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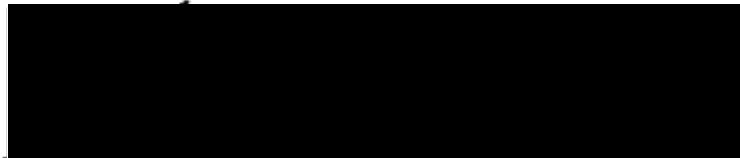
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A large black rectangular redaction box covering the signature of the faculty advisor.

Signature of Faculty Advisor

5/24/24

Date

Children's Wellbeing and ADHD among Rural and Urban Families

A Plan B Research Project
SUBMITTED TO THE FACULTY OF
UNIVERSITY OF MINNESOTA DULUTH
BY

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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
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Positionality Statement: Keeping in mind that our identities can influence how we approach science (Roberts et al., 2020), I would like to provide readers with information about my own background. I am a Clinical Counseling Master's student at the University of Minnesota Duluth. With respect to race/ethnicity, social class, gender, and geographical location, I identify as a White, middle-class woman who grew up in rural Minnesota. Growing up in rural Minnesota, I recognized the barriers my rural community faced in regards to mental health resources but also acknowledged the unique aspects my rural community held. This is why I am driven to ask research questions related to the unique strengths and assets of rural communities. Additionally, as someone who grew up in rural Minnesota, a big reason for pursuing a community-based study was to make sure I am directly serving and impacting the communities I am working and walking alongside with as this is something my rural community valued.

Abstract

The purpose of this study was to evaluate the relationship between both positive parent-child relationships and community support to child ADHD symptom severity and child subjective wellbeing across rural and urban families. Past literature has found extensive barriers for accessing quality mental health services among rural families, however there is limited information on assets and strengths of rural families that may facilitate improved mental health. In particular, accessing high quality mental health services is important for assessment and treatment of mental health conditions such as Attention-Deficit Hyperactivity Disorder (ADHD). Additionally, evaluating the relationships between parents and children would be beneficial, as ADHD is a concern of the entire family. The current study's aim is to provide information on the unique experiences of rural families with children with ADHD that may ultimately inform community or school based services. The current study recruited children with ADHD and their families from urban and rural settings to complete surveys on the parent-child relationship, child wellbeing, and community support. Results showed a significant main effect of positive parent-child relationships on ADHD symptom severity. However, location and community support were not significant predictors of ADHD symptom severity. Community support and positive parent-child relationships were significantly associated with each other. Results showed there were no significant main effects of the predictors of location, community support, and positive parent-child relationships on child subjective wellbeing. Implications and limitations of the current study are discussed.

Keywords: rural mental health, ADHD, community support, positive psychology

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Children's Wellbeing and ADHD among Urban and Rural Families

Past literature has found extensive barriers to receiving appropriate mental health services among rural families when compared to urban families (Agarwal et al., 2022; Carson et al., 2021; Hilton et al., 2022; Tolliver et al., 2022). In particular, location can impact the access to and effective utilization of mental health services by children and their families (Agarwal et al., 2022). These differences center around availability of appropriate mental health professionals as well as time and expense barriers that occur within rural settings (Agarwal et al., 2022; Carson et al., 2021; Hilton et al., 2022; Tolliver et al., 2022).

Despite the lower mental health practitioner-to-patient ratio found within rural areas compared to urban settings, rural individuals tend to use services at about the same rate as other geographic locations (Hilton et al., 2022). Consequently, primary care physicians are heavily relied on to provide mental health services within rural communities because about 58% of rural communities have a shortage of mental health care professionals (Agarwal et al., 2022). Importantly, parents are more likely to talk to their child's primary care physician about their child's behavioral concerns than a psychologist or psychiatrist (Tolliver et al., 2022).

In addition to lower availability of mental health practitioners in rural areas, rural families also face barriers regarding extensive travel time and expenses (Carson et al., 2021). For example, one study reported that rural parents drove at least an hour each way to attend their child's appointment (Hilton et al., 2022). Importantly, as family income decreases, prevalence rates increase regarding psychosocial concerns (Tolliver et al., 2022). Lack of services seems to add to a parent's distress with a child with a neurodevelopmental disorder such as ADHD (Maridal et al., 2021), which could be especially prominent in rural communities. Therefore,

although there are evidence-based treatments for neurodevelopmental concerns, access to these treatments for rural children and their families is a major challenge (Tolliver et al., 2022). Stigma has also been shown to be a factor in seeking health services among rural individuals and families (Robinson et al., 2017). Stigma could result in an underuse of care and delays in seeking care, which should be considered when thinking about rural help-seeking for mental health services.

Rural parents have to think of both success and resources differently due to the limited resources in rural communities (Singh et al., 2018). Parents within rural communities look to support success for their child differently than non-rural parents. For example, success for their child is focused on outcomes and is not always consistent with clinical guidelines; flexibility of defining successful outcomes for their child and using external sources is important for rural families. Although success for rural parents is conceptualized more broadly in comparison to non-rural parents, the definition of success for their child did not differ greatly (Singh et al., 2018). Additionally, an emphasis on developing advocacy skills for both the parent and child seemed to be a theme within rural parents that differed from non-rural parents as well as their adaptations to raising a neurodiverse child (Singh et al., 2018). Importantly, rural parents use supports outside of the healthcare system. Education and after-school care centers were critical areas of community support mentioned by parents that helped their child and family outside of formal healthcare (Singh et al., 2018).

Assets of Rural Communities and Rural Mental Health

Although researchers have identified several barriers to accessing mental health services for rural families, there are also various assets to families within a rural community. Community

and social supports are important assets to rural families. Social support is a multidimensional concept that can be defined as social interactions that assist individuals with coping and benefit them in times of stress (Letvak, 2002). Perceived social support is a better predictor of mental health outcomes than objective measures of social support (Letvak, 2002). In particular, adolescents benefit from social support. Lack of social support is associated with depression, decreased self-esteem, and hopelessness (Letvak, 2002). Social support can also predict resiliency among children and adolescents (Letvak, 2002). One study suggests that relationships between peers, teachers, and their family were the strongest predictors of a child's wellbeing (Newland et al., 2014).

Outside of the immediate family, community support also could be beneficial for children with mental health diagnoses and their families in rural communities. In general, close community bonds and connections are an asset to rural communities (Crouch et al., 2020). Past literature has shown that rural children are more likely to volunteer in their community, school, or church, which allows for broader and more influential social engagement (Crouch et al., 2020). In addition, the community functions as a protective factor for rural families. Community members often build close relationships and social bonds with families and in turn may know the children of that family better as well within rural families (Crouch et al., 2020; Singh et al., 2018). Mentors, which are common among rural communities, are considered important and unique assets to rural youth (Crouch et al., 2020). One study found that children with special needs in rural areas were more likely to have resources outside of the parent-child relationship, which included after-school programming or faith-based organizations when compared to urban areas (Robinson et al., 2017). More social support resources like after-school programming

among these rural families lowered the percentage of children who had a parent with poor mental health, which suggests that community social support mitigated parental stress in these rural areas (Robinson et al., 2017).

Attention Deficit/Hyperactivity Disorder (ADHD) in Rural Communities

Attention Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that interferes with functioning or development in at least two different settings, such as home, work, school, or other activities (American Psychiatric Association, 2022). ADHD has three predominant subtypes: inattentive type, hyperactive/impulsive type, or a combined presentation of both hyperactivity/impulsivity and inattention. Symptoms of ADHD must be present prior to the age of twelve. Some common inattentive symptoms include: making careless mistakes, forgetfulness, and difficulty organizing or sustaining attention during tasks. Common hyperactive and impulsive symptoms include fidgetiness, talking excessively, blurting out answers, and often interrupting others (American Psychiatric Association, 2022). Attention and concentration concerns are present throughout the lifespan, but they tend to gradually improve with age (Taghizade et al., 2022). However, a delay of the diagnosis of ADHD can cause social problems (Brook & Boaz, 2005). Individuals with ADHD also report long standing difficulties with low self-esteem (Brook & Boaz, 2005). In addition, stigma related to ADHD behaviors can lead to peer rejection, another functional consequence of ADHD (Na & Mikami, 2018).

Research findings have reported inconsistent rates of ADHD among rural populations. For example, one study found that ADHD was diagnosed less among rural children than children living in urban areas (Brownell & Yogendran, 2001). By contrast, the National Survey of Children's Health (NSCH) on childhood mental, behavioral, and developmental disorders found

a higher prevalence rate of ADHD for children living in rural areas compared to urban areas (Agarwal et al., 2022). ADHD prevalence also seems to increase with an increase in socioeconomic status (Yallop et al., 2015). This could be due to more educated parents having the ability to recognize concerns and have the means to receive a formal ADHD assessment or other mental health services (Brownell & Yogendran, 2001).

ADHD is often comorbid with other disorders, including learning disorders, autism spectrum disorder, and oppositional defiant disorder. Specifically, oppositional defiant disorder co-occurs with ADHD in about half of children and a quarter of children with conduct disorder also have a co-occurring diagnosis of ADHD (American Psychiatric Association, 2022).

While ADHD is more common among males than females, females have higher rates of specific comorbid disorders, like oppositional defiant disorder, autism spectrum disorder, personality disorders, and substance use disorders (American Psychiatric Association, 2022). Importantly, children with a combined inattentive and hyperactive/impulsive presentation of ADHD are more likely to be diagnosed with oppositional defiant disorder and conduct disorders.

As mentioned, there is a lack of mental health services in rural communities, especially when it comes to specialized services. Further, rural children who have neurodevelopmental disorders and their families are at a particular disadvantage as specialized services to assess and treat neurodevelopmental disorders, such as Attention-Deficit/Hyperactivity Disorder (ADHD), are not present (American Psychiatric Association, 2022).

