

Harmony at Home: The Experience of Raising a Child with Externalizing Behavior

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ABSTRACT

The objective of this study was to understand the meanings parents make while parenting their children with externalizing behavior in a rural, isolated community. How parents have come to understand their child's behavior, what attributions they make, what their experience has been with mental health or counseling services within the community and treatment beliefs were examined. Participants were 5 parents from diverse ethnic backgrounds living in a rural area of Northern Canada. Data were analyzed for themes within and across the participant's descriptions. In-depth semi-structured phenomenological interviews revealed the following common experiences: participant's had similar histories of inconsistent parenting in their family of origin, became parents at a young age, entered early into a relationship and parented their child alone or with a step or co-parent. Participants reported an inconsistent parenting style and response to behaviour than their co-parent, described stress within the family and feelings of frustration, hopelessness, anger, and anxiety. Parents attributed externalizing behaviour to factors within the child or environment and identified barriers such as distance to specialized services, long wait times and lengthy intake systems. Therapeutic treatment was believed to be most beneficial before medications would be considered. The results of this study are discussed in relation to the existing research on parental attributions of children's behavior, and the social-cognitive model of Dix and colleagues (Dix & Grusec, 1985; Dix, Ruble, Grusec, & Nixon, 1986). Implications for health care providers are discussed and recommendations for future research are suggested.

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CHAPTER 1

Introduction

Overview

When a child arrives we realize that in this world the reality of parenting is much more than a loving dream, it is a daily demand of knowing what to do and when to do it. These demands continue in some form as long as our children live. Given the importance of parenting in relation to child Attention Deficit Hyperactivity Disorder and Oppositional Defiant behavior, it is critical to gain a better understanding of how parents of these children approach the parenting task (Johnston, Chen & Ohan, 2006). Studies in developmental psychology have related parents' attributions to child's behavior to both parenting behavior and child outcomes (Bugental & Johnston, 2000). The attributions that parents make for their child's behavior can assist in our understanding the family difficulties associated with childhood Disruptive Behavior (Johnston et al., 2006).

I grew up in a small northern community with a population of approximately 50% Aboriginal and 50% European decent citizens, a short distance from where the current research took place. I am a white woman with no children, from a middle class and fairly well known family in the community. I've held various positions both in my home community and the community in which the participants in this study and I now reside; teacher, educational psychometrist, counselor and social worker. Having worked as a mental health clinician I began to ponder the research questions that are addressed in this study. I saw children in my office from the ages of 5 to 18 on a daily basis, while the children came in to see me the parents rarely did. These children were regularly referred by the school or child protection system, and on occasion by the parents themselves. Parents brought the children to the door and came back later, not often coming in and working together with me to find a solution to their child's struggles. I would see parents at an intake appointment and usually never again, despite trying to encourage their involvement. I wondered, did the parents see the child as having a problem at all? Did they feel it wasn't as serious as the referring agency or school personnel? Did they simply feel powerless about changing the situation? Both my current and home community offer services through mental health, social services and The Friendship Center which focuses on providing culturally

specific service to Aboriginal clients. The health office on the reservation also provides counselors offering culturally specific service. While it seemed like there are at least a few agencies offering service, the wait lists are long, retaining staff is difficult in the north and there remains a large number of children in need of service. Although the services are there I wondered if they were truly being utilized by those most in need, and if not, why?

In both communities there remains a divide between Aboriginal people and those of European descent. Not only in land and housing, but in school we often see the children separate themselves, prejudices are alive. Words are spoken between children, between adults in the community, within the school and in the private homes of individuals. We have come a long way from our history of repression and devastating treatment of the Aboriginal people, but we have a long way to go. While working very closely with parents and children of European Canadian and Aboriginal backgrounds in my community and surrounding areas it has been apparent that parenting no matter what your ethnicity, can be very difficult. Children deserve every opportunity they can get to reach their highest potential, and the families they live in are their first and most important resource. By providing families with the support they need to live and grow, and by empowering community institutions to provide the right kind of programs, we enable parents to thereby ensure that children have the support they need to succeed (Pigott & Monaco, 2004). Sensitive parenting that is attuned to children's capabilities and to the developmental tasks they face will promote emotional security, behavioral independence and intellectual achievement (Belsky, 1984).

As a researcher, a mental health professional, and teacher this research was intended to help me understand how I can improve my own practice. How we as health professionals and educators can work with children and families in collaboration, focusing on parents and family strengths. Realizing the potential of each parent despite their difficult circumstance is important as we attempt to invite parents to work with us. Approaching parents with the understanding that families are very resilient, have enormous strength, and in the end they want what we all want, a peaceful and loving home for their children.

This research addressed, from the parents perspective, the attributions made regarding children's behavior, parent's response to that behavior, and the choices parents make regarding treatment. Furthermore, I examined the perceived barriers to treatment within the community.

Purpose of the Study

The purpose of this phenomenological study was to discover and describe the experiences of parents raising children with externalizing behavior. This could include disorders such as Conduct Disorder (CD), Oppositional Defiant Disorder (ODD) and Attention Deficit-Hyperactivity Disorder (ADHD). I hoped to understand how parents make meaning of the difficulties their children face, what services they seek and what barriers they have faced when seeking or receiving help. I was interested in the experience of raising children with externalizing behavior in three small Northern Manitoba and Saskatchewan communities and how parents came to the decisions about the treatment they may or may not seek for their children and themselves as parents.

Rationale for the study

As a counselor I have witnessed the struggle parents experience when parenting children with disruptive behavior disorders. Through this study I hoped to gain a better understanding of what parents experience and what meaning they make of the difficulties their children face. I also hoped to make a difference in a professional capacity assisting parents to make meaningful changes in the lives of their children by understanding their experiences, from their point of view.

The rationale for this study was to provide a framework for understanding parents needs as they attempt to raise their children who struggle with externalizing behavior. I hoped to gain a context to each participant's life by learning about their background experiences and what led to them becoming parents. I was also interested in understanding what sense parents make of their children's behavior, what they attribute the behavior to, and what emotions and effects the behavior has had on their relationships and the family as a unit. I also wanted to understand whether they believe adequate services are available in our northern rural community, what services they have used and what their beliefs were in regards to treatment of externalizing behavior in children. As a counselor it is important for me to understand the meaning that parents attach to their child's behavior in order to build connections with a family and help them in the most appropriate way.

The literature indicates that help-seeking for mental health problems are predicted by beliefs about mental illness (Ng, Jin, Ho, Chua, Fones & Lim, 2008). We know that understanding parent's perspectives about their child's mental health and the attributions they give to their child's behavior is paramount in providing the best treatment approach. Parent's attitudes toward their children and their perceived efficacy as a parent can influence the way they react to their children and how open they are to receiving support from others (Bradshaw, Glaser, Calhoun & Bates, 2006). Research has been conducted in other countries regarding cultural differences in perception of mental health. Studies in urban Singapore have indicated barriers to service including stigma and beliefs about the curability of mental illness (Ng et al., 2008). Studies in the United States have also indicated the differences between parents' perceptions about the mental health of their children within different cultures (Roberts, Alegria, Roberts & Chen, 2005). Very little research has been conducted regarding the perceived barriers to mental health service in rural communities, in particular those in Northern Canadian communities and the specific population that lives in this area. The aim of this study is to address the gap in the literature on the perspectives of parents of various cultures specifically in rural isolated Northern Canadian communities and to gain an understanding of their experiences with services in these communities. The proposed study will give voice to the parents of children with externalizing behavior in order to understand their experiences, beliefs and explore their help seeking practices.

Significance of Research

The results of the study will provide a better understanding of how to support families and youth at-risk in managing externalizing behavior, promote youth supports and capitalize on youth and family strengths. This will result in our ability to improve on the overall health and well-being of children and their families so as to affect positive adaptations and change. I believe that this study will be an important addition to the current literature on the experience of parenting children with externalizing behavior. In order to affect positive change in children's lives we must work very closely with parents, become aware of the challenges they face, and find appropriate ways to support and encourage them.

This study will address the following questions:

1. What is the meaning of parenting children with externalizing behavior for parents in a rural, Northern, isolated community?
2. How have parents come to understand their child's externalizing behavior and what attributions do they make in regards to this behavior.
3. What has been parents' experience with health or counseling services in a Northern, rural, isolated community and what barriers have they faced?

Methods

This phenomenological study focused on the interpretation of the human experience. Phenomenology is associated with research that investigates the underlying meanings inherent in an experience, which are derived from extensive and insightful descriptions provided by the individualized experiences of participants (Morrisette, 2000). Van Manen (1990, p. 9) states, "phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences." "Phenomenology differs from other science in that it attempts to gain insightful descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying, or abstracting it" (Van Manen, 1990, p. 9). Van Manen (1990, p.36) further states, "the aim of phenomenology is to transform lived experience into a textual expression of its essence in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful."

Parents of children who struggle with externalizing behavior in their children within three small communities in Northern Manitoba and Saskatchewan were recruited for the study. In order to gather data, the primary parent was given an open-ended, semi-structured, qualitative interview. Using purposive sampling, 4 families from three communities were recruited. A local school offered its support for the study and recruitment of participating parents.

Data collected during interviews was transcribed, organized and reviewed, searching for patterns and themes. Because this study involved human participants the proposal was submitted to the University of Saskatchewan Behavioral Research Ethics Board for ethical review.

Definitions

Disruptive Behavior Disorders (DBD): include Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and Attention Deficit Hyperactivity Disorder (ADHD) (American Psychiatric Association, 1994).

Oppositional Defiant Disorder: is a persistent pattern of negativistic, hostile, and defiant behavior, which includes overt disruptiveness and disregard for rules and emotional dysregulation (American Psychiatric Association, 1994).

Conduct Disorder: is described as a persistent pattern of behavior in which the rights of others and age-appropriate social norms are violated. It includes acts of physical aggression, destruction of property, deceitfulness or theft and breaking major school or home rules (American Psychiatric Association, 1994).

Attention Deficit/Hyperactivity Disorder: is characterized by age-inappropriate hyperactivity and impulsive behavior and inattention (American Psychiatric Association, 1994).

CHAPTER 2
Literature Review
Background

Children's externalizing behavior, which can include Disruptive behavior disorders such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) and Attention-Deficit Hyperactivity Disorder (ADHD) (American Psychiatric Association, 1994), is a significant burden to children, their families, and society in general because of their prevalence, lifespan consequences and economic costs (Petitclerc & Tremblay, 2009). Symptoms of Disruptive Behavior Disorders are a common reason children are referred to mental health specialists (Petitclerc & Tremblay, 2009). These symptoms are associated with high school noncompletion, and have been shown to increase risk for numerous adjustment problems during adolescence and in adulthood (Ferguson, Horwood & Ridder, 2005; Vitaro, Larose, Brendgren & Tremblay, 2005).

In a 25-year longitudinal study, Ferguson et al. (2005) investigated the associations between conduct problems in middle childhood and psychosocial outcomes in adulthood. They found that early conduct difficulties appear to influence later development with the effects spanning: crime, substance use; sexual and partner relationships; and mental health, (Ferguson et al., 2005). Bongers, Koot, van der Ende, and Verhulst (2004) found that children with the highest level of oppositional behaviors at the end of the preschool period continued to show much higher levels than their peers until age 18. Individual differences in property violations are stable for people between the ages of 4 and 18 years, while status violations such as truancy and underage drinking generally increased during adolescence (Bongers et al., 2004).

Vitaro et al. (2005) conducted a study which examined whether two aspects of disruptive behaviors observed in kindergarten predicted non-completion of high school by early adulthood. Two aspects of disruptive behavior were examined; cognitive (i.e., hyperactivity-inattention) and the social (i.e., aggressiveness-opposition). The results showed that the cognitive aspect of disruptiveness made a significant contribution, at both the high and average levels; the contribution of the social aspect of disruptiveness was more modest (Vitaro et al., 2005). These findings suggest that disruptive behaviors, especially hyperactivity-inattention and, to a lesser

extent, aggressiveness-opposition, in kindergarten serve as early predictors, if not precursors, of the negative trajectory leading to high school non-completion (Vitaro et al., 2005).

Broidy et al. (2003) conducted an extensive 6-site, cross country study to examine the developmental course of physical aggression in childhood and its linkage to violent and nonviolent offending outcomes in adolescence. Consistent with the Nagin and Tremblay (1999) study, Broidy et al. found that physical aggression in childhood is a distinct predictor of later violent delinquency. The findings also suggest that this relation extends to nonviolent offending as well (Broidy et al., 2003). The results clearly indicate, however, that these conclusions are reserved exclusively for boys, because no consistent relation emerged between childhood physical aggression and adolescent offending among girls (Broidy et al., 2003). This data also indicated that for boys, childhood physical aggression was the most consistent predictor of violent and nonviolent offending in adolescence (Broidy et al., 2003).

There was also evidence to suggest that independent of physical aggression, early nonaggressive conduct problems increased the risk of later violent delinquency and early oppositional behaviors also independently increase the risk of nonviolent delinquency (Broidy et al., 2003). It is important to note that this study found no evidence that hyperactivity had an independent influence on adolescent delinquency (Broidy et al., 2003). Although it is possible that hyperactivity interacts with other disruptive behaviors in childhood to aggravate their influence on later offending, it does not appear to be an independent predictor of offending outcomes (Broidy et al., 2003).

Cohen (2009) conducted a study investigating the costs incurred by high risk youth. Findings suggest that the present value of saving a 14 year-old high risk youth juvenile from a life of crime range from \$2.6 to \$5.3 million in the United States (Cohen, 2009). Thus, the prevention of Disruptive Behavior Disorders can potentially reduce not only the child's and their family's suffering but also substantial public costs (Petitclerc & Trembley, 2009).

Co-morbidity

Although the typical age of onset for ADHD is prior to age 7 and typical age of onset for CD and ODD is typically later in childhood, there is a strong co-morbidity between the disorders (American Psychiatric Association, 1994). Wilens et al. (2002) evaluated the clinical characteristics, psychiatric co-morbidity and functioning of preschool children and school-aged

youth with ADHD. A minority of preschool children had non-co morbid ADHD, typically they had at least one other psychiatric disorder (Wilens et al., 2002). Patterns of psychiatric co-morbidity were similar between preschool and school-age children (Wilens et al., 2002). Disruptive disorders in general and oppositional disorders in particular were the most common co-morbid conditions (Wilens et al., 2002).

