015) recommended further research how ADHD symptoms are influenced by neighborhood environments, family strain, parenting, peer deviancy, and social support. Practical implications included devising interventions to help ethnic minority boys, with low SES, decrease negative affect and to help ethnic minority girls, with low SES, decrease inattention (Martel, 2015).

Research on race and children's ADHD has also included focus on the underdiagnosis of ADHD in African-American children. This underdiagnosis can lead to a lack of treatment and, consequently, overrepresentation of young African-American

adults in the criminal justice system (Moody, 2016). This line of research counters that of Linton (2015), who investigated the overdiagnosis of African-American children's externalizing behavior as ADHD. Moody observed that racism in some schools may contribute to African-American children's underdiagnosis of ADHD, and that overpunishment of African-American children may be caused by underdiagnosis and a lack of treatment of ADHD. A school-to-prison pipeline phenomenon may be a result of these disparities (Moody, 2016). Moody conducted a review and analysis of the literature focused on the processes of underdiagnosis and overpunishment, as well as on how parents, teachers, and administrators form ideas about punishment and behavioral disorders.

Moody's (2016) findings extended and added to those of Singh (2003) on African-American parents' views of their children's ADHD. Moody found that African-American children often end up in the school-to-prison pipeline as a direct result from being under-diagnosed for ADHD. Although African-American parents see an ADHD disability as negative, African-American parents also are often distrusting of school and health-care systems (Moody, 2016). Interestingly, African-American parents think Ritalin, a drug to help control and manage their children's behaviors, erodes their children's African-American identities by diminishing their children's boldness and individualism (Moody, 2016). Moody also found that African-American parents lacked information about the causes of ADHD and, consequently, many believed that corporal punishment should be used to address their children's behavioral problems at school.

Based on the above findings, Moody (2016) recommended more study of the mechanisms that influence over-punishment of African-American children, better understanding of the ways in which overrepresentation of African-American children in the criminal judicial system are influenced by the underdiagnosis of ADHD, and how African-American children's behaviors are perceived by parents, teachers, and administrators. Moody added important information about African-American parents' perspective on their children's ADHD, which informed the present study. African-American parents may distrust educational and health-care systems; lack knowledge of ADHD; and believe that stimulant medication, such as Ritalin, erodes their children's African-American identities. Therefore, African-American parents may fear and distrust ADHD diagnoses, have strained relationships with teachers, and lack understanding of the causes and treatment of ADHD.

Limitations of Previous Research

Parents and ADHD Diagnosis and Treatment

Recent literature on parents, ADHD diagnosis, and ADHD treatment contains limitations. Although Coletti et al. (2012) explored parents' perspectives on medication treatment; the researchers did not examine the difference in the perspectives of fathers and mothers and did not focus on race in relation to treatment. Additionally, although Efron et al. (2016) found that 1 in 7 Australian parents did not agree with their children's ADHD diagnosis, the researchers did not describe the study population in detail, and did not focus specifically on father's perspectives.

Hansen and Hansen (2016) found that parents struggled with the decision to use stimulant medication to treat their children's ADHD, even though stimulant medication was shown to improve academic performance. However, Hansen and Hansen did not explicitly identify fathers' perspectives. Although Moldavsky and Sayal (2013) concluded that health-care providers and parents may have different views about their roles in the shared decision-making process while working together on the diagnosis and treatment of children with ADHD, Moldavsky and Sayal did not focus specifically on the perceptions of fathers.

Pajo and Cohen (2013) also found that parents' perspectives of treatment and diagnosis of their children with ADHD were important and could influence treatment decisions. However, Pajo and Cohen largely excluded examination of fathers' perspectives. Sollie et al. (2016) recommended that parenting programs should be designed to enhance fathers' involvement in treatment decisions. Wong and Goh's (2014) study included fathers' perspectives of their sons' ADHD behaviors. However, the study did not focus solely on fathers' perspectives of diagnosis and treatment. Sherman (2015) conducted a case study to explore treating children diagnosed with ADHD, which can be contentious because medication is sometimes considered a quick fix for a potentially overdiagnosed condition. However, Sherman did not focus specifically on the perceptions of fathers, which is consistent with most of the literature on parents' perspectives of their children's ADHD and treatment.

Mothers and ADHD Diagnosis and Treatment

Literature on mothers and ADHD diagnosis and treatment also contained limitations. Bull and Wheelan (2006) showed the need to further research on the differences in the feelings about mothers' and fathers' role in managing their children with ADHD. Bussing et al.'s (2016) study was another example of research focusing on mothers' roles in the treatment and management of ADHD instead of fathers'.

Fathers and ADHD Diagnosis and Treatment

Although some researchers focused on fathers and ADHD diagnosis and treatment, their research also contains limitations. For example, Chang et al. (2013) interpreted findings within a cultural framework of Confucian traditions and found that Chinese fathers used authoritarian parenting styles with children diagnosed with ADHD, as children with ADHD tended to struggle with academics. These findings, however, are not universal and may be limited to the Chinese culture and Confucian traditions.

Morris (2014) conducted a case study to explore one Caucasian father's perceptions of mental illness after his son's diagnosis of ADHD. However, generalizability of findings to other populations is difficult because of the sample size. Phares et al. (2005) reviewed 577 articles on the topic of child psychopathology and found only 1% included fathers only; 26% included both mothers and fathers studied separately; 25% included mothers and fathers, but not studied separately; and 48% of studies included mothers only. Phares et al. recommended researchers conduct parallel examinations into both maternal and paternal processes involved in pediatric psychology, as pediatric psychology lacked inclusion of fathers in family-based interventions.

Romirowsky and Chronis-Tuscano (2013) found child conduct problems for childhood ADHD were significantly positively related to paternal ADHD symptoms. It may follow that ADHD diagnoses in fathers may influence how fathers perceive diagnosis and treatment for their sons' ADHD.

Fathers are becoming increasingly involved in the management of their children's medical conditions (Roy, 2014) and, in recent years, research on fathers' roles of their children's ADHD diagnosis and treatment has begun to emerge. Singh's (2003) study was foundational for identifying two major perspectives on Caucasian fathers' diagnosis of ADHD: tolerant nonbelievers and reluctant believers. However, Singh's study involved a Caucasian population, and more research is needed on African-American fathers' perceptions of their sons' ADHD diagnoses and treatments.

Parents, Race, and ADHD

Although there is research on parents, race, and ADHD, literature on race and fathers is limited. For example, Linton (2015) focused on African-American mothers' and children's perceptions of ADHD; however, African-American fathers' perspectives of their children's internalizing and externalizing behaviors were not included. Martel (2015) recommended further research on how ADHD symptoms are influenced by neighborhood environments, family strain, parenting, peer deviance, and social support, which included the influence of fathers. Practical implications in Martel's study included devising interventions to help ethnic minority boys from low SES families decrease negative effect. Moody (2016) found that African-American children often ended up in the school-to-prison pipeline as a direct result of being underdiagnosed for ADHD.

Finally, Hinjosa et al. (2012) found that parental strain varied by race and may have implications for how African-American fathers perceive treatment for their children with ADHD.

Although research on fathers' perceptions of their children's ADHD was emerging, it was clear more research was needed. Additionally, more research was needed on children's ADHD in diverse populations. This study helps to fill this gap in the literature by extending the knowledge in the discipline on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD.

Summary

Parents' perspectives and their decisions regarding their children's ADHD diagnosis treatment are important, and research indicates that mothers and fathers can perceive their children's ADHD and its treatment differently (Sherman, 2015; Zhou & Yi, 2014). These differences can influence whether their children receive treatment and the types of treatment they receive (Sherman, 2015; Zhou & Yi, 2014). For example, fathers may explain their sons' ADHD-related behavior in nonmedical terms, such as boys just being boys (Singh, 2003), which leads fathers to not agree with medication treatment. Researchers have also studied the perspectives of treatment and diagnosis of mothers and fathers together. Although mothers are much more represented than fathers are in the literature, research on fathers' perspectives is emerging.

Recently, researchers have found that attitudes that toward ADHD can promote or interfere with medication adherence (Coletti et al., 2012), minority populations may underuse health-care services for ADHD because of inaccuracies in parent knowledge

about ADHD etiology and interventions (Berger-Jenkins et al., 2012), and health-care providers and parents may have different views about their roles in the shared decision-making process concerning diagnosis and treatment for children (Moldavsky & Sayal, 2013). Additionally, fathers are less willing than mothers to ascribe to a medical cause for ADHD behaviors in their children (Pajo & Cohen, 2013; Singh, 2003), and fathers experienced less child involvement, less parental efficacy, and parenting stress than mothers in dealing with their children with ADHD (Sollie et al., 2016).

Although parents often struggle with the decision to use stimulant drugs because of their potential long-term side effects, parents (mothers more so than fathers) are willing to balance side effects with functional improvements and enhanced academic performance in their children (Hansen & Hansen, 2016). Hinojosa et al. (2012) found that ADHD has a greater impact on minority families, including Latino and African-American families, because these families were less likely to engage in treatment than non-Latino White families were.

Researchers have begun to study fathers' perspectives of their children's ADHD diagnosis and treatment. Although Singh's (2003) study on fathers and their children's ADHD was foundational, Singh's focus did not focus on the ethnic differences of fathers. In a later study, Chang et al. (2013) found that Chinese children with ADHD struggling academically can lead to increased authoritarian control from fathers because of the high academic performance expectations of Confucian traditions. Throughout the recent literature, however, although research on fathers' perceptions of their children's ADHD is emerging, it was clear more research was needed. Additionally, more research was

needed in this area in diverse populations. This study helps to fill this gap in the literature by extending the knowledge in the discipline on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD using a qualitative phenomenological framework through semistructured interviews. Chapter 3 contains the following sections: research design and rationale, discussion of my role as the researcher, and a description of the methodology. Discussion of the methodology will include participation selection, instrumentation, procedures for recruitment, participation, data collection, and the data analysis plan. Issues of trustworthiness are also discussed in Chapter 3, including issues of credibility, dependability, conformability, and ethical procedures.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to explore African-American fathers' perspectives of their sons' diagnosis and treatment for ADHD. Singh (2003) found that fathers' perspectives of their sons' diagnosis and treatment for ADHD was important in Caucasian populations. In this chapter, the research design and rationale are presented followed by a discussion of my role as the researcher and methodology, including participation selection logic, instrumentation, procedures for recruitment, participation, data collection, and data analysis plan. Issues of trustworthiness are also discussed in this chapter, including credibility, dependability, conformability, and ethical procedures.

Research Design and Rationale

The overarching research questions guiding this study were:

RQ: What are African-American fathers' perspectives and lived experiences related to their sons' diagnosis of and treatment for ADHD?

SQ1: How do African-American fathers interpret and make decisions regarding their sons' ADHD behaviors?

SQ2: How do African-American fathers experience and perceive their sons' ADHD diagnosis?

SQ3: How do African-American fathers experience and perceive their sons' ADHD treatment?

ADHD is a neurodevelopmental disorder characterized by disorganization, inattention, and/or hyperactivity-impulsivity (APA, 2013). This study was designed to explore African-American fathers' experiences and perceptions regarding their sons' ADHD behaviors, diagnosis, and treatment. The research tradition used in this study was qualitative, and the selected design was phenomenology. This phenomenological approach was selected based on the type of data collected, the type of research questions investigated, and also because of the paucity of existing literature related to the phenomenon of interest. Data collection included the use of interviews. The rationale of conducting interviews using a qualitative phenomenology design was based on gaining insight into lived experiences and perceptions related to the phenomenon investigated in this research study (Braun & Clarke, 2013).