ADHD and Parent-Child Relationships

Family functioning is a central component of youth wellbeing and sets the stage for youth to develop strong and healthy relationships outside of the family (Suldo & Fefer, 2013). Within

the family, the parent-child dyad is especially important. Due to the wide ranging functional, behavioral, and cognitive deficits associated with ADHD, ADHD can be considered an issue of the entire family, not just the individual experiencing it (Brook & Boaz, 2005). Rural families are often criticized by community members about their inability to teach their children obedience (Brook & Boaz, 2005). However, children with ADHD are often inattentive and “disobedient” due to the hyperactive and impulsive symptoms and functional characteristics of ADHD (American Psychiatric Association, 2022). A variety of family characteristics have been identified as significant protective and risk factors for impairment related to ADHD. For example, family cohesion was found to be beneficial as a family-wide coping mechanism while tension or brokenness worsens the difficulties with adolescents with ADHD (Brook & Boaz, 2005). Familial financial and environmental stress also reduced the quality of parent-child relationships (Clark & Ladd, 2000), which is an important factor to consider as rural areas tend to have a lower income than their urban counterparts.

More severe ADHD symptoms are associated with several negative parent-child relationship dynamics. For example less positivity within parent-child relationships is associated with a greater amount of symptoms (Deater-Deckard, 2017). Parent-child dependency, defined as the degree of abnormal dependence among children and their mothers, can be quite detrimental, as noted by research showing an increase in behavioral problems resulting from an increase in parent-child dependency (Taghizade et al., 2022). By contrast, intimacy is an important piece to a parent-child relationship as well, because the more relationships that are grounded in intimacy lead to greater joy and positive emotions in children (Taghizade et al., 2022). Among families of children with ADHD, intimacy was negatively associated with behavioral problems, meaning an

increase in intimacy was related to a decrease in behavioral problems, while conflict was found to increase behavioral problems (Taghizade et al., 2022). Positive interventions for parents of children with ADHD, specifically mothers, individually or in a group setting, were found to decrease problematic dependence and conflicts (Jacobvitz et al., 2004; Taghizade et al., 2022). It has yet to be determined whether the impact of positive parent-child relationships on ADHD symptom severity and overall child well being depends upon the broader community context, specifically between rural and urban settings.

Positive Psychology and Child Wellbeing

Although psychology often focuses on the negative aspects of situations, it is important to also take into account strengths and assets of individuals, parent-child relationships, and communities, which is what positive psychology strives to accomplish. Discussing strengths in addition to deficits creates a more holistic understanding of an individual, family, or community, such as the above review of important assets found within rural communities. Positive psychology strives toward helping individuals flourish, not just symptom alleviation (Suldo & Fefer, 2013). Much research has been published on the importance of adverse childhood experiences (ACEs) to child development and risk for negative physical and mental health outcomes. Alternatively, positive childhood experiences (PCEs) are described as experiences that foster overall wellbeing and resilience that serve as protective factors against ACEs (Crouch et al., 2020). An example of a PCE is the involvement of the child in an after-school activity, like clubs or organizations (Crouch et al., 2020). Another example of a PCE is when the child has the ability to share and discuss things that matter (Crouch et al., 2020). Important to note is that rural children are more likely to volunteer and have a mentor within their community, which

establishes the groundwork for children to experience PCEs (Crouch et al., 2020). Understanding PCEs would provide a more comprehensive understanding of a child's needs and assets (Crouch et al., 2020). PCEs have not been evaluated in terms of their role between the wellbeing of rural and urban children.

It is known that parental wellbeing impacts the parent-child relationship. Understanding positive characteristics of the child could also be essential in improving or supporting the parent-child relationship (Suldo & Fefer, 2013), which can become strained due to the impacts of a child's ADHD symptoms. One study found that developing social support for adolescents by providing structured parental social support enhanced the parent-child relationship (Letvak, 2002). Positive characteristics of children with ADHD indicated by past literature include willingness to help others and empathy specifically with animals (Brook & Boaz, 2005). Obeldobel and Kerns (2021) found that children's gratitude is not only related to the positive parent-child relationship but also to the child's own wellbeing. Gratitude is theorized to improve parent-child relationships as well as increase life satisfaction and increase psychological wellbeing (Obeldobel & Kerns, 2021). Positive aspects of rural life, like the connections between the child, family, and the community are all connected to rural children's subjective wellbeing (Newland et al., 2014). Additionally, rural children reported mostly positive home, peer, neighborhood, and school environments (Newland et al., 2014).

Positive Psychology and Parent-Child Relationships

Looking at positive child characteristics is important to the parent-child relationship, but recognizing the potential bidirectional association can bring additional awareness of how parent-child relationships can also impact the child's individual functioning. Particularly,

connectedness and sympathy should be considered in positive parent-child relationships.

Connectedness is defined as the emotional availability of the caregiver for the child (Clark & Ladd, 2000). In general, children with more connected parent-child relationships had higher levels of harmony and less conflict within their friendships (Clark & Ladd, 2000).

In addition to the importance of connectedness within parent-child relationships, sympathy is also an area important to parent-child relationship wellbeing. Parents who provide hands-on experiences or involvement of prosocial behavior resulted in greater sympathy and prosocial behavior among their adolescents (Carlo et al., 2007). Importantly, links between parenting practices, sympathy, and prosocial behaviors varied by type of prosocial behavior or parenting practice. Important to note is that although prosocial behaviors can be fostered through sympathy and parenting practices, the ability to continue prosocial behaviors when it could harm oneself, also known as altruism, cannot (Carlo et al., 2007). Positive parenting behaviors which could include providing learning experiences and opportunities inside and outside of the home have the ability to mediate child mental health outcomes (Robinson et al., 2017). For example, parenting behaviors that provide access to reading to the child or having age-appropriate toys inside the home can help with the child's development. Additionally, parents who bring their child to parks or libraries are all ways to help mediate child mental health outcomes (Robinson et al., 2017).

Broader social connectedness can also positively impact the parent-child relationship. The ability to express emotions not only internally but externally to others could be beneficial for the parent-child dyad (Yoo & Cordova, 2022). Processing emotions with others could pave a pathway to receive support and empathy from other supports, and validation and inclusion

throughout society (Yoo & Cordova, 2022). A sense of intimate safety with one's parents also predicts social connectedness; however, attachment style mediates this relationship between intimate safety and connectedness (Yoo & Cordova, 2022). Further, the ability for parents to model a space for their children to be their authentic selves, the less they express anger, which could be explained by the parents' abilities to model their own genuine emotions (Yoo & Cordova, 2022). Importantly, this suggests that recognizing and leveraging connected and empathic parent-child relationships, can be helpful for children broadly but also children with ADHD, which was assessed within the current study.

The Current Study

There is a gap in past literature because little research has centered around children with ADHD within rural areas. Understanding the relationship between parent-child relationships and ADHD symptom severity specifically in rural communities is important to serve rural families more comprehensively. Barriers to accessing effective mental health treatments in rural communities when compared to urban communities has been researched extensively, whereas assets within rural communities are not as prominent within the literature. However, several important assets have been recognized within rural areas that may contribute to family strengths and cohesion, ADHD symptom intensity, and overall child wellbeing. Research in this area can help future professionals serve rural families better and allow mental health professionals to better understand how rural families have adapted resources through greater community support and how this may differ as a result of one's residence, rural or urban.

This study evaluated three different predictors and their relationships to two separate dependent variables as well as their interaction with each other. The three different predictors

included: positive parent-child relationships, community support, and location. All three of these predictors and their relationships with ADHD symptom severity and overall child wellbeing were assessed. Hypothesis one predicted a model that positive parent-child relationships and greater community support would be associated with lower ADHD symptom severity, while rural location would be negatively associated with ADHD symptom severity due to the lack of mental health services in rural communities. Hypothesis two predicted a model that positive parent-child relationships, greater community support, and rural location would be positively associated with child subjective wellbeing.

Method

Participants

Participants within this study included parents or guardians and their children who have ADHD within the Superior, Wisconsin and Minneapolis, Minnesota area school districts. Participants were from both rural and urban schools, both defined depending on the population of the town the schools were in.

Location

Within the current study, school districts within the Superior, Wisconsin and Minneapolis, Minnesota communities were recruited via communication with school psychologists and special education directors and case managers starting in May of 2023 through January of 2024. In the current study, rural is defined as a community whose population is about 20,000 and urban is defined as a population of more than 20,000, which was determined by the zipcodes reported by participants. This has been previously used to define rural and urban populations in past literature (Morrissey et al., 2022).

Superior, Wisconsin at the time of this study had a population of about 27,000 people, which was where the rural sample was recruited from in the current study. Rural schools included Cooper Elementary School, Great Lakes Elementary School, Four Corners Elementary School, Bryant Elementary School, Lake Superior Elementary School, and Superior High School. Minneapolis, Minnesota at the time of this study had a population of about 430,000 people, which was where the urban sample was recruited from within the current study. Urban schools included Nova Classical Academy and Great River School, both of which are public charter schools serving students in grades kindergarten through 12th grade.

