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## Experiences and Perceptions of Mental Health Professionals Considered Effective in the Diagnosis and Treatment of Adults with Attention Deficit Hyperactivity Disorder

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**EXPERIENCES AND PERCEPTIONS  
OF MENTAL HEALTH PROFESSIONALS CONSIDERED EFFECTIVE  
IN THE DIAGNOSIS AND TREATMENT OF ADULTS  
WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER**

by

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Old Dominion University in Partial Fulfillment of the  
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## **ABSTRACT**

### **THE EXPERIENCES AND PERCEPTIONS OF MENTAL HEALTH PROFESSIONALS CONSIDERED EFFECTIVE IN THE DIAGNOSIS AND TREATMENT OF ADULTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Bonita H. Erb

Old Dominion University, 2013

Dissertation Chair: Dr. Theodore P. Remley, Jr.

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder that has been documented in medical and mental health literature for over 100 years (Still, 1902). ADHD is a neurobiological based disorder characterized by three major symptoms identified at clinical levels and validated by diagnostic criteria established for the diagnosis of children before the age of seven (*Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> edition-Text Revision; *DSM-IV*; American Psychiatric Association, 2000). The three diagnostic criteria are inattention, impulsivity, and hyperactivity that have been observed at clinical levels.

Because many signs of the disorder were believed to discontinue with maturity, it was originally believed that ADHD did not apply to adults (Nadeau, 1995). Barkley, Murphy, and Fischer (2008) argued that nearly 5% of adults or 11 million adults in the United States have been identified as ADHD adults. Research suggests that ADHD remains hidden in adults and the prevalence of other comorbid conditions further complicates diagnosis and treatment (Wasserstein, 2005).

Due to a growing realization that adults can have ADHD, there is a pressing need

for diagnosis and psychological treatment. Diagnosis and treatment options for this population are largely under researched. No qualitative studies have been located that have asked mental health professionals who have experience treating adults with ADHD about their practices. This study will explore the experiences and perceptions of mental health professionals who provide diagnosis and treatment to adults with ADHD. The *DSM-IV* (APA, 2000) was the diagnostic standard used and discussed by research participants during the majority of the study. The *DSM-5* (APA, 2013) was introduced in May, 2013; the implications of these diagnostic changes are yet unrealized. It is anticipated the results of this study will contribute to the field to provide information on best practices in treating ADHD adults.



## DEDICATION

This dissertation is dedicated to my father, James Hale, who passed away during the final days of the dissertation process.

He was an ADHD adult who was never diagnosed. My dad faced life challenges with positive energy and a deep personal faith that disallowed ADHD to define him negatively. My desire to explore ADHD came from observing the disorder through my father's life experience and later through my ADHD son. I have witnessed the struggle of the disorder and the courage that is required to harness its influence.

My father did not see my dissertation completed, but his example of facing life challenges with positivity and courage will live on as his legacy.

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My clients who inspired me to reach my personal goals.

My family and friends, who listened, sympathized and continued to support me. Special thanks to my husband, Gene, our daughter Emiley and our son James for their patience and encouragement.

My editor, Christy Pettitt, who labored without complaint, over “one more change” to the dissertation, lending her invaluable expertise to the finished product.

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## CHAPTER ONE

### INTRODUCTION

#### Overview of Research Area

##### Brief Summary of Relevant History

ADHD is listed in the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV-TR, American Psychiatric Association, 2000) used by mental health professionals for the diagnosis and treatment of mental health disorders. The current diagnostic criterion for ADHD includes endorsing six or more symptoms of inattention, hyperactivity, or impulsiveness that has persisted for at least six months to a degree that is maladaptive and inconsistent with developmental levels for children between the ages of 7-10 years old. A current diagnostic criterion requires mental health professionals to diagnose adult ADHD after determining that symptoms were present when the client was a child or adolescent. One of the difficulties in diagnosing adults with the disorder, however, is that adult clients with ADHD may or may not have been diagnosed or treated in childhood.

Current research suggests that in order to make a correct diagnosis, the mental health professional should include some of the following: a medical and social history, functional impairment testing, family history, any childhood diagnosis information, family member validation, school records, and comorbid conditions documentation (Wadsworth & Harper, 2007).

According to Goldstein and Ellison (2002), there has been controversy regarding the diagnosis; especially, they point out, the suitability of the current diagnostic criteria to identify adult ADHD. Some of the arguments these scholars have made against a diagnosis of ADHD in adulthood include the following: hyperactivity tends to disappear



in adolescence; onset of the disorder in childhood cannot be proven; pharmacotherapy is less effective in adults; and other disorders can also account for many of the symptoms such as anxiety, depression, or personality disorders. Despite these concerns about diagnosing adults with ADHD, adults continue to be diagnosed and treated by mental health practitioners for this disorder.

There appears to be growing agreement that adult ADHD exists (Barkley, Murphy, & Fischer, 2008; Goldstein & Ellison, 2002). However, diagnosis and treatment protocols for adults with ADHD are slow to garner agreement among researchers and mental health professionals (Goldstein & Ellison, 2002). According to Wilens, Spencer, and Biederman (1998), ADHD is highly likely to continue into adulthood with a large percentage of adults diagnosed in childhood. They stated a belief that ADHD is a chronic condition.

Recent research studies have also revealed that ADHD adults are more likely to suffer with comorbid psychiatric conditions (depression, anxiety, obsessive-compulsive disorder, etc.), interpersonal trauma, emotional and work-related problems, and physical maladies. Driving concerns, higher insurance risk, and risky behaviors are also noted as higher in probability for this ADHD population (Barkley et al., 2008).

Multicultural issues surrounding the diagnosis have not been adequately addressed and may influence decisions regarding the diagnostic interventions devised for ADHD adults in a diverse and multicultural population. Children in the original *DSM-IV* (APA, 2000) field trials were young European American boys. Using this narrow scope of norms, it seems clear that a myriad of issues exist with diagnosis criteria and treatment decisions that did not include cultural sensitivity and diversity.

Monolithic beliefs surrounding the current criteria in the *DSM-IV* (APA, 2000) regarding definitions of culturally based behaviors using terminology such as normal and pathological contributes to the current confusion surrounding definitions of adult behaviors and their relevance to a diagnosis of adult ADHD. Waite (2010) stated that labels are potentially problematic in developing more culturally sensitive standards of practice. As pointed out by Draguns (1973), the diversity of American culture will increasingly influence health care professionals understanding of behavior and diversity and must be taken into account.

In children, the gender differences in the prevalence of ADHD in males and females are pronounced. Research shows that the diagnostic prevalence rates for ADHD indicate that at least three-times more males than females receive the diagnosis. Adult ADHD research does not reflect the childhood ratio of more males than females with ADHD. There are no clear reasons for this phenomenon, but it seems to underscore the difference between adult and childhood populations of individuals with ADHD (Haavik, 2010).

Impairments from ADHD adults extend beyond inattention and impulsiveness (Goldstein & Ellison, 2002). The impact of ADHD is yet unknown, but it is clear that adults are and will be seeking diagnostic and treatment services. Limited research in the field has provided little guidance for mental health professionals who work with this population. Research studies are needed to enable mental health professionals to provide appropriate services for adults seeking care.

Ratey, Greenberg, Bernporad, and Linderm (1992) conducted a retrospective chart review of 60 cases of adult ADHD which was the first published research study that

drew conclusions regarding the treatment of ADHD adults. Ratey et al. (1992) established objectives for treatment that all subsequent research studies regarding the treatment of ADHD adults have followed. He concluded that treatment for ADHD should include the improvement of the core self, changes of habitual modes of behaving, and should teach self-control (Weiss et al., 2008). Ratey et al. (1992) also argued that effective therapy should involve structured, short term, and behavioral ingredients. Psychoeducational training was also seen as valuable for ADHD client to understand themselves and to learn self-advocacy techniques.

Kessler, (2006) recommended therapeutic treatment models for ADHD adults that might focus on time management, organizational skills, communication skills, decision making, self-monitoring and rewards, changing large tasks into smaller tasks, and changing faulty cognitions and beliefs into more appropriate ones.

McDermott (2000), Wilens et al. (1998), and Safen, Sprich, Chulvick, and Otto (2004) systematized the objectives for treatment and based on the earlier research of Ratey et al. (1992) and other available studies, developed a structured, short term, behavioral cognitive behavioral therapy model for treatment of adults with ADHD (Weiss et al., 2008). While research is scarce regarding effective treatment for ADHD adults, cognitive behavioral therapy and medication management are most often mentioned in research literature as potentially beneficial and advantageous to the ADHD population (Knouse & Safren, 2010).

Given that prior research seems to support a strong neurobiological basis for ADHD, it is believed that the deficits of the disorder cause the ADHD adult to be hindered in their ability to acquire coping strategies. This further adds to their tendency

to feel overwhelmed, take on negative cognitions, reinforce the cycle of avoidance and failure, and develop maladaptive coping skills (Knouse & Safren, 2010).

As indicated by Knouse and Safren (2010), “Learning and maintaining compensatory skills in addition to medication management have been found to be successful at breaking the link between core symptoms and continued failure and underachievement” (p. 499).

A research forum on psychological treatment of adults with ADHD yielded five empirical studies of psychological treatments for adults with ADHD (Weiss et al., 2008). Practice guidelines recommend multimodal interventions including medication management. Knouse and Safren (2010) argued for the effectiveness of cognitive behavioral therapy both with and without medication management for adults with ADHD.

Other hopeful therapies have emerged with limited research to recommend their effectiveness. ADHD coaching has shown promise as well as medication management with multimodal possibilities (Goldstein & Ellison, 2002).

### **Conceptual Framework**

Grounded theory is designed to gather information, experiences, and perceptions of a phenomenon that is being studied. The purpose of this grounded theory research study is to discover and conceptualize the experiences of mental health professionals. Grounded theory techniques lend themselves to using systematic and careful analysis in the construction of a theoretical explanation of the phenomenon of diagnosing and treating adults with ADHD (Denzin & Lincoln, 2000).

There have been very few research studies on therapeutic interventions for adults

with ADHD. I have been unable to find any qualitative studies interviewing mental health professionals considered experts in the field. There are few recommendations regarding effective therapies for adults with ADHD, but as noted, therapeutic interventions with ADHD adult clients is an emerging field of study. Dorsten and Hotchkiss (2005) have discussed how qualitative research explores “subject matter that is too complicated to be quantified. Qualitative research documents what happens and describes the structure of what is seen ... it also provides insights into cause and effect relationships that we likely would overlook otherwise” (p. 61).

There is much to be discovered about adult ADHD. The therapeutic interventions that work, the appropriateness of diagnosis, the interplay of comorbid conditions, the role of changing symptoms in adults as opposed to the documented symptoms of children and many other issues are open and unexplained. Perspective and insight provided by mental health professionals will provide input to develop a fuller and more meaningful perspective of providing counseling services to ADHD adults.

Using grounded theory research, I hope to identify themes that will add to the body of knowledge giving meaning and perspective to new information about ADHD diagnosis and treatment.

### **Rationale for the Study**

The purpose of this study is to explore the effectiveness of therapeutic interventions and counseling techniques in adult clients with a diagnosis of ADHD. Currently, a diagnosis of adult ADHD is only indicated when based on the presence of childhood symptoms of ADHD and is not dependent on whether or not the adult was diagnosed or treated during childhood. Research suggests that ADHD remains hidden in

many adults and the prevalence of other comorbid conditions further complicate diagnosis and treatment (Wasserstein, 2005).

ADHD is associated with global impairment in fundamental areas of life functioning. The ability to maintain attention and exert self-control is fundamental to healthy adjustment in adulthood. Impairment with ADHD extends beyond inattention and impulsivity. The scope of assessment for ADHD adults is daunting (Goldstein & Ellison, 2002).