I selected a qualitative methodology for the study because the goal of the study was to explain real-life experiences that invoke feelings and attitudes that may be elusive to quantify (Kofodimos, 1990). I accessed rich data informing themes regarding African-American fathers' perspectives and lived experiences related to their sons' ADHD diagnosis and treatment. These themes facilitated an enhanced understanding for practitioners of the lived experience and meaning of the phenomenon of interest (Cooper, Fleischer, & Cotton, 2012). A qualitative approach was best suited for the study because qualitative methodology focuses on a phenomenon in its natural setting in an inductive manner (Denzin & Lincoln, 2011; Tracy, 2013). I used a qualitative approach to access data from African-American fathers situated in their unique context. This approach

facilitated exploration to capture the nuanced experiences and feelings of participants who navigated the process of ADHD diagnosis and treatment for their sons.

There are numerous data collection tools available to qualitative researchers, including life stories, interviews, observations, historical texts, and social media (Malterud, 2001). For the present study, I used interviews as the primary source of data. I used semistructured interviews to ensure data addressed research questions while affording the flexibility to explore emerging topics of interest. This enabled the gathering of data that was salient, dynamic, contextualized, and relevant to the research question (Bevan, 2014). The interviewing technique enhanced participation among participants and facilitated the sharing of sensitive data (Wiles, Crow, & Pain, 2011). I coparticipated in the sense-making experience of African-American fathers as they described their sons' ADHD diagnosis and treatment, and evaluated the way meaning was developed by participants (Teddlie & Tashakkori, 2009). Because I became involved with participants through this detailed exploration of the phenomenon of interest, a qualitative approach was appropriate for the study.

I employed a phenomenological design in the study to facilitate an exploration of the human experience, where individual experiences were examined for better understanding (Reiter, Stewart, & Bruce, 2011). A phenomenological design was best suited for the study, because I investigated the lived experiences and perceptions of African-American fathers regarding their son's ADHD diagnosis and treatment. Phenomenological studies may consist of multiple sources of data for triangulation, which enhance accuracy and credibility within the research (Datt, 2014).

Phenomenological research involves a considerable interaction between the researcher and the participants (Gelling, 2011). The researcher engaged with the participants through in-depth interviews to glean insight related to ADHD diagnosis and treatment. Because the goal of the research was to use these in-depth interactions to offer depth and breadth of understanding related to African-American fathers' lived experiences and perceptions related to their sons' ADHD diagnosis and treatment, the phenomenological approach was an appropriate research design.

Role of the Researcher

As a qualitative researcher, I served as an instrument of data collection, interpretation, and analysis (see Tracy, 2013). I collected data from each participant and parsed through the data to determine the central themes that come through the data analysis. Because I was thoroughly integrated in the process of data collection and analysis, I acknowledged and set aside biases and preconceived notions during the research process. I engaged in bracketing to manage potential bias (Fung, Chan, & Chien, 2013). I maintained a reflexive journal to not only chronicle feelings and beliefs, but to also clearly outline the decision-making process. This was done to ensure that the findings were reached and presented in an objective manner.

My personal and professional relationships were separate from the participants. I had no supervisory or instructor relationships involving positions of power with the participants and there were no research biases and/or power relationships to manage. No ethical issues existed, such as a study within one's own environment, conflict of interest,

power differentials, or justification for use of incentives. Incentives were not offered. However, participants were offered a copy summary of the research conducted.

Methodology

Participant Selection Logic

The population selected was African-American fathers who have sons diagnosed with ADHD. Fathers lived in the home with the child. Fathers were the biological fathers of the children. Sons were 18 years of age or younger.

Participants were not excluded based upon career, employment status, or marital status. I secured a sample of 10 participating fathers. The rationale for this number was based on saturation. Saturation occurs at the point when no new data is observed from the data analysis, meaning there is a consensus among the participants (O'Reilly & Parker, 2013). Marshall, Cardon, Poddar, and Fontenot (2013) said that sample size is rarely justified in qualitative research, and sample size estimates are formed under the intent to reach saturation. Burmeister and Aitken (2012) said data saturation is not necessarily concerned with the number of participants, but depends on the depth of the data collected. Saturation is achieved when adding new participants to the sample no longer contributes substantive information to the study (Dworkin, 2012). In reaching saturation, sufficient data must be present to detail novel themes and illuminate relationships between identified themes (Dworkin, 2012). Qualitative phenomenological studies should have a sample size of four to 10 participants (Stake, 1995). This study had a sample size of 10 participants.

Instrumentation

The interview protocol entailed 15 questions aimed at gathering insight on African-American fathers' experience with their son's ADHD diagnosis and treatment. The questions were crafted to address the three subquestions related to how African-American fathers interpret and make decisions regarding their son's ADHD behaviors: how African-American fathers experience and perceive their son's ADHD diagnosis; and how African-American fathers' experience and perceive their son's ADHD treatment based on Singh's (2004) study. The interview questions are listed in Appendix A.

The interviews took approximately one hour. The interview questions were reviewed by experts familiar with the topic of ADHD research. The questions were given to two psychologists who work with children diagnosed with ADHD. They were asked to give feedback on the questions regarding wording, appropriateness, and relevance to the process of ADHD diagnosis and treatment. The questions were modified based on feedback from the psychologists.

Procedures for Recruitment, Participation, and Data Collection

I recruited 10 participants for this research study using Qualtrics after failing to recruit participants using flyers (Appendix B) posted in specific mental health facilities and flyers posted on the Walden Participant Pool. Potential participants were screened to ensure they met the inclusion criteria (Appendix C). Participants who met the inclusion criteria were offered an interview. Individuals who did not meet the inclusion criteria were not offered an interview and were thanked for their interest in participation. The

interview was scheduled by choosing a time to meet at a local public library that was convenient for me and the participant.

Data collection occurred in one meeting. Once participants arrived at their individual interview, I greeted them, assigned a pseudonym to protect their identity and confidentiality, and asked them to complete a consent form. Once the participant completed the consent form, the interview began. The interviews lasted approximately one hour. Data were recorded using an audiotape recorder. I secured approval to record via the consent form prior to the interview. When participants exited the study, they were provided contact information to contact me if they had any questions. I shared the results of the analysis with any participants who contacted me.

Data Analysis Plan

Prior to data analysis, I reviewed the transcripts to become familiar with the content. I read and reread the documents to glean a basic understanding of the contents. This step provided the foundation for the ensuing data analysis.

The transcripts were uploaded into NVivo Version 11 for data organization and management. NVivo Version 11 is computer software that is used to assist with qualitative data analysis. Once the data were uploaded into the software, I analyzed the data using Braun and Clarke's (2006) thematic analysis method. The thematic analysis method includes six stages: (a) familiarization with the data, (b) coding, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) reporting.

Following familiarization, as described above, I coded each case from participants. Cases constituted all documents contributed by individual participants.

Segments of text that indicate occurrence of specific units of information were assigned a code (Gläser & Laudel, 2013). Codes were sorted into categories that later became themes. Once individual cases were reviewed and coded, I compared codes across cases, or participants. This step allowed me to assess common patterns and identify divergent data points that added additional depth to the analysis (Yin, 2014). This cross-case analysis highlighted commonalities and discrepancies in the dataset (Merriam & Tisdell, 2016). Once themes were finalized, I assigned descriptive names to the themes. The themes were then reported, with excerpts from participants' raw data, to bolster the findings. The overall findings of the analysis were reported in narrative form with tables included as appropriate and organized by research questions to aid in reader's ability to understand the emerging themes.

Issues of Trustworthiness

Rigor within qualitative research is assessed using a specific framework for validity and reliability that accounts for the unique nature of qualitative research (Anney, 2014). Merriam and Tisdell (2016) stated that validity and reliability are assessed considering issues of trustworthiness. Credibility, transferability, dependability, and confirmability are the specific issues that compose trustworthiness in qualitative research (Guba & Lincoln, 1989).

Credibility

Credibility refers to consistency in qualitative research (Merriam, 1998). Establishing credibility requires use of well-established research methods (Shenton, 2004). To achieve credibility, the researcher must ensure that their own perceptions do

not bias the analysis and reporting of data. Credibility of internal validity includes appropriate strategies, such as member checks, data saturation, and triangulation (G. Bowen, 2008). I used member checking in the present study. Member checking refers to providing participants with an opportunity to review transcripts or summaries to ensure that their experiences are reported accurately (Merriam & Tisdell, 2016). I provided a summary report of the emergent themes and encouraged participants to provide feedback. Participant feedback was incorporated into the final presentation of the findings. Data saturation may occur by using member checking. Member checking contributes to data saturation (Fusch & Ness, 2015; Lincoln & Guba, 1982). I triangulated the findings from the data analysis using interview transcripts and the reflexive journal. Triangulation was used to corroborate the emerging themes through multiple forms of evidence (Bekhet & Zauszniewski, 2012).

Transferability

Transferability refers to the ability for readers to identify similarities between the context of their study and their own context (Duggleby & Williams, 2016).

Transferability is not a primary concern within qualitative research; however it can be enhanced using thick description and a diverse sample (Morse, 2015). Thick description is achieved by painting an in-depth look into participants' experiences. Thick description enhances reader's ability to understand the context of the phenomenon under investigation, which enables readers to determine if they have experienced a similar situation (Tracy, 2013). As readers digest the findings, they can review the findings and identify similarities to their own experiences.

Dependability

Dependability refers to the ability to generate similar results given the same context, methods, and participants (Lub, 2015). Dependability, the qualitative counterpart to reliability, was established using an audit trail. Audit trails provide in-depth explanation of the process within this research, so future iterations of research may follow the same process and achieve the same results. Use of an audit trail increases the rigor of a study (Houghton, Casey, Shaw, & Murphy, 2013). I maintained fidelity to the prescribed study protocol (i.e., data collection process) to ensure that future researchers can replicate the study. Member checking was used to increase dependability by ensuring that the reported conclusions aligned with participants' insight. Participants were provided a copy of the findings for their review, which allowed participants to confirm the veracity of the results and fidelity of the findings to the data collected from participants.

Confirmability

Confirmability represents the intersection of credibility, transferability, and dependability (Anney, 2014). Confirmability, the qualitative counterpart to objectivity, was established through strategies such as reflexivity. Confirmability refers to the degree to which findings reflect participants' voices and inform the emergent themes. Reflexivity involves activities to help the researcher to reflect upon personal assumptions and biases (Guba & Lincoln, 1982). Reflexivity helps to process and set aside any biases so they do not influence how the findings are reported or how the participant data is interpreted (Guba & Lincoln, 1982). For the present study, I employed reflexivity

through the use of reflexive journaling. As a qualitative researcher, I maintained the integrity of the participants and their authentic stories by not allowing personal biases to color the process of collecting, analyzing, and reporting the data.

Ethical Procedures

Ethical issues in this study were addressed through specific procedures. Participants were protected during the research process by obtaining permission through the Institutional Review Board. Participants were provided my contact information in case any issues arose related to their participation in the study. Participants were asked to sign an informed consent before beginning the interview process.

During the recruitment process, participants were screened for inclusion criteria. Those not meeting the criteria were given a detailed explanation as to why they do not meet the criteria. Participants' identity and confidentiality were protected by assigning them pseudonyms. Pseudonyms were used in all reports, and no identifying information was included in the report of the findings. Sensitive areas were dealt with during the probing process by allowing participants some time to process their thoughts and giving participants the opportunity to stop the interview process at any time.

Data were stored in an electronic file on my personal password protected computer. Hard copies of the data were stored in a locked filing cabinet. Data are only accessible to the researcher and the dissertation committee. Data will be stored for 5 years following the close of the study. At the end of this time, I will shred all hard copies of the data and delete all electronic files from the computer's drive. There were not any power differentials or conflicts of interest, as participants had no relationship to the

researcher. Incentives were not used to insure participants answer authentically (see Lincoln & Guba, 1987).

Summary

The purpose of this qualitative phenomenological study was to explore African-American fathers' perspectives of their sons' diagnosis and treatment for ADHD. The target population for the study was African-American fathers who had sons diagnosed with ADHD. A sample of 10 fathers was recruited for participation in the study. Fathers lived in the home with the child, were the sons' biological fathers, and sons were 18 years of age or younger. I used interviews and reflexive journaling as the primary means of data collection.