The criteria for inclusion within the current study was as follows: parents/guardians with children who have ADHD and other co-occurring conditions with ADHD. Participants were not included if children did not have an ADHD diagnosis, unless their child was undiagnosed but still fell within the borderline clinical or clinically severe range for ADHD symptom severity on parent report study surveys of ADHD symptoms. Participants were originally invited to participate in this study in their 504 Plan meetings during the fall of 2023, which was where families with youth diagnosed with ADHD were given the current study's recruitment pamphlet. However, due to low recruitment, this study later recruited participants via email from their school psychologists, case managers, special education teachers, or other mental health professionals. However, due to low recruitment and in order to reach the target sample size, participants were also recruited via their school's virtual newsletter. Data collection began in October 2023 and ended in March 2024. The final number of participants before coding for inclusion criteria was 360. The families were sorted into rural and urban samples based on the zipcodes they reported. See Table 1.1-1.3 for demographic information of the participants.

Procedures

Before beginning the survey, administration of consent took place with the parents and affirmative assent followed from the children who were eight years or older. Following the consent and assent procedure, the parents took the survey followed by their children ages eight and older who took the subjective wellbeing portion of the survey. Children seven years old or younger did not complete the child subjective wellbeing measure. Funding was applied for in April of 2023 and granted in May of 2023 to reimburse families. Participants were informed before taking the survey they would be compensated with a \$20 gift card if they were to take the survey, via the University of Minnesota Duluth's ClinCards. This procedure was approved by the University of Minnesota Institutional Review Board (IRB) before conducting the survey.

Measures

Demographic Questionnaire

Basic information regarding the child's age, race/ethnicity, diagnosis, diagnostic assessor, and gender was collected. The participants' zip codes were also collected to determine whether they were included in the rural or urban sample. Additionally, information about the socioeconomic status of the families and parental education levels were also collected. See Table 1.1-1.3 for demographic information of the participants and Appendix A for the demographic questionnaire.

Personal Resource Questionnaire (PRQ; Weinert & Brandt, 1987)

The PRQ was completed by the parents in the current study. The PRQ is a two-part, normed measure, which assesses social support (Weinert, 1987). Part one presents 10 life situations with which one may need help, and the participant is asked to respond with the

resources available to them and the satisfaction with these resources. Only part one of the PRQ was assessed in this study, as this provided information about the participants' social networks. Part one is not standardized in regards to scoring, so the current study's researchers chose to calculate each individuals' support by summing the support systems they indicated on this measure, such that a higher score indicates greater social support. Support systems included: parent, child, partner, relative or family member, friend, neighbor or co-worker, spiritual advisor, professional, agency, self-help group, no one (no one available), or nobody (prefer to handle it alone). The current study did not assess Cronbach's alpha as the measure's authors did not assess Cronbach's alpha for part one of this measure either. See Appendix B for the Personal Resource Questionnaire.

Child-Parent Relationship Scale (CPRS; Pianta, 1998)

Parents within the current study also completed the CPRS. The CPRS is a 30-item scale used to measure parental perceptions of their relationship with their children. Three subscales make-up the CPRS: conflict, dependency, and closeness. Conflicts are defined as negative aspects of the relationship, whether that be anger, unpredictability, or disobedience. Dependency is an abnormal dependence of the children on their parents. Lastly, closeness is described as the perception the parents have that their relationship with their child is warm and comfortable. An overall positive parent-child relationship emphasizes intimate parent-child relationships. Because this study focuses on the overall positive parent-child relationship, only the closeness subscale was used to assess the positive parent-child relationship.

The CPRS is a five-point Likert scale, with anchor options of: (1) *definitely does not apply*, (2) *not really*, (3) *neutral or not sure*, (4) *applies somewhat*, and (5) *definitely applies*. To

score this measure, items were grouped based on the closeness subscale and then summed together once grouped. To establish the mean, the sum was divided by the number of questions within the closeness subscale section. A higher score on the closeness subscale suggests the relationship with their child is characterized by warmth, affection, and open communication. An example of an item on the closeness scale includes: "I share an affectionate, warm relationship with my child." A higher score is desirable on the closeness scale, which is the primary interest of the study focusing on the positive aspects of the parent-child relationship. Past research found the CPRS had a Cronbach's alpha of 0.80 for overall positive relationship (Driscoll & Pianta, 2011). The current study found a Cronbach's alpha of 0.76 for the overall positive relationship, which is adequate. See Appendix C for the Child-Parent Relationship Scale.

Child and Adolescent Behavior Inventory-Parent Version (CABI; Burns et al., 2001)

Parents within the current study completed the CABI to assess mental health concerns their child was experiencing. The CABI has several different subscales that can be used separately. Therefore, the current study used the ADHD (18 items), ODD (9 items), anxiety (6 items), and depression (6 items) subscales. Only the ADHD scores are utilized in this study's analysis. Six-point anchors of (0) *almost never (never or about once per month)*, (1) *seldom (about once per week)*, (2) *sometimes (several times per week)*, (3) *often (about once per day)*, (4) *very often (several times per day)*, and (5) *almost always (many times per day)* are used within defining symptom occurrence. An example of an ADHD-HI (hyperactivity/impulsivity) item is, "Fidgets with or taps hands or feet or squirms in the seat." The CABI is scored by creating the mean scale score. Higher scores indicate greater impairment.

The CABI is a widely used measure and has been standardized for children in kindergarten through 12th grade (Burns et al., 2022). The borderline clinical range for the CABI is a score between 67-70. A score of 71 or higher indicates clinical severity. A recent study found an internal consistency of $\alpha = 0.94$ for the inattentive presentation of ADHD, $\alpha = 0.92$ for the hyperactive presentation of ADHD, $\alpha = 0.92$ for ODD, $\alpha = 0.78$ for anxiety, and $\alpha = 0.92$ for depression, which are all common comorbidities of ADHD (Burns & Becker, 2022). Convergent validity was found to be moderate to substantial with related measures for all modules (Burns et al., 2022). Discriminant validity was found to be significant as well noted by Burns et al. (2022), which is promising for its current use within this study. The current study determined that the CABI had a Cronbach's α of .95, which indicates good internal reliability. See Appendix D for the included modules of the Child and Adolescent Behavior Inventory.

Brief Multidimensional Student Life Satisfaction Scale (BMSLSS; Seligson, Huebner, and Valois, 2013)

Children eight years or older within the current study completed the BMSLSS to address child subjective wellbeing as the BMSLSS has been used on children as low as the age of eight years old (Valois et al., 2019) but has been used broadly across middle school to high school age students (Seligson et al., 2003). This measure was chosen given this study's focus on school-age children and because ADHD symptoms are commonly identified during early elementary school age. The BMSLSS has six items and assesses quality of life for school-aged children across specific domains as well as general domains of life satisfaction. There are seven domains which include: family, school, friends, self, living, environment, and general life satisfaction. The BMSLSS is a 5-point Likert scale, with anchors that include: (1) *very dissatisfied*, (2) *somewhat*

dissatisfied, (3) neither satisfied nor dissatisfied, (4) somewhat satisfied, and (5) very satisfied.

An example of an item from the friend domain is, "How satisfied or dissatisfied are you with your friendships?" To score the BMSLSS, scores were summed across the five domains and then divided by five. A Cronbach's alpha of 0.75 was attained for the BMSLSS (Seligson et al., 2002). The items also showed desirable item-total correlations ranging from 0.65-0.76 (Seligson et al., 2002). Past literature has found that construct validity was 0.46, reflecting a moderate correlation with another wellbeing scale (Seligson et al., 2002). See Appendix E for the Brief Multidimensional Student Life Satisfaction Scale. Data from the current study's sample found that the BMSLSS had a Cronbach's alpha of 0.84, which shows good internal reliability.

Data Analyses

Participant Decisions

The survey included 360 participants originally, but in order to define the location variable, participants needed to report their zipcode. Of the original 360 cases, 86 did not report their zipcode so these participants were deleted as location is one of the primary variables of interest. This left 274 cases, but 184 zipcodes were in states outside of Wisconsin and Minnesota, suggesting there were bots as the zip codes were in states which included California, Michigan, and outside of the United States. With this in mind, some of the responses appeared to be answered by bots because several responses were not reporting zipcodes or were responding outside of the Minnesota and Wisconsin school districts. This study only reached out to the schools mentioned previously, so any participants outside of those areas were assumed to be bots. These cases were deleted. After this deletion, 90 cases remained. See Figure 1 for the flowchart of inclusion and exclusion decisions based on zipcodes.

One of the inclusion criteria for this study was that the family needed to have a child diagnosed with ADHD. Of the remaining 90 cases, eight cases reported their child was not diagnosed with ADHD. However, as an alternative to parent report ADHD diagnosis for their child, researchers decided to use the parent report CABI ADHD symptom severity score. If this score was within the borderline clinical or clinically severe range of 67-70 those participants were still included in this study. Of the eight cases that reported no diagnosis of ADHD, two participants were still within the borderline clinical or clinically severe range of the ADHD CABI subscale, and were therefore included within the current study. The other six participants were deleted. The final sample size was then 84 participants. However, because the child subjective wellbeing measure was only validated on eight year olds and up, the child subjective wellbeing outcome analysis had a final sample size of 40 participants.

Power Analysis

Based on the medium effect sizes of past literature assessing similar predictors, it was estimated the current study needed a minimum of 76 participants to find a similar effect (Green, 1991). As stated previously, this study had a final sample size of 84 participants for the ADHD symptom severity outcome variable and a final sample size of 40 participants for the child subjective wellbeing outcome variable.

Missing Data

After computing missing values, missing data was found for one child participant, who reported on the child subjective wellbeing measure. This participant was missing one item out of six items, which is less than 20%, or two out of 6, items on the measure, so this participant was

not deleted. Additionally, this participant was also kept due to the lower sample size. Therefore, the missing data was adjusted using mean substitution.