Risk Factors

Risk factors for Disruptive Behavior Disorders, both environmental and genetic, have been widely studied. Low income and single parenthood are classic predictors of youth antisocial behavior (Tremblay, Nagin, Seguin, Zoccolillo, Zelazo, Boivin, et al. 2004). Tremblay et al. (2004) examined the predictors of physical aggression during early childhood. Results from this study indicated that smoking during pregnancy predicted high levels of physical aggression in infancy. These are consistent with the findings of Weissman, Warner, Wickramaratne and Kandel (1999) who found that smoking during pregnancy predicted antisocial behavior during later childhood.

Tremblay et al. (2004) found that children who are at highest risk of not learning to regulate physical aggression in early childhood have mothers who have a history of antisocial behavior during their school years, who start childbearing early, who smoke during pregnancy and have parents who have low income and serious problems living together.

Disruptive behavior disorders are associated with multiple interacting risk factors, including quality of parenting. In reviewing the literature on attachment, Bowlby (1988) asserted that “variations in the way these attachment bonds develop and become organized during the infancy and childhood of different individuals are major determinants of whether a person grows up to be mentally healthy” (p.2). An individual’s experience with their primary caregiver as reflected in their attachment security is a factor that directly or indirectly affects behavior or other developmental processes including emotion regulation and social attributions (Guttman-Steinmetz & Crowell, 2006).

Ooi, Ang, Fung, Wong and Cai (2006) conducted a study investigating the effects of the quality of parent-child attachment on clinic-referred boys’ aggressive behavior, social stress and self-esteem. Boys whose parents reported having a higher quality of parent-child attachment were found to be less aggressive, have lower social stress and higher self-esteem (Ooi et al.,

2006). Findings from this study highlight the importance of the parent-child relationship in understanding the risk and protective factors in clinic-referred boys' social and emotional development (Ooi et al., 2006).

Studies have indicated that a secure parent-child attachment is also related to higher sociability, higher compliance with parent request and more effective emotional regulation (Bowlby, 1944, as cited in Guttman-Steinmetz et al., 2006). Infants with insecure attachments with caregivers are less sociable and have more problematic peer relationships, greater anger and lower self-control during the pre-school years and beyond (Thompson, 1999, as cited in Guttman-Steinmetz et al., 2006). It is likely that some forms of ODD and CD have little or no association with relationship processes, in other cases an inherent vulnerability is elicited or exacerbated by relational difficulties (Guttman-Steinmetz et al., 2006). Diagnosis and treatment requires one to look into the broader context of how different factors relate to, and interact with one another that lead to the development of certain behaviors in a child.

Research has consistently suggested that exposure to stressful family events or family dysfunction in childhood is associated with maladaptive behavior. The relation between exposure to family stress and behavioral outcome might not be a direct or unidirectional one and might be moderated by several other variables (Jackson, Sifers, Warren & Velasquez 2003). These other variables are referred to as "risk/protective factors" and might serve to diminish or enhance the relation between family stress and behavioral outcome in children (Jackson et al., 2003).

Having positive relationships with family members, opportunities for personal growth within the family, and the provision of structure have been proposed as possible protective factors (Jackson et al., 2003). Jackson et al. (2003) suggest that it may be a positive family environment that helps children to develop adaptive coping responses to family stress, which lessens the probability of developing maladaptive behavior.

Parent Attributions

Parental attributions for child behavior have considerable potential to advance our understanding of the origins and trajectories of parent-child problems in families of children with ADHD, ODD, and/or CD problems (Johnston & Ohan, 2005). Research has shown that parent-child interactions are key contributors to the emergence and maintenance of child disruptive behavior (Johnston & Ohan, 2005). Johnston and Mash (2002) found that negative parent-child

interactions are particularly strongly associated with child oppositional or conduct problems, although families of children with ADHD also typically exhibit more of these difficulties than comparison families. The interaction difficulties of parents and children with disruptive disorders are well established, what is less well understood, are the cognitive or motivational factors that may underlie these interaction difficulties (Johnston & Ohan, 2005). The attributions that parents offer for their children's behavior may be a vital component of these problems (Johnston & Ohan, 2005).

Often the causal attributions that parents offer to explain their children's problems seem to reflect not only the child's behavior, but also characteristics of the parent, the parent's history with the child and or the family's circumstances (Johnston & Ohan, 2005). While one parent may describe a child's failure to focus in school in terms of situational factors such as an over stimulating environment, another parent might view inability to focus as internal and controllable to the child. Although the attributions that parents offer are typically seen as interpretive filters, in actual fact, attributions vary in the extent to which they are accurate or objective interpretations of the child's motivations or are more biased and distorted appraisals reflecting more about the parents than the child (Johnston & Ohan, 2005).

Social-Cognitive Model

A number of models of attribution processing and outcomes within the parent-child context have been proposed, one of the most influential is that of Dix and colleagues (Dix & Grusec, 1985; Dix, Ruble, Grusec, & Nixon, 1986). This basic social-cognitive model states that parental attributions mediate between children's behaviors and parent's reactions to these behaviors (Johnston & Ohan, 2005). Social cognitive models can guide research regarding how parent's cognitions about behavior and treatment influence the decisions they make regarding how they manage their child's behavior (Jiang & Johnston, 2010). The interpretations that a parent makes for a child's behavior function as interpretive filters that give meaning to the child's behavior and guide the parent's affective and behavioral reactions to the child (Johnston & Ohan, 2005).

Locus, control and stability are the three dimensions most commonly used across attributional models and research (Johnston & Ohan, 2005). Judgments of locus address whether the cause of the behavior is seen as residing within the child or outside the child (Johnston &

Ohan, 2005). Attributions of control indicates whether the behavior is believed to be controlled by the child and stability attributions are whether the behavior is believed to be present in the future (Johnston & Ohan, 2005). Although the current research is grounded in a social-cognitive model, this model does have some limitations. Attributions only partially mediate the association between child behavior and parents' responses (Johnston & Ohan, 2005). Parents' reactions to a child's behavior are influenced by many things such as culture, beliefs and personality. In past research these factors have been excluded or controlled for (Johnson & Ohan, 2005).

A social-cognitive model suggests that the child behaves in a certain way, the parent makes an attribution and due to this attribution the parent reacts to the child's behavior. It does not necessarily infer causality, the actual relations among child behavior, parental attributions and parenting reactions are transactional and complex (Johnston & Ohan, 2005). It is important to recognize that this model presents only a partial account of how parental attributions may operate within the complexities of actual parent-child interactions (Johnston & Ohan, 2005). Despite these limitations, the model is a useful heuristic for integrating and guiding research (Johnston & Ohan, 2005).

Looking at the first connection in the model, associations between child behavior and parental attributions, Johnston, Hommersen and Seipp (2009) found evidence to support this association when they conducted a longitudinal study of ADHD and nonproblem children. This study found that the extent to which mothers saw their children's oppositional behavior as attributable to persistent and pervasive factors within the child was a significant predictor of higher levels of oppositional behavior one year later (Johnston, Hommersen & Seipp, 2009).

A study by Johnston, Chen and Ohan (2006) compared attributions for child behavior among mothers of 38 nonproblem boys, 26 boys with attention deficit hyperactivity disorder, and 25 boys with ADHD and oppositional behavior. Mothers of boys with ADHD and co-occurring ODD behavior offered the most attributions for child behavior (Johnston et al., 2006). Mothers with ADHD/ODD boys saw child failure as due to internal and controllable causes and saw success as due to uncontrollable factors more often than did mothers of nonproblem boys (Johnson et al., 2006). Mothers of boys diagnosed with ADHD alone did not differ significantly from mothers of nonproblem boys (Johnston et al., 2006). These results suggest that co morbid ADHD and ODD are linked more closely to negative parent attributions than ADHD alone (Johnston et al., 2006).

Renk, Roddenberry, Oliveros and Sieger (2007) examined the relationships among maternal depressive symptoms, parental stress and perceptions of children's emotional and behavioral problems. In this study mothers who were experiencing depressive symptoms and parenting stress rated their child as having higher externalizing and internalizing behavioral problems (Renk et al., 2007). Mothers who were experiencing stress and depressive symptoms reported higher negative perceptions of their children (Renk et al., 2007).

Previous research has linked parenting styles with child outcomes; however parent's attitudes toward their child and their beliefs about the effectiveness of their parenting skills may also play a role (Bradshaw, Glaser, Calhoun & Bates, 2006). Parent's beliefs and practices may be effected by their children's behavior and the context in which they parent (Bradshaw et al., 2006). Bradshaw et al. (2006) explored the beliefs and practices of parents of aggressive and oppositional adolescents. Specifically they examined whether parents beliefs and behaviors varied by the severity of their adolescent's problem behavior (Bradshaw et al., 2006). It was hypothesized that parents whose adolescents had the most serious behavior problems would have negative beliefs and emotions regarding their child, including being afraid of the child, angry at the child, feeling hopeless about the child's future and feeling inadequate as a parent (Bradshaw et al., 2006).

Bradshaw et al. (2006) found moderate to strong associations between the parent variables and the youths problem behavior. Consistent with prior research on parents attributions toward children with ADHD/ODD compared to nonproblem children (Johnston et al., 2006), this study also concluded that parents with the least problematic adolescents were more inclined to give their child the benefit of the doubt and view the current infraction as an anomaly (Bradshaw et al., 2006). Parents who had adolescents with more severe problem behavior were less inclined to make excuses (Bradshaw et al., 2006). Parents whose children were violent and disobedient were the most hopeless, angry and fearful (Bradshaw et al., 2006). Parents who reported strong feelings of inadequacy viewed themselves in a self-blaming manner in regards to parenting and lacked consistency in enforcing the rules and expectations. Parent's attitudes toward their children and their perceived efficacy as a parent might influence their effort to monitor their children and their openness to support from others (Bradshaw et al., 2006).

A study conducted by Daggett, O'Brien and Peyton (2000) is another example of the importance of understanding parental attitudes and the factors that affect these attitudes when it

comes to raising children. In this study mothers perceived childhood experiences, attitudes about life and developmental expectations were related to their interpretations of their child's behavior (Daggett et al., 2000). Negative interpretations of child behavior and negative attitudes about life in general were directly related to the provision of a low-quality child-rearing environment, and negative attitudes about child behavior (Daggett et al., 2000). Mothers who reported harsh parenting as children, negative attitudes about life and unrealistic developmental expectations had negative attitudes about their own child; these attitudes were also related to lower quality home environments (Daggett et al., 2000). Compared with the amount of research that has been conducted on parenting practices few studies have examined the role of parents' beliefs and attitudes regarding their child's behavior (Bradshaw et al., 2006).

The second connection in the social-cognitive model examines the associations between parental attributions and parenting reactions (Johnston & Ohan, 2005). There is considerable support that parental attributions are predictive of parenting reactions. Johnston and Patenaude (1994) found that parents who saw their child's behavior as intentional, internal and stable, responded with more negative affect and harsher discipline. A study with 90 mothers of ADHD and nonproblem boys further demonstrates these associations (Scoular & Johnston, 2002). This study assessed mothers attributions of their own child's behavior, the extent to which a mother saw her child's failure on a task as due to laziness was predictive of her use of criticism over and above her negative evaluation of the child's performance (Scoular & Johnston, 2002). Following success, when a mother saw her child's behavior as internal and controllable she was more likely to use praise. It is acknowledged that causality in the social-cognitive model is not strictly linear, however, there is evidence that causality can flow from child behavior to parental attributions to parenting reactions (Johnston & Ohan, 2005).

Treatment Choice and Adherence

Although therapeutic treatments are designed to change child behavior, parents play the most critical role not only in identifying the child's problems but also in choosing the treatment (Jiang & Johnston, 2010). In a study by Johnston, Seipp, Hommersen, Hoza and Fine (2005), parents of 5-13 year old children with ADHD were surveyed regarding the types of treatments they were using for their children. Johnston et al. (2005) found that 49% of these parents tried vitamin and naturopathic treatments, 52% had attempted diet and supplemental treatments, 29%

had tried individual child psychotherapy and 3% had tried bio-neuro feedback treatment. The parents in this study felt that medication and behavioral management were higher in efficacy than alternative treatments, rating the two evidence based treatments as above average and alternative treatments as below average in effectiveness (Jiang & Johnston, 2010). Despite parents ratings of these treatments they still implemented alternative treatments not supported by research. Treatment adherence is also problematic for both behavioral and medication treatments for ADHD. Ohan and Johnston (2000) found less than optimal rates of adherence even over short intervals.

Johnston, Hommersen, and Seipp (2008) examined the views of mothers regarding acceptability and effectiveness of medication and behavioral treatments for boys with ADHD. Mothers rated behavioral management as more acceptable than medication, despite rating the two treatments as equivalent in effectiveness for hypothetical children and rating medication as more effective for their own children (Johnston et al., 2010). This may suggest that parental views of treatment acceptability are in opposition to their beliefs regarding the effectiveness of the two types of treatment (Jiang & Johnston, 2010). Parent's rate behavior management as more acceptable and they prefer it over medication, however, they rate medication as more effective, this incongruence may explain why parents try other treatments and have trouble committing to one treatment for a certain period of time (Jiang & Johnston, 2010). This problem with treatment adherence calls for greater clinical research attention to the parental cognitions thought to impact treatment utilization (Jiang & Johnston, 2010).

Health Belief Model

Our everyday experiences; teaching in a school, walking through a mall, driving down a city street, remind us that there appear to be many more people in need of mental health service than could possibly be using it. Individuals clearly in need of psychological treatment often fail to recognize their own need and to seek services for it (Smith, 2009).

