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ARAŞTIRMA MAKALESİ RESEARCH ARTICLE

Parental Distress Tolerance in the Face of Adolescent Problems: A Qualitative Study

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Abstract

Objective: This research examines how parents tolerate the psychological distress (PD) of their adolescent children. In particular, the study explores what kinds of PD adolescents experience, what factors affect parents' tolerance of their children's PD, how they appraise their responses to their children's PD, how they cope with the emotions arising from their children's PD, and how they manage their attention in this process.

Method: The study used qualitative research methods and semi-structured interviews with ten parents. The interviews with participants identified through purposive and snowball sampling were conducted via video conference. In the interviews, we used five questions inspired by the theoretical conceptualization of distress tolerance. The study used deductive and inductive methods and analyzed data along four sub-factors of distress tolerance.

Results: Participants reported that their children experienced distress related to technology use, self-regulation, social relationships, family communication, exposure to bullying, negative body perception, and academic problems. Distress, parent, and child-related factors affect parents' tolerance towards these problems. Inadequacy, regret, or positive comments are prominent in parents' self-appraisal. Acceptance of distress, taking time for themselves, seeking support, thinking about the problem until it is solved, and crying are the methods of regulation used by parents. Finally, while some parents are absorbed in rumination and worry, others may use avoidant or flexible attention.

Conclusion: Considering the impact of parental DT on children's emotional development, we believe that interventions to support parental DT are crucial. However, it is seen that there are not enough studies on parental DT in the literature, and the studies that have been conducted have mainly been performed on clinical samples. Thus, we consider that the results of this study will be helpful to for parental DT research to be conducted on non-clinical samples and for interventions to improve parental DT.

Keywords: Psychological Distress, Parental Distress Tolerance, Adolescence

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Ergen Sorunları Karşısında Ebeveyn Sıkıntı Toleransı: Nitel Bir Çalışma

Öz

Amaç: Bu araştırma, ebeveynlerin ergen çocuklarının psikolojik sıkıntılarını nasıl tolere ettiklerini incelemektedir. Özellikle, ergenlerin ne tür psikolojik sıkıntılar yaşadıkları, ebeveynlerin çocuklarının psikolojik sıkıntılarını tolere etmelerini etkileyen faktörleri, çocuklarının psikolojik sıkıntılarına verdikleri tepkileri nasıl değerlendirdikleri, çocuklarının psikolojik sıkıntılarından kaynaklanan duygularla nasıl başa çıktıkları ve bu süreçte dikkatlerini nasıl yönettikleri araştırılmaktadır.

Yöntem: Çalışmada nitel araştırma yöntemi kullanılmış ve on ebeveyn ile yarı yapılandırılmış görüşmeler yapılmıştır. Amaçlı ve kartopu örnekleme yoluyla belirlenen katılımcılarla yapılan görüşmeler video konferans aracılığıyla gerçekleştirilmiştir. Görüşmelerde, sıkıntı toleransının teorik kavramsallaştırmasından esinlenen beş soru kullanılmıştır. Çalışmada tümdengelim ve tümevarım yöntemleri kullanılmış ve veriler sıkıntı toleransının dört alt faktörüne göre analiz edilmiştir.

Bulgular: Katılımcılar, çocuklarının teknoloji kullanımı, öz düzenleme, sosyal ilişkiler, aile içi iletişim, zorbalığa maruz kalma, olumsuz beden algısı ve akademik sorunlarla ilgili sıkıntılar yaşadığını bildirmiştir. Sıkıntıya bağlı faktörler, ebeveynle ilgili faktörler ve çocuğa ilişkin faktörler ebeveynlerin bu sıkıntılara karşı toleransını etkilemektedir. Ebeveynlerin kendilerini değerlendirmelerinde yetersizlik, pişmanlık veya olumlu yorumlar öne çıkmaktadır. Sıkıntıyı kabullenme, kendine zaman ayırma, destek arama, sorun çözülene kadar düşünme ve ağlama ebeveynler tarafından kullanılan regülasyon yöntemleridir. Son olarak, bazı ebeveynler ruminasyon ve endişeye kapılırken, diğerleri kaçınmacı veya esnek dikkati kullanmaktadır.