Outliers

Outliers were assessed by computing z-scores of all the primary variables of interest, including positive parent-child relationships, community support, ADHD symptom severity, and child subjective wellbeing. The sample size in this study was a large sample size of more than 80 participants, as there was a final sample size of 84. Therefore, the outlier cutoff score used was ± 3.0 (Field, 2018). After z-scores were computed, no outliers were found across the primary variables of interest so no participants were deleted.

Skew

Skew was assessed by calculating the skew score, which is determined by the skew statistic divided by the skew standard error. All primary variables were assessed for skew. The skew cutoff was ± 2.58 (Field, 2018) as this was a large sample size of 84 cases. The community support variable, the PRQ-85, was found to be positively skewed with an original skew score of 2.80, which is higher than the skew critical value of ± 2.58 . Therefore, the community support variable needed to be transformed. In order to lessen the impact of the skew of the PRQ variable on the analyses, the skew was transformed by taking the square root of the PRQ variable which lessened the impact of the skew on the data. Therefore, the square root of the PRQ was used throughout the rest of the analyses.

Statistical Analysis

All hypotheses were analyzed using a multiple regression analysis. A multiple regression analysis allows the main effect of independent predictors to be considered independently and

then together in the complete model (Field, 2018). The predictors of the current study include both categorical and continuous variables, which is why a regression analysis is appropriate. The current study has three predictors: positive parent-child relationships, location, and community support. Therefore, a multiple regression analysis is best suited to test the data of the current study. The two dependent variables are continuous variables, which also fits within a regression analysis. Additionally, this study assessed the moderating effect of location on positive parent-child relationships and the two outcome variables as well as the moderating effect of location on community support and the two outcome variables. To assess this moderating effect, an interaction was computed and used in the multiple regression.

Results

Hypothesis 1: ADHD Symptom Severity

A multiple regression analysis ($n = 84$) was run to determine the relationship between positive parent-child relationships, community support, and location as predictors of ADHD symptom severity. There was a significant main effect of positive parent-child relationships on ADHD symptom severity, $r(82) = -.23, p = .02$, and this effect was still significant when the additional predictors were added, $b = -.32, t(80) = -2.42, p = .02$. However, the overall model was not significant $R = .31, F(5, 78) = 1.63, p = .16$. Community support, $b = .11, t(80) = .82, p = .41, r(82) = .08$, and location, $b = -1.06, t(80) = -1.27, p = .21, r(82) = -.09$ were not significant. There were no significant moderating effects for location on positive parent-child relationships or community support on ADHD symptom severity. The correlation between positive parent-child relationships and community support was also found to be significant, $r(82)$

= .28, $p = .00$. See Table 3 for results for regression coefficients and Table 4 for a correlation matrix for Hypothesis 1.

Hypothesis 2: Child Subjective Wellbeing

A multiple regression analysis ($n = 40$) was run to determine the relationship between positive parent-child relationships, community support, and location as predictors of child subjective wellbeing. No significant main effects among predictors were found with child subjective wellbeing, $R = .28$, $F(5, 34) = .58$, $p = .72$. There were no significant main effects for positive parent-child relationships, $b = .10$, $t(36) = .40$, $p = .69$, community support, $b = .10$, $t(36) = .41$, $p = .68$, or location, $b = -1.00$, $t(36) = -.78$, $p = .45$ on child subjective wellbeing. There were no significant moderating effects for location on positive parent-child relationships or community support on child subjective wellbeing. The correlation between positive parent-child relationships and community support was found to be significant, $r(38) = .39$, $p = .01$. See Table 5 for results for regression coefficients and Table 6 for a correlation matrix for Hypothesis 2.

Discussion

Hypothesis 1: ADHD Symptom Severity

The current study's two aims were to assess the relationship between the predictors of positive parent-child relationships, community support, and location on the outcome variables of ADHD symptom severity and child subjective wellbeing. The first part of hypothesis one of the study was that positive parent-child relationships would be significantly associated with ADHD symptom severity, which was supported. Positive parent-child relationships were significantly negatively associated with ADHD symptom severity, suggesting that positive parent-child

relationships are associated with lower ADHD symptom severity. This is in line with previous literature that parents who include their child in learning experiences, display positive parenting behaviors (Robinson et al., 2017), and hold a close and intimate relationship with their child (Taghizade et al., 2022), have the ability to mediate mental health outcomes for their child (Robinson et al., 2017; Taghizade et al., 2022). Other research has shown that children express anger less when they have parents who allow them to be their authentic selves (Yoo & Cordova, 2022). Because this is a correlational study, it could also be that lower ADHD symptom severity had a lower impact on the parent-child relationship as there could be less conflict due to less severe behavioral disruption.

Community support and its relationship to ADHD symptom severity was also assessed, but this was not shown to be a significant predictor of ADHD symptom severity. This may mean community support is not significant as a sole predictor of ADHD symptom severity. However, this study found that positive parent-child relationships and community support were significantly associated with each other. Therefore, although community support alone does not predict ADHD symptom severity, community support may contribute to positive parent-child relationships, which in turn was associated with ADHD symptom severity. This is in line with previous literature which has shown that communities serve as a protective factor for parents, as the close relationships within communities allow the communities to know the parents' children better (Crouch et al., 2020; Singh et al., 2018).

The last part of the hypothesis involved location as a moderator to the effect of the parent-child relationship and ADHD symptom severity. This hypothesis was not supported, such that location did not moderate the relationship between parent-child relationship and ADHD

symptom severity. In terms of main effects, there was no significant difference between rural and urban children and their families regarding ADHD symptom severity. This may suggest although rural families have a lack of access to high quality mental health services, there may be other aspects of ADHD symptoms that location does not fully capture. For example, rural children and families receive medication from their pediatrician or psychiatrist that may help with their ADHD symptoms which can help address those symptoms despite the location differences and access to resources. Additionally, rural children had a higher percentage of school psychologists diagnosing their ADHD than urban children so the resources that come out of the diagnostic assessment process may differ.

Hypothesis 2: Child Subjective Wellbeing

The other aim of this study was to examine the relationship between child subjective wellbeing and the predictors of positive parent-child relationships, community support, and location. Part one of hypothesis two was to assess the relationship between positive parent-child relationships and child subjective wellbeing, which was not supported by the current study. Although past literature has suggested a close and intimate parent-child relationship was related to a child's ability to experience more joy and positive emotions (Taghizade et al., 2022), other aspects of their lives could impact their wellbeing (Newland et al., 2019). This null finding may be due to interrater differences, as the parents reported on the parent-child relationship and the children reported on their wellbeing. Therefore, this difference in reporting could contribute to some discrepancies in perspectives from the caregiver and child. Additionally, children within this study reported relatively high wellbeing scores, so there may not have been adequate variability among the wellbeing scores. Although positive parenting behaviors, such as providing

warmth and support are associated with childrens' happiness across cultures, parenting beliefs and practices differ across cultures (Demir & Sumer, 2018). Parenting happiness, which is often associated with child happiness, depends on a large variety of factors, including: age, gender, child age, child functioning, family-level socioeconomic status, policies, and norms (Demir & Sumer, 2018). With this in mind, differences in parenting beliefs and parenting happiness were not assessed within the current study and could be related to child subjective wellbeing.

Community support was not significantly associated with child subjective wellbeing in the current study. Although past literature has established that social support including from peers, friends, or other community members has been related to child wellbeing, the current study did not find this relationship. This may be due to the fact that perceived social support is more predictive of mental health outcomes than objective social support (Letvak, 2002). The children reporting their wellbeing were not asked about their perceived community support because the parents reported on the community support variable. Therefore, the parent's perceived social support may differ from their child's perceived support, which could be why there was no significance found. Another reason significance was not found may be due to the fact that the sample size for collecting data for children who are eight years old or older was very small ($n = 40$), which is close to half of the original sample ($n = 84$). Therefore, this study may not have been adequately powered to find significance in this sample despite past literature that has shown a relationship between community support and elements of child wellbeing (Crouch et al., 2022; Robinson et al., 2017).

Location as a moderator did not significantly impact the association between either parent-child relationship or community support on child wellbeing. Although past literature has

stated that rural children are more likely to engage in community activities, mentorship opportunities (Crouch et al., 2020), and establish close community bonds (Crouch et al., 2020; Singh et al., 2018), which could influence their overall mental health concerns and general wellbeing, there may be some reasons why the relationship between community support and child subjective wellbeing was not supported. For example, urban children may have similar aspects of their communities that do not significantly differ from rural children when it comes to their wellbeing. Another reason location was not significantly associated with child subjective wellbeing may be that the rural area within the current study had similar resources to the urban area, as it is within twenty minutes of a highly populated area. This may suggest that rural children have similar experiences to their urban counterparts within the current study.

Additionally, the urban sample was recruited from charter schools within the Minneapolis and St. Paul area school districts rather than public schools. Therefore, qualities may differ amongst charter schools when compared to public schools. For example, charter schools often have a cap on admission, while public schools do not, meaning that children may have smaller classroom sizes, similar to rural schools. Additionally, charter schools are funded by both government and other funding sources, suggesting there may be an understanding of community among charter school students. Another reason this hypothesis was not supported may be due to the similarities across rural and urban childrens' own sense of community. Past literature found that communities especially bound together by tradition and loyalty where teamwork, participation, and consensus are valued, are helpful in fostering a strong sense of community (Boyd & Larson, 2022). Although the relationship between community support and child subjective wellbeing was

hypothesized to be different among rural and urban children, a sense of community may still be present depending on their own unique traditions.

Implications

The findings for this study show important implications for schools and practitioners working with children and families with children that have ADHD. Importantly, positive parent-child relationships may have the ability to decrease symptom severity for children with ADHD. Therefore, schools and practitioners may want to focus on increasing the positive aspects of the parent-child relationship in addition to addressing the conflicts in parent-child relationships instead of focusing solely on the negative aspects of the parent-child relationship.