Barkley et al. (2008) noted, “With the increasing public awareness about ADHD in adults, clinicians should prepare themselves to properly recognize, diagnose and manage these adults as they become an increasing percentage of the clinically referred outpatient population” (p. 25).

This study will endeavor to describe the potential treatment issues that diagnosis based criteria normed for children might present for mental health professionals. Hopefully, this study will provide insight into diagnostic methods and best practices in therapeutic interventions that mental health professionals who are considered experts in the field are utilizing.

Smith (2011), addressing the diagnostic and treatment issues confronted by mental health professionals in the past, pointed out “only 20% of children with ADHD received any treatment in the 1960s and 70s compared with roughly 70% to 80% today.” He stated further that “the rise in diagnosis is not bad news; It’s good news. Frankly, we were doing an awful job 20-30 years ago” (p. 51). While research and clinical experiences available to mental health professionals dealing with childhood ADHD has grown over the years, the information in the field regarding adults with the disorder is

relatively new. There is a need to educate concerning adult ADHD; its identification, treatment possibilities and outcome effects.

Research is needed to address the types of psychological treatment most likely to benefit adults with ADHD. It would also be advantageous to know if treatment affected some of the impairments most often associated with ADHD, such as driving, educational issues, parenting, relationship concerns and substance abuse problems. Comparison between different types of therapies might enhance our knowledge of the kinds of interventions most effective in particular interventions (Weiss et al., 2008).

ADHD is a persistent and pervasive disability diagnosis. It is believed that as diagnosis, treatment measures, and education improve regarding the disorder, more adults with ADHD-like symptoms will present themselves for services. This study will seek to add to the body of knowledge concerning the diagnosis and treatment of ADHD adults, thereby enhancing the knowledge of the field.

### **Research Question**

What are the experiences and perceptions of licensed mental health providers considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder?

### **Definition of Terms**

#### **Key Definitions**

##### ***Adult ADHD***

ADHD is Attention Deficit Hyperactivity Disorder. ADHD is currently a *DSM-IV* (APA, 2000) diagnosis that includes impulsiveness, inattention, and hyperactivity. The diagnosis is generally made between the ages of 7 years and 10 years of age. Currently

no diagnosis is documented in *DSM-IV* (APA, 2000) for adult symptomology alone.

Although the *DSM-5* (American Psychiatric Association, 2013) was introduced in May 2013, this study was conducted using the *DSM-IV* (APA, 2000). The ramifications of changes in diagnosis and subsequent treatment are yet realized.

The majority of the endorsements for the diagnosis are related to childhood symptoms. Therefore, their relationship to adult symptom presentation relies on mental health professionals to make reliable decisions regarding diagnosis. At the present time, childhood symptoms (either treated or untreated in childhood) must be documented as present before the diagnosis of adult ADHD can be considered.

### ***Diagnostic and Statistical Manual***

*Diagnostic and Statistical Manual IV* (APA, 2000) is the manual used to identify and diagnose individuals who seek treatment from mental health professionals. It lists symptoms and criteria that might lead to a particular diagnosis. This is the official mental health coding system of the United States. It is updated periodically by the American Psychiatric Association. The *DSM-5* was revised by review committees and participating mental health practitioners and was published in 2013.

### ***Mental Health Professionals***

Mental Health Professionals are defined as Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Psychologists, Licensed Marriage and Family Therapists, Psychiatrists, Psychiatric Nurses, and other professionals licensed by a state to provide mental health services to individuals. Mental health professionals in Virginia are licensed through a process of education, experience, and updated continuing education regulated and maintained by the Virginia Department of Health Professions.



These mental health professionals currently make up the field of those who are trained and qualified to diagnose and treat adult mental health conditions.

### ***Grounded Theory***

Grounded theory is defined as a general research methodology that develops theory grounded from data that is gathered and an analysis performed to develop a systematic theory. It is generally used with untested and experimental subjects when deeper meaning and richer context is desired. Denzin and Lincoln (2000) described grounded theory as a theoretical explanation of a phenomenon resulting from the experiences of those being studied.

### ***Diagnosis***

Mental health professionals are often required to diagnose a mental health condition. This involves an educated and informed technique that requires training in mental health conditions and their presentation in life circumstances. It might also require consultation with other mental health professionals, other diagnostic tools, and effective use of the *Diagnostic and Statistical Manual* that is published and updated by the American Psychiatric Association.

### ***Psychological Treatment***

Mental health professionals engage in treatment protocols for identified populations of clients using best practice and research validated treatment strategies that are recognized and approved by the mental health profession, the preparation of the treating mental health professional, and the agreement of the client. The purpose of treatment is to remediate limiting, painful, or life-threatening symptoms within an identified client.

### **Summary**

In conclusion, it seems clear that this emerging area of study of counseling adults with ADHD is in need of research and review of diagnosis criteria and treatment options. Limited qualitative studies have included mental health professionals. Theoretical comparisons are tools that list properties that look at something objectively. This qualitative study will engage in interviews of mental health professionals with experience treating adults with ADHD about their practices using comparisons of methods deemed best practice techniques. It is anticipated that the results of this research study will provide improved understanding of the treatment methods currently employed with ADHD adults.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is a challenging disorder to persons diagnosed with ADHD and to those who interact with those individuals. A challenge for loved ones and professionals, of course, is how to help the persons with ADHD achieve their highest potential.

Mental health professionals are challenged with the complexity of the disorder, the surrounding issues of a newly acknowledged *adult version* of the disorder, and the implications that all of these factors present in diagnosis and treatment. This study will examine the experiences and perceptions of mental health providers who are considered experts in the diagnosis and treatment of ADHD adults. The literature review in this chapter, divided into two parts, will explain how the complexity of the disorder and adults with the disorder are connected, and how they interconnect.

Section one will include a brief history and the research implications of ADHD as a condition of childhood. This section will also include diagnostic and treatment guidelines for treating children and adolescents with the disorder. *Diagnostic and Statistical Manual DSM-IV* (APA, 2000) and *International Classification of Diseases* (World Health Organization, 2010) criteria will be included.

Section two will include a brief history of ADHD including the history and research implications of ADHD as a lifespan disorder. Section two will also include diagnostic and treatment suggestions that surround adult ADHD. Controversies surrounding diagnosis and treatment of adults with ADHD will be discussed. Early

research with adults and treatment recommendations will be included. This section will include a discussion of what is missing from the literature with ADHD adults, thus setting the current study in the context of previous research and providing a rationale for this research study.

### **History of ADHD in Childhood**

Attention Deficit Hyperactivity Disorder has been documented in medical and mental health literature for over 100 years. In 1902, Dr. George Frederic Still published in a British medical journal a description of a syndrome displaying “a morbid defect of moral control” (Still, 1902). Still described an inhibition disorder that we now believe was Attention Deficit Hyperactivity Disorder.

An earlier mention of ADHD may have appeared in a poem by a German doctor and author, Dr. Heinrich Hoffman. The 1844 poem entitled, “The Story of Fidgety Philip” described the effects of a young boy’s behaviors as he...”won’t sit still; He wiggles and giggles, and then, I declare, swings backwards and forwards, and tilts up his chair” (Hoffmann, 2011).

Early identification of ADHD was laden with assumptions regarding the ability or inability of a child to maintain attention and focus. ADHD was thought to be prompted by emotional or attitudinal motivation or personal disincentives to control unacceptable behaviors.

The discussion of the effects of biological factors and environmental influence was and continues to be significant in the *nature-versus-nurture* debate regarding the origins of ADHD. Numerous researchers have pointed out that these variables do not function independently but are intertwined to produce human behaviors (Ingersoll, 1998).

As new information and research has become available, thinking about ADHD has changed.

Researchers in North America following the 1917-1918 encephalitis epidemic witnessed many survivors showing what they thought were ADHD-like behaviors. They attempted to identify the cause of these behaviors and as a result upgraded Still's original findings from *morbid moral defect* to *minimal brain damage* ("Adhd history," 2011). Dr. F. G. Ebaugh theorized that the encephalitic virus caused inflammation of the brain of the children who were exhibiting the inattentive and hyperactive behavior patterns. While no supportive physical evidence existed, either then or now, of viral activity causing ADHD, the disease theory for ADHD had its beginning in the early 1900s (Stein, 2001).

Controversy has always accompanied a diagnosis of ADHD. The name has changed numerous times in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* published by the American Psychiatric Association (2000). The *DSM-IV* (APA, 2000) is used as a means of providing a classification of mental disorders. It is used in North American and around the world to provide a common language for clinicians, researchers, and health insurance and pharmaceutical companies. Many European countries and other parts of the world use the International Classification of Diseases (ICD) which is produced by the World Health Organization (2010). They have both been coded to provide international coordination of mental health services.

*DSM-I* (APA, 1952) was established following World War II. The set of symptoms (inattention, impulsiveness, and hyperactivity) that make up the current diagnosis of ADHD in the *DSM-I* were originally identified as Minimal Brain Damage and Minimal Brain Dysfunction.

In 1968, the diagnosis was renamed Hyperkinetic Reaction of Childhood. *DSM-II* (APA, 1968) diagnostic criteria reflected a consensus that the syndrome was biologically based. While many researchers of the time believed that the causes were environmental, it was theorized that a popular psychologist coining the phrase *Hyperactive Child Syndrome* and the advent of widespread treatment for ADHD with stimulants led to the belief that ADHD was biologically based ("Adhd history," 2011).

ADHD was linked with drug therapy in the 1970s when the use of the drug Ritalin, (Methylphenidate, mixed amphetamine salts) was recognized as effective with children suffering inattention and hyperactivity. The use of medication to control hyperactivity, inattention, and concentration in children ignited an international debate. Prevailing opinion was that ADHD was a disorder that was developmental in nature and would be outgrown in adolescence (McGough & McCracken, 2006). Early research on the brain's frontal lobe seemed to suggest that as children's brains matured, improvement in their ability to concentrate would follow. Medication was viewed as a means to aid the developing brain.

Colley (2010) suggested that the bio-medical paradigm existed because of attempts to oversimplify the causes and treatments of a very complex disorder. He stated further that ADHD is best understood as a bio-psychosocial disorder that "involves complex gene-environmental interactions and not seen as a gateway into simplistic interventions" (p. 84).

*DSM-III* (APA, 1980) re-named the disorder giving it a key symptomatic handle. The disorder became Attention Deficit Disorder (APA, 1980). In *DSM-III-R* (APA, 1987), published 7 years later, ADD focused on hyperactivity, and the disorder was

changed to Attention Deficit Hyperactivity Disorder.

Since 1993, ADHD has been recognized through the ICD system giving credibility to international acceptance as a mental health disorder. Currently, the ICD identifies ADHD as a sub-category under the general category of Hyperkinetic Disorders. It offers a definition of the disorder and four types of hyperkinetic disorders; one of which is Attention Deficit Disorder (World Health Organization, 2010).

Publication of the editions of the *DSM-III* (APA, 1980), *DSM-III-R* (APA, 1987), and the *DSM-IV* (APA, 2000) established a more neutral etiology. The *DSM-IV* (APA, 2000) listed ADHD as a category that includes ADHD combined type, ADHD predominately inattentive type, and ADHD predominately hyperactive-impulsive type. The *DSM-IV* manual also lists ADHD not otherwise specified (APA, 2000). Empirical basis for diagnostic criteria began to emerge, and ADHD has increasingly been recognized as biologically driven and considered a brain-based neuro-developmental disorder (McGough & McCracken, 2006).