The Health Belief Model (HBM; Becker, 1974, as cited in Henshaw & Freedman-Doan, 2009) is based in a socio-cognitive perspective and hypothesizes that people are likely to engage in a given health related behavior to the extent that they believe they are susceptible to a given disease or problem, believe that the problem or illness has serious consequences for their life, believe that the intervention will be effective and perceive few barriers to taking action

(Henshaw & Freedman-Doan, 2009). All of these are influenced by demographic variables such as race, age and socio-economic status (Henshaw & Freedman-Doan, 2009). By identifying attitudes that may inhibit appropriate help seeking, mental health service providers can use research findings to develop interventions for addressing maladaptive attitudes or inaccurate beliefs about mental health and its treatment (Henshaw & Freedman-Doan, 2009).

Cultural Factors

Little research has been conducted regarding how individuals of different ethnic backgrounds perceive their mental illnesses (Henshaw & Freedman-Doan, 2009). Health beliefs about mental health problems are providing explanations about why some people seek help and others do not (Ng et al., 2008). Some of these reasons include, self-rating of mental health, stigma, overestimation of coping skills and lack of trust can predispose, enable, or impede the use of services that is not well studied or understood (Ng et al., 2008). Okazaki and Kallivayalil (2002) found that individuals from different ethnic backgrounds view the severity of their illness symptoms differently and that individuals from minority cultures are more influenced by their own culture's norms about mental illness symptoms. Information from health care providers may be more effective and accepted by clients if it is framed in a way that is congruent with individuals attributions about their symptoms (Henshaw & Freedman-Doan, 2009). Providing education about symptoms in a culturally sensitive manner may be necessary (Henshaw & Freedman-Doan, 2009).

A study by Roberts et al., (2005) examined problem recognition across ethnic groups by focusing on parents reports of the mental health problems in adolescents. Comparisons were made between European, African and Latino Americans. European Americans were more likely to rate the mental health of adolescents as fair or poor, were twice as likely to report that adolescents were dissatisfied with their lives and that adolescents had a mental health problem in the past year (Roberts et al., 2005). It was not clear whether there was lower parental recognition because of the different interpretations of mental health problems or because of lower awareness of mental health problems (Roberts et al., 2005). Roberts et al (2005) suggest that interventions to help minority families in the identification of youth mental health problem may need to address cultural differences in the definition of mental health problems.

In a study of health beliefs and help seeking for anxiety and depressive disorders among Urban Singaporean adults, Ng et al., (2008) found that self-rating of mental health was indicative of help seeking behavior. In Singapore's health and social system equitable and affordable services are available to all citizens within a very small area, thus, there are no major structural barriers to mental health service (Ng et al., 2008). In this study poor self-rated mental health was correlated with the presence of a mental health disorder and was a valid indicator of health service use (Ng et al., 2008).

Vicary and Westerman (2004) conducted a qualitative study in which seventy Aboriginal people were interviewed about their beliefs and attitudes towards mental health, western psychology, practitioners and strategies for improving mental health care delivery. The study supported the view that when someone is suffering from some sort of mental illness, treatment is dependent upon the cultural explanation given to the illness (Vicary & Westerman, 2004). The study also found that there were a number of traditional methods to treat mental disorders and if these methods were not successful the individual might then be taken to a western health service (Vicary & Westerman, 2004). Seventy-two percent of respondents indicated that they believed that Aboriginal people did not perceive depression as a state that could be treated but as a characteristic of an individual (Vicary & Westerman, 2004). Participants in the study indicated that western therapy was ineffective with Aboriginal clientele (Vicary & Westerman, 2004). Some of the reasons for this were environmental concerns; uncomfortable with an office setting, non-Aboriginal therapists, not understanding the therapeutic process, not having input in the therapeutic process and poor knowledge and understanding of Aboriginality was considered a barrier by all study participants (Vicary & Westerman, 2004).

There have been few studies examining ethnic differences in reports of mental health problems among youth as reports by parents, although these studies indicate minority parents are less likely to report mental health problems in their adolescents than are the majority groups, direct evidence on this topic is sparse (Roberts et al., 2005).

Although Aboriginal peoples in Canada, Australia and New Zealand comprise extremely diverse cultures, they have faced similar historical predicaments (Kirmayer, Simpson & Cargo, 2003). Counseling in Canada and the United States are based almost entirely on a Western paradigm of health that differs from an Indigenous worldview (Gone, 2004). The differences in perspectives

can form a barrier to effective health promotion services for Native peoples seeking mental health support (Stewart, 2008).

There is a disparity between the Aboriginal and non-Aboriginal conceptions of mental health (Vicary & Westerman, 2004). The need to recognize this difference has long been stated by indigenous people (Vicary & Westerman, 2004). Although there have been many attempts to define Indigenous mental health concepts, the common theme has been that Indigenous mental health needs to consider the holistic nature of health and well-being (Vicary & Westerman, 2004). Treatment options must also reflect the difference in perceptions about mental health, and existing frameworks of healing within Aboriginal communities need to be acknowledged (Vicary & Westerman, 2004). Vicary and Westerman (2004) also suggest that within the assessment process the extent to which the particular mental health issue is symptomatic of the individuals underlying cultural and/or spiritual issues are explored. Often mental health issues manifest themselves spiritually or culturally and therefore can often only be resolved in this manner (Vicary & Westerman, 2004). Differences may exist in the phenomenology of all mental health disorders with Aboriginal people (Vicary & Westerman, 2004).

Stages of Change

Another consideration in parent's attributions and beliefs about their child's behavior are those parents who are referred to mental health services by courts, social workers or teachers and administrators at school. Prochaska and DiClemente (1984) address this issue in their stages of change model. They explain that clients come to therapy in varying degrees of readiness from seeing no need to change, being ambivalent to change, preparing for change and actually making changes (Prochaska & DiClemente, 1984). Each stage requires a different intervention and attempts to move clients from one stage to the next (Henshaw & Freedman-Doan, 2009).

Perceived Barriers

In addition to the understanding of parental attributions and beliefs about child behavior and treatment, studies have also examined attitudes towards perceived barriers to treatment. Jiang and Johnston (2008) conducted a study investigating the types of barriers mothers of 5- to 10-year-old children perceived when implementing the strategies they learned in a single session of Behavioral Parent Training (BPT). Results indicated that the barriers mother perceived were

not the barriers that they actually experienced (Jiang & Johnston, 2008). Mothers anticipated that their own characteristics such as inconsistency would keep them from using the BPT strategies however it was other factors such as a lack of time which they actually experienced as a barrier to implementing the strategies (Jiang & Johnston, 2008).

Problems with service access often results from economic, geographic and cultural factors (Letvak, 2002) however, it is the children and families in Northern rural communities who may face the greatest difficulty in accessing mental health service and support when compared to those in more urban centers. Geographically, rural communities have difficulty attracting trained mental health professionals because of their more isolated locations. When mental health is the focus of research there is little literature documenting the mental health experiences of rural communities and especially families and children in these communities (Fuller, Edwards, Procter & Moss, 2000).

Boydell, Pong, Tilleczek, Wilson and Lemieux (2006) examined issues of access to mental health care for children and families in rural communities. Three thematic areas captured the main barriers to care; personal, systemic and environmental (Boydell et al., 2006). Personal barriers consisted of stigma, due to small community size, families felt that everybody in town knew when mental health service was sought out, they also described a lack of information or awareness of where to get mental health help as well as financial difficulties (Boydell et al., 2006). Families in rural centers often have to travel longer distances to access professional care which involves the cost of missing work to travel, travel expenses, meals and accommodation (Boydell et al., 2006). Systemic barriers identified in this study were a lack of human resources, policy issues such as rigid intake systems and long wait times due to staff shortages (Boydell et al., 2006). Finally, barriers identified in regards to environmental factors were distance; parents had difficulties travelling long distances to see specialists, especially in the winter months where travel was more difficult and dangerous (Boydell et al., 2006).

All of these barriers can leave parents with poor outcome expectations about the use of mental health services for their children (Starr, Campbell & Herrick, 2002). In this study there were also many advantages mentioned by parents to living in a small town and receiving mental health service, such as flexible service, a close-knit feel in the community and the supportiveness of a small community, and more personalized feeling within therapy (Boydell et al., 2006).

Starr et al. (2002) examined parent's expectations in regards to outcomes of mental health treatment, therapeutic relationships and access to service. In this study parents did not see access to service as a barrier, however, this study was conducted in a southern community where there were more likely more professionals willing to work in the area and they were likely in closer proximity to a larger center. Parents did expect that the mental health service provider would not be able to build a relationship with their child and also viewed stigma as a major concern. If parents perceive stigma as well as believing that the mental health service provider will not form a meaningful relationship with their child, parents may be less willing to seek help for their child (Starr et al., 2002).

Summary

The literature review for this study has identified several key concepts regarding parenting children with disruptive behavior disorders: outcomes in adulthood, co-morbidity, risk factors, parent attributions, treatment choice and adherence, cultural factors and perceived barriers. Several studies have demonstrated that early behavioral difficulties often persist into adolescence and early adulthood and influence later development (Ferguson et al., 2005; Bongers et al., 2004; Vitaro et al., 2005; Broidy et al., 2003). Studies have also shown that there is a strong co-morbidity between disruptive behavior disorders including ADHD, Oppositional Defiant Disorder and Conduct Disorder (Wilens et al., 2003).

Studies have demonstrated that secure parent-child attachments are related to healthy coping responses to stress and lessen the probability of developing maladaptive behavior (Jackson et al., 2005). Johnston and colleagues have done extensive research on parental attributions. Johnston and Ohan (2005) refer to a basic social cognitive model that suggests parents attribute certain factors to their child's behavior and as a result react in a certain way. This model also suggests that parents' attitudes and perceptions about their child's behavior is a major influence on their parenting style and the types of treatment decisions they make.

The literature review also concluded that cultural factors are a major influence on how people perceive mental illness and the types of treatments they seek (Vicary & Westerman, 2004; Roberts et al., 2005). There is a strong need to understand the difference in perceptions about mental health and deliver a service to people of various ethnic backgrounds that is directly related to cultural and spiritual beliefs.

In addition to understanding parental attributions and beliefs it is important to understand the perceived barriers to accessing mental health service. Although there is little research documenting mental health experiences in rural communities the literature reviewed here concluded several important issues regarding access to service that are; stigma, not knowing where to get help, distance and travel expenses, and lack of human resources (Boydell et al., 2006; Star et al., 2002).

The studies reviewed in this chapter demonstrate the importance of focusing on how parental cognitions or beliefs about disruptive behavior disorders influence decisions at the initial stages of recognizing child problems and entering mental health services (Jiang & Johnston, 2010). Assessing parent's beliefs about the origin of disruptive behavior, treatment and barriers to treatment provide us with a basis for developing programs to challenge those beliefs. In attending to these beliefs and attributions regarding behavior, perceptions of treatment and barrier producing beliefs, progress can be made in closing the gap between those who would benefit from mental health treatment and those who receive it (Henshaw & Freedman-Doan, 2009).

CHAPTER THREE

Methodology

Qualitative Research Inquiry

The proposed phenomenological study sought to understand the complex and diverse nature of the lived experience of parents raising children with externalizing behavior. I hoped to explore in a relaxed and non-threatening environment, the experiences and perceptions of parents who are raising these children in a small Northern community. Further, to reveal what is true for a group of parents as they authentically described, for themselves, their experience in, perceptions of, and insights into their own parenting practice.

The research questions addressed in this study were: What is the meaning of parenting a child with externalizing behavior in a rural, Northern, isolated community? In this study I described the experiences of parents raising children with externalizing behavior: How they come to understand their child's behavior, what attributions do they made in regards to their child's behavior and their experience with health or counseling services in rural, Northern, isolated communities.

Phenomenology was chosen as the methodology for the present study, with its purpose of examining the lived experience and essence of parenting children with externalizing behavior. Husserl is widely accepted as the founder of phenomenology dating back to the early 1900's (Creswell, 2007). According to Patton (2002), "Edmund Husserl, a philosopher associated with phenomenology, defined it as; the study of how people describe things and experience them through their senses," (p.105). This implies that all of our understanding comes from the sensory experience of phenomenon, but that experience must be described, explicated, and interrupted yet descriptions of experience and interpretations are so intertwined that they often become one (Patton, 2002). There are many branches of phenomenology, the present study will be guided by Moustakas's (1994) transcendental or psychological phenomenology which focus's less on the interpretations of the researcher and more on a description of the experiences of the participants (Creswell, 2007).

Although phenomenologists believe that there are multiple realities, they search for common threads among the different views. Causality and generalizations are not the goal of phenomenology; instead a thorough understanding of the experience is sought (Moustakas,

1994). Overall, phenomenology seeks to elucidate the essence of people's lived experiences and describe them accurately (Moustakas, 1994)). For the purpose of this study the essence of parent's experiences in child rearing was described, more specifically the meaning parents gave to the difficulties their children experienced. Because of the personalized nature of the data being collected, the goal of phenomenological research was not to generalize the results to the entire population, but rather, to develop a richer understanding of individual experiences (Morrissette, 2000).

Phenomenology is an interpretive research approach seeking to uncover meaning, as well as describing lived experience. This approach to the current study allowed me to pursue understanding of meaning and gave me the methodology to uncover a deep and reflective interpretation of the experience of the participants.

Sample

Because qualitative researchers seek to gain a deep understanding of a particular phenomena, purposeful sampling was used. This technique allowed the researcher to choose participants who provided rich, in-depth and detailed information based on their experience with the phenomenon (Creswell, 2007). A purposeful sample was created through selecting participants based on certain criteria relevant for the study. The criterion that needed to be met by participants for the purposes of this study are that they will be the primary parent or guardian of children exhibiting very disruptive externalizing behavior in school, at home or both. Participants were residents of 3 rural Northern communities, able to communicate in English and will be in agreement with participating in the study

The sample consisted of the parents of four families. More specifically, parents of children attending local schools were selected, for practical reasons. Past research has focused mainly on maternal attributions (Johnston & Ohan, 2005), thus, the current study aimed to understand the perceptions and attributions of both parents where possible. As a teacher and the educational psychometrist at the local community School I already have access to students and families who experience very disruptive externalizing behavior. It was of particular interest to access those who have been referred to the school counselor by either the administration or the teacher due to very disruptive behavior happening within the school and those parents who are not currently seeking professional help for their children. This gave me the opportunity to

understand what meaning they make of their child's behavior and whether they perceive there to be barriers to service within the community.