An option for increasing positive aspects of the parent-child relationships may be for mental health practitioners to ask the families they work with to engage in gratitude. Gratitude has been shown in past literature to be related to the wellbeing of the parent-child dyad and the child's own wellbeing (Obeldobel & Kerns, 2021). Asking parents and children to reflect on positive aspects of their relationship could be helpful in strengthening a positive parent-child relationship.

Another implication of this study is that positive parent-child relationships and community support were significantly related to each other across the two outcome variables of ADHD symptom severity and child subjective wellbeing. Therefore, the data shows that communities have the ability to influence the elements of the parent-child relationship or vice versa, so continuing to support parent-child dyads across communities may be particularly beneficial, especially for children who have mental health concerns, like ADHD.

One takeaway that professionals may utilize from the relationship between positive parent-child relationships and community support may be to leverage community supports and resources within the school and broader community. For example, providing resources for caregivers and their children to engage in extracurricular activities together with their children could be an excellent way to support the parent-child relationship. Setting up a parent association within the school to host community activities and community bonding could also be a way to benefit the parent-child relationship. In this way, parents may feel a sense of community, which may support their ability to engage in positive communication with their children.

Strengths, Limitations, and Future Research Directions

The strengths of the current study is that it adds to the current literature supporting the importance of positive parent-child relationships and their association to children's mental health concerns, including ADHD symptom severity. Importantly, this study includes a clinical sample as all kids who were included in the current study were diagnosed with ADHD and/or were in the clinical range for ADHD symptom severity.

Additionally, because this is a community-based correlational study, the results will be applicable for the Superior, Wisconsin and Minneapolis, Minnesota schools this study collaborated with. Therefore, the results directly reflect the patterns within their schools and what they are doing well. The results of this study were presented to the collaborators in late April of 2024 to inform policy and practice in the schools. Relatedly, the current study recruited from rural, public schools, and urban, charter schools. With this in mind, future research may want to explore what makes charter schools and public schools unique from each other, specifically related to the variables of community support and child wellbeing.

The current study has limitations to keep in mind when interpreting the data. One limitation is the child subjective wellbeing measure greatly limited the amount of children that were able to participate in the child portion of the current study, as it is only validated for children who are eight years or older. Therefore, the sample may not have been adequately powered to find significance. Future research should focus on more inclusive measures of child subjective wellbeing which include the ability to assess children under the age of eight years old.

This sample was recruited from the Superior, Wisconsin and Minneapolis, Minnesota school districts, so this study may not be generalizable to a larger population outside of this area. Relatedly, the recruitment methods first used were to recruit from 504 or IEP Plan meetings. However, no participants responded to the survey using that method. Therefore, the researchers pivoted to having the school psychologists, case managers, or special education teachers reach out to the families individually but this did not increase the sample either. Lastly, the researchers recruited from the school's electronic newsletter which acquired the full sample. Future research should work to recruit a larger sample from more diverse populations to generalize the findings more broadly.

The current study found that positive parent-child relationships and community support are significantly related to each other. Although community support was shown to be a protective factor for parents in past literature (Crouch et al., 2020; Singh et al., 2018), the significance of this relationship was unexpected. Therefore, future research may want to focus on the nuances of the relationship between positive parent-child relationships and community support. Exploring this relationship may shed light on specific moderators or mediators within this relationship as

well as inform policies, schools, and broader professionals, about how to best support children and families.

Conclusion

The current study adds to the current state of the literature by supporting the importance of the relationship between positive parent-child relationships and behavioral concerns, specifically ADHD. This study found that positive parent-child relationships are related to less severe ADHD symptom severity which can inform professionals and support families with children diagnosed with ADHD. Importantly, positive parent-child relationships and community support are significantly associated with each other, suggesting that supporting one may support the other and vice versa. Exploring the nuances of this relationship, recruiting a larger sample size, and creating and testing a more inclusive measure of child subjective wellbeing are all important future research directions to inform policy and practice among schools and professionals working with children and families. Despite the current study's limitations, it is unique in its stance of focusing on strengths and assets of children and families, specifically rural children and families as past literature has focused much more on deficits of these families.

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Table 1.1*Demographic Characteristics of Participants*

Sample Characteristics	<i>n</i>	%
Age		
7 years or younger	38	45.2
8 years or older	46	54.8
Gender		
Boy	58	69.0
Girl	26	31.0
Ethnicity		
Hispanic or Latino	20	23.8
Not Hispanic or Latino	64	76.2
Race		
American Indian or Alaska Native	4	4.8
Asian	3	3.6
Black or African American	23	27.4
Native Hawaiian or Other Pacific Islander	1	1.2
White	50	59.5
Multiracial	3	3.6
School Attended		
Nova Classical Academy	18	21.4
Great River School	10	11.9

Cooper Elementary School	23	27.4
Lake Superior Elementary School	10	11.9
Superior High School	8	9.5
Great Lakes Elementary School	10	11.9
Bryant Elementary School	3	3.6
Four Corners Elementary School	2	2.4

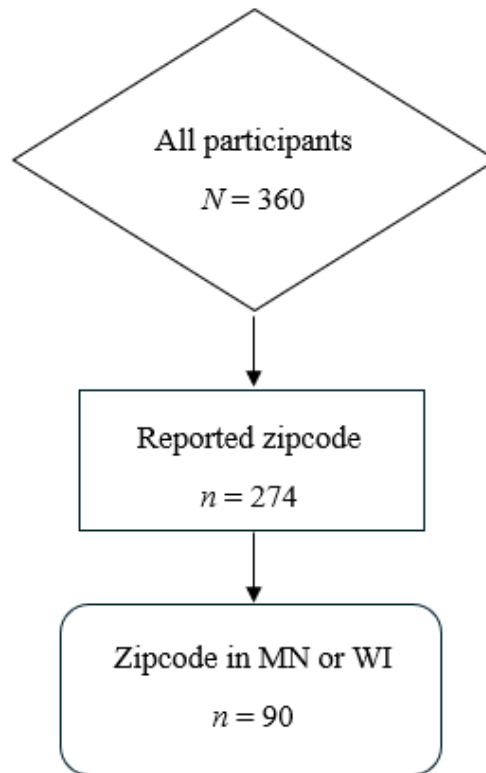
Table 1.2*Demographic Characteristics of Caregivers*

Caregiver Characteristics	<i>n</i>	%
Relationship to Child		
Biological Mother	44	52.4
Biological Father	33	39.3
Step-Parent	2	2.4
Guardian	2	2.4
Foster Parent	3	3.6
Gross Household Annual Income		
Less than \$9,999	2	2.4
\$10,000-19,000	8	9.5
\$20,000-29,000	9	10.7
\$30,000-39,000	6	7.1
\$40,000-49,000	11	13.1
\$50,000-59,000	2	2.4
\$60,000-69,000	5	6.0
\$70,000-79,000	9	10.7
\$80,000-89,000	9	10.7
\$90,000-99,000	7	8.3
Greater than \$100,000	16	19.0

Table 1.3*ADHD Characteristics of Participants*

ADHD Characteristics	<i>n</i>	%
ADHD Diagnosis		
Yes	82	97.6
No	2	2.4
Age of ADHD Diagnosis		
2 years old	2	2.4
3 years old	7	8.3
4 years old	17	20.2
5 years old	13	15.5
6 years old	13	15.5
7 years old	7	8.3
8 years old	9	10.7
9 years old	2	2.4
10 years old	3	3.6
11 years old	2	2.4
12 years old	3	3.6
13 years old	2	2.4
18 years old	1	1.2
ADHD Diagnostic Assessor		
School Psychologist	8	9.5

Clinical Psychologist or Other Mental Health Professional	38	45.2
Neuropsychologist	4	4.8
Pediatrician	27	32.1
Psychiatrist	2	2.4
Nurse Practitioner	2	2.4
Other	1	1.2
Taking Medication		
Yes	72	85.7
No	9	10.7
Medication Prescriber		
Pediatrician	39	46.4
Psychiatrist/Nurse Practitioner	37	44.0
Other	2	2.4
Receiving Psychotherapy		
Yes	55	65.5
No	29	34.5

Figure 1*Flowchart of Participant Decisions*

Note. Participant decisions regarding the reporting of zipcodes, and therefore location, are shown.

Table 2

Overall Model of Positive Parent-Child Relationships, Community Support, and Location on ADHD Symptom Severity and Child Subjective Wellbeing

Variable	<i>R</i>	<i>F (df)</i>	<i>p</i>
ADHD Symptom Severity	.31	1.63 (5, 78)	.16
Child Subjective Wellbeing	.28	.56 (5, 34)	.72

Note. $N = 84$ for ADHD Symptom Severity Model and $N = 40$ for Child Subjective Wellbeing Model.

Table 3

Regression Coefficients of Associations Between ADHD Symptom Severity and Positive Parent-Child Relationships, Community Support, and Location

Variable	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Positive Parent-Child Relationships	-0.32	.44	-2.42	.02*
Community Support	0.11	2.03	0.82	.41
Location	-1.06	33.41	-1.27	.21
Location by Positive Parent-Child Relationships	0.73	.83	0.88	.38
Location by Community Support	0.30	3.76	0.64	.52

Note. $N = 84$, $*p < .05$. Regression coefficients reported above are standardized.