The *DSM-IV* (APA, 2000) was the diagnostic standard used and discussed by the research study participants during the majority of this research study. In May, 2013, near the end of the data gathering for this study, *DSM-5* was released culminating a 14 year revision process. The diagnostic changes that have been implemented and will affect ADHD diagnostic decisions are as follows:

1. “Examples have been added to the criterion items that facilitate application across the life span application.
2. The cross-situational requirement has been strengthened to ‘several’ symptoms in each setting.

3. The onset criterion has been changed from ‘symptoms that caused impairment were present before age 7 years’ to ‘several inattentive or hyperactive-impulsive symptoms were present prior to age 12.’
4. Subtypes have been replaced with presentation specifiers that map directly to prior subtypes.
5. A comorbid diagnosis with autism spectrum disorder is now allowed.
6. A symptom threshold change has been made for adults to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff at five symptoms instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity.
7. ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the DSM 5 decision to eliminate the DSM-IV chapter that includes all diagnoses usually first made in infancy, childhood or adolescence” (APA, 2013, p. 2).

The Americans with Disability Act of 1973 issued a fury of controversy for special accommodations in academic settings for children and adolescents. The need to define impairment with ADHD was significantly more essential in order for children and adolescents to qualify for services and reasonable accommodations. ADHD became a disability as defined in the Disability Act of 1973 (Barkley et al., 2008). Educators and school systems struggled with the development of reasonable accommodations for children with ADHD. Public schools in the United States were required to provide services for children and adolescents who had been diagnosed with ADHD.

The name changes throughout the history of ADHD seem to reflect changing



cultural attitudes about the origin of the disorder and attempts to understand and treat the disorder. The influence of researchers, clinicians, educators, parents, and diagnosed clients with the disorder have produced an increasing awareness of the problem that ADHD presents. Its complex causes and treatment have contributed to ADHD being the most researched psychiatric condition of childhood. The name changes also suggest the changing and complex nature of diagnosis and treatment of this multifaceted disorder.

### **Diagnostic Criteria for Children and Adolescents with ADHD**

The National Institute of Mental Health (NIMH) has estimated that children with Attention Deficit Hyperactivity Disorder account for 2%-5% of the population of the United States (Portrie-Bethke, Hill, & Bethke, 2009). Because of the large number of individuals who are believed to have ADHD and the complexity of the disorder, accurate diagnostic criteria must encompass numerous considerations. ADHD affects the child who is diagnosed with the disorder, the family, the school, and the community. Children and adolescents with ADHD have pronounced impairments and may experience long-term adverse effects. Academic performance, vocational success, and social emotional development may be compromised in various ways with the diagnosis of ADHD.

### **Environmental Effects as Diagnostic Criteria for ADHD**

There are no objective, laboratory-based tests that can establish the diagnosis of ADHD. It is widely accepted that ADHD is a series of neuro-developmental delays that undermine the developmental path and influence the interactions of a child with others and their environment (Colley, 2010). As a result, accurate diagnosis often includes exploration of the child's developmental background, teacher questionnaires, and parental information. The role of environmental factors in the diagnosis of ADHD in

children and adolescents continues to be controversial. ADHD represents the convergence of several biological risk factors and multiple environmental issues that contribute to both diagnosis and treatment (Goldstein, 2006). ADHD skeptics have argued that children diagnosed with ADHD and living in high risk situations garner the diagnosis due to the environment and not as a result of underlying neurological conditions. ADHD is “universally understood by professionals and policy makers to be biological in origin, but psychological and social in expression, in which outcomes are determined by a complex set of relationships between the individual and the environment that they experience” (Colley, 2010, p. 85).

Families with children who have ADHD are prone to increased levels of parental frustration, marital discord, and divorce. In addition, children with ADHD, like other chronic disorders, represent a serious financial burden for families who seek medical and psychological assistance for their children. Viewing the disorder from a broader perspective, it has been shown that ADHD individuals consume a disproportionate share of resources and attention from health care systems, schools, criminal justice systems, and mental health agencies (National Institute of Health, 1998)

### **Comorbidity as Diagnostic Criteria for ADHD**

Many ADHD children and adolescents present with comorbid conditions. It is well established that ADHD frequently is comorbid with other psychiatric disorders. It is, therefore, essential that diagnosis include rule-outs for other disorders. Clinicians should be prepared to encounter a wide variety of psychiatric symptoms that must be managed and sorted as ADHD or non-ADHD (Pliska, Burnet, Burkstein, & Walter, 2007). Common comorbid conditions include the following: language or learning

disabilities (25-35% of children diagnosed with ADHD); oppositional disorder or conduct disorder (54-84% of children diagnosed with ADHD); anxiety (33% of children diagnosed with ADHD); and depression (33% of children diagnosed with ADHD (Edwin, 2011)).

### **Brain Imaging and Genetics as Diagnostic Criteria for ADHD**

Current research of the ADHD brain has led to an understanding of brain function and impairment of higher order cognitive processes. Brain imaging was first recognized as early evidence that the brain of a person with ADHD was structurally different than a normal brain (Zametkin et al., 2007). New information regarding the etiology and epidemiology of ADHD over the last two centuries has yielded insights into brain development and functioning. Non-invasive brain scanning technology and genetics have allowed for greater confidence and more precise diagnosis of ADHD.

Scientists reported that while they did not find a single gene that was responsible for ADHD, they did discover that ADHD was 80% biologically-based (Hechtman, 1993). This report demonstrated, according to scientists, that a genuine application exists in the role of genes and neurotransmitters and their influence on the human body. New technology led to a growing body of knowledge that identified ADHD as a physical condition with psychosocial implications. Both brain imaging and genetic research continue as on-going efforts to pinpoint the origins of ADHD. Neither of these methods is advanced enough to provide a definitive physical diagnosis, but researchers are hopeful that further exploration will eventually lead to a brain scan that could identify ADHD.

### **The International Classification of Disease (ICD) as Diagnostic Criteria for ADHD**

The ICD describes ADHD as follows: A group of disorders characterized by

early onset (1-5 years) with the following characteristics:

- Lack of persistence in activities that require cognitive involvement;
- Tendency to move from one activity to another without completion;
- Disorganized and ill-regulated with excessive activity;
- Reckless, impulsive and prone to accident;
- Disciplinary troubles because of being thoughtless;
- Socially disinhibited with lack of normal caution;
- Unpopular with others and may become isolated;
- Impaired cognition;
- Delays in motor and language discordant (World Health Organization, 2010).

Bauermeister, Canino, Polanezyk and Rohde (2010) noted that current research validated ADHD across cultural lines and that cross cultural equivalence was established. ICD-10 (World Health Organization, 2010) and *DSM-IV* (APA, 2000) have contributed to an acceptance of ADHD symptoms as international diagnoses. The ICD is used most often internationally whereas the *DSM-IV* (APA, 2000) is used more often in the US to diagnose mental health conditions.

### ***Diagnostic and Statistical Manual (DSM) as Diagnostic Criteria for ADHD***

Diagnostic criteria in the *DSM-IV* (APA, 2000) delineate the symptoms of ADHD and place them into three symptom groupings. Inattention, hyperactivity, and impulsivity make up the major symptom categories of the diagnosis of ADHD. In order to be diagnosed with the disorder, clinical documentation must establish the presence of six or more of the symptoms for inattention and six or more of the symptoms of hyperactivity-impulsivity. The disorder must have persisted for six months or longer and be

maladaptive and inconsistent with developmental levels of the child.

The symptoms of inattention include

- Poor attention to detail;
- Making careless mistakes;
- Failure to listen;
- Difficulty maintaining attention;
- Not following through;
- Problems organizing;
- Dislike of continued mental activity;
- Misplacing things;
- Distraction and forgetfulness;

The symptoms of hyperactivity include

- Frequent fidgeting;
- Leaving the seat when remaining seated would be expected;
- Inappropriate activity levels;
- Problems being quiet;
- Persistently being active;
- Talking excessively;

The symptoms of impulsivity include

- Trouble waiting turn;
- Interrupting or intruding on others;
- Blurting out answers (APA, 2000);

The criteria in the *DSM-IV* (APA, 2000) states that ADHD “must be present

before the age of seven years. Symptoms must be present in two or more settings and there must be clear evidence of clinically significant impairment in social, academic or occupational functioning” in order to receive a diagnosis of ADHD (p. 63).

Present diagnostic criteria for ADHD are based around childhood behaviors, age inappropriate and impairment in functions of hyperactivity, impulsivity, and concentration (Haavik, 2010). The criteria in the *DSM-IV* (APA, 2000) are used to diagnose and treat ADHD.

### **Children and Adolescents Diagnosed with ADHD**

According to Kessler et al. (2006) clinicians, in order to produce an accurate diagnosis of ADHD, must take a number of factors into consideration before determining a diagnosis of ADHD. They must assess any possible functional impairment in more than one setting. Clinicians should complete a comprehensive medical, social, and academic evaluation of each potential client. A detailed family history, including comorbidity, should be executed. Careful consideration should be given to the use of standardized assessment instruments for child, parent, and teacher. The child's response to stimulant medication should be evaluated.

It is important to note that children who exhibit hyperactivity, concentration problems, and impulsivity are not abnormal. The intensity, persistence, and patterning of the symptoms predict the behaviors becoming a diagnosable disorder. It is important to identify and treat ADHD for several reasons. It provides appropriate direction for treatment planning and relief for a child who is struggling with symptoms. Early diagnosis tends to decrease the risk of problem behaviors that are likely to develop later in life (Wender, 2000).

## **Treatment for Children and Adolescents with ADHD**

### **Psychotherapy as Treatment for ADHD**

The role of psychotherapy as a treatment for ADHD has not been well defined (Ingersoll, 1998). Therapy or *talk therapy* encompasses a wide variety of methods and techniques aimed at helping people with change in attitudes, emotions, and behavioral patterns. Ingersoll (1998) pointed out that therapeutic approaches like behavioral therapy, cognitive, family, or group therapy could be effective for the ADHD child. Parents being pro-active and mindful of the family's and child's needs are the key to successful therapeutic interventions.

According to Kessler et al. (2006), therapies for children and adolescents with ADHD have shown the most improvement when medication management and education were included. Kessler et al. (2006) argued that therapy could be effective only when good management of comorbid conditions existed and when psychoeducational training for parents and children was included in therapeutic planning.

### **Multimodal Treatment**

The American Academy of Child and Adolescent Psychiatry published practice parameters for the assessment and treatment of children and adolescents with ADHD. The practice parameters suggested numerous treatment recommendations including taking into account that ADHD is a chronic disorder and the inclusion of pharmacological interventions as therapeutic interventions (Pliska et al., 2007).

In 1999, the National Institute of Mental Health conducted a study that included thousands of children and numerous university clinics offering services to ADHD children and adolescents. The purpose of the study was to identify the types of

interventions that seemed most effective in treating ADHD. The 14 month research study revealed that children with ADHD showed symptom improvement, including the ability to learn and activate new skills, when enrolled in a multimodal program of pharmacology, social skills training, and behavioral therapy. Improvement was more significant and was shown to be maintained over a 14 month period when several methods of treatment were combined (National Institute of Mental Health, 1999).

Current research suggests that children and adolescents benefit most from a multimodal approach to treatment. Combined elements of medication, therapeutic interventions, and social skills training have been documented as the most successful for ADHD children. Successful treatment should include three areas of concern for the ADHD child: medical, psychological, and educational (Wender, 2000).

### **Non-Traditional Treatment for ADHD**

Treatments that have been attempted with limited research validation include biofeedback, nutrition, yoga, and herbal remedies. While not accredited by research findings, some alternative therapies are commonsense theories; for example, eating protein-rich foods and including several servings of whole grains to help control dietary triggers for hyperactivity. Exercise was encouraged as a means to overcome helplessness that failures in other endeavors might evoke in the ADHD child. There is a long history of alternative interventions for ADHD, and while these interventions have generated a great deal of attention, there is little empirical evidence to endorse them as effective treatment strategies (National Institute of Mental Health, 1999).