Role of the Researcher

There are several important issues in regard to qualitative research and the researcher's role that need to be addressed (Subchyshyn, 2002). These issues include: the role of the researcher as the research instrument, the researcher/interviewer role, and the role of the researcher as a learner (Subchyshyn, 2002). Because the primary research instrument in qualitative research is human, all observations and analyses are filtered through human being's worldview, values and perspective." (Merriam, 1998, p.22). In phenomenological research the interview is the primary method of data collection wherein the researcher attempts to uncover the essence and structure of the meaning of experience (Merriam, 2002).

Moustakas (1994) focuses on one of Husserl's concepts, epoche (or bracketing), in which the researcher sets aside their own experiences in order to take a fresh perspective toward the phenomenon (Creswell, 2007). van Manen (1994) stated that by knowing too much as opposed to too little about a phenomena we wish to investigate may be a problem as our "common sense" pre-understandings and assumptions predispose us to interpret the nature of the phenomenon before we "come to grips with the significance of the phenomenological question." Van Manen (1990) explained that scientific knowledge and everyday knowledge already have a lot to say about a phenomenon such as what parenting is or what parents should or shouldn't do before actually understanding what it means to be a parent in the first place. We should try to suspend these beliefs and try to come to terms with our assumptions not to forget them but to hold them aside and expose its shallow character (van Manen, 1990). For the present study, the use of a reflexive journal throughout the research process ensured that I was able to bracket my knowledge and assumptions, and to revisit the phenomena freshly in a wide open sense, in order to keep any biases from interfering with the trustworthiness of the research.

The researcher must remain aware of their role of researcher throughout the interview process. Throughout the interview the researcher is managing many tasks (Berg, 2001). A researcher must remember to utilize previously scripted questions, track responses to those questions, remain aware of any non-verbal messages transmitted by the participant and maintain a relaxed empathic environment (Berg, 2001).

The last role of the researcher is that of the learner, the researcher must remain interested in learning from, and with, the participants (Glesne & Peshkin, 1992). When the learner role is not accepted the researcher is in danger of taking on an expert role which can alienate the participant and compromise the data collected (Glesne & Peshkin, 1992). Throughout this study I attempted to remain aware of the concepts above, understanding the various roles of a researcher helped to ensure the quality of data collection and analyses.

Data Collection

The preliminary contact consisted of sending a letter explaining the study to those parents who have children attending school who are displaying very difficult externalizing behavior at home, school or both (see Appendix C). In-depth, phenomenologically based interviews were the methods used in this study (Seidman, 1998). This method combines life-history interviewing and focused, in-depth interviewing (Seidman, 1998). In this approach interviewers use, primarily open-ended questions and to build upon and explore the participants responses to those questions (Seidman, 1998). A series of three separate interviews were conducted with each participant (Seidman, 1998). The first interview established the context of the participants' experience, the second allowed the participant to reconstruct their experience and in the third the participant reflected on the meaning of their experience (Seidman, 1998). Each interview provided a foundation of detail that illuminated the next (Seidman, 1998). Subsequent contact involved setting up the second and third in-person interviews with each of the participants. The interviews were audio taped and transcripts were reviewed in order to identify and chunk the data into themes.

Interviewing allowed me to enter the participant's world and gain an understanding of their view. Open-ended questions (see Appendix B) worked best because they allowed for richness of information and for new questions based on the participant's answer. Each interview was held in a place of the participant's choosing and one that was comfortable for them; this included space offered at my office at the local school. Interviews were conducted with both parents where possible to gain a better prospective on the parenting experience as a whole, within the family.

Along with interviews, field notes were used during the audio taped interview, these notes included what I saw, felt and thought during the course of the interview. Some information

described could be about the setting of the interview and details about the participant. Looking back on the field notes enabled me to reflect on my own behavior and thoughts during the interview, as well as the participant's behavior.

At the interview, participants were provided with information about the research, ensured confidentiality and were asked to sign a consent form (see Appendix A). The consent form outlined a statement of the study's purpose and objectives and that they had consented to participate. Participants were also informed about the voluntary nature of participation and promised confidentiality. Participants were encouraged to ask any questions or voice any concerns they have.

Explication of the Data

Hycner explains that explication implies an "investigation of the constituents of a phenomenon while keeping the context of the whole," whereas data analysis usually means "breaking apart," which has dangerous connotations for phenomenology (1999, p.161). The present study incorporated Hycner's explication process with a version of Moustakas' transcendental of psychological phenomenology which have many similarities. Both processes bracket the researcher's beliefs and assumptions, delineate units of meaning, cluster these units of meaning to form themes, and from that, write a composite description which highlights the essence of the participant's experience. This process of explicating the data is described in more detail below.

Following the signing of consent forms, parents' experiences were explored using semi-structured in-depth interviews. Data was organized and collected from transcripts which were listened to and then transcribed. A list of significant statements were developed from the transcripts and grouped into larger units of information called "meaning units" or themes (Creswell, 2007). With the list of non-redundant units of meaning the researcher must continue to bracket any assumptions in order to remain true to the phenomenon (Groenewald, 2004). Groenewald, (2004), states that by rigorously examining these units of meaning the researcher will try to elicit the essence of meaning units within the holistic context.

Clusters of themes are typically formed by grouping units of meaning together (Creswell, 1998; Moustakas, 1994). Moustakas (1994) described writing a description of "what" the participants experience with the phenomenon, this is the textural description. Next, a structural

description was written about how the experience happened, reflecting on the setting and context in which the phenomenon was experienced (Creswell, 2007). Finally, a composite description of the phenomenon was written, this is the essence of the experience and represents the culminating aspect of the phenomenological study (Creswell, 2007).

Validity and Trustworthiness

All research has standards through which it is evaluated. In qualitative research we do not have the luxury of falling back on statistical numbers and significant levels, we have to look for meaning in the data and for its repetition and redundancy across cases (Worthen, as cited in Merriam & Associates, 2002). Validation is the attempt to assess the “accuracy” of the findings, as best described by the researcher and the participants (Creswell, 2007). Validity will be demonstrated by showing that data was collected in a thorough and authentic manner, the analysis was rigorous and alternate or competing meanings can be explained (Worthen, as cited in Merriam & Associates, 2002). Polkinghorne (1989) discusses whether the findings of a study are “valid,” validation refers to the notion that an idea is well grounded and well supported.

Polkinghorne (1989) identified five questions that researchers might ask themselves to ensure validity and trustworthiness in a study. These questions, which were incorporated into the current study, they are; first, did the researcher influence the contents of the participants’ descriptions in a way that the descriptions do not truly reflect the participants’ actual experience. Second is the transcription accurate and does it convey meaning? Third, in the analysis of the transcripts are there conclusions other than those identified by the researcher that could have been derived? Fourth, is it possible to go from the general structural description to the transcripts and to account for the specific contents and connections in the original examples of the experience? Fifth, is the structural description situation specific, or does it hold general for the experience in other situations? (Polkinhorne,1989).

A common strategy for ensuring validity in qualitative research are member checks (Merriam, 2002). Member checks were used throughout the course of this research. Here the researcher takes the written transcripts back to the participants in order to assure that the transcription authentically represented what the participant described in their interview. Saturation was reached once the researcher begins to hear the same information over and over

and no new information had surfaced (Merriam, 2002). Field notes were utilized to record thoughts and feelings that arise during the research. These notes can provide the researcher with a way of checking on personal biases (Merriam, 2002).

Ethical Considerations

Ethical Approval of the Study

This study was designed in accordance to the ethical guidelines developed by the University of Saskatchewan Advisory Committee on Ethics and Behavioral Science Research. Prior to approaching potential participants the study was approved by the thesis committee (see Appendix D and Appendix E).

Consent

Prior to setting up in-person interviews participants consented to be involved in the study by responding to a letter explaining the study. Upon meeting, the study was reviewed and I ensured that the participants were able to make an informed decision about participating in the study.

Confidentiality

Confidentiality was ensured by using pseudo names for all participants in order to keep their personal information private. Private interviews were conducted within small and private space of the participants choosing. All field notes, transcripts, tapes and data analysis were kept in a locked file cabinet.

Feedback and Debriefing

Follow-up interviews were held in the case that the participant or the researcher had further questions or needed clarification on any topics mentioned. Participants were encouraged to ask questions for clarification throughout the interview. Participants were also provided with a copy of their transcript for review (see Appendix F and Appendix G); also upon completion participants were provided with a copy of the research at their request, and an opportunity to meet with myself to discuss the findings.

CHAPTER 4

Results

Introduction to the Four Participants

An introduction to the participants consists of descriptions of their personal experiences. Participants have been given a pseudonym in order to protect their privacy and ensure confidentiality. These descriptions will enable the reader to become acquainted with each of the participants and their stories.

Wanda

Personal History

Wanda is a quiet and reserved young woman who grew up in the city with her mother. Wanda did not get along with her stepdad, feeling that he favored his own children over her. After the marriage of her mother and stepfather, Wanda moved in with her grandmother. She didn't have a relationship with her biological father until the age of 16. While living with her grandmother, Wanda had little contact with her mother. She recalls her experience:

I never knew my real dad, we ended up moving around a lot. I never really got along with my stepdad: he had his favorites he liked his own kids and he picked on us, me and my sister. It was difficult: I hated living with him so I moved out. During grade 9 to 12, I moved with my grandma. I only talked to my mom once a year.

Wanda felt that her stepfather had stronger feelings for his own children making it difficult to feel accepted.

Becoming a Parent

Wanda had her daughter at a young age. She admitted to often drinking on weekends and becoming pregnant at the age of 17. Her stepfather suggested an abortion but she refused. After becoming pregnant, Wanda moved out on her own. Pregnancy was a frightening experience: she describes feeling distressed, crying and worrying, having little prior experience with children. Eventually becoming more comfortable with motherhood, she was happy raising her new daughter. The relationship between Wanda and the baby's father lasted several years following

the child's birth but eventually failed, leading to Wanda having two more children with her current boyfriend. Wanda's daughter does not have a relationship with her father to this day.

Externalizing behavior and parenting response.

Wanda is parenting her daughter Michelle, with her fiancé Stan who is Michelle's stepfather. When Wanda refuses a particular demand from Michelle, going out with friends, material possessions or a bus ticket to visit her grandmother Michelle's externalizing behavior is triggered. Wanda describes:

At home if I don't do what she wants then she gets mad. It started when she became a teen and she has her attitude, she has anger problems. If she doesn't get her own way then she will get mad, she'll swear and get lippy. I try to say no but she bosses her way. It's mainly her attitude, in school and at home, she just always wants her own way.

The behavior is happening at school as well. She explained that Michelle's behavior occurs "whenever she wants something." Wanda stated that "she gives attitude, tells her teacher off, swears and screams." Wanda receives calls weekly from the school, and is frustrated having to meet with principals as well as the school board.

Wanda described a difficult experience with parenting due to the differences in hers and her fiancé Stan's discipline style. Stan is the disciplinarian and Wanda feels that he treats her daughter differently than he treats their children together:

I think my husband treats her differently 'cause she is not his real daughter. Now that she is a teen and she has her attitude, he is quick to say, "I don't want you living here." If it were his kids it would be a different story.

Wanda describes her own parenting as "easy going," and "letting [Michelle] get away with everything and spoiling her." Wanda admitted that she didn't discipline her daughter sufficiently and felt that she was too "easy going," providing her with "too much freedom." Wanda stated that she needs to find a way to discipline her daughter consistently but admitted having difficulty and eventually "giving in" because it was easier. Although Wanda is uncomfortable with her husband treating her daughter differently, she explained that when he is present Michelle listens to him. Wanda often feels like "hiding behind him" and letting him manage her behavior. Being her first child, Wanda explains spoiling her daughter and "letting her get away a lot." She wonders if this is part of the reason Michelle has an attitude, having less discipline than the later children. Wanda's boyfriend Stan had a good relationship with Michelle

as a young girl but as Michelle became older and exhibited more difficult and defiant behavior, this relationship has become strained. Wanda feels that he now treats Michelle differently, that he is mean to her and treats her worse than his own children.

Recently, Michelle wanted to visit her grandmother out of town. When Wanda refused to purchase a bus ticket, Michelle became angry with her mother, continually arguing until Wanda succumbed to her daughter's demands. Michelle becomes very upset, yelling and swearing when her demands are not met. Wanda feels helpless and frustrated in these situations, ultimately giving in to Michelle to avoid the constant arguments. Wanda worries that if she continues to let Michelle have power over her the other children will start to act in the same manner.

Emotions

Wanda has experienced a range of emotions in regards to her daughter's behavior. She explained feeling angry and upset and wanting to hide from her own daughter. She has attempted to explain her feelings to Michelle but this goes unheard. Wanda has also described feeling like she wanted to let her fiancé do the parenting at times. She explained feeling hopeless, frustrated and very sad in regards to her daughter's behavior. She explained a desire to "just give up and send her to live with her grandmother," because she wasn't sure what else to do.

Family Stress

Wanda's partner is the stepfather to her daughter and she has expressed that their fiancé treats her daughter unfairly and is stricter than herself. Wanda and Stan often disagree on how to manage Michelle's difficult behavior. This leads to many arguments and stress in her relationship with Stan, upsetting the harmony in the entire family. Wanda is concerned about the stress on the other children; she worries her younger children will start behaving like Michelle. She sees this behavior beginning and worries it will extend to the children as she fears they may act out to receive the same attention as Michelle. Wanda described arguments with Stan because she felt he does not treat Michelle fairly. Having had a stepfather growing up, Wanda is very familiar with the pain this can cause a young girl.

Making sense of it all

Wanda believes that her daughter's behavior was due mainly to an environmental factor, specifically wanting to live in the city with her grandmother rather than in a small town. She also wondered whether the home was too small for the children and Michelle was acting out because she felt there was a lack of space in the home. Wanda admitted that she may have given her daughter too much freedom and may not have been as consistent with discipline as she should have in the past.