Table 4*Correlation Matrix for all Primary Variables of Interest and ADHD Symptom Severity*

Variables		ADHD Symptom Severity	Positive Parent-Child Relationships	Community Support	Location	Location by Positive Parent-Child Relationships	Location by Community Support
ADHD Symptom Severity	<i>r</i>	1	-.23	.08	-.09	-.09	-.05
	<i>p</i>		.02*	.24	.22	.22	.34
Positive Parent-Child Relationships	<i>r</i>	-.23	1	.28	.09	.17	.12
	<i>p</i>	.02*		< .01**	.22	.07	.15
Community Support	<i>r</i>	.08	.28	1	-.07	-.05	.08
	<i>p</i>	.24	< .01**		.27	.33	.23
Location	<i>r</i>	-.09	.09	-.07	1	.98	.96
	<i>p</i>	.22	.22	.27		< .01**	< .01**
Location by Positive Parent-Child Relationships	<i>r</i>	-.09	.17	-.05	.98	1	.96
	<i>p</i>	.22	.07	.33	< .01**		< .01**
Location by Community Support	<i>r</i>	-.05	.12	.08	.96	.96	1
	<i>p</i>	.34	.15	.23	< .01**	< .01**	

Note. $N = 84$. * $p < .05$, ** $p < .01$.

Table 5

Regression Coefficients of Associations Between Child Subjective Wellbeing and Positive Parent-Child Relationships, Community Support, and Location

Variable	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Positive Parent-Child Relationships	0.10	.22	0.40	.69
Community Support	0.10	.99	0.41	.68
Location	-1.04	13.11	-0.76	.45
Location by Positive Parent-Child Relationship	1.09	.35	0.74	.46
Location by Community Support	-0.01	1.44	-0.02	.99

Note. $N = 40$. Regression coefficients reported above are standardized.

Table 6*Correlation Matrix for all Primary Variables of Interest and Child Subjective Wellbeing*

Variables		Child Subjective Wellbeing	Positive Parent-Child Relationships	Community Support	Location	Location by Positive Parent-Child Relationships	Location by Community Support
Child Subjective Wellbeing	<i>r</i>	1	.24	.16	.02	.06	.06
	<i>p</i>		.07	.16	.45	.36	.37
Positive Parent-Child Relationships	<i>r</i>	.24	1	.39	.05	.14	.10
	<i>p</i>	.07		< .01**	.37	.19	.28
Community Support	<i>r</i>	.16	.39	1	-.07	-.04	.13
	<i>p</i>	.16	< .01**		.34	.40	.21
Location	<i>r</i>	.02	.05	-.07	1	1.00	.95
	<i>p</i>	.45	.37	.34		< .01**	< .01**
Location by Positive Parent-Child Relationships	<i>r</i>	.02	.14	-.04	1.00	1	.95
	<i>p</i>	.45	.19	.40	< .01**		< .01**
Location by Community Support	<i>r</i>	.06	.10	.13	.95	.95	1
	<i>p</i>	.37	.28	.21	< .01**	< .01**	

Note. $N = 40$. * $p < .05$, ** $p < .01$.

Appendix A: Consent Form

Title of Research Study: Children's Wellbeing and ADHD among Urban and Rural Families

Investigator Team Contact Information

For questions about research appointments, the research study, research results, or other concerns, call the study team at:

Investigator Name: Kathy Dowell, Ph.D., L.P. University of Minnesota Duluth Psychology Department Phone Number: (218) 726-6742 Email Address: kdowell@d.umn.edu	Student Investigator Name: Callie Coleman Phone Number: (507) 514-1627 Email Address: colem910@d.umn.edu
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Supported By: This research is supported by the University of Minnesota Duluth Psychology Department.

Key Information About This Research Study

The following is a short summary to help you decide whether or not to be a part of this research study. More detailed information is listed later on in this form.

What is research?

- The goal of research is to learn new things in order to help people in the future. Investigators learn things by following the same plan with a number of participants, so they do not usually make changes to the plan for individual research participants. You, as an individual, may or may not be helped by volunteering for a research study.

Why am I being invited to take part in this research study?

We are asking you to take part in this research study because your child is enrolled in a school that is participating as a data collection collaborator. Your child's school case manager, counselor, or psychologist is inviting families of students who are requesting or receiving academic support for ADHD and/or other learning difficulties to participate in this study.

What should I know about a research study?

- The pamphlet you were handed will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.

- You can ask all the questions you want before you decide. Contact information is available at the top of this consent form.

Why is this research being done?

The purpose of this research is to understand the strengths and experiences of families with a child with ADHD and the support they can get from their communities. Each family will receive \$20 for their participation.

How long will the research last?

We expect that you will be in this research study for about 15-20 minutes.

What will I need to do to participate?

You will be asked to fill out a brief survey, one portion filled out by the guardian and the other filled out by the child. More detailed information about the study procedures can be found under "What happens if I say yes, I want to be in this research?"

Will being in this study help me in any way?

We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits include providing information that may help schools provide more effective general support to students and their families.

What happens if I do not want to be in this research?

There are no known alternatives, other than deciding not to participate in this research study. Nothing, it will have no impact on the services your child receives from the school.

Detailed Information About This Research Study

The following is more detailed information about this study in addition to the information listed above.

How many people will be studied?

We expect about 15-20 families from your child's school will be in this research study out of 80 to 120 families in the entire study regionally.

What happens if I say "Yes, I want to be in this research"?

If you decide to participate in this study, you will be asked about your child, the supports your family receives, and your relationship with your child. Your child will also be asked about different domains in their life, including school and other areas of their life.

What are my responsibilities if I take part in this research?

If you take part in this research, you will be responsible for completing the survey.

What happens if I say “Yes”, but I change my mind later?

You can leave the research study at any time, and no one will be upset by your decision.

Choosing not to be in this study or to stop being in this study will not result in any penalty to you or loss of benefit to which you are entitled. This means that your choice not to be in this study will not negatively affect your right to compensation.

What are the risks of being in this study? Is there any way being in this study could be bad for me? (Detailed Risks)

There are no serious risks to participating in this survey. You may experience mild distress as you reflect on your child's ADHD or learning difficulties.

Will it cost me anything to participate in this research study?

There will be no cost to you for any of the study activities or procedures.

What happens to the information collected for the research?

No names will be linked to survey responses, and you can choose to provide your name and address in a separate survey at the end to receive compensation. All of this information will only be accessed by the two investigators and stored in a secure database.

We will share the combined results of this study with the participating school administrators, but no individual results will be included. We may also publish the results of this research as a combined sample, no individual results will be included.

Whom do I contact if I have questions, concerns or feedback about my experience?

To reach the research team: Please see the “Investigator Contact Information” section at the beginning of this form.

To reach someone outside of the research team: This research has been reviewed and approved by an IRB within the Human Research Protections Program (HRPP). To share feedback privately with the HRPP about your research experience, call the Research Participants' Advocate Line at 612-625-1650 (Toll Free: 1-888-224-8636) or go to z.umn.edu/participants. You are encouraged to contact the HRPP if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You are having difficulty reaching the research team.

- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide feedback about this research.

Will I have a chance to provide feedback after the study is over?

If you are asked to complete a survey and you would like to share feedback, please contact the study team or the HRPP. See the “Investigator Contact Information” of this form for study team contact information and “Whom do I contact if I have questions, concerns or feedback about my experience?” of this form for HRPP contact information.

Can I be removed from the research?

Your responses may be removed from the research if you do not complete the surveys.

Will I be compensated for my participation?

If you agree to take part in this research study, we will pay you \$20 for your time and effort. Payment will be made using a pre-paid debit card called ClinCard. It works like a bank debit card. We will give you a debit card and you will receive payment for participation in this study after you have completed the survey.

You may use this card at any store that accepts MasterCard or you can use a bank machine to remove cash. However, there may be fees drawn against the balance of the card for cash withdrawals (ATM use) and inactivity (no use for 6 months). We will give you the ClinCard Frequently Asked Questions information sheet that answers common questions about the debit card. You will also receive letters with additional information on how you can use this card and who to call if you have any questions. Be sure to read these letters, including the cardholder agreement, for details about fees.

The debit card system is administered by an outside company. The company, Greenphire, will be given your name, address, and birthdate. They will use this information as part of the payment process. They will not receive any information about your health status or the study in which you are participating.

Additionally, you will have the option to receive updates related to payment reminders and updates via text message and email message (Standard text messaging rates will apply). You will have the opportunity to opt-in to receive these messages, you are not required to provide your cell phone or email address to be enrolled in the study or use a ClinCard. If you choose to receive messages and decide later that you want to stop these messages, you will have the ability to opt-out.

Payment you receive as compensation for participation in research is considered taxable income.

Optional Elements:

The following research activities are optional, meaning that you do not have to agree to them in order to participate in the research study. Please indicate your willingness to participate in these optional activities by placing your initials next to each activity.

Yes,
I agree

No,
I disagree

_____ _____ The investigator may contact me in the future to see whether I am interested in participating in other research studies by Callie Coleman

_____ _____ I would like to receive reminders using Greenphire.

If yes, provide the following contact information:

Email Address: _____

Phone Number: _____

Signature Block for Capable Adult:

Your signature documents your permission to take part in this research. You will be provided a copy of this signed document.

Signature of Participant

Date

Printed Name of Participant

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

Appendix B: Assent Form

Title of Research Study: Children's Wellbeing and ADHD among Urban and Rural Families

Researcher: Callie Coleman

Sponsor: University of Minnesota Duluth

What is research?

Researchers are committed to your care and safety. There are important differences between research and treatment plans: The goal of research is to learn new things in order to help groups of kids in the future. Researchers learn things by asking a question, making a plan, and testing it.

Why am I being asked to take part in this research study?

A research study is usually done to find a better way to treat people or to understand how things work. You are being asked to take part in this research study because your school case manager, counselor, or psychologist is trying to help you do your best in school this year.