Hirshberg (2010) has shown the benefits of Working Memory Training and cognitive behavioral therapy. Barkley (2010) points out that working memory involves



at least four actions that individuals use to regulate and guide eventual behavior. He suggests that working memory includes verbal and non-verbal memory, emotional regulation and problem solving skills. This educational training is an attempt to teach ADHD individuals to access their own working memory, thereby encouraging behaviors that would fulfill personal goals. Working Memory Training has been utilized with ADHD children and about 75-80 percent of kids tested showed some improvement in the reduction of inattention and hyperactivity (Cogmed.com/research).

About 10,000 children in the U.S. have received neurofeedback treatments. According to the International Society for Neurofeedback and Research, the treatments were intended to help a child refocus and exercise the portion of the brain that was deficient. Currently, there is no rigorous testing that has shown long term positive neurofeedback results for ADHD (“Additude’s Guide,” 2008)

### **Medication as treatment for ADHD**

Medication is recognized by many experts as a first line of treatment for ADHD. Although little research exists regarding the long-term effects of psychostimulants, there is no conclusive evidence that, when used with careful monitoring, the therapeutic use of medication is harmful. Most medications prescribed for ADHD are psychostimulants. Discovered in the 1950’s, Dr. Charles Bradley found that central nervous system stimulants had an unexpected effect of calming restless, overactive children. Stimulant medication (Ritalin, Adderall) was found to assist in focus and curtail hyperactivity. It is ironic that stimulant medication could produce calming effects in ADHD children and adolescents. It is generally believed that stimulants affect the neurotransmitters dopamine and norepinephrine which often produce improved self- control and enhance

concentration (Ingersoll, 1998).

Side effects are generally mild and include decreased appetite and insomnia. Children must be monitored closely to prevent unhealthy weight loss. Other side effects might include a *slump period* when medication is low or ineffective and can affect the ability of medicated children to focus on afterschool work or homework. Generally, psychostimulants produce added attentiveness and ability to concentrate both in school and after school. They also reduce the effects of hyperactivity in the ADHD child.

Primary care physicians, psychiatrists, neurologists, and psychologists are the providers who most often assess, diagnose, and treat children with ADHD. The American Academy of Child and Adolescent Psychiatry have established guidelines for the assessment and treatment of ADHD, but there are wide differences among the way practitioners assess and treat individuals with ADHD. According to the National Institute of Mental Health, family practice physicians diagnose and prescribe medications more quickly than pediatricians and psychiatrists. Some practitioners use structured questionnaires, rating scales, and school input forms. However, there is often poor communication between diagnosticians and those who monitor treatment in schools (National Institute of Mental Health, 1999). There tends to be limited coordination of services for children who take medication and few guidelines for medication services among providers.

Wender (2000) pointed out that the complexity of ADHD is often focused with narrow intensity. He theorized that ADHD might be misdiagnosed as a psychological, educational, or family problem, because those are the arenas in which it is observed. The treatment of ADHD as a medical problem may be too often overlooked. Wender (2000)

offered three reasons why parents might reject medical treatment for ADHD. Some parents, he suggested, have difficulty with the child's behavior having physical roots as opposed to psychological. He also suggested that a second reason to reject medication as treatment for ADHD is the artificiality of the treatment. Parents might feel that medication disallows the child from getting to the root of the problem. Finally, Wender (2000) stated that a third reason for the potential rejection of medication for ADHD treatment might be the fear of drug addiction or dependency on medication to resolve life issues. Education is essential to help parents carefully consider whether or not to use medication as a treatment option.

Effective medical treatments for ADHD have been evaluated primarily within a three month period of time. Random clinical trials have established the efficacy of stimulants. More testing is needed to evaluate the wide range of providers and their use of psychostimulants across communities and physicians. There is currently no evidence regarding the appropriate ADHD diagnostic threshold above which the benefits of psychostimulant therapy may outweigh any risk factors (National Institute of Mental Health, 1999). "A very large fraction of ADHD children can be helped, often to a marked degree, by treatment with medication" (Wender, 2000, p. 68).

### **History of ADHD in Adults**

A recent American national survey reported that a 4.4% prevalence rate of adult ADHD in the general population represents nine million American adults (Waite, 2009). Barkley et al. (2008) pointed out that the prevalence of ADHD adults was taken from longitudinal studies of children followed into adulthood yielding approximately 3.3-5.3%. Larger population studies have shown that nearly 5% of adults or 11 million adults

in the United States alone have been identified as ADHD adults. Barkley et al. (2008) argued that “ADHD is therefore a relatively common mental disorder among adults, affecting at least 5% of the U.S. population” (p. 25).

Early pioneers like Dr. Paul Wender began research on adult ADHD in 1976. Wender advanced the possibility that ADHD continued into adulthood. He and his research team also proposed theories for the diagnosis and treatment of adults with ADHD (Wender, 2000). Over the last 50 years, Attention Deficit Hyperactivity Disorder has been primarily considered a disorder of childhood. Some scholars have suggested that one of the reasons that ADHD has been delayed for consideration as a lifetime condition is that it includes symptoms that have been traditionally attributed to children. Hyperactivity and impulsivity have been thought of as childhood symptoms. ADHD as a lifetime disorder has often been confused with other adult psychiatric disorders.

ADHD adults are likely to suffer with comorbid psychiatric conditions such as depression, anxiety, and obsessive-compulsive disorder. ADHD adults are also prone to interpersonal trauma, emotional and work-related problems, as well as physical maladies. Driving concerns, higher insurance risks, and engaging in risky behaviors are also higher in probability for the ADHD adult (Barkley et al., 2008). The complexity of the disorder and the changing nature of the symptoms in adults have made it very difficult to identify ADHD in adults.

Wender was one of the first researchers to advance the hypothesis that ADHD was genetic in origin. Wender (2000) theorized that ADHD was a medical condition and encouraged early advocates to treat adults as soon as possible due to the assumed trauma that the disorder produced in the life of diagnosed adults.

Barkley (2010) estimated that most adults with “ADHD have at least two disorders: 80-85% have ADHD and one other disorder, and more than half may have three psychological disorders” (p.15). Barkley (2010) also indicated that the most common coexisting disorders were Oppositional Defiant Disorder, Conduct Disorder, Learning Disability, Alcoholism, and Bipolar Disorder. As a result, Barkley (2010) theorized that ADHD could easily have been misdiagnosed in childhood or adolescence. It might also have been confused with other comorbid disorders. Therefore, ADHD may not have been discovered or properly diagnosed until later in the life cycle. ADHD as a lifespan diagnosis has emerged in the last few years.

The *DSM-III* (APA, 1980) recognized that ADD persisted into adulthood as Attention Deficit Disorder, Residual Type. *DSM-III-R* (APA, 1987) also noted that giving the diagnosis of ADHD could be considered if symptoms persisted into adulthood. Adult symptom descriptors were not provided.

*DSM-IV* (APA, 2000) included directions for the diagnosing professional by including some adult-like symptom descriptions, “in adolescents or adults (hyperactivity-impulsiveness) may be limited to subjective feelings of restlessness, often does not follow through on instructions (impulsiveness) and fails to finish chores or duties in the workplace” (p. 63). The *DSM-IV* (APA, 2000) included references to adult ADHD but with limited direction or assistance provided to the mental health professional to utilize the criterion.

The first neuroimaging study of adults was conducted by Zametkin et al. (2007). In the study, researchers used positron emission tomography to study cerebral glucose metabolism. This study and later research showed physical evidence of differences in the

adult ADHD brain and offered conclusive evidence that ADHD was a valid psychiatric disorder of adulthood that could be designated from other adult conditions (Barkley et al., 2008).

Brain Spec Tomography (Single Photon Emission Computed) was used as a procedure to evaluate the cerebral blood flow in the human brain. It evaluated how well the brain was working. It evaluated further whether or not the brain was working too hard in some areas and not hard enough in others (Zametkin et al., 2007).

In the study of the ADHD brain, this type of physical evidence opened the possibility of understanding the brain in new ways. Patterns of brain activity were mapped and studied, and treatment options could be evaluated based on emerging patterns. For the first time, scientists could see the functioning of the ADHD brain and could monitor brain functioning with and without medication. Attention and inattention activity levels could also be monitored.

The possibility of pinpointing ADHD function in brain activity is an intriguing addition to identification and treatment for future study. As the field of brain imaging has emerged, new evidence has shown that ADHD is a condition that can be mapped and identified. As a result, diagnosis and treatment of ADHD as a medical condition became possible (Zametkin et al., 2007).

Hill and Schoener (1996) engaged in long term research following the lives of ADHD children between 4 and 16 years old. These research efforts contained numerous methodology problems but suggested the difficulties of applying childhood criteria to an adult population. This was one of the first longitudinal studies of ADHD that included children-to-adult clients with ADHD. Longitudinal studies conducted with ADHD

children and adults began to produce information on two important fronts: first, ADHD children and teens became ADHD adults; and second, ADHD symptoms (used to diagnose children) were difficult to apply to adults (Goldstein & Ellison, 2002).

*ADHD in Adults* was published (Barkley et al., 2008) following years of research. The research team chose to document in book form due to the scope of the findings. The book detailed two of the largest and most comprehensive studies of adults with ADHD conducted to date. One study was completed at the University of Massachusetts Medical School from 2000-2003 and the second study was conducted in Milwaukee from 1977-1980 and 1999-2003. These studies followed clinic-referral ADHD children from the age of diagnosis until age 27. Both studies were longitudinal and comprehensive research studies. The stated purpose of the research project was to “conduct a comprehensive study of the symptom presentation of ADHD in adult life stage, evaluate a pool of new and potentially useful symptoms reflecting the adult stage of the disorder, better understand other psychiatric disorders associated with ADHD and formulate research and clinical recommendations that might serve future studies of ADHD in adults and improve clinical assessment and management” (p 3).

This landmark research began to open further inquiry into much needed areas of adult research. The research findings widened the body of knowledge concerning adults with ADHD and attempted to clarify some of the questions in diagnosis and treatment unrevealed by earlier predominant childhood ADHD research.

Multicultural issues surrounding the diagnosis have not been adequately addressed and may influence decisions regarding the diagnostic interventions devised for ADHD adults. It is largely unknown how multicultural issues influence the diagnosis and

treatment of ADHD adults.

Due to early research of the disorder that centered on young white males, sexual orientation, cultural diversity, and gender differences have not been appropriately addressed. Waite (2009) identified a case study of an African-American woman whose diagnosis and treatment took place in adulthood. The researchers reported that “obtaining a late diagnosis influenced and shaped her (the person in the case study) early years of life, particularly with negative self-criticism and feeling like a failure” (p. 551). The researchers noted further “there is a strong need for the development of specific diagnostic criteria that is more sensitive and specific to adult (ADHD) functioning. This is particularly important to mitigate the disparities among ethnic minority adult groups concerning assessment, diagnosis, intervention and treatment improvement in evidence based provision of care” (p. 552).

Thus far, adult ADHD research efforts have not reflected the childhood ratio of more male than female adults with ADHD. This places further emphasis on the fact that adult and childhood populations of clients with ADHD symptoms differ greatly (Haavik, 2010). ADHD as an adult diagnosis has only recently been acknowledged, and research is limited. The diagnostic criteria for ADHD were established for children and adolescents. Research projects are underway that may answer many questions concerning changes in symptoms from current child-based criteria into how they manifest as an ADHD adult. New research is emerging offering information and directions that will provide guidance to formulate adult diagnosis and treatment protocols. ADHD as a lifecycle disorder is a developing concept.