The data were analyzed using Braun and Clarke's (2006) framework for thematic analysis. The research design and rationale, role of the researcher, methodology, issues of trustworthiness, and ethical procedures were presented in this chapter. Chapter 4 contains a description of the data collection and sample, and a presentation of the results.

Chapter 4: Results

Introduction

The purpose of this qualitative phenomenological study was to explore African-Americans fathers' perspectives of their sons' diagnosis and treatment for ADHD. The literature reflects the lack of diversity in study samples and the need to study ethnically diverse groups, including African-Americans. To better understand fathers' perspectives of the symptoms, diagnosis, and treatment of their sons' ADHD in ethnically diverse populations, the current study focused on African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD using Singh's (2003) findings as a base. Findings from this study may lead to better understanding of the role of African-American fathers in their sons' diagnosis and treatment of ADHD, thereby potentially leading to enhanced intervention for African-American boys.

The study adds to Singh's (2003) research of Caucasian fathers' perspectives and Chang et al.'s (2013) study of Chinese fathers with children diagnosed with ADHD. In addition, this research has the potential to add to psychology literature regarding better understanding the treatment of ADHD in children generally, and the study may also lead to social change by informing treatment approaches of ADHD in African-American populations. Exploring African-Americans fathers' perspectives of their sons' diagnosis and treatment for ADHD can lead to information regarding what both hinders and facilitates ADHD treatment for children. The overarching research question guiding this study was,

RQ: What are African-American fathers' perspectives and lived experiences related to their sons' diagnosis of and treatment for ADHD?

SQ1: How do African-American fathers interpret and make decisions regarding their sons' ADHD behaviors?

SQ2: How do African-American fathers experience and perceive their sons' ADHD diagnosis?

SQ3: How do African-American fathers experience and perceive their sons' ADHD treatment?

In Chapter 4, I highlight the research setting and participant demographics as they relate to the research study. Following these sections, I will describe the data collection and data analysis process for the research. After outlining the resulting themes from the research, I will provide evidence of trustworthiness for the study's findings before presenting the results. I organized the results based on subquestions with applicable themes. Finally, I will conclude the chapter by summarizing the answers to each subquestion and transitioning to Chapter 5.

Setting

I conducted the interviews via phone in my personal home office. This setting allowed me to talk without interruption and audio record the telephone interview. Participants' locations were unknown to me. Participants selected locations that offered minimal distractions.

Demographics

I recruited 10 participants for this study using Qualtrics after I failed to recruit participants using flyers posted in specific mental health facilities and the Walden Participant Pool. Potential participants from Qualtrics reached out to me via phone or e-mail; I then screened them to ensure they met the inclusion criteria. The inclusion criteria for participants were that they must be an African-American father to a son diagnosed with ADHD, must live in the home with the child, must be the biological father of the son, and the son must be 18 years or younger. Table 1 outlines the participant demographics as they applied to the study.

Table 1

Participant Demographics

Participant #	Gender	Race	Age	Location	Age of son at diagnosis
Participant 1	Male	African-American	40	Pennsylvania	9 ½
Participant 2	Male	African-American	34	Ohio	7
Participant 3	Male	African-American	47	Florida	8
Participant 4	Male	African-American	47	Alabama	10
Participant 5	Male	African-American	36	Illinois	7
Participant 6	Male	African-American	37	New Jersey	4
Participant 7	Male	African-American	37	Texas	7
Participant 8	Male	African-American	41	Arkansas	10
Participant 9	Male	African-American	54	California	8
Participant 10	Male	African-American	38	Pennsylvania	6

Data Collection

Ten participants participated in in-depth interviews for this study. I interviewed a total of 10 participants over 2 weeks, beginning April 3, 2018, and ending April 14, 2018. The length of interviews ranged from 11 to 73 minutes, with a mean of 31 minutes and median of 25 minutes.

For each participant, data collection occurred through one communication outside of the member-checking process. Once each participant connected onto the phone call, I asked each participant to confirm their consent to be audio recorded, member check their

respective interview transcript, receive a one-to-two page summary of the findings, and sign the informed consent form. While I received signed informed consent forms from participants before scheduling the interviews, I wanted to ensure that each participant still wished to provide informed consent to participate in the study. I reiterated the voluntary nature of participation and that they were able to rescind their consent at any time during the interview. After confirming this, I then screened participants to confirm their eligibility to participate in the study. Once I confirmed their eligibility to participate in the study, I began the interview process by describing the three sections of the interview protocol, with each section relating to one subquestion.

After I completed interviews, I invited participants to share any last thoughts regarding the research topic before stopping the audio recording. I thanked participants for participating in the study and reminded those participants who allowed consent to participate in the member-checking process to review their e-mails approximately four weeks after the completion of the interview for a copy of their respective interview transcript. Once I completed all interviews, I began the process of transcribing the data into a Word document.

I transcribed the data by playing, listening, pausing, rewinding, and replaying each interview several times as I typed out the transcript. After I finished one interview transcript, I would relisten and follow along with the audio recording to verify that I did not miss any information. As I completed each transcript, I e-mailed a copy of the transcript to the respective participant, provided that the participant expressed to consent to member-check the interview transcript. In the member-checking email, the researcher

noted that if the participant did not provide any response to the e-mail after a period of 2 weeks, the researcher would begin the data analysis process with the interview transcript not being member checked. The process of transcribing interviews and conducting member-checks continued until the researcher finalized all interview transcripts. At the end of the 2 weeks, only two participants responded to the member-check e-mails indicating the interview transcripts were correct.

Data Analysis

Since I transcribed the interviews, the data analysis process began during the transcription of the interviews. During the transcription process, the researcher became familiar with the data through the process of listening, writing, rewinding, relistening, and verifying the interview transcripts. Familiarization is the first step in Braun and Clarke's (2006) thematic analysis and was the process whereby a qualitative researcher reads the interview transcripts to identify prevalent topics from the data. I noted some preliminary topics that were prevalent during the transcription process during the familiarization process. These preliminary topics helped me to begin the coding process of the data.

After identifying the preliminary topics from the interview transcripts, I uploaded the transcripts into a computer-assisted qualitative data analysis software called NVivo 11. I used NVivo 11 as a qualitative data analysis management tool to help organize the data by assigning unique codes to segments of raw data. Once I uploaded the transcripts into NVivo 11, I began the second step of thematic analysis: coding the data.

I assigned segments of raw data with unique labels using NVivo's manual coding options. I went line-by-line to label these segments of data until I coded the entire transcript. This process continued for each transcript until the researcher had a total of 168 unique codes. I assessed the relationships between the codes to look for underlying patterns and connections among the codes themselves. I clustered codes with similar meanings, patterns, or connections together under labels that identified the relationship between the codes. The process of reducing codes to clusters continued until no further reduction was possible, leaving only the clusters themselves. These clusters formed the basis for the initial themes created during Step 3 of thematic analysis. Table 2 outlines the resulting themes from this process.

Table 2

Themes and Subthemes

Theme	Subtheme 1	Subtheme 2	Subtheme 3
Sought advice	From doctors and professionals	From family and friends	From internet/online research
Dismissal of symptoms initially	None	None	None
Feelings of powerlessness and hopelessness	Child's behavior	None	None
Resources available to me	Doctors and professionals	Internet/online research	None
Frustration, shock, and disbelief	Diagnosis	None	None
My role as a parent	Support for child	Enforcer of treatment	None
Want what is best for my child	None	None	None
Successes of treatment plan	None	None	None
Beliefs on medication versus alternative therapies	Medication is necessary	Prefer alternative therapies	None

After creating the initial themes, I began the fourth step of thematic analysis, verifying and reviewing the themes against the raw data. I reread the interview transcripts to ensure the themes both captured the data correctly and did not omit any prevalent or significant aspects of the interviews. I included the discrepancies among participants' experiences within each account of the theme to illuminate the aspects of interviews that

were not common across participants but were important to their individual experience with the phenomenon.

Once I verified the themes were accurate, I began the fifth step of thematic analysis, naming and defining the themes. I assessed the relationships among each cluster to create an appropriate name for each theme. These relationships also informed me about how to define each respective theme. The final step of thematic analysis was creating the final report of the results.

Nine themes that emerged from the data analysis process: (a) sought advice; (b) dismissal of symptoms initially; (c) feelings of powerlessness and hopelessness; (d) resources available to me; (e) frustration, shock, and disbelief; (f) my role as a parent; (g) want what is best for my child; (h) successes of treatment plan; and (i) beliefs on medication versus alternative therapies. Each theme answered at least 1 of the 3 subquestions. Some themes answered more than one sub-question.

As noted, there were discrepancies in participants' experiences with the phenomenon. Discrepancies in the experiences related primary to situations where parents described feeling as if the son purposefully created strife within the family home, using church as a means of dealing with ADHD behaviors, and their individual journeys throughout the experience. While there were overwhelming similarities across participants, each participant had unique journeys throughout their respective son's diagnosis and treatment. Some fathers had the support of the child's mother. Some parents were single dads who had to make the decisions themselves without the other parent present.

Evidence of Trustworthiness

Credibility

Credibility refers to consistency in qualitative research (Merriam & Tisdell, 2016). Establishing credibility requires use of well-established research methods (Shenton, 2004). To achieve credibility, a qualitative researcher must ensure that their own perceptions do not bias the analysis and reporting of data. Credibility of internal validity will use appropriate strategies such as member checks, data saturation, and triangulation (G. Bowen, 2008). I used member checking within the current study. Member checking refers to providing participants with an opportunity to review transcripts or summaries to ensure that their experiences are reported appropriately (Merriam & Tisdell, 2016). I provided a summary report of the emergent themes and encouraged participants to provide feedback. Since only two participants responded to the summary with affirmative responses, there was no explicit feedback to incorporate into the final presentation of the findings. Member checking contributed to verifying the data was completely saturated (see Fusch & Ness, 2015; Lincoln & Guba, 1982). I triangulated the findings from the data analysis using interview transcripts and the reflexive journal. Triangulation was used to corroborate the emerging themes through multiple forms of evidence (Bekhet & Zauszniewski, 2012).

Transferability

Transferability refers to the ability for readers to identify similarities between the context of their study and their own context (Duggleby & Williams, 2016).

Transferability is not a primary concern within qualitative research. However, it can be

enhanced using thick description and a diverse sample (Morse, 2015). Thick description was achieved by painting an in-depth look into participants' experiences. Thick description enhances reader's ability to understand the context of the phenomenon under investigation, which enables readers to determine if they have experienced a similar situation (Tracy, 2013). As readers digest the findings, they may be able to review the findings and identify similarities to their own experiences.

Dependability

Dependability refers to the ability to generate similar results given the same context, methods, and participants (Lub, 2015). Dependability, the qualitative counterpart to reliability, was established using an audit trail. Audit trails provide in-depth explanation of the process within this research, so future iterations of research may follow the same process and achieve the same results. Use of an audit trail increases the rigor of a study (Houghton et al., 2013).

I maintained fidelity to the prescribed study protocol (i.e., data collection process), which ensured future researchers can replicate the study. Member checking was used to increase dependability by ensuring that the reported conclusions aligned with participants' insight. Participants were provided a copy of the findings for their review. This gave participants an opportunity to confirm the veracity of the results and fidelity of the findings to the data collected from participants.

Confirmability

Confirmability represents the intersection of credibility, transferability, and dependability (Anney, 2014). Confirmability, the qualitative counterpart to objectivity,

was established using reflexivity. Confirmability refers to the degree to which findings reflect participants' voices and inform the emergent themes. Reflexivity involves activities to help the researcher to reflect upon personal assumptions and biases (Guba & Lincoln, 1982). Reflexivity helps to process and set aside any biases so they do not influence how the findings are reported or how the participant data is interpreted (Guba & Lincoln, 1982). For the current study, I employed reflexivity using reflexive journaling. As a qualitative researcher, I maintained the integrity of the participants and their authentic stories by not allowing personal biases to influence the process of collecting, analyzing, and reporting the data.