Sonuç: Ebeveyn DT'sinin çocukların duygusal gelişimi üzerindeki etkisi göz önüne alındığında, ebeveyn DT'sini desteklemeye yönelik müdahalelerin çok önemli olduğuna inanıyoruz. Ancak literatürde ebeveyn DT'sine ilişkin yeterli sayıda çalışma bulunmadığı ve yapılan çalışmaların da çoğunlukla klinik örneklemler üzerinde gerçekleştirildiği görülmektedir. Bu nedenle, bu çalışmanın sonuçlarının klinik olmayan örneklemlerde yapılacak ebeveyn DT araştırmalarına ve ebeveyn DT'sini geliştirmeye yönelik müdahalelere yardımcı olacağını düşünüyoruz.

Anahtar Kelimeler: Psikolojik Sıkıntı, Ebeveyn Sıkıntı Toleransı, Ergenlik Dönemi

Introduction

Adolescence, derived from the Latin "adolescere" (Kar et al., 2015), is an uncertain and fluctuating period between childhood and adulthood, a time of significant change (Slusher et al., 1993). The fact that adolescence is a period of biological and social change (Blakemore & Mills, 2014) causes adolescents to face various sources of psychological distress (PD). In fact, from a biological point of view, adolescence is a universal phenomenon; adolescents' bodies experience puberty changes regardless of their background (Natsuaki, 2021). However, contextual variables appear to influence the psychological impact of puberty (Ge & Natsuaki, 2009).

Given the fluctuating nature of adolescence, it is noteworthy that several risk factors can be a source of PD for adolescents. There is evidence that factors such as being bullied (Myklestad et al., 2012), parental support (Siziya & Mazaba, 2015), academic pressure, relationship problems, negative self-perception (Huang et al., 2009), loneliness, anxiety and worry (Peltzer & Pengpid, 2016), sexual orientation (Safren & Heimberg, 1999), substance use (Bilsky et al., 2019), hormonal changes (Swansboro & Brown, 2020) and social media influence (Zhang et al., 2024) have been associated with PD. The presence of such risk factors points to the importance of the ability of both adolescents and their parents to tolerate adolescent distress.

Distress tolerance (DT) is the ability to experience and tolerate uncomfortable psychological states (Simons & Gaher, 2005). DT refers to the behavioral effort involved in a person's determination to persist despite physical or emotional distress (Leyro et al., 2010; Veilleux, 2023; Zvolensky et al., 2011).

It is associated with avoiding relaxation-oriented behavior immediately after experiencing an unpleasant sensation (Gifford, 2002). Conversely, the tendency to respond immediately to the quick reward of relaxation is expressed as distress intolerance (DI) (Faraone et al., 2019; McHugh et al., 2010; Trafton & Gifford, 2011). High DI leads to problems in coping skills and attributes more meaning to distress (Zvolensky & Otto, 2007). People with high DI interpret distress as unbearable; they feel ashamed of being distressed; they use avoidance-oriented ER strategies and cannot manage their attention (Simons & Gaher, 2005). This statement indicates that DT is a meta-emotional construct of tolerance, appraisal, regulation, and attentional absorption (Simons & Gaher, 2005).

Different studies have associated DT with other concepts, and rather than a single definition, different conceptualizations of DT have emerged (Zvolensky et al., 2011). The theoretical similarities between DT and concepts such as discomfort intolerance (Schmidt et al., 2006; Schmidt & Cook, 1999), tolerance of ambiguity (Furnham & Ribchester, 1995), experiential avoidance (Hayes et al., 2004; Simons & Gaher, 2005), intolerance of uncertainty (Carleton, 2016), and anxiety sensitivity (Reiss, 1991; Zvolensky & Otto, 2007) have pioneered the study of the relationship between DT and various psychopathological disorders and symptoms. In particular, there is growing evidence that DT is strongly associated with anxiety disorders (Bernstein et al., 2011; Keough et al., 2010; Schmidt et al., 2011; Wolitzky-Taylor et al., 2015). When low DT is combined with other anxiety-related risk factors, an increase in symptoms can be seen (Timpano et al., 2009). Another disorder associated with DT is substance abuse (Kaiser et al., 2012; Shorey et al., 2017). Individuals with poor DT may see substance use as a means of avoiding the burden of distress, thus maintaining substance use through negative reinforcement (Richards et al., 2011). Finally, DT is associated with difficulties in emotion regulation (ER) (del-Valle et al., 2022). Perceiving distress as unbearable leads to affect dysregulation and poor affect management (Linehan, 1993).