What should I know about being in a research study?

You do not have to be in this study if you do not want to do so. It is up to you if you want to participate and if you want to, talk to your parents or guardians about any questions or concerns you have about the study. You can choose not to take part now and change your mind later if you want. If you decide you do not want to be in this study, no one will be mad at you. You can ask all the questions you want before you decide.

If you become an adult (turn 18 years old) during this study, we will ask you if you want to continue to be in this study as an adult.

Why is this research being done?

In this study, I want to find out more about how your family is being supported when using services at school and in your community to better serve you and your family in the future.

How long will the research last?

I expect that it will take you 10 minutes.

What happens if I say "Yes, I want to be in this research"?

If it is okay with you and you agree to join this study, you will be asked to fill out 6 questions on a phone or other device.

What happens to the information collected for the research?

The researchers will share your information, including research study records, to only people who have a need to review this information. For example, sometimes researchers need to share information with the University or other people that work in research to make sure the researchers are following the rules. The researchers may publish the results of this research or share the resulting data. However, we will keep your name and other identifying information confidential.

What else do I need to know?

If you agree to take part in this research study, the researcher will give your family \$20.

Who can I talk to?

For questions about research appointments, the research study, research results, or other concerns, call the study team at:

Researcher Name: Kathy Dowell University of Minnesota Duluth Psychology Department Phone Number: (218) 726-6742 Email Address: kdowell@d.umn.edu	Study Staff (if applicable): Callie Coleman Phone Number: (507) 514-1627 Email Address: colem910@d.umn.edu
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To reach the research team: Please see the “Investigator Contact Information” section above.

To reach someone outside of the research team: This research has been reviewed and approved by an Institutional Review Board (IRB), a group of people that look at the research before it starts. This group is part of the Human Research Protection Program (HRPP). To share concerns privately with the HRPP about your research experience, call the Research Participants' Advocate Line at 612-625-1650 (Toll Free: 1-888-224-8636) or go to z.umn.edu/participants. You are encouraged to contact the HRPP if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You are having difficulty reaching the research team.
- You want to talk to someone besides the research team or your parents.
- You have questions about your rights as a research participant.
- You want to get information or provide feedback about this research.

Signature Block for Child Assent

Signature of child

Date

Printed name of child

Printed name of person obtaining assent

Date

Signature of person obtaining assent

Appendix C: Demographic Questionnaire

1. What is your child's age? [enter number] _____
2. What was your child's gender?
 - a. Boy
 - b. Girl
 - c. Nonbinary
 - d. Transgender
3. How do you describe your child's ethnicity?
 - a. Hispanic or Latino
 - b. Not Hispanic or Latino
4. How do you describe your child's race?
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Native Hawaiian or Other Pacific Islander
 - e. White
5. What is your zipcode? _____
6. Where does your child attend school? _____
7. Has your child been diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD)?
 - a. Yes
 - b. No
8. How old was your child when they were diagnosed with ADHD? [enter number] _____
9. If your child has been diagnosed with ADHD, how did they get diagnosed?
 - a. Assessment conducted by a school psychologist
 - b. Assessment conducted by a clinical psychologist or other mental health professional
 - c. Assessment conducted by a neuropsychologist
 - d. Assessment conducted by a pediatrician
 - e. Assessment conducted by a psychiatrist
 - f. Assessment conducted by a nurse practitioner
 - g. Self-diagnosed
 - h. Other (please specify): _____
10. Is your child currently taking medication for their ADHD?
 - a. Yes
 - b. No
11. Who prescribed the medication for their ADHD?
 - a. Pediatrician
 - b. Psychiatrist/nurse practitioner
 - c. Other (please specify): _____
12. Is your child receiving psychotherapy?
 - a. Yes
 - b. No

13. Does your child have other mental health diagnoses?
 - a. Yes
 - b. No
14. If your child has other mental health diagnoses, which of the following are they diagnosed with (please check all that apply)?
 - a. Depression
 - b. Anxiety
 - c. Oppositional Defiant Disorder (ODD)
 - d. Autism Spectrum Disorder
 - e. Other (please specify): _____
15. What is your relationship to this child?
 - a. Biological Mother
 - b. Biological Father
 - c. Step-parent
 - d. Grandparent
 - e. Guardian
 - f. Foster Parent
 - g. Other (please specify): _____
16. What is your gross annual income?
 - a. Less than \$9,999
 - b. \$10,000-\$19,999
 - c. \$20,000-\$29,999
 - d. \$30,000-\$39,999
 - e. \$40,000-\$49,999
 - f. \$50,000-\$59,999
 - g. \$60,000-\$69,999
 - h. \$70,000-\$79,999
 - i. \$80,000-\$89,999
 - j. \$90,000-\$99,999
 - k. Greater than \$100,000

Appendix D: Personal Resource Questionnaire

In our everyday lives there are personal and family situations or problems that we must deal with. Some of these are listed below. Please consider each statement in light of your own situation. CIRCLE the number before the person(s) that you could count on most in each situation that is described. You may circle more than one number if there is more than one source of help that you count on. In addition, we would like to know if you have had this situation or a similar one in the past SIX MONTHS, and how satisfied you are with the help you received.

1A. If you were to **experience urgent needs (crisis)**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain)_____

B. Have you had urgent needs (crisis) in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have experienced urgent needs (crisis) in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

2A. If you needed **help for an extended period of time in caring for a family member who is sick or handicapped**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain) _____

B. Have you needed help in caring for a sick or handicapped family member in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have needed help in caring for a sick or handicapped family member in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

3A. If you were **concerned about your relationship with your spouse, partner, or intimate other**, who would you turn to for help?

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY

10 SELF-HELP GROUP

11 NO ONE (No one available)

12 NO ONE (Prefer to handle it alone)

13 OTHER (Please explain) _____

B. Have you had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS?

1 YES

2 NO (If NO, skip to Q-2a.)

C. If you have had concerns about your relationship with your spouse, partner, or intimate other in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED

2 FAIRLY DISSATISFIED

3 A LITTLE DISSATISFIED

4 A LITTLE SATISFIED

5 FAIRLY SATISFIED

6 VERY SATISFIED

4A. If you needed help or advice for a **problem with a family member or friend** who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT

2 CHILD OR CHILDREN

3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER

4 A RELATIVE OR FAMILY MEMBER

5 FRIEND

6 NEIGHBOR OR CO-WORKER

7 SPIRITUAL ADVISOR (minister, priest, etc.)

8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)

9 AGENCY

10 SELF-HELP GROUP

11 NO ONE (No one available)

12 NO ONE (Prefer to handle it alone)

13 OTHER (Please explain) _____

B. Have you needed help or advice regarding a problem with a family member or friend in the past SIX MONTHS?

1 YES

2 NO (If NO, skip to Q-2a.)

C. If you have needed help or advice in the past SIX MONTHS regarding a problem with a member or friend, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

5A. If you were having **financial problems**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain) _____

B. Have you had financial problems in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have had financial problems in the past SIX MONTHS to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

6A. If you **felt lonely**, who would you turn to? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain) _____

B. Have you felt lonely in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have felt lonely, in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

7A. If you were **sick and not able to carry out your usual activities for a week or so**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY

10 SELF-HELP GROUP

11 NO ONE (No one available)

12 NO ONE (Prefer to handle it alone)

13 OTHER (Please explain) _____

B. During the past SIX MONTHS, have you been sick for a week and not able to carry out your usual activities?

1 YES

2 NO (If NO, skip to Q-2a.)

C. If you have been sick for a week in the past SIX MONTHS to what extent do you feel satisfied with the help you received?

1 VERY DISSATISFIED

2 FAIRLY DISSATISFIED

3 A LITTLE DISSATISFIED

4 A LITTLE SATISFIED

5 FAIRLY SATISFIED

6 VERY SATISFIED

8A. If you were **upset and frustrated with the conditions of your life**, who would you turn to for help? (Please CIRCLE all that apply.)

1 PARENT

2 CHILD OR CHILDREN

3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER

4 A RELATIVE OR FAMILY MEMBER

5 FRIEND

6 NEIGHBOR OR CO-WORKER

7 SPIRITUAL ADVISOR (minister, priest, etc.)

8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)

9 AGENCY

10 SELF-HELP GROUP

11 NO ONE (No one available)

12 NO ONE (Prefer to handle it alone)

13 OTHER (Please explain) _____

B. Have you been upset and frustrated with the conditions of your life in the past SIX MONTHS?

1 YES

2 NO (If NO, skip to Q-2a.)

C. If you have been upset and frustrated with the conditions of your life in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

9A. If you were having **problems with your work at home or at your place of employment**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain) _____

B. Have you had problems related to your work in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have had problems with your work situation in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

10A. If you needed someone to talk to about your day-to-day **personal concerns**, who would you turn to for help? (Please CIRCLE all that apply.)

- 1 PARENT
- 2 CHILD OR CHILDREN
- 3 SPOUSE OR PARTNER OR SIGNIFICANT OTHER
- 4 A RELATIVE OR FAMILY MEMBER
- 5 FRIEND
- 6 NEIGHBOR OR CO-WORKER
- 7 SPIRITUAL ADVISOR (minister, priest, etc.)
- 8 PROFESSIONAL (nurse, counselor, social worker, employer, etc.)
- 9 AGENCY
- 10 SELF-HELP GROUP
- 11 NO ONE (No one available)
- 12 NO ONE (Prefer to handle it alone)
- 13 OTHER (Please explain)_____

B. Have you needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS?

- 1 YES
- 2 NO (If NO, skip to Q-2a.)

C. If you have needed someone to talk to about day-to-day personal concerns in the past SIX MONTHS, to what extent do you feel satisfied with the help you received?