Results

Nine themes that emerged from the data analysis process: (a) sought advice; (b) dismissal of symptoms initially; (c) feelings of powerlessness and hopelessness; (d) resources available to me; (e) frustration, shock, and disbelief; (f) my role as a parent; (g) want what is best for my child; (h) successes of treatment plan; and (i) beliefs on medication versus alternative therapies.

Several themes had additional subthemes to further elaborate on the content within each theme. As mentioned in Table 2, each theme connected to at least one subquestion. The theme discrepancies in experiences will be reported individually, as it related to all three subquestions.

SQ1

The first subquestion related to how African-American fathers interpreted and made decisions regarding their son's ADHD behaviors. Three themes helped answer this

research question: (a) sought advice, (b) dismissal of symptoms initially, and (c) feelings of powerlessness and hopelessness. The theme, sought advice, had three subthemes, each that applied to this subquestion. The theme, feelings of powerlessness and hopelessness, had one subtheme that applied to this subquestion.

Sought advice. Three subthemes within this theme answered the first subquestion: (a) from doctors and professionals, (b) from family and friends, and (c) from internet/online research. Participants talked about reaching out to these social support systems to identify potential solutions regarding their child's ADHD behaviors. For many participants, their sons' teachers reached out to them about the ADHD behavior and the teachers were often the first individuals sought out for advice regarding their sons' behaviors. This was true for Participant 3, who shared how his son's disruptive behaviors began in prekindergarten. Participant 3 said:

Disruptiveness in classes, even from pre-k [prekindergarten]; his behavioral patterns when he used to be in the classroom settings; and the reports from the teachers made us have to draw concern and they recommended that we sit with the psychologist, and all of that started getting bigger and bigger as he got older.

Participant 3 further explained how he and the child's mother went to seek advice from professionals because

he [Participant 3's son] would get defiant towards adults that tell him he can't have something or he's not suppose to do this; and his disrespectful actions, that I knew that was not normal because that was not one of the ways we were raising him. So, this had to come from somewhere else.

Participant 3 elaborated about when he and the child's mother began reaching out to professionals and looking for resources to understand their child's behaviors. He shared,

When he got to elementary school, grade school, that's when the school social worker got involved, because the way he was interacting with the other kids and disrupting the class. So, the first-grade teacher asked him to be seen by the social worker; and then through the social worker, they was trying to help mediate the situation; and then each year for first, second grade, third grade, it just got going more and more disruptive, after that ordeal. So, I would say it wasn't straight and framework that just asked and found. It was through the meetings that we would have in the schools. They would come to that assessment through the group meetings. What would be the course of action to help him to function like a normal kid in the classroom, and not insist on being disruptive or having his way?

Participant 1 talked about how his son's behaviors became an issue when he would "constantly get calls to come to school because he took someone else's belongings, or he was disruptive in class." In conjunction with that, his son "was constantly getting 3's in behavior" that made his behavior start to stand out to Participant 1. Participant 1 shared,

The first person I went to was my great aunt who happens to be a pastor. I thought maybe he just needed to seek God's help. I know that sounds kind of silly, but that was the first thing, but then once another family member told me about that he may have that issue, I talked to his primary-care physician about his behavior that

it might be more of a mental-type thing, or like just something that kids— as you know, ADHD is much more easily diagnosed than it was in the day when I was growing up.

One participant shared how he went to a variety of social support systems to receive advice about his son's behavior. Participant 9 shared,

We [Participant 9 and child's mother] asked educators at his school, primarily just to get a kind of a baseline of what was going on, but as we saw it happening at school, at church, at extracurricular activities, then we sought the Internet for others that have done this. We looked at books. We consulted a lot of people in areas that deal with children before we actually went to a professional.

Participant 5 shared how his son's teacher was very straightforward with him regarding his son's behavior. The teacher called for a student-teacher conference with him and the son's mother to discuss his behavior. During the meeting Participant 5 said, "she said, 'He wasn't paying attention, wasn't being still and sitting in class' and all that and she asked [us] to get him checked out." After that student-teacher conference, Participant 5 said, "I talked to my mom a little bit and I looked at a lot of documentaries and stuff on YouTube to get some information on it and obviously we talked to the doctor."

Participant 4 expressed how his initial reaction was to reach out to his family members after dealing with his son's behaviors. Since his parents already passed away, he was not able to ask them "did I act like that when I was his age" (Participant 4). Participant 4 said,

I have 3 other siblings, 2 of them have kids, and have boys. I asked, ‘Did you go through this with [name of nephew]?’ which is my nephew. She said, ‘You know there's some stuff here and there, but not like that.’ My other sister said, ‘He's acting out for attention.’”

Participant 2 mentioned that “the first person we asked was our parents about it, and then after that we took him to his doctor.” He reported how his son had “a lot of trouble concentrating in school, and out of school. He talked very fast. He had really fast thoughts, and we were wondering what was going on with him” (Participant 2).

Dismissal of symptoms initially. Several participants did not think anything of their son’s behaviors because they thought it was normal for a young boy. Participant 10 stated,

Well, I as a man, at first, his hyperactivity, I thought was ok, but when he wasn’t attending to classes and wasn’t doing too well with his social, with friends, it kind of concerned me, as well as his attention and his ability to pay attention to detail.

One participant explained that his son’s behaviors were prominent even when he was an infant. Participant 9 said,

Ever since he was born, for instance, he did not sleep through the night for 13 months, for over a year. So, we knew he was a very active child. I guess I was a very active child. And I felt at first this is my mother's revenge. But at first I was a little concerned with how he was going to, you know, get along in school, but I felt like well he is young, he will probably grow out of it. So I wasn’t too concerned about it, initially.

Participant 9 elaborated on his initial perception because “his [son’s] behaviors, in a sense, weren't thrilling, but you know, we really saw it around 3 or 4. his hyperactive, very, very can't sit still, and lack of focus. Obviously, in a small child, that's not uncommon.”

Participant 1 admitted that while some of his son’s behaviors were concerning, he largely dismissed them because, as he explained,

At home he was that way towards other siblings, but he wasn't quite as—I guess I didn't see him that way because he was my child. So, I didn't think it was a big issue, but when he was in other social situations, it was a problem.

Similar to Participant 1, Participant 5 initially thought his son’s behaviors were normal. He said,

When he is at home, when he is with me, he's not really too bad, but like I said, when he was on his own at school that's when really when his behavior, you know, was a little out of line, but, you know, I just contributed [sic] a lot of them being a child, a boy, and so.

Participant 4 shared that at home, he and his son’s mother thought “he was just misbehaving all the time” by “getting into stuff [and] drawing on the wall”. Even when his son started school and he would receive a call to come to the school because of his behavior, he did not think it was anything out of the ordinary. Participant 4 said,

I went a couple of times just to observe what the teacher was saying as far as, she would say drawing. It was him, sitting in class, twirling his crayons, or pencils, or

something; and not paying attention; and running off; just to get up and running off. At that time, to me I thought that he was just being a hyperactive boy.

Participant 4 realized once his son was older that “there’s something more to it than just being a boy and misbehaving.”

Participant 8 dealt with something similar with his son; however, to a different extreme. He described his son as “like antidepressant. He's doesn't function with other kids correctly. He's not fully kid friendly.” Participant 8 shared his initial thoughts on a potential diagnosis for his son, and said,

Well, at that time, I thought, my son was going through, you know like, he's going to be autistic. He's going to be slow. We had a family function and he went and hid in the corner by himself. So my mother said, ‘Do you think something is wrong with him?’ I said, ‘No, I thought that was the way kids acted normally, when they don't want to play with other kids.’ So, the next thing, he went to school and the teacher gave me a call. The counselor gave me a call and said. ‘Now he's thrown out of that school.’ At first, he was being antisocial, and not playing with other folks, and now all of a sudden he's at school fighting.

Participants considered their respective child’s behavior to be normal until others pointed out the behavior. Afterwards, participants sought advice from others to try to understand their son’s behaviors. As noted in the theme, sought advice, several participants reached out to family, friends, doctors, professionals, and even researched the Internet to assess their son’s behaviors.

Feelings of powerlessness and hopelessness. Participants reported feeling powerless and hopeless regarding their son's behaviors, especially when they struggled to understand why their son's behaved the way he did. For many, they felt powerless in trying to manage the behaviors themselves and hopeless in trying to prevent the behaviors in the first place. Participant 7 shared how his son's behaviors would make him feel powerless, especially when his son would act out in public:

Ok, sometimes when we were around, out in public, like at a grocery store, something like that, and he would run away from me. He would be screaming. He would scream at the top of his lungs. Like, I could be standing right there by him and he would be screaming at me. I couldn't hear him or he would be running around or running away where I couldn't catch him. And that would be embarrassing. I would have to tell him to calm down, to stop. Sometimes he would tell me "no."

Participant 4 shared how he struggled with powerlessness and hopelessness as a parent, especially when he began to doubt himself as a parent. Participant 4 said,

My reaction was that I really started questioning something we are doing wrong as far as parenting. I am an executive chef. I spend a lot of hours away from the home, so I started questioning if that, by being the male figure, was part of the problem, that he's not getting a male figure in his life. I just didn't know what to think because I had never seen it before.

My reaction was more or less questioning our parenting skills. Are we doing something wrong? What could we be doing something better? What are we

missing here? Like I said, the spankings were not working. The taking away the things were not working. Thinking he's not getting enough rest; just trying different things at first.

Participant 4 struggled with this doubt until that point and felt powerless in trying to change the behaviors because he would tell his son, “This is not the type of behavior you need to have; you need to sit down and listen to the teacher; or when we’re telling you something, you need to listen.”

Participant 3 also felt doubt as a parent, and he would ask himself questions like, “[Is] what I am actually applying helping him? Is it working? Is it the right way?” Several participants shared how common it was for them to feel helpless in the face of their sons’ behaviors, especially when they were first beginning to take the behavior as an indication for a larger problem.

SQ2

The second subquestion related to how African-American fathers experienced and perceived their son’s ADHD diagnosis. Three themes that answered this research question: (a) resources available to me; (b) frustration, shock, and disbelief; and (c) my role as a parent. The theme, resources available to me, had three subthemes that answered the subquestion; whereas, the theme, my role as a parent, had one subtheme that answered the subquestion.

Resources available. Two subthemes within the resources available theme are (a) doctors and professionals and (b) Internet/online research. These were the primary sources of information regarding their child’s diagnosis, especially for those participants

who wanted to understand the best way to treat their son. These various resources were valuable to each participant as they received the diagnosis. Participant 1 mentioned,

It was a couple pamphlets, and we just talked to him [their son]. One thing we did really well together was one of his big things that I first went to was a behavioral place. I don't know what you call it, but something like a behavioral course, and the therapist would sit behind him and he would sit on the floor, I would sit on the floor, the therapist would sit on the floor. While he was talking, explaining how things were told to me, and I would talk back to him, [the therapist] would like hug him, and make him feel assured, and reassure him, keep him calm while he talked, with something like was angering him. I have never seen it before, but it was really helpful and very impressive, and [my son] opened up about the third or fourth time we went, but that's what happened first, but I really thought they were going to put him on medication, because that what I've heard that they gave kids that have ADHD, but I tried going to an alternative therapy before that, because I don't want to dope my kid up.

Participant 3 talked about the struggle he faced while accessing several different professional resources to help his son. Participant 3 shared,

Alright, so we started with Child Guidance Center, that's the center out there when I was living in Connecticut; and then we put him in Reese Program, which is designed for children with his condition; and then of all these things, went to one thing to another thing that wasn't working; then he went to Yale, New Haven,

they had a study where they were treating children with that diagnosis; and then we went to Child Guidance Center.

Participant 3 went through various resources to understand the diagnosis and to give his son the help he needed. He explained:

They (doctors) tried to put him on Seroquel and Ritalin and all that stuff; and it messed him up, because the Seroquel was messing with his eye. I made the decision to get him off of that. So, we went to the medication route, and the psychiatrist was the one who was issuing it to him, and it was the wrong thing for him. It was doing more harm than good, with the medication.