DT is significantly related to ER skills (Leyro et al., 2010), and this relationship has been extensively studied (Simons & Gaher, 2005). Although various researchers have suggested that DT is a subcomponent of ER (Zvolensky et al., 2011), there is no empirical evidence to support this; however, DT is thought to influence the consequences of negative emotional (Schmidt et al., 2011). For example, in group skills training, Dialectical Behaviour Therapy teaches ER and DT skills in response to threats such as self-harm and extreme anger (Dimeff & Koerner, 2007; Hollander, 2008; Linehan, 1993, 2015). This empirical evidence has enabled the study of DT and ER in various contexts, including the family environment.

Studies showing that the family context influences ER (LaMontagne et al., 2023; Morris et al., 2007; Mota et al., 2023) have led to an examination of the relationship between the ability to tolerance distress and the family environment (Daughters et al., 2014; Rutherford et al., 2015; Selles et al., 2018). These studies suggest that the child's poor tolerance for distress is reinforced by the parent's poor tolerance for the child's distress (Selles et al., 2018). Because the effect of parental DT on parenting behavior seems to impact children's emotional development significantly (Daughters et al., 2014).

Although the literature contains some evidence about the effect of parental DT on adolescents' ER and DT, the number of studies is limited; therefore, we perform a qualitative study of how parents tolerate distress in their children. In line with the theoretical conceptualization (Simons & Gaher, 2005), we identified five questions for this purpose. Through these

questions, we wanted to find out what kind of distress adolescents experience, what factors affect parents' tolerance of adolescents' distress, how they appraise themselves, how they regulate their distress, and finally, how they manage their attention. Hence, we have identified the following research questions.

1. What types of distress do adolescents experience?
2. What factors affect parents' tolerance?
3. How do parents appraise themselves in terms of how they respond to their children's distress?
4. How do parents regulate their emotions arising from the child's distress?
5. How do parents manage their attention during difficult times for their children?

Table 1. Sociodemographic Data of the Participants

Participants	Gender	Age	Profession	Gender (C)	Age (C)	Grade Level (C)
P1	Female	53	Teacher	Male	13	7th
P2	Female	48	Homemaker	Female	14	10th
P3	Female	50	Teacher	Male	15	9th
P4	Female	52	Teacher	Female	15	10th
P5	Female	42	Teacher	Male	16	10th
P6	Female	55	Teacher	Male	17	11th
P7	Female	38	Teacher	Male	13	7th
P8	Male	48	Teacher	Male	15	9th
P9	Female	49	Teacher	Female	13	7th
P10	Female	45	Homemaker	Male	17	11th

(C) = Child

Method

Participants

The study population was parents with adolescent children in Türkiye. We used purposive and snowball sampling in the study and reached 10 participants. In purposive sampling, people are found according to the characteristics of the population of interest (Palinkas et al., 2015). In contrast, snowball sampling asks each research participant to identify other potential participants with a particular inclusion characteristic (Christensen et al., 2015). Initially, we contacted three parents whose adolescent children were experiencing distress, and then, on their suggestion, we interviewed seven more parents. Nine participants were female (%90), one was male (%10), two were homemakers (%20), and eight were teachers (%80). The females' ages ranged between 42 and 55, and the male was 48. Participants were also asked for information about their children: Seven were male (%70), and three were female (%30). The children's school grades, whose ages ranged between 13 and 17, were between the 3rd grade of secondary school and the 3rd grade of high school. **Table 1** presents the sociodemographic data of the participants.

Measurement Tools

In Video conferencing methods through ZOOM and Google Meetings software were used to increase accessibility during the data collection process. The interviews, for which participants consented to audio recording, lasted approximately 15 minutes. In addition to obtaining the sociodemographic information of the participants, we utilized the semi-structured interview technique, which refers to a structured interview technique with open-ended questions (Fraenkel & Wallen, 2009). We prepared the interview questions in line with the theoretical conceptualization of DT. After two

academicians reviewed the questions, we finalized the questions based on the expert's opinions:

1. What types of distress does your child experience?
2. What factors influence your tolerance of your child's distress?
3. How do you appraise yourself regarding how you respond to your child's distress?
4. How do you regulate the emotions that arise from your child's distress?
5. How do you manage your attention during difficult times for your child?