Barriers

Wanda has found several counselors in the community who were willing to help and Wanda had confidence that this would benefit not only her daughter but would lessen the stress on her family as well. She feels there are many options for service for her daughter in the community and was satisfied by the welcoming response she received when she sought out counseling for Michelle. Wanda preferred services that offered Aboriginal counselors she already had a relationship with and whom she felt would understand her circumstance. Further, she described a feeling of comfort with the services offered by the Indian and Metis Friendship Center in the community which offered counseling services she felt would be most relatable to her daughter. She also expressed feeling a closer connection with the workers, having known some of them personally. Overall Wanda did not meet any barriers when seeking out service for her daughter. However, when the appointments were set up, Michelle refused to attend them, frustrating Wanda further.

Treatment beliefs

Wanda has attempted to get counseling for Michelle in the community through various sources outside the school, however, Michelle refuses to talk to anyone. Wanda truly believes that one on one counseling and therapy for Michelle would be beneficial and will help Michelle learn to control her behavior. She stated that therapy is more acceptable than medication and saw medication as effective but would choose it as a last option after nothing else worked.

Leah

Personal History

Leah is a caring mother who advocates for her children. Growing up in the city with her mother and abusive stepfather until the age of 13, she began to rebel against them and was later placed into foster care. Leah has always questioned why she was placed into care and wishes her mother would have tried to understand her behavior as a teen. Leah was eventually placed in many homes over the years. She shared:

He was very abusive, my stepfather. I went through a lot of hitting and I believe that's why I got put into foster care. I just rebelled, I went against it all, she got fed up and chose him over me. I know she loved me but she would always choose the man; she was afraid to be alone. It was very hard, I always felt like the black sheep, I was in one home for awhile and then in another one and then I went back home and back into foster care again until I was 17. I knew they didn't care for me; they didn't love me like their own. I always questioned why my mom was giving me up, why she didn't just get me the help I needed, why didn't she push it and find out why I was doing what I was doing?

After a brief period of dating in tenth grade, Leah met the father of her sons, became pregnant and moved out on her own. Later at age 19, Leah's second child Drew was born. Leah never felt supported by their father. The relationship lasted several years and when it ended he continued to deny Drew was his son despite DNA tests proving otherwise.

Becoming a Parent

From the beginning Leah has loved being a parent. She was excited when she became pregnant with her first son, feeling that it was going to change her life positively. Leah's boyfriend's parents tried to convince her to have an abortion with her second pregnancy, making the situation more difficult. Leah has enjoyed raising the boys and describes them as very helpful. There is a genuine sense of accomplishment and pride when she talks about raising the children. When Leah became pregnant the second time the experience was different; she was almost forced to get an abortion although she refused. The baby's father not only abandoned the child but also denied that Drew was his. Leah describes her son's father as never following through with promises and states that the boys have given up on him, and consider their stepfather to be their only father now.

Externalizing Behavior and Parenting Response

Leah met her fiancé eight years ago. The boys were reluctant to accept him in the beginning, however, they now consider him to be their dad and go to him to discuss feelings about their biological father. Leah describes her parenting style as passive, resulting from negative experiences with physical punishment as a child, therefore, she doesn't believe in spanking her sons. Leah describes her fiancé as the disciplinarian and states that they often disagree on parenting decisions, causing disagreements and stress within the family and in their relationship.

It was when Leah was living in Vancouver with her family that she first became concerned with Drew's behavior. At daycare he threw over a coffee table, kicked over a garbage can and ran away. She immediately asked the school about his behavior. It was recommended that Drew be assessed by a physician. He was quickly diagnosed with ADHD and prescribed medication. Leah discontinued the medications after feeling that he was having difficulty with the pills and they were making him sick. Later, the family moved to a small northern Saskatchewan community and Drew's behavior became increasingly difficult at school. Leah received a call from the school every other day as Drew was walking out of class, throwing his papers and kicking the teacher. Leah recalls:

[I was] getting called every day by the school 'cause he was walking out of class, ripping up his papers and kicking a teacher. I was having similar behavior at home. He didn't like the word NO, you would look at him and you just knew he was going to rebel, there was no way of bringing him down when he got angry, you had to let him destroy your house or whatever.

Admitting that both Len and herself have different discipline styles, Leah stated that her son will attempt to manipulate them. Realizing that Drew's behavior would escalate and become difficult to manage when he received an undesired response, Leah and Len would eventually succumb, avoiding this difficult behavior. Drew's behavior has isolated Leah from her friends as she is afraid to take him out in public. It has also caused increased stress on her relationship. Leah feels that Len is too strict with her sons. When Leah does not submit to Drew's demands, he reacts with externalizing behavior.

Emotions

Leah has described feelings of frustration, fear and worry when it comes to her son's behavior. She explained entering the school crying and asking for help, feeling helpless and

scared that he might harm himself, she felt that she was out of control. Leah also felt like her relationship has been in jeopardy when her and Len disagree on how to deal with misbehaviour. Leah is often torn about whether to discipline her son in the same manner as Len would prefer or to provide him with love and affection.

Family Stress

Leah described the difficulty she has had in her relationship due to her and Len's differing parenting styles. Leah is a very passive parent and has described herself giving in to her son's demands in order to avoid fighting, embarrassment and stress. Leah's fiancé Len is a disciplinarian but being the stepfather it is difficult for Leah to allow him to discipline her sons. Leah describes some of the stress this has placed on their relationship:

It has definitely caused fights between me and Len, where he will say, "Well then you can be the only one to discipline them, I won't do anything." I don't want to be the only one; I just think that he is too hard on them, I believe he is a lot harder on them than he needs to be. It causes a lot of stress on us too; we fight a lot about it.

Leah stated that before they knew what was wrong, Len was distancing himself. She felt he wanted to solve the problem himself and this caused a lot of fighting between them. Leah has experienced stress in her relationship where her partner feels the need to give up and let her parent the boys on her own due to their differences. Leah has also broken off her relationship at times when things became too difficult.

Making Sense of it All

Asked about her beliefs in regards to Drew's behavior Leah was in a somewhat different situation having had her son assessed and already diagnosed with ADHD. She recalled:

In the very beginning I honestly had no idea why he acted this way, I couldn't believe it was happening to my family. I was ready to take him to another city to get a diagnosis 'cause I knew there would be a wait list here. I was told to go to mental health or social services but I didn't want to do that 'cause I had bad experiences with them as a child. I thought they would think I was the one making him that way. I believed the doctor's diagnosis and put him on his medications. At first I didn't like it so I took him off them, now I put him on another kind and he is so much better.

Leah admitted to having problems with attention deficit and learning difficulties as a child, throughout her school years. Having struggled with these issues herself, Leah recognized the

symptoms in Drew and agreed with the diagnosis of ADHD. Leah attributes Drew's behavior to factors that are internal to his personality and perhaps genetics. Leah has been very open to assessments and treatments and is happy with the results. She believes that Drew's externalizing behavior is a symptom of ADHD. Due to the continued difficult behavior in school after the family moved, Leah eventually found a medication that she was comfortable giving to her son. His behavior has improved significantly both at home and at school as a result.

Barriers

Leah has been pleased with the services she has received from the school. She did not have to go out of the community in order to have her son assessed and prescribed medications. Her son has also received counseling services from the school which did not prove helpful because he was not willing to talk with a counselor. However, she was impressed that the service was offered. Leah has not felt comfortable accessing services from mental health or social services. She felt they might think she was to blame for her child's behavior and she has had difficult personal experiences with them while she was growing up.

Treatment beliefs

Leah feels that counseling can be helpful for children initially however she is open to the option of medication treatment as a last resort. Leah did not believe in using medications to control behavior in the past, however, she now views it as the most effective. Her son is currently being medicated for his behavior and it has made a tremendous difference in her and her family's life.

Jeanette

Personal History

Jeanette is an Aboriginal woman who grew up in a small northern Saskatchewan community with her 11 siblings until the age of six when her father passed away. Subsequently, Jeanette attended residential school in Prince Albert from grades 2 through 10. Initially the residential school experience was positive, but later on abuse led to Jeanette dropping out of school. She reveals her experiences with abuse:

I went to residential school when I was 10, I was abused later on when I was in school. I'm going through an abuse claim now, it was terrible. I started not listening after that and running away, I started to rebel. I was pretty much kicked out when I was 15.

Jeanette rebelled, running around and not coming home at night. During this period, Jeanette's mother was having problems with alcohol that lasted several years. Coming home from school on holidays Jeanette remembers her mother often drinking and having parties. Jeanette never did return to school. She does not feel that the experiences in her past have traumatized her.

Becoming a Parent

Jeanette feels fortunate to have had the support of her mother whom she has lived with most of her life. Jeanette became pregnant with her first son at age 21, with her former boyfriend. Jeanette went on to have three more sons with two more fathers. She has enjoyed raising her sons with her mother and found it to be "quite easy." She describes her relationship with Alex's father:

We have never lived together but we are together on and off; we have our rough patches. I found it easy raising the boys, I got a lot of help from my mom. They were all good babies, parenting got easier, they were easy to take care of.

Although Jeanette has one son in a group home and another living with his grandmother, she perceives the experience of raising her boys to be an easy and positive one.

At the age of 27, Jeanette became pregnant with her youngest son, Alex, 8 months into her relationship with his father. Continuing to live at home and receive support from her mother after the birth of Alex, Jeanette says that parenting has become easier over time. She describes a very positive approach to parenting, rewarding the children for good behavior, telling them that she loves them daily and reporting that she feels very close to all her children. Jeanette explains that her only struggle as a parent has been financial, as the four growing boys have put financial pressure on the family.

Externalizing Behavior and Parenting Response.

Jeanette has four boys, with the youngest two currently living at home. The oldest son lives in a group home in the city; her second son resides with his paternal grandmother. Jeanette

is co-parenting her youngest son Alex with her 79 year old mother. Having raised her sons together, Jeanette and her mother haven't always agreed on the way they disciplined the boys. Jeanette does not feel that either were more strict or passive in their discipline styles, however, she stated that they do disagree at times. Recognizing that Alex often tries to manipulate them, Jeanette and her mother communicate so they continue to be well informed. Alex's father, who resides in a separate community, does not make regular parenting decisions. Jeanette does not believe that Alex's behavior has had an effect on her relationship with his father, explaining that they work together and have a good relationship when it comes to parenting Alex.

Jeanette expressed that she did not have difficulty with her son's behavior at home, and that the behavior was only a recent problem, isolated to the school environment. When Alex was in Grade 2, Jeanette noticed that his behavior had changed. He had trouble concentrating, a short attention span and very aggressive behavior in school. When Alex became aggressive with peers, expressed violence by throwing furniture and was verbally abusive towards teachers, he was asked to be evaluated by a doctor before returning to school. Jeanette describes Alex's behavior: He did good in kindergarten and in grade 1, he just didn't want to do what the other kids were doing, studying and reading. He'd be fiddling around, he couldn't concentrate, had no attention span, then they sent him home and told us we had to get him to see a doctor. He was throwing chairs, knocking things down and swearing. He said he hated his teacher.

Alex was diagnosed with ADHD and began medication upon consultation with a physician in Prince Albert. A subsequent reaction to the medication made Jeanette uncomfortable and she discontinued use. Jeanette also does not agree with the diagnosis of ADHD as she does not observe this type of behavior at home. Jeanette believes her son is a normal young boy; she clearly does not share the same beliefs about her son as the school does. She admits that he has freedom, staying up as late as he wants and sleeping in late in the morning, however she feels this is normal.

Emotions

Jeanette did not express any emotions when it came to her son's behavior. She felt that it was an issue only in the school and that her son was a regular child. Having these beliefs seems to have enabled her to remain stress free when it comes to her son's behavior.

Family Stress

Jeanette stated that she and her mother argue at times about how to parent Alex, however, they speak to each other and usually agree on how to deal with difficult behavior. Jeanette is not parenting her son with his father as an equal partner in the everyday parenting, her mother is her co-parent and she does not feel that Alex's behavior has had an impact on their relationship in anyway.

Making Sense of it All

Jeanette describes her son as "normal and well adjusted." She stated that he may act out in school because he is frustrated by little space within the house, has a lack of patience, is unable to release his emotions, has trouble expressing his emotions and is bullied by others due to his mixed heritage. Jeanette does not believe that Alex has ADHD; she acknowledges that he has a lot of energy but states that when he wants to focus he can, and he simply lacks sleep. Jeanette also described that Alex can become impatient when his demands are not immediately met.

Barriers

Residing on a reservation outside of the community, Jeanette stated that she did not have transportation to access services and, even if she did, she was unaware of any services that would help her son. Alex was seeing a counselor at the school but Jeanette felt that beyond that there wasn't a lot of help in the community. Jeanette reported lower income and therefore found it difficult to travel longer distance to receive services. She had difficulty getting to Prince Albert for Alex's consultation with a physician but overall she does not feel that Alex requires additional support. Jeanette enjoys living on the Reservation and indicated that she rarely had to worry about her son because everyone knew the children and "kept an eye on them." She felt most comfortable accessing the limited services available to her there, stating that Alex could benefit from the summer camps offered by the band office on the reserve.

Treatment Beliefs

Jeanette feels that counseling would be a best option for a child with externalizing behavior. She also stated that although her son was not in need of any services, if he did, she

would be comfortable having him speak with a counselor preferably on the reserve and that medication would be a last option if counseling was not successful.

Dean and Lori

Personal History

Dean and Lori came to the interview together and it was clear that Dean was very interested and passionate about discussing his daughter's behavior. Lori was quiet throughout our interview, but voiced her opinion when she had the opportunity. Both Dean and Lori grew up in a small northern community. Lori was raised by her mother and stepfather and has two siblings. Her parents divorced when she was 23 and she describes difficult experiences with bullying in school. Having no relationship with her biological father, Lori often questioned whether she was treated fairly by her stepfather, who was the biological father of her two siblings. Lori moved in with Dean when she was 15 years old and became pregnant at age 16.