When Participant 10 received the diagnosis for his son, he received some information regarding the diagnosis itself along with some “city sources, a couple of doctor business card or what have you, and . . . some other counselor sources.”

Participant 9 said about accessibility to public resources:

We were offered things by some of the public school system; one public school system, like when he was in first or second grade. They had specialists that could deal with him. One educator wanted to put him in a remedial class, that type of thing. So we really didn't seek out or ask for resources outside of just advice, initially.

Participant 4 did not feel as if he and his son's mother were “given enough information” about his son's diagnosis from the doctor. Participant 4 explained,

She [the pediatrician] talked to us about different options as far as treatment on what we could do. At the time, I am trying to recall, we were given pamphlets to

read; and trying to understand it, and cope with it, and help him to cope with it.

We were told the best way to go forward was probably to get him on medication to help him to focus; and when he did, I'm trying to remember, it was Ativan. As far as resources, it was more of the doctor's word and the information she provided to us and recommendation for it.

Participant 6 shared that he went and got a second opinion. He stated,

A specialist came to me, and said to me that “your son has ADHD.” So, I had to get a second opinion from my therapist, my own therapist. She also said, “Yes, he does have ADHD.” So, I went and started from there.

Participant 8 reported, “We were given counseling; and then going to counseling, they prescribed him some medication.” Participants talked about seeking counseling for their sons, for diagnosis, as a resource.

Frustration, shock, and disbelief. Several participants reported that they felt a variety of emotions regarding the diagnosis of ADHD for their sons. One participant shared his disbelief and sadness about his son’s diagnosis, even going as far as feeling as if he failed his son. Participant 3 said,

I felt like I let him down in the beginning when I was hearing the diagnosis. I could not face that kind of circumstance, as far as a child of mine, and it just put me in a sour place because now I have to deal with all these professionals and it was costing me a lot of extra money for the professional services. So, at that point I was kind of feeling real up in my emotions, put it like that. I was feeling real

anger, not at myself. I just was feeling very negative about all the direction that he was going into because it was new to me.

Participant 3 shared how his wife at the time and he “had to sit down and coach ourselves [to] keep ourselves in line, so that he doesn't get the best of us” during the “early stages” of his son’s diagnosis. Unfortunately, the agreement he came to with his wife at the time did not last, which he said created further strife within the home.

Similar to Participant 3, Participant 2 “felt like maybe my son had ADHD because of something that I did, or maybe something that I didn’t prevent,” that maybe “it could have been my fault.” Participant 2 also stated “I was shocked at some of his behavior, and how he was acting, and the things he would do and say.”

Participant 6 said,

I was frustrated at first, but I never expressed it, because I didn't want him to see how frustrated I was, because I know that a child is like a sponge. So, I didn’t want him to see that I was getting mad at everything that he was doing.

Participant 6 shared how his younger brother, who was also “diagnosed with it (ADHD)” self-medicated by “smoking weed,” and hoped “that in the future, my son doesn't go venture out into self-medicating” like his younger brother.

Participant 7 felt a myriad of emotions after learning about his son’s diagnosis. Participant 7 stated,

I was kind of upset, mad, and shocked all at the same time. I was like, I didn’t know how to feel about it, but I guess I had seen kids that are around have the

same behavior that he has, but I don't know if that's normal for children to be that way or to act that way. I don't know, it just, it was like, shocked.

Similar to Participant 7, Participant 4 was shocked by his son's diagnosis.

Participant 4 reported,

Shocked. How? How could this be? What happened? Is my daughter going to be this way? So many things: Where do we go from here? I didn't even know what it was, technically, did not. I think growing up in school, kids may have made jokes like, "Oh, you're ADHD." Things like that, but I never really knew the scope of it. It meant someone who is crazy or acts crazy, but never understood the real challenges that it ensued [sic]. So, my initial reaction to it was kind of shock, disbelief, that maybe they're getting this wrong. It was really just a combination of things. The biggest one is disbelief; disbelief that this could be happening, that he can be suffering from this.

My role as a parent. The most common role that participants played was the supporter for their sons. Many participants wanted their sons to not feel different about who they were because of their diagnosis. They wanted their sons to still be themselves and worked hard to give their sons the opportunity to be children. Participant 2 noted,

I just wanted to be there for my child, to comfort him, to make sure that he understood that there was nothing wrong with him. We were just trying to get him the resources that he needed to be able to function.

Participant 9 noted, during his interview, that he had an important role in getting his son diagnosed in the first place. Participant 9 admitted,

Initially, my wife didn't want there to be any type of diagnosis whatsoever, thinking that would kind of mark him for the rest of his life. My role was to persuade her to do it since, you know, he is not going to get any better on his own. So, we need to go and find a professional to help us with this.

Participant 4 reported that his role as a parent was to “support him and try to find out what was wrong.” He explained,

As a parent, I guess I never want to hear that there is something wrong with your child, and you just don't know, but at the same time, I do want to know, what's going on. Like I said, it didn't seem normal to me. It didn't seem right. We use to jump around like stuff, saying in the early days, like, this kid acts like he is possessed. I just kind of regret saying stuff like that, because he wasn't so much him being possessed, it was just things he couldn't control and how he was acting out.

Now, I think making some of the tougher decisions, and probably some of the more unpopular decisions, was one of my roles in dealing with this. You know, even with my wife, I think she had a—her thing was we just got to give him more love, and give him more affection, and things like that, and he'll be fine. I was like; it's more than just that. We got to do something for him, because it's not that he's not getting enough love or that he's not getting enough attention. This is more; and pushing to continue with that, she felt like he's going to be fine. I'm like we've got to find out what's going on.

Since the doctor diagnosed his son, Participant 4's role has changed to being "kind of the bad guy, as far as dealing with the actions and response of his behavior." He shared that while he and his son's mother "share the responsibilities as far as the behavior [goes]—if there's something that he does, or he has done, I'm always the one who has to handle the disciplinary course."

Participant 7 acknowledged that his "role was to support her, to back her up, if she needed; but basically, she was there at the diagnosis, when they diagnosed him." The opposite was true for a couple of participants. Participant 8 reported that he was the "primary parent, so it was all up to me."

SQ3

The third subquestion referred to how African-American fathers experienced and perceived their son's ADHD treatment. There were four themes that answered this research question: (a) want what is best for my child, (b) successes of treatment plan, (c) my role as a parent, and (d) beliefs on medication versus alternative therapies. The theme, my role as a parent, had one subtheme that applied to this subquestion, and the theme, beliefs on medication versus alternative therapies, had two subthemes that answered this subquestion.

Wanting what is best for my child. Every participant wanted what was best for his son, especially when it related to getting treatment and help for him. For many participants, that meant creating a tailored treatment plan for their sons to address their child's needs. Participant 9 said,

I'm going forth with an open mind. I want the best for my child, my son. If there is a better diagnosis, I want that, and we haven't exhausted, obviously, all the things we could try. So, for the most part it [the current treatment plan] is working.

Every participant shared how their current treatment plan was tailored to their child's individual needs, which was what they felt was best for their child. One participant matched his son's individual needs with the tools necessary to move forward in the future as a person with this diagnosis. Participant 3 expressed,

The process for the treatment plan would be, like I said, a lot of different agencies that we went through, so there never was one treatment plan, because each agency would want to develop their own treatment plan. They didn't really want to rely on the previous plan, from the past previous agency. It was taken into account, but they always want at the end to add their spin on his treatment plan. So, the treatment plans varied from techniques, how to take things away from him, or when he needs to be rewarded, when he is not to be rewarded. It was just a real hands-on, step-by-step thing to try to curb his behavior at home and then curbing at school, because at times he would curb it at home, but then he would not do it at school, or he would do it at school and be disruptive at home. He would do a treatment plan at a behavior program, complete it, and then still go back to doing the wrong thing; then that would call for another program to be entered, then he would cruise through the program like he is really into it, knowing that he is doing

it for the mean time. Then, like I said, once he became in the double-digit age, that's when he started to take it more seriously.

For Participant 3, it was important for his son to have “tools that he would pick up to use to address whatever concern he might have” in the future.

Participant 10 explained that after receiving the official diagnosis, he and his son's mother became involved in creating a treatment plan tailored to their son. He shared,

At this point in time, this is where they wanted me to make sure that the mother was a participant and on board. We came up with a couple of plans: social ability, meal plans, education; where he would probably have some difficulties, and what we needed to prepare for. So, we basically set up a regimen, as well as, the mother and I, from the plan that we've adopted, we made some changes, but they seemed to work well.

Participant 1 made sure his son's doctors took into consideration his concerns regarding the medication. Participant 1 explained,

They were going to put him on a high dose, at first, and then see how it works, but I said, “Why not go just go low to high, instead of going up as high as you can, and him being like a zombie, and then having to lower it down after every couple of weeks, or whatever?” So, I totally reversed the plan they were going to go with on the medication. So, we decided to go low up to higher, but that first low dose that they gave him was what he needed. It really helped him. So, we didn't have to go any higher than that [initial dose].

Participant 1's son's doctors took his feelings into consideration and allowed him to tailor his son's medication.

Participant 4 did not have a similar experience to Participant 1. Participant 4 explained,

The original medication that he was on, like I said, I just did not like the state that it put him in. Yes, he was calm, but he just didn't seem like himself. I didn't like it. I didn't like it; and I was very much bent on what are some of the other options? What else can we do, because this is not working for me now. I don't want my son to sit there in a tranquil state. I do want him to be a kid. It's not that I don't want him to play. I want him to be a normal kid. I want him to have fun. It's kind of like, I guess I was looking more in favor of a more conventional way of trying to help him. Something that was going to be, not such much beneficial for him and us, but also something that I felt that he could adapt to, something that was not going to require him taking medication every day for.

Many participants did not want a sedated or somber child. Instead they wanted their sons to still be children, to still be active and engaged, but at a level where they were no longer disruptive to others. Participant 8 spent time creating a tailored treatment plan for his son that involved "daily activity at the school," a "session with the counselor" at the school, and "a session [together] with the psychiatrist" at an outside agency. He said, "After going through the process, and us going to counseling together, it made us bond more. So, I felt highly appreciative really about the whole process."

Successes of treatment plan. Participants talked about how their tailored treatment plans worked for their sons. Several participants talked about incredible changes their sons went through because of these tailored treatment plans, whereas others noted the beginning stages of progress being made. Participant 3 shared his son's accomplishments because of the tailored treatment plan. For him, an important part of the tailored treatment plan was removing medication and replacing it with sports. Participant 3 explained,

Once he became in the double-digit age, that's when he started to take it more seriously. That's when the basketball came into play, and then he really started excelling at it, and now he's in the AAU [Amateur Athletic Union]. He's playing at the Basketball Hall of Fame in Massachusetts. He's really doing a good thing. He's going to be a college prospect; basically, a high school prospect, All-American, that's the road, path, that he's on now. So, I really give up going through this dialogue with you, I really don't reflect on it that much anymore, because I am too focused on the now with him. How far he's come! He has developed into a great young man. He owns his past. He wants to do everything in his power to never relive it. He's comfortable in his own skin. Before, he wasn't comfortable in his own skin. He was on the path to where he didn't want to live, because of all the consequences and all the things that would come from his behavior, that he wasn't pleased with. So, a lot of those times were real dark and gloomy.

Despite the hardships Participant 3 mentioned, he said, "I'm very proud of him; every day I am proud of the product that I have turned him into now."

Participant 1 reported the behavioral therapy his son went through early on in his treatment plan "helped him communicate verbally without acting out physically." He explained,

Behavioral therapy he was doing, she [the therapist] was helping him being in tune with his emotions, but she was very physical with him, like touching him, like reassuring him every time he said something, that he would think that would hurt my feelings. Have you ever seen counseling from someone when they say, "Would you do this to me, if you knew this would make me feel this way?" That's how it was with this behavioral therapy. It was like giving each other feedback on what we did to each other or how he feels when we are not able to communicate with each other, or when I'm not able to communicate.