Procedure

Before the data collection process, ethical permission was obtained from the Social and Humanities Scientific Research Ethics Committee with the decision dated 17/05/2024 and numbered 2024/412. The study used a phenomenological design, a qualitative research method that describes the participants' internal experiences of a particular phenomenon (Alase, 2017; Moustakas, 1994). To analyze the data, we conducted a thematic analysis (Guest et al., 2012), which allows researchers to interpret data in a systematic way to uncover underlying meanings. We followed Braun & Clarke (2022) as a guide in the thematic analysis process.

The research utilized inductive and deductive approaches (Creswell & Creswell, 2018) to examine how parents respond to PD in their adolescent children. The study was conducted within four theoretically defined sub-dimensions: Tolerance, appraisal, regulation, and absorption. This theoretical framework guided our data analysis processes. The researchers transcribed the audio recordings and then read the participants' transcripts several times. Both researchers independently coded following the initial themes. Then, in a joint decision, the themes were clarified and reported. The themes and categories we finalized following the expert opinions are presented in the relevant section.

Results

To examine parental DT, we identified five themes in line with the conceptual construct of DT: types of distress experienced by adolescents, factors affecting parental tolerance, parental self-appraisal, parental regulation, and parental attention. This section provides the themes we have created and the categories related to the themes.

Types of Distress Experienced by Adolescents

According to parents, adolescents experience various types of distress. Almost all participants reported that their children experience distress related to technology use, self-management, social relationships, and academic problems. A small number of parents mentioned bullying and negative body perception. **Table 2** shows the frequency table of the categories created for the types of distress experienced by adolescents.

Table 2. Categories Related to the Theme of Type of Distress

Categories	Frequency
Technology Use	8
Social Relationship	7
Self-Management	7
Academic Problems	7
Family Communication	4
Exposure To Bullying	1
Negative Body Perception	2

The majority of parents stated that their adolescents experienced difficulties in using technology. P6 expressed her child's problem with technology: *"He does not pay attention to his lessons because of his intensive use of mobile phones, and then he has problems in his lessons."* Another parent, P8, explained, *"My child is like a game addict. If we do not remind him of his duties, he forgets and neglects to fulfill them."* As it is seen, adolescents

experience academic distress due to the problems they experience in technology use. For example, P10 said, *"My son is constantly playing with his phone even though the exam year is approaching. He watches short videos on social media accounts. His grades drop because of his phone use, and he is very upset."* P3 said, *"He has much difficulty studying; he wants to study less. He cannot concentrate on his lessons."* Another parent, P1, expressed, *"He spends time with computer games all the time; he has great problems studying. He gets upset because he disrupts his lessons."*

Another type of problem that many parents mention is social relationships. P1 said, *"He has many problems in social relationships; these problems cause him to be timid."* P4 said, *"How should I put it? For example, he has problems in his friendships. Making friends, choosing friends for himself or joining a group"*. One of the parents stated that their child was exposed to bullying. Exposure to bullying is related to social relations; however, in the category of social relations, we included the child's difficulties in socialization. Bullying was related to the behavior of friends rather than the child. Therefore, we evaluated them as separate categories. Regarding bullying, P5 said, *"He has much difficulty making friends. Because some of his friends bully him constantly, my son withdraws into himself and gets stubborn with us."*

In addition to adolescents' friendships, parents mentioned problems in family communication. Regarding family communication, P5 expressed, *"He has problems expressing his wants and needs at home. He is constantly stubborn and insistent with us."* P7 said, *"He always has an attitude like I know everything. That is why we have arguments."* P10 said, *"My daughter is very irritable at the moment. She always has an aggressive behaviour towards us. When she is at home, she always closes herself in her room."*

Self-management was another category expressed by a large number of parents. Parents think that their children have self-management-related difficulties and that these difficulties make their children's lives more difficult. For example, P10 said, *"We bought him a mobile phone when he started high school, but he had no self-management at all in high school. I thought he would be aware of his responsibilities. He delays and postpones everything."* Another parent, P2, said, *"It is like he does not care about anything. He does not fulfill his duties and then suffers for it."*

Finally, two parents stated that their children experienced distress related to negative body image. Parents believe their children's body perception affects their friendships and social skills. Regarding her child's body perception, K2 stated, *"He interprets his body badly; he does not like himself. His attention is always on his body."* The other parent, K5, said, *"He does not want to go out even though he is not overweight. "He is trying to lose weight, but it does not work."*

Factors Affecting Parental Tolerance

Another question we were interested in was what factors influence parents' tolerance of their children's distress. Parents mainly mentioned the source of distress, the child's attitude, and their tiredness. We presented the categories of factors affecting tolerance in **Table 3**.