### **Diagnosis of Adult ADHD**



### **Childhood Symptoms of ADHD as Criteria for Adult ADHD**

Currently, a diagnosis of adult ADHD is considered clinically appropriate when based on an earlier childhood diagnosis of ADHD. “Every adult with ADHD had ADHD as a child. If the adult did not have ADHD symptoms, some other psychological problem is present” (Wender, 1995, p. 8).

Goldstein and Ellison (2002) described an adult ADHD pilot study that modeled itself after the American Academy of Childhood and Adolescent Psychology (AACAP) practice parameters for children (Pliska et al., 2007). The similarities of the two were the need to access detailed developmental information and provide collaborative childhood information. Underreporting (by ADHD adults) of childhood ADHD symptoms has been well documented (Barkley, DuPaul, & McMurray, 1990). A parent rating scale was given to be completed retrospectively by the parent or person who knew the adult as a child. Embedded in the questionnaire were the 18 *DSM-IV* (APA, 2000) diagnostic symptoms useful in determining ADHD in childhood. Research has proven that parental recall is a more valid measure of a clinical diagnosis for ADHD than that of the client with ADHD (Goldstein & Ellison, 2002). Implications behind the pilot program have been duplicated leading researchers to conclude that an effective method of identifying adult clients with ADHD should include a clinical interview and a diagnostic interview. If family members or others with past knowledge of client were available, researchers found that the information of these reporters was the most helpful in assessment. If unavailable, researchers completed a careful diagnostic interview with the adult client. This further emphasizes the importance of establishing a childhood diagnosis to accurately diagnose adult ADHD (Goldstein & Ellison, 2002).

Jackson and Farragut (1997) suggested that a diagnostic interview should include open-ended questions centered on childhood memories. This would include completion of assignments (inside and outside school classrooms), behavior difficulties, energy level, social relationships, quality of self-esteem, and hobbies. They also suggested that open-ended questions might include current behaviors regarding coping skills, job performance and quality of family relationships. Other areas to explore would include forgetfulness, time management, difficulty staying on task, self-discipline, and self-esteem (Jackson & Farragut, 1997).

Wadsworth and Harper (2007) suggested that in order to make as accurate a diagnosis as possible, mental health professionals should gather psychosocial history and incorporate an evaluation of cognitive processes as a part of a comprehensive assessment strategy for adult clients presenting with ADHD like symptoms. As noted earlier, a diagnosis of ADHD is made in children and adolescents following assessments of the individual and documentation provided by significant others. This provides collaborative documentation toward a diagnosis of ADHD. Adults are difficult to diagnose due to their limited ability to gain collaborative documentation and poor self-reporting tendencies.

### **DSM as Criteria for Diagnosis of Adult ADHD**

The three primary characteristics common to children, adolescents, and adults with ADHD is inattention, hyperactivity, and impulsivity. These primary characteristics are expressed differently in adults with the disorder. Because children have constant oversight in school and at home, it may be easier to accurately gauge symptoms. These may include being off task, waiting a turn, or sitting still in a seat. Recognizing ADHD symptoms in adults is less obvious and may look very different in adulthood than they do

in childhood (Jackson & Farragut, 1997).

Goldstein & Ellison (2002) stated that there is controversy regarding ADHD diagnosis; especially, they point out, regarding the diagnostic criteria suitable for adult ADHD. They suggest that hyperactivity tends to disappear in adolescence; adult impulsivity may migrate into interrupting conversations of others, disregarding the feelings of others, and becoming thrill seekers. Hyper-activity in adults may result in nervousness, anxiousness, and restlessness. Adults might fidget constantly and sometimes give way to pent up anger and explosive temper displays (Goldstein, 2006).

Wolf and Wasserstein (2010) pointed out “*DSM-IV* criteria for ADHD, subtype and symptom variants often is not specified. As pointed out elsewhere, strict adherence to the *DSM-IV* criteria may not be the most appropriate for diagnosing and identifying potential ADHD subjects in adulthood” (p. 398).

The current diagnostic criterion used for adult clients is established around childhood symptoms and impairment. Many authors argue the need to review the criteria used in the *DSM-IV* for adults (APA, 2000). Barkley et al. (2008) and others have attempted to describe adult symptoms in new ways. In two major studies, Barkley and associates developed a list of symptoms extracted from the *DSM-IV* (APA, 2000). They compiled and refined the symptoms that were the best descriptors in their studies that included large groups of adults with ADHD. The most effective and descriptive symptoms, they concluded, were the most beneficial in discriminating ADHD in adults.

In the Barkley et al, (2008) study, the most discriminating symptoms were the following:

- “Has difficulty sustaining attention;

- Has difficulty listening when spoken to directly;
- Has to be on the go or acts as if driven by a motor;
- Loses things necessary for tasks or activities;
- Is easily distracted” (p. 106).

In the second study, the most discriminating symptoms were the following:

- “Has difficulty sustaining attention to tasks;
- Leaves seat when required to sit;
- Fails to listen when spoken to directly;
- Feels reckless;
- Has difficulty engaging in leisure quietly;
- Talks excessively” (p. 108).

Researchers are attempting to enhance the current knowledge of diagnosis that is garnered from research with ADHD children. Considering the diagnosis as a lifespan diagnosis challenges old beliefs concerning ADHD and forecasts a need for improved adult-specific diagnostic criteria. The *DSM-5* (APA, 2013) offers expanded criteria that will aid mental health professionals in diagnosing adult ADHD.

### **Redefining *DSM* Criteria for Diagnosis of Adults with ADHD**

Researchers have identified a cluster of developmental tasks of adulthood as executive function. While there is limited agreement regarding the components of executive function, there is general agreement that a cluster of characteristics are essential to adult functioning that are impaired with ADHD. Several studies (Barkley, 2007; Beckett, 1994; Nigg, 2001) identified areas of dysfunction that were later labeled executive functions. Executive function includes the need to organize, be self-sufficient,

and engage in reflectivity, planning, and concern for the future. This cluster of control functions are found in adults who are functioning at an optimal level. These behaviors are unique to higher functioning in adulthood. Executive function also includes the need to become more independent, develop better social skills, and become more future oriented in planning and thinking skills (Wolf & Wasserstein, 2010).

There is a growing consensus that ADHD is a fundamental disorder of executive function. While there is disagreement regarding the definition of executive function, it is largely agreed that there are no reliable tools to diagnose adult ADHD. There are few diagnostic tools that take into account the unique symptoms of adults with ADHD. Understanding the role of executive function is currently being researched and refined to better explain the nature of “human self-control and how it comes to be disrupted in those with ADHD. Perhaps then it will be clearer why continuing to refer to this disorder as simply an attention deficit may be a gross understatement. ADHD represents a developmental disorder of behavioral inhibition that interferes with self-regulation and organization towards the future” (Barkley, 2010, p. 3).

Barkley (2011) has developed an executive functioning scale, both a long and short version, to be used by clinicians for diagnostic purposes (Barkley, 2011). Wender (1995) developed the Wender Utah Rating Scale used for adult diagnostic purposes. These researchers have attempted to confront the lack of resources available for appropriate and accurate diagnostic criteria for adult ADHD.

The controversy of diagnosing adults has extended into possible changes in the *DSM-IV* (APA, 2000). The limited information offered in the current *DSM-IV* seems to have spawned potential changes in the diagnostic criteria in the *DSM-5* (APA, 2000). A

workgroup engaged in revisions for the 2013 *DSM-5*. The changes that were under consideration for ADHD diagnosis included the following: coding for inattention, an increase in the number of criteria for impulsivity, and the possibility of broadening the age of onset from on or before age 7 to on or before age 12. Also, under consideration were changes to the number of criteria needed to diagnose any subtype from the current 6 characteristics to 3. The work group recommended obtaining information from the direct report of the individual that is also confirmed by teachers, employers, or significant others (Castellanos, 2010). In less formal discussions, counseling professionals and students enrolled in a list serve known as CESNET engaged in a discussion of the current changes proposed to the *DSM-5* for ADHD adults. Comments on the list targeted the lower diagnostic thresholds for ADHD adults and some concluded that the proposed criteria for 2013 would increase the number of diagnosed adults with ADHD. They further proposed that this would increase the use of stimulant medication thereby (perhaps intentionally) increasing revenue for pharmaceutical companies (Jones, 2011).

“Only recently has a set of criteria been established in the *DSM-IV* (APA, 2000) that can be applied to adults. For counselors to treat adults with ADHD properly in emotional, social, and occupational areas, they must have a clear understanding of the disorder itself and how it affects the lives of their clients. It is important that counselors be able to understand, diagnose, and effectively treat those adults affected” (Jackson & Farragut, 1997, p. 318).

### **Comorbid Conditions as Criteria for Diagnosis of Adult ADHD**

Research suggests that ADHD remains hidden in many adults and the prevalence of other comorbid conditions further complicate diagnosis and treatment (Wasserstein,

2005). Barkley et al. (2008) concluded that like children with ADHD, adults have been found to have comorbid conditions in conjunction with ADHD. Substance dependency and abuse also occurs more frequently in adults diagnosed as children with hyperactivity. Correlations to ADHD and anxiety, obsessive compulsive disorder, and bipolar disorder have all shown significance in past research studies of children and adolescents. It is largely unknown to what extent other psychiatric conditions contribute to adults with ADHD. What is known is that there is convincing evidence that ADHD increases the liability for certain other psychiatric disorders. Barkley et al. (2008) pointed out that “such comorbid conditions and psychological problems are highly likely to require separate treatment approaches than those usually aimed at the management of ADHD symptoms and related impairments” (Barkley et al., 2008, p. 243). ADHD seems to be a cluster of issues that must be addressed in order for treatment to be effective and appropriate.

Goldstein and Ellison (2002) warned that comorbidity can lead to under diagnosis. They suggested that without reliable rating scales and controlled research for adults that ADHD symptoms can be dismissed as another psychiatric condition and misdiagnosed or alternatively be over diagnosed. It is essential to carefully assess the symptoms that are clearly ADHD. Goldstein and Ellison (2002) suggested that abiding by the *DSM-IV* diagnostic criteria is the most prudent for accurate diagnosis.

### **Treatment for Adults with ADHD**

Treatments for children with ADHD are generally focused on their school and home interactions; treatments for adults expand into living with a disability diagnosis, functioning at work, and interpersonal relationships. In order to treat ADHD in adults, it

is essential to understand the multi-level approach that treatment must embrace simultaneously. ADHD is primarily neurological with secondary psychological features that coexist with other psychiatric conditions that must be addressed for treatment to be effective for adults (Goldstein & Ellison, 2002). It is also important to note that adult ADHD is an emerging field of study. There is very little research available on treatment and treatment outcomes for adults.

### **Medication as a Component in Treatment for Adult ADHD**

Medication treatments effective for children with ADHD have been found to be just as effective for adults with ADHD (Barkley et al., 2008). Medication is considered one factor in a multimodality approach to treat ADHD adults. Barkley (2010) reported “We know that ADHD medications can normalize the behavior of 50-65% of those with ADHD and result in substantial improvements, if not normalization, in another 20-30% of people with the disorder” (Barkley, 2010, p. 109).

An early scientific trial for the evaluation of the efficacy of stimulants with adults thought to have Minimal Brain Dysfunction was conducted by Wood, Reimherr, Wender, and Johnson (1976). Using a double-blind, placebo-controlled method, the authors found that methylphenidate proved to give favorable results to adults thought to have ADHD-like symptoms.

Many other studies followed that have established the use of medication as essential to treatment for all ages of ADHD patients. Medications for ADHD are among the safest, most effective, and best studied of all drugs according to Barkley (2010). He suggested that adults who are diagnosed with ADHD should consult with their medical professional to attempt a trial of the medication available to treat ADHD. Research on



medication use is primarily devoted to ADHD in children.