When medication was introduced, the opened communication between father and son helped "him eventually fine tune his medication" to a manageable level (Participant 1). To Participant 1, this was a success for him and his son, and they were able to develop a closer relationship built on communicating their needs to one another.

Another success mentioned during the interviews was Participant 4's experience with his son's treatment plan. Participant 4 mentioned that

he [Participant 4's son] really started to show improvement with his behavior.

There was some things here or there, but nothing like it was before; and I was

willing to accept that. Yes, at least I seen him act like a kid again, for him to run

outside, throwing the ball, things like that, versus, kind of being secluded to himself [on medication].

Participant 4 even noted how his medication was currently at an as-needed basis, instead of taken every day. He said:

He is getting to a point where he's feels he doesn't, he's not needing to take it. He can focus on his own. Before, when he was 14, he was more, if he forgot it, he would be calling us from school saying, "I have a test today. I need this. I forgot to have it." Now, he feels he is fine, that he doesn't need it. He feels he is functioning on his own, on his own will, and not that he needs to have this.

Participant 4 was proud of his son for taking agency over his own treatment and learning when he needs to take his medication.

Participant 7 talked about how his son's medication "helped him" not to be "so out of control" anymore. Participant 7 acknowledged that when his son was "on the medicine, he's not so hyper," instead he's "calm" and "a lot more nice" to "everybody that's around."

My role as a parent. Outside of participants noting their role as a support for their child, participants also talked about their role as an enforcer of their child's treatment plan. This included making certain decisions regarding medication and therapy options in addition to ensuring their child maintained his treatment plan. Participant 9 explained how his role was to enforce the treatment plan and acknowledged that he did not have an active role in "the formulation of it [the treatment plan]." He shared:

The carrying it out is more what I do. I'm there to enforce it, make sure that it's done. So there are no loopholes. My son's very, very, very smart. So, he's like a midget lawyer. He tries to get out of everything that we say. So my job is to kind of catch him. And now he's playing one parent against the other—So we are catching that. So my job basically is to know what the parameters of the treatment are, and to collaborate with my wife and to make sure we're on the same page, and that's basically it.

Similar to Participant 9, Participant 6's role as a parent was "to execute it, whatever is decided" regarding his son's treatment plan. He shared,

I am the person that does it. If we give him medication, I will be the one to give it to him. If we don't give him the medication, I am the one that has to find other ways to deal with it.

Enforcement of the treatment plan was not the only role parents often filled for their children, as they also decided on the treatment plan itself. This was especially true for participants who were the primary parent in the house with the child. Participant 4 elaborated,

I was there to make the decision about what type of treatment we were going to do. Where we were going to go from there? So, I want to say, I talked over with my wife, she still was dependent on me to make the final decision as to what we're going to do, as far as what treatment we were going to make, and what treatment option we were going to take as far as he was concerned.

Beliefs on medication versus alternative therapies. There were two subthemes within this theme: (a) medication as necessary and (b) prefer alternative therapies.

Several participants did not want to medicate their child, but recognized the benefits of using the medication on an as-needed basis. Participant 10 was one such example of this. He was not a big proponent of “utilizing medication” unless he believed “it is necessary” to manage disruptive behaviors (Participant 10). Participant 10 shared, “We tried a couple and didn't like the overall somberness. A little bit of change that I saw in him, you know, I was kind of leery” about using the medications consistently. Participant 10 explained,

Utilizing it when I believe it is necessary; going the period that the doctor was going was ok and we'll started a regimen, but what I've seen over time the difference in my child, after a couple of times of utilizing the prescriptions, we didn't really need, we didn't really want to go in that direction. So, yea I would utilize it, but I would be on a lower scale of utilizing, let's say about 40%, 30%.

Participant 1 “told the doctors I do not want to medication. If we are going to do medication, was there any alternative type therapy available? That’s when they told me about behavioral therapy.” After being referred to a behavioral therapist, Participant 1 was optimistic about the treatment plan. He explained,

I thought at first, that all he [Participant 1’s son] needed was to communicate back and forth. Like maybe instead of acting out, to speak out, like say what's wrong with you; use your words, not your actions. So, that's how I felt about it. So, that was the first process, what we did. Later on down the road, once his behavior

regressed and he started acting up again or acting out, I should say, that's when we decided to put him on the medication. (Participant 1)

For Participant 3, “There was never one [consistent] treatment plan [for my son] because each agency would want to develop their own treatment plan.” As a result, his son was exposed to a variety of “techniques” from “real hands-on, step-by-step thing to try to curb his behavior at home and then curbing [his behavior] at school” to different medications Participant 3 explained,

I had to go holistic with his treatment plan. It was holistic, with nothing from a pharmaceutical company any more. I couldn't do that anymore to him; and he was too young, and I didn't want to have to answer for the side effects, and to explain to him why his health was in this position because of the choices that we agreed to. (Participant 3)

Participant 9 shared how his “wife absolutely did not want him [Participant 9's son] on meds” and was skeptical at first because “I don't recall anyone having a problem or you know, growing up to be a serial killer because they took Ritalin” as a child (Participant 9). Instead of medications, Participant 9's wife wanted his son to go through “behavioral modification” and other alternative therapies.

Participant 6 wanted to “stay away from the medication” and explore other alternative therapy options. He explained that “we just keep him occupied” with several different activities and “try to see which way he's going” that day. Participant 6 shared his desire to “see what else I can do for him other than medication.”

Participant 5 shared that while he did not “like the medication” for his son, he recognized “it is something he probably won’t have to do the rest of his life” if combined with alternative therapies as well. He stated,

I'm thinking when he gets older, like you say; when he gets older, he has an improvement, when he's an adult, pretty much, he probably won't need that anymore. You know what I'm saying? He'll be able to find other mechanisms to, you know what, cope with his problems, pay attention to all that. He'll be able to do that as an adult. So, pretty much, just steering him now and trying to get him through school and get him to understand these things, pretty much now.

(Participant 5)

Participant 5 had hope for the future of his son as it related to managing his diagnosis as an adult. This hope propelled him to getting his son involved in behavioral therapy and sports so that he could learn additional coping strategies and focusing strategies.

Summary

In Chapter 4, I highlighted the research setting and pertinent participant demographics. I also outlined the data collection and analysis procedures as they occurred. After I presented the evidence of trustworthiness, I described the research study’s findings as they related to each subquestion. The findings were organized under each subquestion, which ultimately answered the overarching research question: What are African-American fathers’ perspectives and lived experiences related to their sons’ diagnosis of and treatment for ADHD?

Within the reporting of each subquestion, I cited some instances of discrepancies. To answer the first subquestion, overall, participants struggled with interpreting and making decisions regarding their son's ADHD behavior. They reached out to social support systems for advice and guidance during those times, dismissed disruptive behaviors as normal, and felt powerless and hopeless when trying to both stop and understand their son's behavior.

For the second subquestion, overwhelmingly, participants were taken aback by the diagnosis for their son. Several participants felt it was necessary to use the resources available to them to get an understanding of the diagnosis. Many participants reported feeling frustration, shock, and disbelief once they learned about the diagnosis. They questioned and doubted themselves as parents, with several trying to assess whether there was something they could have done to prevent the diagnosis in the first place. Participants also reported taking on the role of a supporter for their sons, to provide comfort and reassurance to their sons.

For the third subquestion, every participant wanted the best for their child as it related to their treatment plan. Several participants reported satisfactory results with their current treatment plan. While a couple of participants expressed the long and arduous journey it took to get to a successful treatment plan, every participant felt their current treatment plan worked for them and their sons. Participants shared their feelings regarding medication, with most participants preferring alternative therapies to medication. Nonetheless, several participants understood the benefits of medication for certain behaviors and even acquiesced to medicating their son on an as-needed basis. It

was during the treatment phase of their son's ADHD that a few participants noted a change in their role from passive parent to enforcer of the treatment plan.

I will discuss these findings in further detail in Chapter 5. In Chapter 5, I will connect the findings to the existing literature and the conceptual framework that underpinned this study. I will outline the limitations of the study and highlight the implications of the study's findings for practitioners. Finally, I will provide the recommendations for future research before concluding the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore African-American fathers' perspectives of their sons' diagnosis and treatment for ADHD. Singh (2003) found that fathers' perspectives of their sons' diagnosis and treatment for ADHD was important in Caucasian populations. The present study was important because there was limited prior research regarding African-American fathers' perspectives of their sons' diagnosis and treatment of ADHD. Findings from this study may help explain the roles African-American fathers play in their sons' diagnosis and treatment of ADHD. Findings of the present study add to Singh's (2003) research of Caucasian fathers' perspectives and Chang et al.'s (2013) study of Asian fathers with children diagnosed with ADHD. In addition, this research has the potential to add to psychology literature leading to social change by informing treatment within African-American populations based on African-American fathers' perspectives. Exploring African-Americans fathers' perspectives of their sons' diagnosis and treatment for ADHD can lead to information regarding what both hinders and facilitates ADHD treatment for children.

Ten themes emerged from analysis of the data and answered the overarching research question: What are African-American fathers' perspectives and lived experiences related to their sons' diagnosis of and treatment for ADHD? Three subquestions were used to facilitate this exploration.

SQ1: How do African-American fathers interpret and make decisions regarding their sons' ADHD behaviors? Three themes helped answer SQ1: sought advice, dismissal of symptoms initially, and feelings of powerlessness and hopelessness.

SQ2: How do African-American fathers experience and perceive their sons' ADHD diagnosis? Three themes helped answer SQ2: resources available to me; frustration, shock, and disbelief; and my role as a parent.

SQ3: How do African-American fathers experience and perceive their sons' ADHD treatment? Four themes helped answer SQ3: wanting what is best for my child, successes of treatment plan, my role as a parent, and beliefs on medication versus alternative therapies.

Interpretation of the Findings

SQ1

The first subquestion is related to how African-American fathers interpreted and made decisions regarding their sons' ADHD behaviors. Within the theme, sought advice, there were three subthemes: from doctors and professionals, from family and friends, and from Internet/online research. Within the theme, feelings of powerlessness and helplessness, there was one subtheme, child's behavior.

The first theme, sought advice, identified participants who reached out to support systems to help understand their children's ADHD behaviors. Those support systems included doctors and professionals, such as teachers, family and friends, and information from the Internet and online research. The second theme, dismissal of symptoms initially, identified participants who dismissed their sons' ADHD behaviors. Participants

mentioned they thought their sons' behavior was normal, until others pointed out the behavior as not normal. The third theme, feelings of powerlessness and hopelessness, identifies participants who reported feelings of powerlessness in trying to manage the behaviors themselves and hopelessness in trying to prevent the behaviors in the first place. Fathers also expressed doubt in their own parenting abilities.

Regarding SQ1, participants struggled with interpreting and making decisions about their sons' ADHD behavior. They reached out to social support systems for advice and guidance during those times, dismissed disruptive behaviors as normal, and felt powerless and hopeless when trying to both stop and understand their sons' behavior. These findings support the findings from other major research. According to Singh (2003), fathers' explanations of their sons' ADHD behavior fell within three themes: *a* boys will be boys rationale, lack of motivation, and indulgent mothering. Many African-American fathers believed their sons were just being boys, and one father reported that his son's mother excused his son's behavior as not getting enough love. Participants initially believed their sons could control their behavior and in some cases needed more discipline, such as corporal punishment. However, several participants changed their mind about using corporal punishment as a means of discipline and controlling their sons' behavior and began viewing their sons' behavior as something more serious than a boys will be boys explanation. At that time, participants started reaching out to their friends, family, doctors, professionals, and the Internet for help.

Possibly, participants initially thought their sons' behavior was typical of boys behaving badly because they were unfamiliar with the symptoms of ADHD. However,

participants changed their beliefs and began to investigate their sons' conditions after other parents from their sons' school and their sons' teachers expressed concerns about their boys' behaviors. Once the participants' sons began experiencing behavioral problems in school, participants started looking for answers from pediatricians, the Internet, family, and friends. This led to the next step of participants' sons receiving a diagnosis of ADHD, typically from their pediatricians. Once participants received the diagnosis of their sons' condition, participants started taking their sons' behavior more seriously.