Table 3. Categories Related to the Theme of Factors Affecting Tolerance

Categories	Frequency
Distress-Related Factors	
Source of Distress	5
Frequency And Severity of Distress	3
Parent-Related Factors	
Tiredness	4
Well-Being	1
Child-Related Factors	
Child's Attitude	5

One of the most critical factors influencing parents' tolerance of child distress was the source of the distress. While the participants stated that it was much more difficult to tolerate distress in more challenging issues, P8 said, *"I can accept everything, but one thing I cannot accept is a lie. Let him be honest with me. Even if he steals, he should tell me honestly. This is my red line."* In addition to the source of distress, another critical factor was the frequency and severity of the problem. P2 expressed, *"It bothers me a lot to keep going through the same things. I cannot tolerate it anymore, and I get angry and start yelling. His uncaring attitude infuriates me."*

Parents mentioned situations related to themselves as another factor affecting their tolerance levels. Tiredness was one of these factors. For example, P7 said, *"Especially when I come home tired from work, there are moments when I cannot tolerate it. I sit and cry. I think this is not my child. I question whether I love my child or not. I feel terrible because of these thoughts."* Another participant, P1, said, "*Tiredness affects tolerance a lot. Sometimes I run out of patience."* One parent referred to her psychological well-being as well as tiredness. P4 said, *"My tolerance also depends on my mood. When I feel bad, I cannot tolerate any inconvenience."* Two of the participants stated that experience also has an impact on the tolerance level. P1 expressed, *"I generally feel like I can tolerate my child's troubles. I get psychological support when I think I cannot bear it. Knowing that my child is an adolescent increases my tolerance. I know it is a temporary process because I have experience with my other children."*

The final factor affecting parental tolerance was the child's attitude. Participants thought the child's attitude influenced parental tolerance in parent-child interactions towards distress. For example, P7 expressed this as follows: *"I cannot tolerate anything when the other person has an I-know-everything attitude."* Similarly, P2 said, *"When I talk about a problem, my child's reckless attitude makes me angry."* Lastly, P3 stated that the child's behavior affected parental tolerance: *"He used to be very active, but now he is calmer and more mature. So, I can be more understanding."*

Parental Appraisal

Participants had both positive and negative self-appraisals of their ability to tolerate their children's distress. Self-appraisal mostly reflected inadequacy, regret or positive comments. **Table 4** presents the frequency table of the categories we created for the theme of appraisal.

Table 4. Categories Related to the Theme of Appraisal

Categories	Frequency
Inadequacy	6
Regret	3
Positive Comments	7

Dysfunctional comments on parents' self-appraisal were generally related to perceptions of inadequacy. For example, regarding her reaction to her child's distress, P1 expressed, *"I feel inadequate about my motherhood. I do not want to raise children like my own mother. I feel uncomfortable when my reactions to my child are like my mother's."* Another mother, P3, said, *"My evaluations about myself change. Sometimes, I like my reactions; sometimes, I don't. I think I should not have done it like this. I feel like I failed as a mother."* In some parents' responses, the perception of inadequacy was accompanied by regret. P2 expressed her regret: *"I regret thinking that I wish I had not yelled so much. I question what kind of a mother I am."* Similarly, P4 stated her regret: *"I don't think I was a perfect mother. I could have communicated with her better."*

Some parents positively appraise their reactions to their children's distress. The fact that compromise emerged due to the

reactions seems to make parents think the reactions were positive. For example, P3 said, *"Even though I overreacted at the beginning, later we can compromise. I feel better when we reconcile. I feel better when we compromise without wearing him and myself out too much."* P1 said, *"I like some of my behaviors; I see that I can produce solutions. Especially when I get expert support, I think I am doing the right thing."* Another participant, K4, stated that he predominantly made negative self-evaluations but rarely liked their reactions: *"I think I give appropriate reactions, even if they are rare. For example, I like two out of ten reactions. I try to be as good as I can."*

Parental Regulation

We analyzed the theme of regulation to find out how parents reacted to the discomfort arising from their children's distress. Participants gave answers that ranged from acceptance of distress to crying. There was no dominant answer; the category frequencies were very close. **Table 5** presents the categories and their frequencies.