Dean is a middle child who was raised by his mother and his abusive father in a small town. Dean described some very traumatic incidences throughout his childhood, such as getting beaten to the point of bleeding and having bruises all over his body. He moved in with his grandparents for periods of time to escape his father's abuse. Dean often had violent fights with his brothers. He recalls, at one point, having his teeth punched through his lip. Dean describes an abusive upbringing:

I remember going to swim class and they found bruises from my shoulders to my knees. I lived with my grandparents after that. My dad was angry. He wasn't around a good chunk; when he got home it was like he was making up for the three months that he wasn't there and he would beat me. My father was the kind of man that you did something wrong you got a spank, you flinched, its two more. If I was talking to my brother at 11 o'clock, and I'm supposed to be in bed at 10 o'clock, he'll give me the strap with the belt. It literally made me bleed when I got spanked with it. I mean I literally got the shit whipped out of me, I cried I'd get another, 2 more for flinching.

Dean recalls on occasion being beaten 30 to 40 times a night. He also was moved into his grandparents' home and had several parental figures throughout his childhood, including his parents and grandparents.

Becoming a Parent

Dean and Lori met at a party and six months into the relationship she became pregnant. Shortly after the birth of their first son, Lori became pregnant again. They were able to continue socializing with friends because they had the support of Lori's parents who would often look after the children. Lori says she was happy when she first became a mom, reporting that the children were happy, reaching all their milestones at the appropriate times. When their second child was two they became pregnant again with Lynn, their first daughter. Becoming a parent was an overall happy experience for Lori:

We got our first apartment when I was 15, I found out I was pregnant about six months into the relationship. I was happy to be a new parent, my dad took it well also. What else can you do but deal with it?

From the beginning, parenting was different with Lynn because she was the girl, and she was the baby. Dean describes successfully managing his sons' behavior with physical punishment; Lori would not allow him to punish Lynn in this way. Dean questioned whether her behavior would be improved if he had parented her similarly to the boys.

Externalizing Behavior and Parenting Response

Lynn has had problems attending school from an early age, however, Dean and Lori have difficulty identifying when Lynn's behavior started to become unmanageable. Having a challenging experience with a teacher in grade 3, Lynn changed schools within the community, which separated her from her peer group. Transitioning into the new school she was bullied relentlessly, and her attendance started to deteriorate, attending a few days a week and later only a few days a month. Dean and Lori were not equipped to deal with the bullying and the issues with attendance, as they felt unsupported by the teachers and administration. Dean and Lori were informed by the principal that he was going to contact Child and Family Services regarding Lynn's attendance, therefore, they initiated contact on their own for the support they needed.

Not only are Dean and Lori experiencing a struggle at school with Lynn's behavior, there is a tremendous amount of difficulty at home as well. Lynn's behavior escalates starting with screaming, then arguing and finally becoming violent, until Dean and Lori give in to her demands. Lynn's behavior causes tremendous stress on the family. Dean has a chronic heart condition, and explains he doesn't have long to live. Dean and Lori together described a very

intense and stressful experience with their daughter Lynn's behavior and their inconsistent parenting styles. What stood out for them were the two extremes in which they parent their child, causing stress on the family unit as well on their relationship. Being the disciplinarian, Dean tries to set rules, boundaries and consequences for Lynn's behavior, Lori described herself as a passive parent, having a difficult time staying consistent with discipline. Staying home full time, Lori feels this is more challenging as she has to deal with her daughter's arguments and temper tantrums. Lori admitted that it is often easier to give in to the demands and avoid the stress. Although Dean describes frustration with his wife's parenting style, he also admitted that if possessions were taken away, Lynn would be left with "nothing to do" and would be in their "hair all friggin' day."

Dean and Lori both admit that their opposing parenting styles can lead to Lynn receiving inconsistent messages regarding the appropriateness of her behavior. Lynn's externalizing behavior may be triggered by this inconsistency as well as her parents' refusal of her demands for material objects such a new pair of shoes or a pet mouse. According to Dean:

I give her consequences for continued bad behavior; her mom just ignores her. We have different parenting styles. My wife needs to realize that what she does is causing damage. She will say to me, "Your at work so you don't have to deal with her." My wife always gives in, she needs to hold tight and say NO. [Lynn] knows that you're always going to give in; she doesn't have to deliver on anything because she knows the second I go to work you're going to undo anything I have done. At home she gets anything she wants. She wanted this mouse and she said she would look after it and clean it but we told her no. She came home with it anyways, she wasn't doing anything to take care of it. She asked if I would by her the bedding for the mouse and she would pay me back, so I ended up having to get the bedding, and do you think she paid me back? NO. I ended up taking her allowance away to pay for the mouse bedding and her mother gave her back the money! [Lynn] doesn't care, she disrespects us. If she doesn't get her own way we have to deal with her screaming and arguing and wrecking our house all day.

Dean shared that he felt disrespected by his daughter when she becomes violent, destroys their property and yells or swears at them. Although Dean has a heart condition he believes his daughter would not care if the stress at home resulted in him being admitted to the hospital. He recalls a time where he informed Lynn of his chest pains, stating that she was not concerned if he "went to the hospital and died." Dean described feeling unloved by his daughter; the stress that this puts on both the relationship and on the family was very evident. Dean expressed that if his wife continues to give in to her they are never going to get out of the cycle they are in.

Emotions

Dean describes becoming so angry at times that he wanted to become physical and hit his daughter. He also describes feeling unappreciated, uncared for and disrespected when she fails to thank him and swears at him regularly. Dean has experienced a range of emotions that have begun to have an effect on his failing health. It was evident in the interview that this was impacting his wife Lori as well; she became tearful when he spoke of his heart condition and the effects his daughter's behavior has on him. Both Dean and Lori expressed feeling helpless and frustrated; they also described feelings of hopelessness and anger.

Family Stress

When it came to discussing Dean's and his wife's different parenting styles, the most frustration was elicited. During the interview, when Dean spoke about his and Lori's parenting differences, he became very angry. This anger was clearly directed towards his wife. He pointed at her, raised his voice and expressed his irritation with her passive parenting style. Lori remained very quiet throughout. This suggested that perhaps Dean was not only frustrated with his daughter's behavior but also felt a sense of helplessness, frustration and anger towards his wife for giving in to their daughter's demands.

Dean and Lori describe a positive relationship most of the time, however, when they discuss managing their daughter's behavior the relationship becomes more difficult. Dean also has health problems and struggles to deal with the stress that this puts on his physical well-being. He and his wife are very emotional about the impact Lynn's behavior has on Dean's health. Dean did not go into the details of the relationship but, from his voice and behavior in the interview, this was a subject he was very passionate about. Dean loves his daughter and is struggling with how to bring some peace into the home. Dean and Lori have spoken about their other children not receiving equal attention due to demands Lynn puts on their time and energy. Dean and Lori also indicated that their other children don't like their daughter which adds stress to the dynamic of the family as a whole. Dean stated:

She makes us feel like we are going crazy and our other kids hate her. It is stressful because the other kids don't get along with her and it has an impact on our relationship with our other children. Our focus is always on her, the others get left out and they shouldn't, but that's just the

way it is. My wife and I argue when we talk about her because [Lori] always gives in and it drives me crazy; things are never going to get better.

Making Sense of it All

Dean and Lori both believe that the problems with Lynn's behavior lie within Lynn and are due to her personality. Dean believes that Lynn has an underlying psychological issue or a low emotional quotient (EQ). He describes this EQ as being her inability to understand and control her own emotions and deal with stress. An emotional intelligence quotient is said to be the study of social behavior and relationships, and the ability to identify, assess, and control one's emotions (Harms, P.D. & Crede, M. 2010). Dean described:

She has an underlying psychological issue or at the very least a very low EQ and a very difficult time dealing with stress. Every time we figure we are getting through to her something happens to us and it gets worse; its one step forward, two steps back. We can't make any headway; the problem lies somewhere within Lynn. At some point she learned some extremely bad tools for dealing with stress; she needs to be taught how to deal with stress. She doesn't draw results, consequences and actions; there is something blocking her from believing that her actions have consequences period.

The above comments illustrate Dean's belief that Lynn cannot understand how her behavior will result in unwanted consequences. He believes that Lynn continues to act out despite the stress it places on her and the family. Although Dean states this behavior is due to her difficulty responding to stress, his wife Lori explained that the behavior is due to adolescence, growing up, and trying to find out who she is.

Barriers

Dean and Lori were referred to the Mental Health by the school so that Lynn and the family could work on her behavior. Dean was angry that the school would refer them to Mental Health stating that [the school], "couldn't handle it themselves." Dean was contacted by Mental Health and asked to fill out the intake form which he felt was much too long, intrusive and time consuming; therefore, it never was completed. Dean states:

There was a huge intake form that I thought was too much; I never got around to filling it out. They wanted me to write down more information then you are asking us here; it was ridiculous. With social services I am so frustrated they constantly make promises and never follow through. They tell us they are going to put her in a program, oh, the program got cancelled. She was going

to get a big sister, never happened, she was going to get respite, it never happened. Then they tell us to do things with our daughter that doesn't make any sense, like give her rewards when she throws a fit; why would I do that?

Dean illustrated several examples of how his family has been let down by the educational, Social Service and Health systems. He feels that the school has supported Lynn's bully, whereas, Lynn has no rights. He also described several incidences where he was promised services such as respite and a big sister program which never materialized leaving the family with no support. His perception of barriers - such as lengthy intake processes, empty promises, and an inadequate education system - leave him with a clear sense of hopelessness. Dean and Lori continue to work with Child and Family Services, however, they have mixed feelings about the caseworker. They have found her helpful as an additional support, but feel there is inconsistency in the service as well.

Treatment Beliefs

Dean suggested that Lynn's externalizing behavior is the result of factors internal to her personality and should be dealt with in counseling. He believes that talk and behavior therapy, as well as the appropriate tools to deal with her emotions, will help her to overcome these issues. He explained:

I feel like, in order to help my daughter, someone should sit down and talk with her first and give her the tools to deal with stress and make her accountable to use those tools. If talking doesn't work, then medication could be the last alternative, farther down the line. I really hate to medicate my child but in order to have some resemblance of normalcy in the home, not just for me, but for the other children.

Dean does not feel that medication is necessary unless all other attempts have failed. He expressed a willingness to try medications if it would improve the family conditions.

Summary

This phenomenological study described the lived experiences of parents raising a child with externalizing behavior. Many of the participants I engaged with described bearing a child at a young age and early on into a relationship that for three of the four participants ended in failure. The participants experienced their children's acting out behavior and felt emotions

ranging from frustration, hopelessness and anger to fear and a lack of respect. Most of the participants attributed their children's behavior to personality and lack of appropriate coping skills. None of the parents perceived that they had a major influence on the behavior in any way nor did they believe that there was anything they could do now to resolve the behavioral issues of their child. In terms of level of satisfaction and use of service within the community for their children the experiences were quite different; two participants were happy with services, one of the participants was not happy with services at all and one participant did not see a need for service for her child so had never sought it out. Although all of the participants believed that talk therapy and counseling were the most appropriate treatment choices for their children and other children like their own, only one participant had used this option for her child and ultimately chose medication as the most helpful in the end. All of the participants believe medication is the last option for treatment for children and would be used when all else had failed.

CHAPTER 5

Discussion

Overview

Van Manen (1990) states that qualitative methods and specifically phenomenology is not about finding a solution to a problem that needs to be solved but rather to evoke the mystery of a phenomenon such as parenting. Therefore, I am not attempting to unravel a problem but instead to “recapture direct contact with the world of those living with children by awakening the soul to its primordial reality” (van Manen, 1994, p. 50). The current study was unique because it sought to gain insight into the rich experiences of a few purposefully selected parents by engaging with them in a dialogue that led to a rich and deep understanding of the essence of their personal experiences. The aim of this study was to address the gap in the literature on the perspectives of parents of various cultures, specifically in rural isolated Northern Canadian communities. It was also the intention to gain an understanding of participants’ experiences with services in these communities.

Van Manen (1994) stated that while exploring the current research on parenting and the literature by specialists of parenting, a large majority does not address the question of the meaning of parenting. Advice is given and books become more of a “how-to” on parenting; this still holds true today. The current literature does not bring us closer to understanding the true nature and deep meaning of what it is to experience being a parent. Very little research has been conducted regarding parents’ experiences raising children with externalizing behavior, their perceived barriers to mental health services, and beliefs about treatment- in particular those in rural Northern Canadian communities. The research conducted in the last several years has largely been quantitative and focused in larger urban areas (Jiang, Y., & Johnston, C. 2010; Johnston, C., Chen, M., & Ohan, J. 2006; Johnston, C., Hommersen, P., & Seipp, C. 2009; Johnston, C., & Patenaude, R. 1994; Ng, T., Jin, A., Ho, R., Chua, H., Fones, C.S.L., & Lim, L. 2008). In spite of the current research efforts, the question of the nature of the parenting experience still remained.

The present study has enhanced the current literature as it enables the reader to gain personal insights into what it means to experience being a parent in two small Northern communities in Canada, through the rich descriptions, in the personal language of four parents.

This study has provided insight into how parents of different cultures native to Northern Canada experience their children's behavior and what attributions they make regarding this behavior. It has also illuminated the perceived barriers to service in this unique situation of living in the isolated north. What I have always believed is what stood out as the single most important lesson of this research: when professionals are sought out due to the externalizing behavior of any child, the child should not be seen in isolation of the parents and family. It has been shown that programs exclusively involving youth have proven to be less effective than those that involve parents and caregivers in helping buffer youth from making unhealthy choices (Farrington & Welsh, 1999, Reese, Vera, Thompson, & Reyes, 2001, Tolan & Guerra, 1994). The following educational implications are written with the belief that if we approach any child's problem behavior within the context of family and include and support the parents involved, we will achieve the best possible result.

Educational Implications

Beliefs and Attitudes about Parents

Health care providers may be more helpful if they approach clients with the belief that the parent is the expert in their own life, that what they experience and perceive is what is true for them. Taking on a phenomenological approach to therapy can be a valuable tool to use when attempting to form the extremely important therapeutic relationship with parents. Challenging what we, as service providers, believe are inaccurate beliefs or attitudes may not be the way to approach clients, at least in the beginning stages of therapy. We cannot approach clients with preconceived notions about them: from what we have learned from a brief intake, heard as a small town rumor or through staff room chatter about parents or children. We have to approach clients with the fairness of fresh eyes and a non-judgmental perspective. Although we are the "professionals," we are human too: we make mistakes and we don't have all the answers.