SQ2

The second subquestion was related to how African-American fathers experienced and perceived their sons' ADHD diagnosis. Three themes helped answer SQ2: resources available to me; frustration, shock, and disbelief; and my role as a parent. Within the theme, resources available to me, there were two subthemes: doctors and professionals, and Internet and online research. Within the theme, frustration, shock, and disbelief, there was one subtheme: diagnosis. Within the theme, my role as a parent, there were two subthemes: support for child and enforcer of treatment.

The first theme, resources available to me, identified participants who reached out to support systems to help understand their children's diagnosis of ADHD and to help understand the best way to treat their sons. Those support systems included doctors, professionals, the Internet, and online research. These various resources were valuable to some of the participants as they received the diagnosis, while some participants expressed that the medication prescribed to their sons did more harm than good. The second theme,

frustration, shock, and disbelief, identified participants who felt a variety of feelings regarding the diagnosis of ADHD for their sons, including disbelief, sadness, failure, anger, guilt, shock, and frustration. The third theme, my role as a parent, identified participants who felt that their role as a parent was to support their sons. Some fathers felt their role was to support their sons' mothers. In other cases, the father was the primary parent and all decisions were up to them.

Regarding SQ2, participants were shocked by the diagnosis of their sons. Several participants used resources available to them to help understand the diagnosis. Many participants reported feeling frustration and disbelief once they learned about the diagnosis. They questioned themselves as parents, with several trying to assess whether there was something they could have done to prevent the diagnosis. Participants also took on the role of supporter for their sons, to help provide comfort and reassurance.

Findings from this study support the findings from other major research. According to Harborne et al. (2004), parents struggled to understand the causes of their children's ADHD. Some parents believed the cause of ADHD was biological, while others believed it was caused by psychological and social factors. Harborne et al. reported that parents battled feelings of blame they perceived from professionals, family members, and friends for their children's behavior; additionally, parents struggled to understand the origin of their children's ADHD, which caused parents emotional stress. Findings of the present study support Harborne et al.'s findings, as fathers expressed frustration, shock, and disbelief after hearing the diagnosis of their sons' condition. Fathers blamed themselves for their son's diagnosis, believing they did something to

cause their son's behaviors. According to Moldavsky and Sayal (2013), parents and their children diagnosed with ADHD often report stigmatizing experiences stemming from misconceptions about ADHD. One father expressed that he did not want his son placed in a special education class and labeled as special needs.

Once participants heard the diagnosis, some were relieved to have an explanation for their sons' behaviors. However, initially, most experienced shock and disbelief. Most fathers said they were in shock over the diagnosis and in disbelief because they were not sure how their son could have ADHD, since most fathers were unfamiliar with the symptoms of ADHD. Some fathers reflected on their own childhood and compared their sons' behaviors to their own behaviors growing up. Some fathers expressed feelings of guilt over their sons' diagnosis, as they felt that perhaps they did something to cause their sons' ADHD or they did not do something to prevent it. Some fathers' disbelief stemmed from not believing their son could have this diagnosis, thinking their son was just being an active boy, similar to Singh's (2003) finding of beliefs that boys will be boys. However, fathers became more accepting of their sons' diagnosis and began looking for ways to support their son in a nondisciplinarian way.

All fathers did not like hearing their son was diagnosed with ADHD. One father expressed he was angry over the diagnosis. Many fathers referred to their son's behavior as a behavior problem and not ADHD, even after the diagnosis. Most fathers expressed their dislike of medication for their son. All fathers expressed that their son needed help and that they wanted what was best for their son.

SQ3

SQ3 was related to how African-American fathers experienced and perceived their sons' ADHD treatment. Four themes helped answer SQ 3: (a) want what is best for my child, (b) successes of treatment plan, (c) my role as a parent, and (d) beliefs on medication versus alternative therapies. Within the theme, beliefs on medication versus alternative therapies, there were two subthemes: (a) medication is necessary, and (b) prefer alternative therapies.

Regarding the first theme, want what is best for my child, many participants were not happy with the original treatment plan regarding the level of medication prescribed. However, all parents expressed that they were satisfied with their sons' current tailored treatment plan. The second theme, successes of treatment plan, for some participants meant removing medication entirely and replacing medication with sports or behavioral therapy. Other participants mentioned using medication on an as-needed-basis. One participant mentioned once the medication was fine tuned to a manageable level, they were able to develop a closer relationship built on communicating their needs to one another.

Regarding the third theme, my role as a parent, participants talked about their supporting for their children and as an enforcer of their children's treatment plan. Participants, including those who were the primary caretaking parent, expressed they also decided on the treatment plan itself. The fourth theme, beliefs on medication versus alternative therapies, had two subthemes: (a) medication as necessary and (b) preferring alternative therapies. Several participants did not want to medicate their child, while

others recognized the benefits of using the medication on an as-needed basis or at a reduced dosage to the one prescribed. Other participants expressed optimism about using behavioral therapy, sports, and additional coping and focusing strategies, as alternatives to medication. A few participants used medication in conjunction with behavioral therapy. Several fathers expressed their dislike of the results of the medication. Therefore, they either reduced the dosage or completely discontinued the dosage. Fathers who continued with the medication expressed a desire to comfort their sons, making sure the side effects were not affecting them adversely.

To answer SQ3, participants wanted what was best for their sons as it related to their treatment. Every participant felt their current treatment plan worked for them and their son. Most participants preferred alternative therapy to medication. Some participants understood the benefits of medication on an as-needed basis or at lower dosage than originally prescribed. Other participants utilized alternative therapies such as sports, behavioral therapy, and other coping strategies, instead of medication. Findings from this study support the findings from other major research. According to the CDC (2016), since 2000, typical drug treatment for children with ADHD has included stimulants, such as Daytrana, Focalin XR, Intuniv, Kapway, Methylin, Ritalin LA, Strattera, and Vyvanse. Participants of the present study mentioned the above medications as some of the medications their sons were prescribed for treatment of ADHD. According to CHADD (2015), behavioral interventions are also an important form of treatment and include approaches that focus on consistency, positive reinforcement, teaching communication, self-advocacy, and problem-solving skills. Interventions may also include classroom and

behavioral accommodations for children with ADHD. Some fathers of the present study preferred alternatives to medication, such as behavioral therapy, sports, and other coping skills. Most fathers preferred alternatives to medication because they did not like the idea of putting their sons on medication to control their sons' behavior.

According to Zhou and Yi (2014), parents' perspectives and their decisions regarding their children's ADHD treatment are crucial in managing children's neurodevelopmental disorders, such as ADHD. The present study supports Zhou and Yi's claim, as fathers participating in the study were involved in decision making regarding their sons' ADHD treatment. Father's beliefs about medication played an important role in their son's treatment plan. Most fathers did not agree with medicating their son. Therefore, their son's treatment plans either included medication on an as-needed basis or not at all. Many fathers believed in behavioral therapy as an alternative to medication. Additionally, according to Singh (2003), fathers influence whether their sons received treatment and the types of treatment they receive. In the present study, African-American fathers influenced whether their sons received treatment and the type of treatment they received.

In a foundational study on fathers and ADHD treatment, Singh (2003) observed a paucity of literature on fathers' input regarding their children's ADHD treatment in prior research. Singh found that mothers tended to accept drug treatment to help manage their sons' ADHD, while fathers resisted medication and current medical frameworks for understanding their sons' ADHD behaviors. Findings from the present study support

Singh's findings, as most African-American fathers resisted current drug treatment to help manage their sons' ADHD.

Pajo and Cohen (2013) found that African-American parents tended to not medicate their children, attributing ADHD to nonmedical causes. Finding of the present study supported Pajo and Cohen's findings, as fathers preferred not to medicate their sons and attributed their son's ADHD to non-medical causes. Participants of the present study preferred alternative treatments such as behavioral therapy and other coping strategies.

According to Chang et al. (2013), father-child interactions with a child diagnosed with ADHD received decreased family support and involved negative father-child relations. Findings of the present study did not support Chang et al.'s findings for African-American father-son relations. In fact, the opposite occurred. African-American fathers wanted to do what was best for their sons, were very supportive, and engaged in their sons' treatment. Among the fathers participating in this study, father-child relations appeared strong, unlike the findings found in Chang et al.'s study. According to Chang et al., father involvement generally can lead to enhanced well-being, social competence, and cognitive development of their children. All African-American fathers in the present study were satisfied with their sons' current treatment and expressed, through their involvement with their sons, their sons were doing better. Such involvement may lead to enhanced well-being, social competence, and cognitive development.

Palkovitz and Trask (2014) found that fathers' parenting was distant, while that of mothers was more proximate than fathers. Findings of the present study did not support this finding, as African-American fathers were not distant but involved with their sons'

diagnosis and treatment. Fathers participating in this study appeared close, with a strong father-son bond. Coletti et al. (2012) explored parents' perspectives of initiating medication treatment for their children's ADHD, and found that parents did not adhere to medication regimes. The present study supported this finding, as African-American fathers either reduced or discontinued initial dosage because they were concerned about medication side effects. Most fathers participating in this study did not agree with medicating their sons to control their behaviors. Instead, they were more in agreement with alternative methods, such as behavioral therapy.

Wong and Goh (2014) said that children and parents have the power to create positive and negative moments when living with ADHD. Wong and Goh asserted that children with ADHD are active agents, not passive recipients, and that parents can also help their children by recognizing their children's talents, possibilities, vision, and hopes. The present study supported Wong and Goh's findings, as African-American fathers study showed resilience and belief in their sons' potential. All fathers in this study believed in their sons and were determined to do what was necessary for their sons' well-beings. According to Efron et al. (2016), parents of boys less than 13 years of age experienced more stress than did parents of boys 13 or older. The present study supported Efron et al.'s study, as all of the participants reported their sons' date of diagnosis occurred when they were less than 13 years old, and fathers reported high levels of family stress.

According to Sherman (2015) and Hansen and Hansen (2016), parents struggle with the decision to use stimulant drugs because of their potential long-term side effects.

Additionally, several themes emerged surrounding medication, therapy, balancing side effects, improvements in academic performance, functional improvements, concerns about lifelong medication, side-effect costs, and dilemmas after medication termination, improving the atmosphere at home, the role of medication in children's futures, preparing to cope without medication, and stimulants as a postsecondary aid (Hansen & Hansen, 2016; Sherman, 2015). The present study supported Sherman's and Hansen and Hanson's findings, as fathers struggled with using stimulants with their sons due to potential side-effects. According to Roy (2014), fathers are becoming increasingly involved in the management of their children's medical conditions and their children's ADHD diagnosis and treatment. The present study supports Roy's findings, as all fathers participating in this study were actively engaged in their sons' diagnosis and treatment of ADHD.

According to Singh (2003), fathers disagreed with drug treatment for their sons' ADHD, and the present study supported Singh's findings, as all fathers in this study struggled with drug treatment for their sons' ADHD. All fathers also struggled with the diagnosis and initial treatment of their son. All fathers continued to reference their sons' diagnoses as a behavioral issue; not one time did the fathers participating in this study say that their son had ADHD. Perhaps their lack of acknowledgment was because they did not totally believe their son had ADHD, but only needed behavioral therapy. One father mentioned that he expected the medication to cure his son's behavior and struggled with the idea that his son's diagnosis may last through his adult life.

Chang et al. (2013) interpreted their findings within a cultural framework of Confucian traditions, which involve high academic performance expectations of children.

Because ADHD affects individuals' attention levels that can adversely influence academic performance, children diagnosed with ADHD often struggle to perform academically. This struggle can lead to increased authoritarian control from fathers, overprotection from fathers, and increased tensions in father-child interactions (Chang et al., 2013). This study did not support Chang et al.'s study, as the participants in the present study were supportive of their sons. Father-son interactions were of a supportive nature, as fathers wanted what was best for their sons. Fathers wanted their sons to excel in school, but not to a level that caused tensions in father-son interactions. Fathers in this study demonstrated leniency, patience, and empathy with their sons.