### **Psychotherapy as a Treatment for Adult ADHD**

Kessler et al. (2006) recommended therapeutic models for ADHD adults. He stated further that they might focus on the following: time management, organizational skills, communication skills, decision making, self-monitoring and rewards, changing large tasks into smaller tasks, and changing faulty cognitions and beliefs into more appropriate ones. While research is scarce regarding effective treatment for ADHD adults, cognitive behavioral therapy and medication management are most often mentioned in the literature as beneficial and advantageous to this population (Ramsay, 2010; Young & Amarasinghe, 2010).

A research forum on psychological treatment of adults with ADHD yielded five empirical studies of psychological treatments for adults with ADHD. Practice guidelines to date recommend multimodal interventions including medication management. The conclusion drawn from the forum is noted as “treatment may play a critical role in the management of adults with ADHD who are motivated and developmentally ready to acquire new skills as symptoms remit” (Weiss et al., 2008, p. 642).

Krouse and Safren (2010) argued for the effectiveness of Cognitive Behavioral Therapy both with and without medication management for adults with ADHD. Goldstein and Ellison (2002) offered guidance to the therapist working with the ADHD adult suggesting that it would be helpful to consider the therapy session as a microcosm of the issues faced by the client. They recommended that structure and learning devices (audiotape, notes, etc.) might enhance the effectiveness of therapy. There is a need for future research to explore what treatment (or combination of treatments) offers the most

effective treatment for ADHD adults.

### **Non-Traditional Treatments for Adult ADHD**

Other hopeful therapies have emerged with limited research to recommend their effectiveness. ADHD coaching has shown promise, as well as medication management with multimodal possibilities (Goldstein & Ellison, 2002).

Given that prior research seems to support a strong neurobiological basis for ADHD, it is believed that the deficits of the disorder cause ADHD adults to be hindered in their ability to acquire coping strategies. Those deficits further add to their tendency to feel overwhelmed, take on negative cognitions, reinforce the cycle of avoidance and failure, and develop maladaptive coping skills (Knouse & Safren, 2010). This lends support to the use of community and family support groups as underpinning for adults to make and maintain lifestyle changes.

Support groups such as Children and Adults with Attention-Deficit Hyperactivity Disorder ([www.chadd.org](http://www.chadd.org)) and other on-line groups specifically designed for adults with ADHD have cropped up as methods to connect and consult with others. Dr. Barkley (2010) lists ADD Consults ([www.addconsults.com](http://www.addconsults.com)) and Attention Deficit Disorder Association (ADDA) ([www.add.org](http://www.add.org)). Coaching has become popular as a non-therapeutic method of guidance for adults (Barkley, 2010).

Distractibility, poor follow through and poor memory all may contribute to an adult being unsuccessful in therapy and life skills. Mental health professionals would benefit from working cooperatively with trained life coaches. Life coaches can provide support and practical assistance to therapeutic work with the ADHD adult.

Learning and maintaining compensatory skills in addition to medication

management have been found to be successful at breaking the connection between core symptoms and continued failure and underachievement. Encouraging clients and being sensitive to the effects that ADHD has on a complex individual with complex issues is essential to effective work with ADHD adults. Openness to interfacing with other paraprofessionals and professionals is also essential to ensure that therapeutic effectiveness remains at productive levels (Goldstein & Ellison, 2002).

Tutors may also be employed to help adults master achievement based employment tests or university class exams (Barkley, 2010). Cooperative efforts within the helping professions will serve the adult client most effectively. Job coaches may be available to help clients find appropriate jobs for their strengths and weaknesses and also to aid in reducing the negative impact that the ADHD may have on job performance. Family and marital therapy might enhance the understanding of ADHD adults (their spouses and families) regarding the challenges of ADHD and its social and emotional implications.

### **Treating ADHD across the Lifespan**

#### **Work and ADHD**

Adults with ADHD have significant issues that are related to the workplace. ADHD as a disability and work-related issues intersect for adults. Patton (2009) pointed out that three factors influence human resources (HR) in most workplaces ability to deal effectively with ADHD as a disability. The perceived role of HR concerning mental illness, the confusion surrounding disability laws in the workplace, and the general attitudes about adult ADHD are the factors that Patton (2009) pointed to as detrimental to appropriate management of ADHD employees. Currently, most state laws embrace the

personal decision to disclose a disability to employers. Lack of disclosure offers anonymity, but withholding disclosure disallows disability services.

Patton (2009) stated further that a broad definition of ADHD employees should be given reasonable accommodations in the workplace. Adults with ADHD are responsible for disclosing their condition to their employer. This is made difficult by the fact that many adults do not recognize that they have the condition, therefore increasing the negative effects on the individual, work, and the workplace. ADHD untreated in the workplace can lead to absenteeism, the inability to complete tasks, or get along with others. These behaviors can lead to disciplinary problems, performance issues, and turnover problems.

### **Disability and ADHD**

Understanding the significance of a long-term disability is essential for mental health professionals to offer appropriate service to ADHD adults. Stone and Colella (1996) developed a theoretical model that explored the factors involved in the treatment of disabled employees showing that negative perceptions of others play a leading role. Their research showed that disabled workers who had displayed strong work performances in past work environments and who had pleasant interactions with others had fewer problems. Impulsiveness and poor work performances may keep ADHD adult workers from being successful employees. Adult ADHD is real and a serious problem for many employed adults (Patton, 2009).

### **Conclusion**

Since adult ADHD is an emerging field, mental health professionals may be more reliant on research related to children and ADHD. The *DSM-IV* (APA, 2000) offered

little guidance concerning treatment for adults with ADHD. There are many diagnostic concerns related to symptoms recognized in children and adolescents that must be applied to adult diagnosis. The *DSM-5* (APA, 2013) addresses some of these concerns. Since ADHD is the most researched disorder of childhood, there is much knowledge from that research that is applicable to adults with ADHD. Finding ways to apply the research to adult clients is under review.

There has been limited research regarding the effectiveness of treatments for adults due to ADHD being categorized as a childhood disorder. Some treatments have proven to be effective for children, adolescents, and adults, but there is much research that is needed to develop and enhance early results. Because of the complex nature of ADHD in adults, it is widely understood that effective treatment should be multidimensional.

There have been no qualitative studies exploring the experiences and perceptions of licensed mental health providers in diagnosing and treating adult ADHD clients. Using grounded theory research, I hope to identify themes that will add to the body of knowledge. According to Goldstein and Ellison, (2002) “As is often the case in emerging sciences, practicing clinicians may advance beyond the known certainties provided by empirical research and clinical trials” (p. xviii).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Introduction**

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder that has been documented in medical and mental health literature for over one hundred years (Still, 1902). ADHD has become the most researched psychiatric condition of children. The purpose of this study is to explore the experiences and perceptions of licensed mental health professionals who are considered experts in their field who counsel adult clients who have a diagnosis of ADHD.

Currently, a diagnosis of adult ADHD is only clinically possible when based on a childhood diagnosis of ADHD. Research suggests that ADHD remains hidden in many adults and the prevalence of other comorbid conditions further complicate diagnosis and treatment (Wasserstein, 2005).

This study will seek to describe the potential diagnostic and treatment issues that childhood-based diagnostics can produce. The study will explore the methods and techniques employed by experts in the treatment and diagnosis of adult ADHD. It will also attempt to identify findings that are substantive and could contribute to the knowledge development in this emerging field. Experts may assist with ideas toward best practices in therapeutic treatments for adult ADHD clients or they may offer personal insights that could lead to improvements in the understanding of the field.

ADHD is a persistent and pervasive disability diagnosis. In the last few years, ADHD has entered a new phase; research now suggests that ADHD identified in childhood may develop into ADHD in adults (Barkley et al., 1990). Since ADHD has

long been thought to be a disorder of childhood, very little research regarding the diagnosis and treatment of adults exists. The *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) used by mental health professionals for diagnosis and treatment of mental health disorders provides clinical criteria for childhood based symptomology and impairment. This lends itself to confusion and limited direction in both diagnosis and treatment for mental health professionals who seek to treat ADHD adults.

The need to identify and treat adults with ADHD is apparent. This study will focus on how mental health professionals are coping with limited clinical information in a disorder based on childhood criteria. With a growing population of clients seeking treatment, counseling professionals are seeking insights culled from other mental health professionals in the treatment and diagnosis of adults with ADHD. Insights will be explored and reported on this study.

Emphasis will be placed on the perceptions and experiences of the professionals as they work in this emerging field. Treatment of adults with ADHD is a largely unexplored and under researched field. Given the limited amount of research in this area, exploratory research is warranted.

### **Rationale for Using Qualitative Methodology**

Qualitative research lends itself to a fluid, evolving, and dynamic problem-solving approach as opposed to the more rigid and structured format of quantitative research methods (Corbin & Strauss, 2008). Qualitative research allows the researchers to reach into the experiences of the participants and discover meaning rather than a process that is confined to testing variables. It allows researchers to delve into the inner meaning of the

experiences of the participants and in so doing to determine how meaning is formulated (Corbin & Strauss, 2008). This allows researchers to connect at a human level with their research findings. This could also lead to a discovery of order in disorder in unexplored and complex relationships.

Grounded theory is inductive research which is meant to build theory rather than test theory. It attempts to provide tools for researchers. These tools are used to assist in the analysis of masses of raw data. The purpose is to develop alternative meanings with careful and systematic regard for the data. It enlightens the building blocks of the theory (Patton, 2002).

Since there is such a limited research base surrounding ADHD adults and few research studies available. The use of qualitative methodology is the most effective means of understanding and explaining current challenges and aid in projecting future challenges for mental health professionals working in the field. It is hoped that a grounded theory developed from the experiences and perceptions of mental health professionals considered experts currently working with adult ADHD clients will bring new insights into this emerging field.

### **Researchable Problem**

Qualitative research begins with a broad question. Concepts are identified and constructed from the data. Identification of a research problem can come from several sources: personal and professional experiences.

Professional experiences often lead to a judgment or experience that might lead to a research question. As a mental health professional, my personal experience confirms that diagnosing and treating adults with ADHD has become increasingly difficult. The



*DSM-IV* (APA, 2000) offers little assistance to identify adult symptoms. Currently, there are no best practice guidelines and limited research showing therapeutic interventions and their effectiveness.

As a result, in my own practice, I have found that a need exists to research adult ADHD diagnosis and treatment options. Based on questions and answers that often ensue in informal conversations with other mental health professionals, I have wondered what experts in ADHD would offer to the body of knowledge. Interviewing mental health professionals and uncovering their experiences and opinions would deepen the understanding of therapeutic interventions and could potentially enhance the decision making ability of mental health professionals (Corbin & Strauss, 2008).

Another source of developing the research problem is the research itself. There is very little research and even less qualitative research in this new field. When communicating with Dr. Russell Barkley, an acknowledged expert in the field of ADHD in childhood, I asked him to expound on the subject of diagnosis and treatment for adults. He replied, "There is very little on the issue of just what therapists are doing for diagnosis and treatment" (R. Barkley, personal communication, April 6, 2011). Therefore, the need for research in the area of ADHD adults and the perceptions and experiences of mental health professionals in the treatment of ADHD adults is pronounced and obvious (Corbin & Strauss, 2008).

### **Research Question**

Developing a grand research question is the first step in grounded theory research (Corbin & Strauss, 2008). For my research purpose, the following question has been developed: What are the experiences and perceptions of licensed mental health providers

considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder?