The results of this study have shown that parents do care, they feel many emotions and frustrations due to their child's behavior. They feel the effect on their family and they try their best to help change the behavior. As mental health service providers, as well as teachers and school leaders, it is crucial to believe that parents have potential because first of all they love their children. We need to challenge our assumptions about parents coming into schools and

coming into therapy. We often assume that parents are hopeless, that they don't care and they won't change. We see children alone in therapy and feel that parents are not invested. We teach children in school and we deal with constant behavioral problems and disruptions to our teaching when children act out externally. It becomes frustrating on a daily basis and we begin to blame parents for a lack of support in the handling of their child's behavior. I now know that these parents are often dealing with the same frustrations and behaviors at home, and they simply are worn down, are unaware of what to do and are feeling helpless. Pushor (2009) described it best when she stated, "It is not about looking outward at others; it is always about looking inward. It is about how willing we are as educators to ask honest questions of ourselves. It is about how willing we are to act honestly on what we learn when we ask those questions. Are we giving parents real and safe opportunities to share their thoughts and feelings, to provide input, to have a voice in decisions which impact their children? Are we truly listening and hearing what they say to us, without believing that we always have the answer (p.1)?" Parents should be invited into therapy or into the school to be engaged with in a dialogue, to collaborate, and invite their input as the experts in their own lives.

Ultimately, the goal is to align our own professional knowledge with parents experience, knowledge and beliefs to inform our treatment of children with externalizing behavior. This would help us decide what types of programs we offer to these families and how we design our procedures and intake systems. Changing the intake process in mental health service agencies could make seeking out counseling services more inviting, more engaging and less demanding. New clients should feel like they are an important person with an important issue, rather than another file or number on paper. Clients should walk away feeling heard and believing that they matter, not wondering if they will be contacted when it's their turn on a long wait list.

This study will change the way that I engage with new clients and inform my intake processes as a school psychologist. I now know that having parents meet face to face with me initially is what will make them feel most comfortable as we travel on the road together towards making changes in theirs and their children's lives. My intake questionnaire now includes more parent questions. Parents are requested to comment and reflect on their parenting practice so that I can better understand why they do what they currently do. This also allows parents to reflect on their parenting style and to understand what attributions they make about their children's behavior. This is an important starting point for discussion, reflection and education.

Trust and Relationships

Addressing parents from their perspective in the beginning of a therapeutic relationship and taking what is real for them into consideration can help form trust and build good rapport. Only when this relationship is formed will the therapist and client together be able to challenge and explore current beliefs and realities and attempt to improve the lives of parents and their children. More than just the quality of the relationship between caregivers and service providers, the therapeutic alliance is one in which all parties agree on the tasks and goals of treatment (Wampold, 2010). Because treatment is dependent on working toward specific outcomes, treatment truly begins when this alliance is developed (Wampold, 2010). The implication of this is that the quality of the therapeutic alliance between a professional, youth and their families must constantly be assessed.

Finding a way to align our knowledge with parents' knowledge in order to help them change their child's behavior is paramount. The stories in this study demonstrate some common elements involved in the experience of parenting. Hearing and appreciating these personal stories from their perspectives enables professionals, including counselors, teachers, and administrators, to better understand parents. It reminds us to approach parents and families with openness, inviting them to describe their experiences from their perspectives. In doing so, we avoid forming preconceived ideas and beliefs. Meeting clients where they are could be the most valuable tool for beginning to form the important therapeutic relationship. Once the therapeutic relationship is formed and parents feel connected and understood professionals can collaborate with and support them. Wissow, Gadowski, Roter, Larson, Brown, Zachary, Bartlett, Horn, Luo & Wang (2008) conducted a study in which mental health care providers were trained in communication skills to improve relationships and outcomes in clients. Wissow et al. (2008) hypothesized that providing professionals with training based on engagement with clients would improve the symptoms and functioning of children. Providing training in communication with parents had a positive impact on parents and reduced children's impairment across a range of problems (Wissow et al, 2008). Horwitz, Leaf & Leventhal (1998) found that only 41% of parents with psychosocial concerns about their children chose to disclose them at their doctor visit. In another study only 61% of mental health referrals made were completed (Rushton, Bruckman & Kelleher, 2002). These failures in communication and engagement affect children

and their families (Wissow et al., 2008). Educating parents about the value of consistent rules, maintaining quality relationships, developing a strong parent-child attachment from infancy into childhood and forming a strong and united front when deciding on parenting practices would be my goal once this trusting relationship is formed.

Feelings of Hopelessness and Powerlessness

Parents in this study who described their children as violent and disobedient were the most hopeless, angry and fearful. They all described a lack of consistency in enforcing rules and expectations to some extent, and reported feelings of powerlessness and hopelessness when it came to their children's behavior. Parents' feelings of powerlessness, coupled with their belief that the problems their children were having lie within themselves and their personality, left them in a cycle of hopelessness and feeling a lack of power to make changes. As a result, parents didn't seek out therapy for themselves or for the family as a whole. Therapy was sought out for the child alone and ultimately failed when the child refused or the treatment didn't work.

The results of this study indicated that the breakdown between the behavior continuing or changing was in the parents' belief about their role in making that change. Parents knew the behavior was a problem and felt the effects on their family and on themselves personally. They also felt the child's behavior had severe consequences for their life but did not feel that they had any ability to change it. These were parents who had faced such adversity in life and who became parents at a young age with little life experience. They had lower self esteem, few personal resources and couldn't see that they had the ability to change the behavior. Giving these parents back their power and reminding them what they have come through in life already, how resilient they have been to life's challenges and encouraging them and supporting them should be our goal. Instead of being therapists who give advice, we should use parents as co-therapists and be reminded that parents are feeling a sense of helplessness when they first enter our door. When we take time to hear their stories, their backgrounds and their struggles and we truly see this from the parents' point of view then we can come together with parents as co-therapists. We can provide them with a sense of power and instill the hope that they can make this change. This is in no way an easy feat but, with our support, parents will know that they have power to change the situation.

Educating parents early on in their parenting experience through programs such as Best Beginnings is extremely important in providing that early information before the child becomes school age and behavior problems arise. Preventing these issues before the child becomes this age is a key component in the education provided by such programs. Also, programs such as Families And Schools Together (F&ST, 2006) can be encouraged to improve the communication and relationship between the school, parent and child. F&ST is built on the belief that parents love their children and want a better life for them. The program is designed to promote family members working together with community professionals (e.g. teachers, community agencies) to strengthen the family unit and develop a network of informal and formal social supports to help parents and their children (F&ST Canada, 2006). Informing parents that what they do, the decisions they make and the actions they take do have an impact on the behavior of the child; and in return can actually impact change. Creating experiences in therapy with clients that give them a new story of themselves as parents and of their families can impact change. Forming relationships, developing trust, hearing their stories and setting goals with clients should be our priority. Our role is to walk alongside our clients, support them and provide them with services and education, so that they can give their child the best start in life.

Cultural Responsiveness

Indigenous cultural understandings of mental health and healing are distinctly different from understandings that have prevailed in most North American mental health provider settings, including counseling contexts (Stewart, 2008). Counseling services in Canada and the United States are based almost exclusively on a Western paradigm of health that differs from an indigenous worldview (Gone, 2004). These differences in perspective can form a barrier to effective health promoting services for Native peoples who seek mental health support from formally trained counselors, including those who may be trained in cross-cultural or multicultural approaches (Stewart, 2008). Duran (2006) suggests that counseling Indigenous individuals from a non-Indigenous perspective is a form of continued oppression and colonization, as it does not legitimize the cultural view of mental health and healing.

Being considerate of cultural differences in mental health beliefs and beliefs about treatment is important when helping people of First Nations ancestry. Professionals should approach all individuals with an openness and good understanding of their unique cultural beliefs

and practices. Having services available that are delivered by professionals of the same culture might be most valuable, so Western values are not imposed. Understanding the barriers that parents of certain ethnicities face when attempting to access mental health service can help professionals design a process with parents and families that is easily accessible and reasonable for them.

Vicary and Westerman (2004) conducted a study where Aboriginal people were interviewed about their beliefs and attitudes towards mental health, Western psychology, practitioners, and strategies for improving mental health care delivery. The study found that there were traditional methods for treating mental disorders and if these were not successful the individual might then be taken to Western health services (Vicary & Westerman, 2004). Participants in the study also indicated that Western therapy was not effective with Aboriginal clientele. Of the two Aboriginal participants in the current study, one of them chose not to use any service in the community and the other sought out an Aboriginal counseling service for her daughter. She shared that the advantages of seeing an Aboriginal counselor were that a relationship was already established, they were both from the same small community, and being of the same ethnicity the counselor would understand her circumstance. Further, she described a feeling of comfort with the services offered by the Indian and Metis Friendship Center in the community, which offered counseling services she felt would be most relatable to her daughter. She also expressed feeling a closer connection with the workers, having known some of them personally.

Particularly in small Northern communities where there is a larger population of Aboriginal people, it is important to offer services that focus on traditional methods for treating mental health issues. Also, if traditional services are not offered, Aboriginal practitioners should be employed in Mental Health, health, and counseling agencies. Every professional should be advocating for greater efforts to attract and support young Aboriginal people entering the health care professions (Moffatt & Cook, 2005). Clients could then choose a professional who may better understand their unique experiences and share their cultural beliefs.

The health care system in general needs to become more patient centered and cultural competence is also needed (Moffatt & Cook, 2005). Professionals need to understand the role that culture plays in shaping people's views of the world, health and the values that they hold. Professionals also need to learn, question and accept that patients may have very different

perspectives than the professionals themselves (Moffatt & Cook, 2005). Non Aboriginal health care professionals do best by adopting a holistic approach in offering advice and care for their patients (Macaulay, 2009). They should practice cultural humility by respecting local traditions and by being careful not to impose their own values (Macaulay, 2009).

Future Research

As a continuation to the present study, future researchers could explore in more depth the beliefs that parents have about their parenting practices. The current study highlighted parents' beliefs about their child's behavior and explored the attributions parents made. Future research could explore parents' beliefs about their own parenting practice and how they believe it has contributed to their child's behavior. Specifically, researchers could explore with parents the effects of discipline and consequences on their children. The parents in this study did not make a connection between parenting and child behavior. As researcher, I did not focus on this aspect, however, during the study it became a very interesting possibility as a continuation to the study. Future studies may also be interested in looking at preventative measures such as parenting classes for young parents or parents of very young children with early signs of externalizing behavior. Researchers could also explore how these classes might influence parents' beliefs about how their parenting styles can affect their children's behavior. Aboriginal researchers could continue the current research to gain a clearer understanding of Aboriginal experiences of parenting and beliefs regarding treatment methods and barriers faced when seeking out services within small rural communities.

Conclusion

It has been my intention to take the reader into the private lives of families, to explore the experiences of each participant and understand the meanings they make. Through their stories, I was drawn into their world. If just for a few moments, I witnessed their emotion and heard the struggles that often mark the stories of families contending with the challenges of children's externalizing behavior.

Each participant described the experience raising their child and the attributions they made regarding this behavior. Participants expressed histories of tumultuous and often single parent families and having a child early in life. Parents in this study found themselves in

complex circumstances early in their own lives that have affected the way they parent their own children. Some parents did not have strong attachments with their own parents and some experienced abuse as a child. These experiences can leave parents with lower self-esteem, poor role models and inadequate tools for understanding their child's behavior and their role in relation to it.

Parents attributed externalizing behavior to factors within the environment. Their perceptions were of powerlessness in preventing or improving the behavior, and they believed therapeutic methods would be the most beneficial. Medications were indicated as a final option. Parents' attributions led to their reactions to the behavior which was often inconsistent between the primary parent, step parent or grandparent. Parents who had higher stress and stronger emotions reported their child's behavior as worse than those reporting lower stress. This study also examined the barriers parents perceived, living in a small isolated community and raising children with externalizing behavior. Barriers described by participants were lack of privacy in a small town, not knowing where to access service, rigorous intake systems and long wait times. Participants also expressed barriers of distance from specialized services and specialists in more urban centers and lack of transportation.

Reflecting on how this research began, I am reminded of my bewilderment as a therapist. I sat with children who struggled with externalizing behavior, where parents lived in a world of conflict and confusion, uncertain about the future of their family. They tried to understand how this behavior came to be and why it persisted. My naive perceptions of how a family could "fix" this problem, was unfortunately never aligned with what parents believed, experienced or were prepared to do. The problem remained.

Having completed the study I've realized it doesn't only matter what I believe about a client, what I think I know from experience or what a textbook tells me. What needs to be understood first is what is true for those truly experiencing the phenomenon. This marks the value of qualitative research the ability to gain insights into the human experience, the perceptions and the realities in which they live. I learned that, at the end of the day, although what each participant wished for was peace and harmony at home, it was not always what they got.

While completing this research I was reminded of the passion I have for this subject and the discipline of psychology that began many years ago. I am excited to take what I have gained

and continue to work in this field with families and parents, with a new outlook, new respect and an openness to the unique human experience. Internal life, the private thoughts and feelings that which go on within ourselves are our last real privacy (Johnson, 2010). To be invited on this journey with each client we meet, this is indeed fortunate.

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Appendix A

Consent Form

Title of Study:

Harmony at Home: The Experience of Parenting a Child with Externalizing Behavior.

Researcher:

Wendy Vipond, Master of Education candidate in the College of Educational Psychology and Special Education, University of Saskatchewan

You are being asked to voluntarily take part in a research project entitled, *Harmony at Home: the experience of raising a child with externalizing behavior*.

The goal of this study is to understand your experiences raising a child with externalizing behavior problems in a rural Northern Saskatchewan community. The purpose is to give you the opportunity to share your experiences raising your child with externalizing behavior and how this behavior is impacting yourself and your family. Your participation in this study may have no personal benefit, however it may bring an awareness to you, the participant, of the personal impact of raising a child with externalizing behavior in a rural Northern community and an affirmation of your personal experience. Your personal experiences can also be helpful in potentially improving resources to families in the North.