Some of the parents expressed their acceptance of the distress that had arisen. P4, comparing her child with her adolescence: *"I went through similar things when I was his age. There were times when I thought like him. I grew up and overcame those troubles; my child will overcome them, too."* P1 said, *"I think every think will pass in time. I try to do my best."*

Table 5. Categories Related to the Theme of Regulation

Categories	Frequency
Acceptance	4
Time for Self	7
Seeking Support	
Social Support	3
Expert Support	2
Pondering on Distress	2
Crying	2

Another striking point in the participants' acceptance process was their behavior to take time for themselves and improve themselves. For example, P3 said, *"I do not try to solve the problem immediately; I give myself some time. I try to do something for myself, meditate, and read child development books."* P5 also mentioned the time she allocated for herself: *"I keep a diary; especially when I experience emotional intensity, I express my feelings by writing.*

Another response to discomfort was to seek support. We categorized support into two different types: expert and social. Parents did not report seeking much support; however, some participants considered expert or social support important. For example, P5 crying: *"Sometimes I cannot stand it. Writing relaxes me a lot. When it does not work, I talk to my friends; I get psychological support."* Another mother, P7, said, *"I can't bear it anymore. I talk to my friends and my husband; I get help from specialists. Seeing that similar things happen to my friends is a bit of a relief."*

A few parents said they would consider the problem until it was resolved. P8, the only father among the participants, expressed, *"I constantly think about the problem and try to solve it. The problem stays in my mind until the problem is solved."* The other parent, P10, said, *"I continuously think about the problem. I try to solve it in my head."* Another answer given by two parents was crying. Participants stated that they tried to relax by crying. P7 said, *"There were many moments when I felt hopeless and helpless. I do not want to be a mother who lost her child. I feel sad when I see her like that. I cried a lot to get rid of the sadness."* K9 said, *"I cry. It relieves the burden I carry on my back."*

Parental Attention

Parents reported that during difficult times for their children, they managed their attention in various ways. The management styles ranged from flexible attention to avoidance. Participants generally said they could not take

their attention away from the distress. We presented the categories related to attention management in **Table 6**.

Table 6. Categories Related to the Theme of Attention

Categories	Frequency
Rumination and Worry	7
Disruption of the Functionality	5
Avoidant Attention	2
Flexible Attention	5

Most parents reported being distressed and unable to pay attention to anything else. We named this category rumination and worry. For example, P4 said, *"What else can I do? How can I spare time for him? Should I study with him? What can I do to make him happy? These questions are on my mind all day long. I cannot think of anything else."* P5 also had more future-oriented thoughts, *"How will what we have experienced today be reflected in my child's personality? I cannot get this question out of my mind."* Rumination and worry were related to the disruption of the functionality of daily life. P5 said, *"Whenever I am alone, I think about my child. When I am driving home, I realize that I am distracted."* P9 said about driving a car: "When thinking, I stop the car to avoid hitting something. If I relax, I get in the car again."

Two participants stated that they used an avoidant attention strategy. They considered the discomfort of distress unbearable and thus needed to avoid it immediately. P7 said, *"There is so much distress that I do not want to see anything; there are so many mistakes. No right is enough for me. I try to think about other things; I want to distract myself from this issue."* Similarly, P5 said, *"I try to take my mind away without paying attention. I do not even want to think about the problem."*

Finally, some parents said that they manage their attention flexibly. They mentioned that they could continue their daily routines without ignoring the distress. For example, P8 said, *"If I am at work, I continue to do my work. After the crisis, I occasionally talk to my child about the issue, but I do not prolong it."* Another participant, P9, said, *"We solve the crisis as a family. If we are going to fight, we fight. I try to fix things, but it does not make sense to prolong it. We solve problems by talking. I do not get stuck on the same problem, so I keep thinking about it."*

Discussion

This study analyzed how parents tolerate adolescent distress through qualitative research. For this purpose, we tried to find answers to the research questions through questions designed by the conceptual structure of tolerating distress. The data obtained were analyzed using the thematic analysis method, and this section includes a discussion of the findings.