### **Role of the Researcher**

The role of the researcher is pivotal to the rigor and skills of qualitative research. Patton (2002) stated that the researcher himself or herself is the instrument in this type of research. Some have argued that qualitative inquiry is too subjective since the researcher is both data collector and data interpreter. Arguments against qualitative research also point out that being closely engaged with the people and situations being researched lend themselves to a lack of objectivity. Being objective is considered the strength of the scientific method. Qualitative inquiry, because the human being is the research instrument, requires that the researcher report bias and errors. Qualitative researchers seek to avoid both the term objective and subjective monikers preferring to use the language of trustworthiness and authenticity.

Neutrality is also essential but does not mean detachment. Qualitative inquiry depends on and uses the direct experiences and insights of real world data collected by involved researchers (Patton, 2002).

Empathy comes from personal contact with people. Empathy develops when the researcher begins to understand the stance, position, experiences, and worldview of another person. This empathy can lead to a deeper understanding of the meaning of another's experience. Empathic neutrality is a phrase coined by Patton (2002) describing a stance toward the people who are subjects of the research that a researcher encounters.

Neutrality suggests a non-judgmental acceptance of the emotions, thoughts, and behaviors of the people in the research sample. Neutrality can actually facilitate rapport

that supports empathy, openness, and non-judgmentalism (Patton, 2002).

### **Researcher Bias**

A qualitative researcher should be curious, creative, and unafraid to trust personal instincts (Corbin & Strauss, 1990). Several experiences have influenced the direction of this investigation. I trained as a licensed professional counselor during the late 1980s. During that same period of time, information and research regarding Attention Deficit Hyperactivity Disorder in childhood was beginning to become available to mental health professionals. This helped to drive my diagnostic decisions and my treatment options with children. I have been a mental health professional for over 20 years. ADHD research for childhood has been extensive. Diagnostic criteria and treatment options for adults with ADHD is a new field.

Alternatively, research conducted with adults and acceptance of ADHD as a disorder in adulthood has only recently become a topic for review. A knowledge of the continuous nature of ADHD and its effects on adults is an ongoing area of study. Understanding ADHD and the current symptomology attributed to adults is a new way of looking at familiar symptoms in a new population.

### **Researcher Sensitivity**

I have counseled many children and teens with ADHD. I have been a practicing mental health professional for over 20 years. I have researched and written a consumer-oriented workbook for parents and teachers of ADHD children. I have parented an adult son who received a diagnosis of ADHD at age seven. He was treated during childhood and into young adulthood for ADHD-like symptoms. He has suffered with anxiety, school related issues, and underachievement in adulthood due to his ADHD symptoms.

In short, I have personal and professional experience with the symptoms, treatments, and practical implications of ADHD in children and adults.

In qualitative research the goal is not to control for sensitivity but rather to monitor research beliefs and judgments. Corbin and Strauss (2008) noted, “Sensitivity is required to perceive the subtle nuances and meanings in data and to recognize the connections between the concepts” (p. 32).

### **Containing Sensitivity**

In addition to stating my personal and professional experiences, I am attempting to contain my sensitivity by being aware of and stating at the onset of my investigation strategies that will lead to a balance for potential biases. My current experience with childhood ADHD is an advantage in this research.

### **Reflexive Journaling**

A researcher’s scrutiny of his or her own research experience can be contained in a reflexive journal. The decisions and interpretations that allow a researcher to process and assess his or her own work make up the journal entries. This allows a reader to access the extent to which a researcher’s interests and positions influence inquiry (Chamaz, 2006).

In the data collection, I will include a research journal that will be a personal tracking of my own thoughts and feelings during the research process. Journaling will aid in bracketing my personal prejudices in the study data analysis phase. It will also strengthen the data with rich description.

### **Member Checks**

In this study, participants will be asked at several times to clarify the comments

and perceptions that are recorded as their answers to each interview. Member checks are identified as opportunities for each participant to correct misunderstandings of their perceptions and impressions given in the research discussions. Member checking will also be utilized to elongate a category of exploration. Checking after each of the three meetings with the experts (face-to-face, telephone, or e-mail) to explore the accuracy of the data collected and the opportunity to explore in more detail or elongate the information into other directions will also be explored with each participant (Chamaz, 2006).

After the completion of the data collection and analysis, participants will be sent a codebook and will be asked to give feedback again as to the accuracy of the themes and codes that emerged in the data phase. This will continue to offer accuracy by bracketing researcher sensitivity to the research data and offer on-going accuracy of the information collected from each participant.

### **Research Plan**

In order to pursue the research indicated in this study, I discussed the topic and methods of research with my dissertation committee and gained their approval. I submitted an Appendix G, Old Dominion University Application for Exempt Research to the Human Subjects Committee at Old Dominion University, and permission was granted on May 31, 2011 to conduct the study (Appendix G, Application for Exempt Research at Old Dominion University).

### **Selection of Participants**

Purposeful sampling is identified as using small numbers of individuals for research that contribute information rich data to the research problem. One method of

purposeful sampling is snowball or chain sampling. In this method, the researcher asks others who know about a particular topic to identify persons who are experts in the field (Patton, 2002).

In this research, purposeful sampling will be used with snowballing and nomination of experts as the techniques employed to locate and secure participants. State licensed therapists from four disciplines (Licensed Psychiatrists, Licensed Clinical Psychologists, Licensed Professional Counselors, and Licensed Social Workers) will be selected for interviews based on their experiences and effectiveness in the field of adult ADHD.

I will use a process of nominations of peers (by sending e-mail messages or letters) to providers of counseling services to adults in Southeastern Virginia, Richmond, Virginia, and surrounding communities. Internet sites, professional organizations, peer referrals, and telephone listings or advertisements that list professionals who treat ADHD adults will be accessed. An e-mail message or letter will be sent to explain the purpose of the study and ask for nominations from licensed mental health professionals who know experts that they would nominate as experts in the field of ADHD adult diagnosis and treatment (Appendix A).

### **Gaining Entry**

As a result of my professional standing as a Licensed Professional Counselor, I am known in the community as a mental health professional. After a consultation with my dissertation chair, it was agreed that I would use my networking connections and knowledge of ADHD professionals (exempting those professionals who are coworkers) to gain access to those who may either nominate or participate in snowballing sampling.

It was further agreed that interviewing several experts in the greater Richmond area would enhance the study and decrease the bias of my current and exclusive practice of mental health counseling in Southeastern Virginia.

Gay and Airasian (2008) described criterion sampling as choosing participants who meet specific characteristics and will provide data rich examples of the phenomenon under investigation. The identification of experts will be explored by using professional networking, contacting the Children and Adults with ADHD (CHADD, [www.chadd.org](http://www.chadd.org)) organization, and interfacing with other Attention Deficit Disorder resources groups and professional licensure boards that offer lists of professional counselors.

Mental health professionals will be contacted by e-mail messages and by telephone to recruit for the three interview study model. Experts will be chosen based on the criteria listed below. Study experts will be recommended (by request only) during my professional presentations and in future publications on this subject. These will indicate their expert status and identify them as providers of services to adult ADHD clients.

### **Participant Selection**

The mental health professionals who most often appear in the nominations from the results of returned e-mail messages, letters, and contacts will be assessed. The selection of study experts will be chosen from the most nominated professionals. The expectation is to obtain a list of at least eight experts. The nominated mental health professionals will be asked if they would participate in the research study. (Appendix B). The request for nominations process letters and e-mail messages will be confidential. This sample will be made up of experts who will be identified using the following criteria

suggested by Adler and Ziglio (1996):

1. Knowledge and therapeutic experience with ADHD adults;
2. Willingness to participate;
3. Sufficient time to participate;
4. Effective communication skills.

The participant pool will be limited to the geographical boundary of the state of Virginia, in order to allow for travel, time, and finances involved in face to face interviews. All e-mail messages and other documentation used to secure nominations will be placed in a locked file or enclosed in a password protected computer file to ensure confidentiality. This information will be destroyed at the end of the study.

### **Data Collection Procedures**

The data collection procedures used in this study will include the following:

- Individual participant interviews;
- Researcher's reflexive journal;
- Document reviews;
- Concluding reflective questions/summary.

After participants are identified, face-to-face appointments will be conducted with each participant at a site where they provide services to ADHD adult clients or another private location.

A second appointment will be held via telephone and the third contact will be via e-mail communication. Participants will be informed that each interview will require a review of the transcript of the interview. They will be able to correct or add emphasis to information or insights that they have given.



Permission will be requested to audio or video tape the face to face interview for the purpose of transcription (Appendix C) after receiving informed consent.

### **Face-to-Face interview Questions**

#### **Round One Research Questions**

During interviews with participants, I will start by asking participants to describe their work with ADHD adult clients. After listening to their responses, I will ask the questions listed below if topics have not already been addressed by participants.

- You were chosen to engage in this research because of your status as an expert in ADHD adult diagnosis and treatment. What is your reaction to being considered an expert in adult ADHD?
- Could you talk about some of your experiences with this population?
- The *DSM-IV* (APA, 2000) includes limited information about ADHD adults. How do you overcome the lack of information in diagnostic criterion?
- What is your criterion for giving a diagnosis of adult ADHD?
- What role do comorbid conditions play in your diagnostic decision?
- What other symptoms convince you that the correct diagnosis is adult ADHD?
- Currently, there is no best practice treatment for ADHD adults. How do you overcome the lack of clinical information and make choices that drive your therapeutic interventions?
- What types of clinical interventions do you feel are the most effective with adult ADHD?
- What do you feel has been the most effective means of treatment for ADHD adults?

- How do you determine successful treatment in a client?
- Do you find your work with ADHD adults rewarding? What makes this work rewarding for you?
- Can you talk about working with the adult ADHD population? What drew you to this work?
- What perceptions would you share with a mental health professional starting out in the field?
- What would you offer as advice concerning ADHD adults as clients?

### **Telephone Interview**

#### **Round Two Research Questions**

The round one question responses are the basis of round two questions. The responses will lead the researcher to direct the focus of the research or be directed by the opinions of the experts. Round two questions are intended to deepen and enrich round one information and insights.

Research participants will be asked to review the face-to-face interview transcript and provide any insights or changes that are not accurate or correct. They will also be able to include in this interview any deeper exploration of the subject matter.

### **Interview**

#### **Round Three Research Questions**

Round two responses are used to develop the round three questions to verify the results, to understand the boundaries of the research and to understand where the results can be extended. Typically the questions will become more focused on the specifics of the research. As before, the participants will be asked to review the transcript of the

previous telephone interview and respond to inaccuracies. They may also make corrections to their statements and explain the meanings that the expert participant intended.

The expectation is to interview 8-12 providers who emerge as the most frequently nominated licensed mental health professionals. Each mental health professional interviewed will be advised as to their rights concerning confidentiality and may leave or discontinue their participation in the research project at any time. They will complete a signed Informed Consent Form (Appendix C) and Consent to Record Form (Appendix D). Also, each participant will complete a Demographic Information Form (Appendix E). Interviews will follow a basic protocol (Appendix F), but questions will be added or modified as themes emerge.

The interviews will be recorded by audio or video and will delete any identifying information from the recordings. All interviews will then be transcribed. All participants will be asked to review and comment on the accuracy of their individual transcribed interview. Each participant will be given a pseudonym to protect his or her identity. The identity of each participant will be known only to the interviewer.

All documents used in research will be kept in a secure file cabinet and all electronic responses will be maintained in a password protected computer. No identifiable client information will be used in the dissertation or in any publication following.

Summaries of the research may be used in reports, publications, or presentations. No identifiable information will be released at any time. This study poses no foreseeable risk of civil or criminal liability or any other damaging consequences.

All transcripts, consent forms, and stored data will be destroyed at the conclusion of the study. After the completion of the data collection and analysis, participants will be sent a copy of the codebook and will be asked to give feedback on the accuracy of the themes and codes that emerge in the data.