- 1 VERY DISSATISFIED
- 2 FAIRLY DISSATISFIED
- 3 A LITTLE DISSATISFIED
- 4 A LITTLE SATISFIED
- 5 FAIRLY SATISFIED
- 6 VERY SATISFIED

Appendix E: Child-Parent Relationship Scale (CPRS)

CHILD-PARENT RELATIONSHIP SCALE

Robert C. Planta

Child: _____ Age: _____

Parent: _____

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5
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1. I share an affectionate, warm relationship with my child.	1	2	3	4	5
2. My child and I always seem to be struggling with each other.	1	2	3	4	5
3. If upset, my child will seek comfort from me.	1	2	3	4	5
4. My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5. My child values his/her relationship with me.	1	2	3	4	5
6. My child appears hurt or embarrassed when I correct him/her.	1	2	3	4	5
7. My child does not want to accept help when he/she needs it.	1	2	3	4	5
8. When I praise my child, he/she beams with pride.	1	2	3	4	5
9. My child reacts strongly to separation from me.	1	2	3	4	5
10. My child spontaneously shares information about himself/herself.	1	2	3	4	5
11. My child is overly dependent on me.	1	2	3	4	5
12. My child easily becomes angry at me.	1	2	3	4	5
13. My child tries to please me.	1	2	3	4	5
14. My child feels that I treat him/her unfairly.	1	2	3	4	5
15. My child asks for my help when he/she really does not need help.	1	2	3	4	5
16. It is easy to be in tune with what my child is feeling.	1	2	3	4	5
17. My child sees me as a source of punishment and criticism.	1	2	3	4	5
18. My child expresses hurt or jealousy when I spend time with other children.	1	2	3	4	5
19. My child remains angry or is resistant after being disciplined.	1	2	3	4	5
20. When my child is misbehaving, he/she responds to my look or tone of voice.	1	2	3	4	5
21. Dealing with my child drains my energy.	1	2	3	4	5
22. I've noticed my child copying my behavior or ways of doing things.	1	2	3	4	5
23. When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
24. My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
25. Despite my best efforts, I'm uncomfortable with how my child and I get along.	1	2	3	4	5
26. I often think about my child when at work.	1	2	3	4	5
27. My child whines or cries when he/she wants something from me.	1	2	3	4	5
28. My child is sneaky or manipulative with me.	1	2	3	4	5
29. My child openly shares his/her feelings and experiences with me.	1	2	3	4	5
30. My interactions with my child make me feel effective and confident as a parent.	1	2	3	4	5

Appendix F: Child and Adolescent Behavior Inventory- Parent Version (CABI)

CABI ADHD: Hyperactivity Module

PART 5: The occurrence of these nine behaviors (items 1 to 9) is NOT due to oppositional behavior, defiance, anger, hostility or a failure to understand the task or the instructions.

	Please circle the answer that indicates how often the behavior has occurred in the last month at home and in the community (Do not consider behavior at school).	Almost Never (Never or about once per month)	Seldom (about once per week)	Sometimes (several times per week)	Often (about once per day)	Very Often (several times per day)	Almost Always (many times per day)
1	Fidgets with or taps hands or feet or squirms in seat	0	1	2	3	4	5
2	Leaves his or her seat when remaining seated is expected	0	1	2	3	4	5
3	Runs about or climbs on things when inappropriate (adolescents may report excessive feelings of restlessness)	0	1	2	3	4	5
4	Too loud or noisy during activities	0	1	2	3	4	5
5	Acts as if "driven by motor" or seems "on the go" (e.g., unable to be still or seems uncomfortable/restless being still for an extended time; difficult to keep up with)	0	1	2	3	4	5
6	Talks too much	0	1	2	3	4	5
7	Blurts out answers before questions are completed	0	1	2	3	4	5
8	Has difficulty waiting turn	0	1	2	3	4	5
9	Interrupts or intrudes on others	0	1	2	3	4	5

Does the presence of these 9 behaviors CURRENTLY cause academic difficulties for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Does the presence of these 9 behaviors CURRENTLY cause social difficulties (e.g., difficulties in interactions with parents, siblings, peers, other adults at community activities) for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

CABI ADHD: Inattention Module

PART 4: The occurrence of the following nine behaviors (items 1 to 9) is NOT due to oppositional behavior, defiance, anger, hostility, or a failure to understand the task or the instructions.

	Please circle the answer that indicates how often the behavior has occurred in the last month at home and in the community (Do not consider behavior at school).	Almost Never (Never or about once per month)	Seldom (about once per week)	Sometimes (several times per week)	Often (about once per day)	Very Often (several times per day)	Almost Always (many times per day)
1	Fails to give close attention to details or makes careless mistakes	0	1	2	3	4	5
2	Has difficulty keeping attention focused during tasks	0	1	2	3	4	5
3	Does not seem to listen when spoken to directly	0	1	2	3	4	5
4	Does not follow through on instructions and fails to finish tasks	0	1	2	3	4	5
5	Shows poor organizational skills	0	1	2	3	4	5
6	Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3	4	5
7	Loses things	0	1	2	3	4	5
8	Easily distracted by irrelevant (minor or little) things	0	1	2	3	4	5
9	Forgetful in daily activities	0	1	2	3	4	5

Does the presence of these 9 behaviors CURRENTLY cause academic difficulties for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Does the presence of these 9 behaviors CURRENTLY cause social difficulties (e.g., difficulties in interactions with parents, siblings, peers, other adults at community activities) for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

CABI Oppositional Defiant Disorder (ODD) Module

PART 6: BEHAVIOR TOWARD OTHERS *IN THE HOME AND COMMUNITY (not at school)*

	Please circle the answer that indicates how often the behavior has occurred in the last month at home and in the community (Do not consider behavior at school).	Almost Never (Never or about once per month)	Seldom Occurs (about once per week)	Sometimes (several times per week)	Often (about once per day)	Very Often (several times per day)	Almost Always (many times per day)
1	Argues with adults	0	1	2	3	4	5
2	Loses temper with others	0	1	2	3	4	5
3	Actively defies or refuses to obey adults' requests or rules	0	1	2	3	4	5
4	Annoys others on purpose	0	1	2	3	4	5
5	Blames others for his or her mistakes or misbehavior	0	1	2	3	4	5
6	Becomes annoyed or irritated by the behavior of others	0	1	2	3	4	5
7	Appears angry or resentful toward others	0	1	2	3	4	5
8	Spiteful or vindictive toward others (e.g., says mean things to hurt adults' feelings or does mean things to get back at adults)	0	1	2	3	4	5
9	Seems irritable/cranky for no apparent reason	0	1	2	3	4	5

Does the presence of these 9 behaviors CURRENTLY cause academic difficulties for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Does the presence of these 9 behaviors CURRENTLY cause social difficulties (e.g., difficulties in interactions with parents, siblings, peers, other adults at community activities) for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

CABI Anxiety Module

PART 2

	Please circle the answer that indicates how often the behavior has occurred in the last month at home and in the community (Do not consider behavior at school).	Almost Never (Never or about once per month)	Seldom (about once per week)	Sometimes (several times per week)	Often (about once per day)	Very often (several times per day)	Almost Always (many times per day)
1	Seems anxious about separation from parents	0	1	2	3	4	5
2	Seems anxious about many things (e.g., worries about nearly everything)	0	1	2	3	4	5
3	Seems anxious about specific objects or situations (e.g., dogs, insects, storms getting shots, sight of blood, heights)	0	1	2	3	4	5
4	Seems anxious about contamination (e.g., anxious about germs)	0	1	2	3	4	5
5	Seems anxious about being in social situations	0	1	2	3	4	5
6	Reports having headaches, stomachaches, or feeling sick when there is no obvious reason	0	1	2	3	4	5

Does the presence of these 6 behaviors CURRENTLY cause academic difficulties for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Does the presence of these 6 behaviors CURRENTLY cause social difficulties (e.g., difficulties in interactions with parents, siblings, peers, other adults at community activities) for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

CABI Depression Module

PART 3

	Please circle the answer that indicates how often the behavior has occurred in the last month at home and in the community (Do not consider behavior at school).	Almost Never (Never or about once per month)	Seldom (about once per week)	Sometimes (several times per week)	Often (about once per day)	Very often (several times per day)	Almost Always (many times per day)
1	Seems sad, unhappy, or depressed	0	1	2	3	4	5
2	Seems to feel worthless	0	1	2	3	4	5
3	Seems lonely	0	1	2	3	4	5
4	Seems not to enjoy activities that he or she previously thought were fun	0	1	2	3	4	5
5	Seems to feel hopeless about things	0	1	2	3	4	5
6	Seems not to have enough energy to complete tasks or participate in activities that he or she used to have the energy to do	0	1	2	3	4	5

Does the presence of these 6 behaviors CURRENTLY cause academic difficulties for your son or daughter?

No difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Does the presence of these 6 behaviors CURRENTLY cause social difficulties (e.g., difficulties in interactions with parents, siblings, peers, other adults at community activities) for your son or daughter?

No Difficulty Slight Difficulty Moderate Difficulty Severe Difficulty

Appendix G: Brief Multidimensional Student Life Satisfaction Scale

Peabody Treatment Progress Battery 2010

BMSLSS-PTPB: Youth

Your Satisfaction with Life

Please place an 'X' in the one box that best indicates how satisfied or dissatisfied you CURRENTLY are with each item below. There is no right or wrong answer.

	HOW SATISFIED OR DISSATISFIED ARE YOU WITH...	Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Very Satisfied
1.	Your family life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Your friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Your school experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Where you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Your life overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>