Initially, we asked what kind of distress the adolescents were experiencing. Parents mainly reported distress related to the use of technology devices, self-management, social relationships, and academic problems. These results indicate that this study yielded results consistent with the literature (Anyanwu, 2023; Högberg et al., 2020; Jouriles et al., 2009; Li et al., 2021). Adolescents' screen use time negatively affects their levels of PD (Reardon et al., 2023), and the increase in self-management skills is associated with less PD (Adeniyi et al., 2021). Moreover, there is evidence that social relationships and academic pressure are also associated with PD in adolescents (Khatib et al., 2013; Kristensen et al., 2023). Although fewer, some participants mentioned bullying and negative body image as types of distress for their children. These results are consistent with recent studies. For example, Thomas et al. (2015) stated that adolescents' exposure to various types of bullying is significantly associated with PD. Similarly, some studies have shown that there is a significant relationship between dysfunctional

body image and PD (Murray et al., 2011; Siegel, 2002).

Our second theme in the study was the factors influencing parental DT—answers clustered around the source of the distress, the child's attitude, and parental tiredness. The literature does not contain any information about the change in parents' tolerance levels according to the source of distress experienced by their child and the child's attitude; however, this study may provide further studies in these two areas. Similarly, a limited number of studies examine the effect of tiredness on tolerance levels. For instance, Veilleux (2023) states that psychological resources such as tiredness and hunger affect the ability to tolerate distress. Moreover, there is evidence that tiredness may negatively affect general psychological well-being (McKenna et al., 2023). The fact that parents refer to their well-being has a reasonable basis when the relationship between parental DT and parental psychopathology is considered (Daughters et al., 2014).

The next question was about parents' self-appraisal. The participants' dysfunctional comments were predominantly about inadequacy and regret. However, some parents gave positive evaluations. Parents' positive comments about themselves or comments about inadequacy are pretty consistent with the theoretical structure of DT (Simons & Gaher, 2005). Similarly, poor tolerance may lead to the emergence of shame (Zvolensky et al., 2011). Given the relationship between shame and regret (Fisher & Exline, 2010; Kudinova et al., 2024), the findings of this study support existing research.

People who make negative self-appraisal of their ability to tolerate distress are expected to engage in immediate attempts at regulation (Simons & Gaher, 2005). Thus, we wanted to elicit how parents regulate the discomfort arising from their child's distress. There was no dominant response; acceptance, taking time for oneself, and seeking support were expressed in almost equal numbers. Acceptance is one of the most effective ways to increase DT (Hollander, 2008; Linehan, 1993, 2015). On the other hand, time for oneself can serve distress intolerance if it serves avoidance (Hayes et al., 2004). Nevertheless, our participants also stated that they mainly worked on child development in their allocated time. A few parents mentioned seeking support, trying to solve distress by considering it and crying. Social support and expert support significantly impact ER skills and coping with distress (Christensen et al., 2013; Morford et al., 2022; Perry et al., 2020). Moreover, there is evidence that trying to solve the problem by constantly thinking about it can lead to avoidance as a dysfunctional coping method (Smith & Alloy, 2009). Finally, crying can serve as a catharsis to cope with overwhelming emotions (Miceli & Castelfranchi, 2003). Further research is needed to determine whether parents' regulation styles are functional.

In the final theme, we examined how parents manage their attention. The prominent constructs were rumination and worry, avoidance, and flexible attention. As with regulation, the absorption of attention by rumination and worry may indicate a dysfunctional coping strategy (Smith & Alloy, 2009) and may harm everyday functional behaviors (Eckland et al., 2022; Huang et al., 2022). Avoidant attention strategy can also be associated with experiential avoidance, a construct highly related to psychopathology (Harris, 2019; Hayes et al., 1999). On the contrary, flexible attention enables attention to be directed flexibly and constitutes one of the main components of third wave Cognitive Behavioral Therapies (Hayes et al., 2004; Linehan, 1993; Segal et al., 2002).

Parental DT is a skill that has important implications for a child's emotional development (Daughters et al., 2014; Selles et al., 2018). Hence, we believe that the programs

to be developed to increase parental DT will contribute to the emotional development of adolescents. However, studies in the literature generally focus on one's DT. Although our findings are consistent with the theoretical underpinnings of this construct, there is a need for more research on parental DT. Moreover, studies on parental DT have been conducted mainly with clinical samples. Considering that adolescents experience distress in various contexts in their daily lives, it is essential to conduct non-clinical studies. Moreover, we did not encounter a parental DT scale for which a validity and reliability study was conducted. Our findings may be helpful in the development of a scale measuring parental DT. We consider that a scale measuring parental DT will provide an opportunity for different studies. Finally, our study's participants were predominantly mothers, similar to studies in the literature. Further research on fathers or other caregivers is needed.

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