Additionally, according to Morris (2014), having a son diagnosed with mental illness can change a father's view of mental illness. The present study supported Morris's study, as the fathers were supportive and understanding of their sons' diagnosis and treatment of ADHD. Fathers showed compassion and understanding towards their sons.

According to Hinojosa et al. (2012), Latino and African-American families were less likely to engage in treatment and were more likely to have severe symptomology and psychiatric comorbid conditions than non-Latino White families. Parental strain was also found to manifest as high levels of care burden, increased depressive symptoms, uncertainty, poor health, and poor quality of life. The present study supported Hinojosa et al.'s study, as the African-American fathers reported not supporting treatment that involved medication. Parental strain was also mentioned, as some of the fathers were single parents raising their sons alone. However, all the participants in this study approved of the current treatment plan for their sons, including medication as needed or

an alternative therapy, such as behavioral therapy. Some fathers also incorporated team sports into the son's treatment plan as a way to practice social skills and a way to release excess energy.

According to Moody (2016), African-American parents think Ritalin, a drug to help control and manage their children's behaviors, erodes their children's African-American identities by diminishing their children's boldness and individualism. This study supported Moody's study, from the perspective that fathers in this study did not want their child medicated, as they did not like the effects of the medication on their sons' personalities. Moody also found that African-American parents lacked information about the causes of ADHD, and, consequently, many believed that corporal punishment should be used to address their children's behavioral problems at school. The present study supported Moody's study in that initially, the fathers appeared to lack information about the causes of ADHD and initially believed that corporal punishment should be used. However, as they received information about the causes of ADHD, they soon realized that corporal punishment was not effective in addressing their children's behavior problems at school and at home.

Singh's (2003) research included two hypotheses: Fathers have unique interpretive frameworks for their sons' behavior, and fathers tend to be skeptical of methylphenidate treatment for ADHD diagnosis. The present study supports Singh's two hypotheses, as African-American fathers initially interpreted their sons' behaviors, often through their personal lack of knowledge, until their son was actually diagnosed with ADHD. Once sons were diagnosed, fathers experienced frustration, shock, and disbelief.

African-American fathers were skeptical of methylphenidate treatment and, in many cases they took their son off the medication completely because of side effects and had their sons working with behavioral health specialists.

Limitations of the Study

My unique position with data collection, analysis, and reporting did not pose a limitation to the study. My biases were addressed through journaling. Through journaling, I considered my own biases to ensure they were set aside prior to data collection and analysis. I also utilized member checking within the study. By allowing the participants to confirm the validity of the findings, the veracity of the findings were further confirmed.

The researcher recruited 10 participants for this research study using Qualtrics after failing to recruit participants using flyers posted in specific mental health facilities and flyers posted on the Walden Participant Pool. The findings of this study do not generalize well. Because this study is a qualitative study, there is a low sample size, and a specific population was targeted.

Recommendations

Future research could include a study of African-American boys' perspectives of their own diagnosis and treatment of ADHD. This research would give boys diagnosed with ADHD an opportunity to express their voices and share their perceptions about their own experiences. This research would add to a limited body of research on the subject.

Possible future research might also include identifying psychotherapy treatment approaches in conjunction with medication. Several fathers expressed their desire for

alternative therapy treatments to medication. Several fathers used behavioral therapy in conjunction with medication. Studying effective treatments could help fathers understand ways to help boys diagnosed with ADHD, in addition to medication.

Future study might include investigation of the impact of fathers' ADHD diagnoses on their sons' treatment. Some fathers expressed their own childhood ADHD symptoms. Such research could help fathers identify how their own experiences with ADHD may influence their perceptions of their sons' diagnosis and treatment of ADHD.

Researchers might also focus on fathers' perspective of their son's diagnosis and treatment of ADHD within other racial and cultural populations. Such research could help fathers of other cultural populations identify how their lived experiences with ADHD may influence their perceptions of their sons' diagnosis and treatment of ADHD.

Finally, future research might include alternative settings for teaching children diagnosed with ADHD. This might include homeschooling and/or special schools designed specifically with ADHD in mind, with an emphasis on special accommodations and treatment that would include a wrap-around program. This wrap-around program would encompass behavioral therapy, classroom settings designed with built in accommodations, art therapy, music therapy, physical therapy, family education, family counseling, peer-to-peer counseling, sensory rooms for cool down periods, and a doctor and nurse on site.

Implications

Findings from this study may have implications for practice, research, and social change. The practical application of this research may help clinicians better understand

the role of African-American fathers in the treatment of their children diagnosed with ADHD and devise intervention approaches accordingly. In addition, because the role of African-American fathers in the treatment of their children diagnosed with ADHD is largely unknown and underrepresented in the literature, the findings may add to the literature on the racial and gendered dimensions of treatment for children with ADHD. Finally, the potential social implications of this study could be far reaching. This research could support positive social change by facilitating enhanced treatment options for African-American boys diagnosed with ADHD.

This phenomenological qualitative study used M. Bowen's (1978) family systems theory, which is a theory of human behavior that emphasizes the family as a unit. This implies what one does within the family affects the family as a whole. Therefore, father's perspectives of their son's diagnosis and treatment affect the family as a whole, as well as the son's behaviors also affect the family as a whole. This theory emphasizes the family as a whole that is greater than the sum of its parts. Family systems theory was an appropriate framework to examine fathers' perspectives of their sons' diagnosis and treatment of ADHD because the theory allows for understanding how family dynamics can affect and can be affected by fathers' perspectives of ADHD, including its diagnosis and treatment. This study supported M. Bowen's family systems theory because as the son's diagnosis and treatment progressed so did the family's ups and downs.

Implications from this study could impact the African-American culture as a whole, by showing how African-American fathers genuinely care about their sons' diagnosis and treatment of ADHD. In addition, this study shows that African-American

fathers want what is best for their sons, whether that means medication and/or alternatives to medication. This topic was difficult for several fathers to discuss, especially when they were recalling the earlier days before their sons' diagnosis. However, once sons finally received the treatment they needed, including medication and/or therapy, fathers felt relieved. In all cases, fathers were content with their sons' current treatment plans, whether they included daily medication or were on an as-needed basis, and/or whether their sons were receiving therapy or alternative treatment plans that did not include medication.

From an empirical perspective, the information acquired from this study included direct observation through a phenomenological qualitative methodology. The data were compared and analyzed to determine the emerging themes. The data acquired from this study can also be used as bases for future studies.

Conclusion

This phenomenological qualitative study attempted to answer the overarching question, What are African-American fathers' perspectives and lived experiences related to their sons' diagnosis of and treatment for ADHD? This overarching question was answered by asking three research questions: (a) How do African-American fathers interpret and make decisions regarding their son's ADHD behaviors? (b) How do African-American fathers experience and perceive their son's ADHD diagnosis? (c) How do African-American fathers' experience and perceive their son's ADHD treatment?

Participant requirement included African-American biological father of a son diagnosed with ADHD. Ten African-American fathers participated in this study. This

study showed that African-American fathers with sons diagnosed with ADHD initially think of their sons behaviors using a boys will be boys rationale. As fathers become more informed about the symptoms and treatment of ADHD, they placed less stock in the boys will be boys explanation.

Initially, fathers felt sad, angry, shock, guilt, and disbelief once their sons received a diagnosis of ADHD. However, as fathers learned more about the symptoms and ways to help their sons, they began practicing different strategies to help their sons cope with and manage their own ADHD behaviors, which included using medication and/or behavioral therapy, sports, or other coping strategies. African-American fathers typically prefer alternatives to medicating their son, such as behavioral therapy. Some fathers used sports as an alternative to medication. Some fathers continued to treat their sons' ADHD behaviors with medication on a regular or on an as-needed basis, as they saw the benefit in helping their sons with their ADHD behaviors. In all cases, fathers were satisfied with their sons' current treatment plan, whether the plan included treatment exclusively with medication, using alternatives to medication, or a combination of both.

Fathers in this study demonstrated leniency, patience, and empathy with their sons. In all cases, African-American fathers participating in this study cared deeply about their sons' diagnosis and treatment and wanted what they thought was best for their sons. Fathers were very supportive and engaged in their sons' treatment. Father-child relations appeared strong, and father involvement appeared to lead to their sons' enhanced well-being, social competence, and cognitive development.

Finally, African-American fathers participating in this study initially held beliefs similar to Caucasian fathers found in Singh's (2003) research that their son's behavior was explained initially by a boy's will be boy's rationale. However, as fathers became more informed about the symptoms and treatment of ADHD, they abandoned this initial explanation in favor of medical explanations. In addition, most African-American fathers did not want their sons taking prescription medications to treat their ADHD behaviors, which is also similar to Caucasian fathers' beliefs found in Singh's study. However, unlike Chang et al.'s (2013) findings that Asian fathers of sons diagnosed with ADHD had increased tensions in their father-son relationships, fathers participating in the present study were deeply committed to their sons' successes, and father-son relationships appeared strong.

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Appendix A: Von Raub's Interview Questions and Prompts Protocol

Research question (RQ)	Interview questions
RQ1: How do African-American fathers interpret and make decisions regarding their son's ADHD behaviors?	<p>Interview questions related to your son's behaviors that caused you to seek a diagnosis are as follows:</p> <ol style="list-style-type: none"> 1. What were your son's behaviors that caused you to want to get help for him? 2. Who did you ask for advice about your son's behaviors? 3. What resources were you given to help your son? 4. How did you feel about your son's behaviors? 5. What was your role in making decisions about your son's behaviors? 6. What influenced the decisions you made about your son's behaviors? 7. What was your reaction to decisions about your son's behaviors?
RQ2: How do African-American fathers experience and perceive their son's ADHD diagnosis?	<p>Interview questions related to the diagnosis process are as follows:</p> <ol style="list-style-type: none"> 8. Describe the diagnosis process? 9. What was your role within the diagnosis process? 10. What was your reaction to the diagnosis?
RQ3: How do African-American fathers' experience and perceive their son's ADHD treatment?	<p>Interview questions related to treatment process are as follows:</p> <ol style="list-style-type: none"> 11. Describe the process of developing a treatment plan for your son? 12. What was your role in the treatment plan? 13. Were you included in the process of making a treatment plan for your son? 14. Was the treatment plan tailored to your son's individual needs? 15. What was your reaction to the suggested treatment plan?

Interview prompts
<ol style="list-style-type: none">1) Tell me more about that?2) What led you to ...?3) What led to this?4) What eventually happened?5) Looking back, what would you have done differently, if anything?6) What was the outcome?7) What was the situation?8) Is this typical of you?9) Can you think of another example of this?10) What else can you remember about this situation?11) Give me more detail about what you did, please.12) What exactly did you say?13) I'd like to hear more.14) How does that make you feel?

Appendix B. Recruitment Flyer

**Join Me!**

Are you an African-American father with a son who has been diagnosed with ADHD?

If you are the biological father of a son who has been diagnosed with ADHD and you live with your son, than you are eligible to participate in a research study.

A Doctoral Candidate with Walden University is looking for fathers to participate in interviews to discuss the process of ADHD diagnosis and treatment.

Participants will be asked to take part in one 1-hour interview to be held in a convenient location. There are no known risks involved with participating in this study.

For additional information, please contact Renee Von Raub at 407-268-4868 or renee.vonraub@waldenu.edu
Principle Investigator: Renee Von Raub, Doctoral Student

Appendix C. Screening Questionnaire

Dear Participant,

The selection criteria for this study is as follows:

1. Must be an African-American father
2. Must have a biological son 18 years or younger diagnosed with ADHD
3. Must live with son

Please see checked box to see if you meet the criteria.

Response to participants that meet criteria:

Thank you so much for offering to contact me about this study. Your participation will be appreciated as you meet the criteria. I would like to set up a place and time that is convenient for you. The study will take approximately 1 hour. The locations will be in a local library setting.

Response to participants not meeting criteria:

Thank you so much for offering to contact me about this study, but unfortunately your participation will not be needed due to not meeting the criteria.