Due to the fact that Wendy Vipond is a member and teacher within the community, there is the possibility of prior relationship between the researcher and yourself; consequently, you should not feel any pressure to participate in the study. Participation however, will involve answering interview questions about your experiences and will take place in two interviews consisting of approximately 60-90 minutes each. During the interviews the researcher would like to use a recording device however, you, the participant, may request that the device be turned off at any time. Audio taped and transcribed interviews will be securely stored in a locked file cabinet in my supervisor's office for a minimum of 5 years. Confidentiality regarding the information that you provide will be assured by the researcher and my supervisor and your individual answers will not be shared or presented in any way that would identify you as the source.

Upon beginning the study, you will be given a brief explanation of the study and an opportunity to ask questions. You may refuse to answer any interview questions and are free to withdraw from participation in this study at any time. If you choose to withdraw from this study, all information you provided will be destroyed. Your right to withdraw data from the study will apply until the results have been disseminated. After this it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

Due to the potential for your anonymity to be compromised during the interview, you will review the final transcript and remove or change any of the information at any time. If you are comfortable with the information presented in the transcript you will be asked sign a transcript release and sign-off release form acknowledging that the transcript accurately reflects what was

said in your personal interview and also giving permission to include excerpts from the transcripts to be used in the thesis. Prior to the interview a list of interview questions will be offered to you as an opportunity to prepare for the interview and also to ask the researcher any questions. Further contact by the researcher after the interviews will be to accommodate questions or clarification.

If you have any questions or concerns about the project or the methods used, you should contact Wendy Vipond (researcher) at 306-688-5740 or David Mykota (project supervisor) at [966-5258](tel:966-5258)/david.mykota@usask.ca

The proposed research project was reviewed and approved on ethical grounds by the university of Saskatchewan Behavioral Research Ethics Board on _____, 2011. Please feel free to contact the Ethics office at 966-2084 if you have any questions about this study or the rights of a participant in any study.

I have read and understand the description provided above; I have been provided an opportunity to ask questions and my questions have been answered satisfactorily. I agree to participate in the study described above, with the understanding that I may withdraw this consent at any time. **A copy of this consent form has been given to me for my records.**

Name of Participant: _____

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

Date: _____

Appendix B

Questions of Interest

Interview 1

Focused History:

- 1) Describe your experience as a young girl/boy growing up and being parented by your own parents. (short history of life)
- 2) Describe some early life experiences that led to (child) coming into your life.
- 3) How do you personally experience being a parent, how has it changed over time
- 4) What does being a parent mean to you

Interview 2

Details of experience

- 1) Describe the way you were parented by your own parents, their discipline style, relationship and your experiences.
- 2) Describe your own parenting style, showing love/affection, discipline etc
- 3) What kinds of struggles have you experienced being a parent
- 4) When did you first experience your child's behavior becoming more difficult
- 5) Describe the types of behaviors you experience in regards to (child)
- 6) How do you feel your parenting style has influenced your child's behavior
- 7) Describe your child's behavior and the affect it has on your relationship with your partner/the rest of your family.

Interview 3

Reflection

- 1) When you think about what you have described about your early life and your experiences as a parent how do you feel this has influenced your child's behavior?
- 2) What sense do you make of the challenges your child is experiencing
- 3) What do you think contributed to these behaviors?
- 4) Describe your experiences with health or counseling services in the community
- 5) What kind of experience have you had accessing services of your child?
- 6) Describe the benefits or difficulties raising your child in this community
- 7) Describe your beliefs in regards to treatment of difficult behavior.

Appendix C

Recruitment Letter

Title of Study: Harmony at Home: The Experience of Raising a Child with Externalizing Behavior

Dear Parent:

I am writing to tell you about a research study conducted by my colleague, Wendy Vipond, as partial fulfillment of her Master's thesis. I am letting the parents of students I have been seeing for counseling or those who have been referred to me know about this research project.

The goal of this study is to understand your experiences raising a child with externalizing behavior problems in a rural Northern Manitoba or Saskatchewan community. For the purposes of this study externalizing behavior is defined as one or all of, hyperactivity, aggression, and delinquency or defiance. The purpose is to give you the opportunity to share your experiences raising your child with externalizing behavior and how this behavior is impacting yourself and your family. Your participation in this study may have no personal benefit, however it may bring an awareness to you, the participant, of the personal impact of raising a children externalizing behavior in a rural Northern community and an affirmation of your personal experience. Your personal experiences can also be helpful in potentially improving resources to families in the North.

I am not a member of the research team, however, I am contacting some of my students parents to let them know about eh research in case they might be interested in learning more. It is important to know that this letter is not to tell you to join in the study. It is your decisions. Your participation is voluntary. Whether or not you participant in this study will have no effect on your relationship with the school.

If you do choose to participate, the study will involve a series of approximately three interviews at a location that is of comfort to you. Interviews will be audiotapes and transcribed, you will have the opportunity to review and revise all transcripts for accuracy.

If you are interested in participating in this study or have any questions please contact the researcher Wendy Vipond at 688-5740.

Sincerely,

Sharon Trubiak
Community School Counselor

Appendix D

Application for Ethical Approval

1. Name of Researcher: Wendy Vipond

Supervisor: David Mykota

Department: College of Education, Educational Psychology & Special Education

1a. Name of Student: Wendy Vipond

1b. Anticipated start date of research study: April 2011

Expected Completion date of research study: August 2011

1. Title of Study: Harmony at Home: the experience of raising a child with externalizing behavior problems

2. Abstract:

Given the importance of parenting in relation to child Attention Deficit Hyperactivity Disorder and Oppositional Defiant behavior, it is critical to gain a better understanding of how parents of these children approach the parenting task (Johnston, Chen & Ohan, 2006). Studies in developmental psychology have related parents' attributions to child's behavior to both parenting behavior and child outcomes (Bugental & Johnston, 2000). The attributions that parents make for their child's behavior can assist in our understanding the family difficulties associated with childhood Disruptive Behavior (Johnston et al., 2006). For this study, a qualitative research inquiry, informed by phenomenological interviews, is proposed to answer the question, "What are the experiences of parents raising children with externalizing behavior problems in a rural Northern Saskatchewan community?" Four families will be chosen through purposeful sampling, with the assistance of school administration and school counselors. Interviews will be conducted, using semi-structured interviews, to encourage family members to share their insights and describe their experiences in raising children with externalizing behavior.

3. Funding:

This research is supported by the Social Sciences and Humanities Research Council.

4. Expertise:

None of these criteria apply, since there are no vulnerable populations, distinct cultural groups, or in cases where the research is above minimal risk, so this section may be omitted.

5. Conflict of Interest: There are potential areas of conflict. The first is that I am currently a teacher and psychometrist in the community. The second is that in the past year I was a counselor and psychometrist in the school where the students and families will be selected. Although I was previously a counselor and am currently a psychometrist in the community, effort will be made to select a family that I have had no previous

involvement with although the individuals in the family may have knowledge of who I am as a member of the community. Participation in this research study is 1) distinct from any service or program you, the participant may access; and 2) participation would in no way impact current or future access to programs or services in this area.

6. Participants:

Communication will be established by written letter sent to potential participants by the school administration. The letter will encourage potential participants to contact myself, the researcher, for more information about the study. The criteria that will be used to select potential participants are as follows:

- 1) Participants will be the primary parent or guardian of a child experiencing externalizing behavior problems.
Externalizing behavior problems will be defined as delinquency, aggression and/or hyperactivity. Due to the difficulty in obtaining a formal diagnosis for the above noted problems the researcher will depend on the school counselor and teachers for referral of students with the most severe of these problems in the school. The parents of those children currently involved with or referred to the school counselor for either or all of delinquency, aggression or hyperactivity will be identified as potential participants for this study. Those with the most severe of these problems will be of the most interest to the researcher.
- 2) Participants will be residents of 3 rural Northern communities
- 3) Participants are able to communicate in English
- 4) Participants will be in agreement with participating in the study
- 5) Participants will not be those whom the researcher has had a previous counseling relationship with.

7. Consent:

Consent forms are located in Appendix B and clearly outline the details of the study and the rights and obligations of the participant. Their signature on the form will signify the participants understanding of their consent, obligations and rights.

8. Methods and Procedures:

Three interviews of approximately 60-90 minutes in length will be the mode of data collection in this study. The participants may refuse to answer any question and will be allowed to withdraw from the study at any time without penalty. Phenomenological interviewing methods will be used to obtain information about experiences as a parent of a child with externalizing behavior problems at a community school in Northern Saskatchewan. The interviews will be held in a neutral location to both the researcher and the participant such as a private room in the local public library or another location determined with the participants comfort in mind. The researcher will remain in the community during the time of data collection and a local contact number will be provided to participants should they need to contact myself for clarification or questions. The initial interview meeting will be made to begin building rapport and explain the purpose for the study. The participants will be informed of their rights, consent, and obligations along with an explanation of the consent form. After each subsequent interview, transcripts will be created and participants will be asked to review them for

content and for confidentiality, being able to change, or remove any kind of information they see as necessary. These revisions will be discussed with the researcher by the phone or in person. Following completion of the two interviews and two revisions of content, data will be organized and collected from transcripts. A list of significant statements will be developed from the transcripts and grouped into themes. A description of “what” the participants experience with the phenomena will then be written. Next, a description will be written about how the experience happened, reflecting on the setting and context in which the phenomenon was experienced. Finally, a composite description is written of the phenomenon.

9. Storage of Data:

During the data collection phases, the data will be stored in a locked cabinet in the researchers classroom, to which only the researcher has a key. At the conclusion of this study, the information that has been collected will be stored in a locked, secure file cabinet in my supervisors, David Mykota’s office. This data will be saved for a minimum of 5 years after the completion of the study. After a period of 5 years when the data is no longer required it will be destroyed beyond recovery.

10. Dissemination of Results:

Data collected will be used to provide written material for the thesis. The thesis will be submitted to the College of Graduate Studies and Research in partial fulfillment of the requirement for the degree of Master of Education in the Department of Educational Psychology and Special Education, University of Saskatchewan.

11. Risks, Benefits, and Deception:

Participants will be debriefed in the initial meeting about the nature of the study and given a copy of the interview questions, which will be used in the interview process. Participants may refuse to answer any questions and are free to withdraw from the study at any time without penalty. Should the participant withdraw, all data will be promptly destroyed. Written consent will be obtained from each participant. Audiotapes will be used with the written consent of the participants. Information will be kept confidential and be coded with no identifying information. Pseudonyms will be used in the final written thesis to insure absolute anonymity. The cost/inconveniences/risks of this study include:

1. The understanding that participating requires approximately 60-90 minutes of time (for each of the two interviews).
2. The understanding that the interview will require you to review the interview questions prior to the actual interview.
3. The understanding that the participant will be required to approve the accuracy of their interview transcript.
4. The understanding that the participant’s permission must be given to use their transcript in the final written thesis of Wendy Vipond (Researcher).

Although there may be no benefit to the participants in this study, possible benefits may include:

1. The opportunity to share your experience raising a child with externalizing behavior problems in a rural Northern Saskatchewan community.
2. The opportunity to contribute to a greater understanding of how raising children with externalizing behavior problems in a rural Northern Saskatchewan can impact families.
3. Affirmation of their experience.

12. Confidentiality:

Confidentiality and anonymity of the participants, the school and community will be insured. The participants will be informed verbally and in writing of their rights of confidentiality. They will also be given a consent form (Appendix A) to sign which details the exact nature of the study, the right to refusal about answering any questions, and the right to withdraw from the study at any time without penalty. Signature of the form will signify their understanding of their rights and will be taken as consent of the participant. All data will be coded and the participants will be given pseudonyms to protect the identities of each individual. All participants will have the opportunity to review and revise all transcribed interview data and also remove any of their responses. Interview transcripts will be open to the parent(s) participants. Participants will be requested to sign a transcript release form (Appendix C) wherein they will acknowledge by their signature that the transcript accurately reflects what they said or intended to say. Signing of a sign-off release form (Appendix D) will indicate the participants consent to what it included in the final thesis document.

13. Data/Transcript Release:

The parent(s) will review the final interview transcript and sign the transcript release form found in Appendix C and the sign-off release form in Appendix D. In signing these forms the participant will acknowledge that the transcript accurately reflects what was said in the personal interview and also give permission to include excerpts from the transcripts to be used in the thesis.

14. Debriefing and Feedback:

Opportunity for debriefing and feedback will take place when the data/transcript release and sign-off forms are signed by the participants. Parents will have the opportunity to receive a copy of the final completed thesis.

15. Required Signatures:

Researcher Name: _____ Signature: _____

Supervisor Name: _____ Signature: _____

Department Head: _____ Signature: _____

Dean (College of Education, Educational Psychology & Special Education)

Signature: _____

Contact Name:

Wendy Vipond

Phone: 204-687-7991

Email: wmconaughey@hotmail.com

Appendix E

Data/Transcript Authenticity

Title of Study: Harmony at Home: The Experience of Raising a Child with Externalizing Behavior

This transcript form is to give acknowledgement that the interview data accurately reflects what was said in the interviews with Wendy Vipond (Researcher). This data may be included in the final written thesis of Wendy Vipond (researcher).

I, _____, hereby give acknowledgment that the transcribed interview data accurately reflects what was said in my interview. I am comfortable with the efforts that have been taken to ensure that any identifying information of this material has been altered or eliminated. I have reviewed the transcripts of my interview and hereby acknowledge there in the information and consent form. I have a copy of the Sign-off Permission Form for my own records.

Signature of Participant

Date

Signature of Researcher

Date

Appendix F

Sign-off Release Form

Title of Study: Harmony at Home: The Experience of Raising a Child with Externalizing Behavior

I, _____, have reviewed the descriptions of my experiences written by Wendy Vipond, and I agree that they accurately reflect what I shared in the interviews. I hereby give my permission to include the above material for inclusion in Wendy Vipond's (researcher) final written thesis. I am satisfied with the efforts that have been taken to ensure that any identifying information on this document has been altered or eliminated. I have a copy of the Sign-off Permission Form for my own records.

Signature of Participant

Date

Signature of Researcher

Date