### **Reflexive Research Journal**

In the data collection, I will include a reflexive research journal that will be a personal tracking of my own thoughts and feelings during the research process. This will further aid in bracketing my personal prejudices. It will also offer more access into the insights and thoughts gathered during the interview process.

As noted by Denzin and Lincoln (2005), a research journal allows for observation of the participants' reactions toward the questions of the interview. It may offer insight into the reactions and impressions of the participants' impressions of the researcher.

### **Document Reviews**

A nonspecific document review will be collected from each expert participant. These documents will include agency printed materials or forms. Documents might include nonspecific intake forms, general information that describes therapeutic groups or interventions, therapy notes without client names or distinguishing information, agency marketing materials advertising ADHD services, and any other nonspecific information offered by the expert as exemplary as to their work with ADHD adults. This type of information can add depth, detail, and meaning to qualitative analyses (Patton, 2002).

### **Data Analysis**

I will interview and compile data with the assistance of several masters' level counseling student volunteers. They will assist in coding and validating as determined by

the accuracy of findings by employing certain methods. The methods employed will be to coordinate coding activities, cross check codes, define codes, and check for a drift in definition. The codes agreed upon by the research team members establish the intercoder agreement. Using that intercoder agreement, priority codes will be established with an 80% code agreement system.

Data analysis will include the constant comparison method, a principle of grounded theory. Theoretical comparisons are tools that list properties that view something objectively rather than naming or classifying the property and dimensional levels.

This is the “What is this?” level of research that grounded theory investigates (Patton, 2002). Constant comparison is an attempt to move across the field of research gathering information, analyzing the data, and then returning to the field for more information and continuing the process over and over. This process continues until the data is saturated (repeating themes begin to emerge) and ending when no new themes emerge. This allows for increased validity checking in the research descriptors.

The plan is to code and transcribe each participant’s data before moving to another participant. This will ensure accuracy and careful analysis of individual information collected. Data collection will be completed at this stage.

A research team will be assembled that will help in coding transcripts. Training will be provided to the research team in coding the materials collected. The research team will provide a means to establish and re-establish validity, discuss emerging themes, review prominent quotations, and develop a codebook that will be pivotal in understanding the research results. All identifying information will be deleted from the

coding process, and I will be the only researcher who will have access to the identity of the participants. Having multiple perspectives will increase the likelihood of maintaining objectivity throughout the research process.

Data will be analyzed by using open coding, axial coding and selective coding methods. This will result in data reduction, data display, and conclusion drawing and verification (Miles & Huberman, 1994).

### **Verification Procedures**

Ranking and rating of each round will be maintained by the research team members and me. After tabulation is done, the answers to round one will be released to the experts for further clarification and more input.

Constant verification during the research process is assumed to improve the reliability of the results. Each round is handled in the same manner until all three rounds are completed. The final stage of grounded theory research is to verify and generalize the results. It is suggested that some follow-up interviews may allow for greater verification (Creswell, 2009).

The research project is complete when some consensus is reached and generalization about the research is possible. Triangulation of document reviews and reflexive journal in conjunction with member checking will enhance trustworthiness.

Conformability assumes that the findings of the study are that of the participants and not representative of the researchers' biases. In order to limit the influence of personal or professional bias, I have identified my biases and will use the reflexive journal entries to record my thoughts, feelings, and assumptions during the research process. Member checking and using a research team will also aid in limiting my

personal or professional biases (Creswell, 2009).

### **Summary**

In conclusion, it seems clear that this emerging area of study is in need of research and review of diagnosis criteria and treatment options. Limited qualitative studies have included mental health professionals. This study would contribute to the field to provide further research on best practices in treatment with ADHD adults and explore the experiences and perceptions of licensed mental health professionals could improve diagnosis and treatment for ADHD adults.

## **CHAPTER FOUR**

### **FINDINGS AND INTERPRETATIONS**

#### **Introduction**

Chapter four contains a summary of the results of the research that answers the question “What are the Experiences and Perceptions of Licensed Mental Health Providers Considered Effective in the Diagnosis and Treatment of Adults with Attention Deficit Hyperactivity Disorder?” An analysis of the data found at the end of the chapter will answer the research question.

In the first section of the chapter, entitled Participant Profiles, a group profile of participants will be presented. This will be followed by a within-case analysis of each of the eight participants. The individual profile will include a narrative that explores the themes that emerged during the open coding process. This section will also provide rich description identifying each participant and his or her unique contribution to the research study. A chart will follow that explores each participant’s prominent themes.

The second section of the chapter is entitled Participant Themes and contains the results of axial coding or cross-analysis coding. This section includes prominent themes that emerged across three rounds of data collection. The third section is entitled Grounded Theory and contains the results of the selective coding process.

#### **Overview of Data Collection**

In order to begin the data collection process, I posted a request for nominations of mental health experts who work with ADHD adults on CESNET-L (a national list serve generally accessed by counseling educators). I did not receive any responses to this nomination request. I then asked several peers who are licensed mental health



professionals to nominate those that they considered experts in the field of adult ADHD. I also asked several graduate students working in professional mental health for nominations. I contacted the first nominees and asked them to nominate others. Using this snowballing method, I received 36 nominations of ADHD adult practitioners (19 males and 17 females) perceived as experts in the field. I also received several personal phone calls from nominated practitioners noting their inability to participate in the study due to time constraints, or (in the case of three nominees) their research or teaching responsibilities that disallowed significant ADHD client engagement. I had e-mail and telephone contact with a representative from Shire Pharmaceuticals who offered names of practitioners and with Play Attention ([www.playattention.com](http://www.playattention.com)) (a brain training program) who also offered names and practitioners who might participate in the study. I contacted the national CHADD (Children and Adults with ADD, [www.chadd.org](http://www.chadd.org)) support group and received names of practitioners.

I contacted 12 nominated practitioners to request participation in the study (six women and six men). Of the six women contacted, one was pregnant and declined involvement, and five agreed to participate. Of the six men contacted, one was unable to participate due to time constraints and another due to work issues. Four agreed to participate. All potential participants were thanked for their consideration of the research project and further attempts to contact others were discontinued. This process produced nine participants for the research project (five women and four men).

One of the nine women, believed to be a mental health professional, revealed during the interview that she did not provide mental health services to ADHD adults. Her role was one of disability advocacy and educational services. The interview did not,

therefore, meet the criteria of the research study and will be used with other triangulation materials. Corbin and Strauss (2008) pointed out that “one of the virtues of qualitative research is that there are many alternative sources of data” (p. 27). Triangulation enhances the data collection and potentially increases the richness of the data available for analysis (Corbin & Strauss, 2008). This change in eligibility of participants produced eight participants for the research project (four women and four men).

Each participant met the criteria suggested by Adler and Ziglio (1996). These criteria included the following: knowledge and therapeutic experience with ADHD adults; willingness to participate in research; sufficient time to participate; effective communication skills; and nomination from mental health professionals who identified each as a person as having expertise in professional services to ADHD adults.

Creswell (2009) refers to examples of trace evidence included in the research trail as “*footprints in the snow*.” This includes interviews, public documents, notes, memos, e-mails, field notes, and other data collected in the process of the research. The data for this study consisted of 22 hours of audio and video recordings of initial and follow-up interviews in addition to written e-mail follow-up. I found that map-questing locations and preparing for each interview (appropriate forms to take, etc.) took approximately an hour in advance of each interview. This added up to approximately eight hours of extra preparation time. I also researched each person on the internet and spent some advance study time becoming aware of the counseling center, etc. that I was to visit the following day. I spent about nine hours researching each participant in advance of the interview date.

I spent approximately 49 hours in the field with participants. I traveled to their

offices and toured them. I met the ADHD life coach in her home (and toured her repurposed garden) because her work centered in her home office. I discussed paintings and office décor with several participants and met participants' spouses. I traveled to Washington, DC and Richmond, Virginia to meet participants in their environments. I traveled to Virginia Beach and Hampton and sat in all the waiting rooms of each participant. I had lunch with one participant and sat outdoors as a fountain babbled and threatened my hearing the interview clearly. I allowed the neurofeedback participant to "hook me up" with the electrodes so I could experience something of what neurofeedback is like. One practitioner (director of the center) introduced me to all her staff (and her husband) in advance of the interview and invited me to return and share my research results with her counseling staff after the research was finished. In addition, I spent approximately 29 hours meeting with my research team and my auditor. I also spent over eight hours training and directing my team in coding procedures and transcription procedures. The data collection took place over a seven month time frame. The interviews which totaled 280 pages of verbatim transcription were transcribed from video and audio interviews by a research team member. Other materials included 1,093 pages of written materials provided by ADHD providers, 285 pages of coding charts and memos, and 154 pages of notes. There are 39 pages of research journal notes and 39 pages of journal pictures. The external auditor examined the audit trail which consisted of 1,598 pages of materials.

### **Participant environments**

As part of the research study, each participant was asked to be interviewed in their counseling environments. The exception was the outdoor program field work and the life

coach who works out of her home office. Each participant was chosen for his or her expertise with ADHD adult clients. How clients were greeted and engaged seemed pivotal to how clients began and continued their experiences with the mental health professionals. It also spoke to how rapport was built and maintained by each provider.

In interview one, the waiting room was pleasant with magazines and brochures available in the room. Quiet music was playing, but there was no receptionist. There was a sign that pointed to a door bell device that said, “Ring bell for service.” The practitioner was very welcoming and inquired as to my comfort before beginning the interview process.

Interview number two entailed traveling to Richmond. The practitioner was a life coach and informed me that she met clients at various local meeting spots but would be willing to meet me at her home office. It was in a lovely, older home near a beautiful park. The office and the practitioner were both comfortable and welcoming.

Interview number three was also in Richmond in an office on the second floor of an older office building. The office was decorated with newspaper stories of the programs in the center. The office also sported a handmade quilt hanging in a place of honor and numerous paintings. (I learned later that they were done by clients). A receptionist greeted me as I entered the room. It seemed comfortable and welcoming.

Interviews four and five were in Washington, D.C. The building where both offices were located was made of glass and steel and was very modern and commanding. The waiting room was large and included a children’s table and a video area for children. A large bookcase held books by the clinic director and another bookcase held samples of supplements available for purchase. It was rather “store like” with much activity coming

and going in the waiting room. A sign near the check-in window stated, "Please, don't chew gum if you are here for a brain scan."

Interviews six and seven were in Hampton. Interview six was on Saturday, and there was no receptionist on duty. The office was a nicely decorated one story office in an office complex. The waiting room was comfortable and nicely decorated with calming art work and plaques attesting to a faith-based counseling orientation. Interview seven was during the work week, and a receptionist greeted me upon arrival at the same office complex.

Interview eight was in Virginia Beach in a large steel and glass structure office building near a bustling mall. The building was imposing, but the waiting room was comfortable and quite tastefully decorated and inviting.

It was clear that all the participants had put time, energy, and resources into the comfort and even amusement of their clients. Most waiting rooms were equipped with televisions playing videos for children or soft music to sooth a waiting client. All waiting rooms provided magazines and available informational materials to answer client questions about treatment or diagnosis issues.

In most environments, receptionists greeted clients and answered their questions. Waiting rooms were furnished with comfortable chairs, sofas, and appropriate art work. The message of the seven waiting rooms that I visited seemed to be one of welcome and personal comfort. The life coach described her efforts to make her clients comfortable with their relationship in a virtual setting since the coaching relationship was not held in an office setting. The life coach also described her efforts to establish comfort and welcome in the virtual setting.

## **Participant Profiles**

### **Group Profile**

A demographic description of participants is shown in Table 4.1. All participants were Caucasian. Their ages ranged from mid-30s to late 70s, a fact not listed on the chart but obtained in interviews. Participants included four women and four men who practice in the Southern Atlantic region of the United States (which includes Virginia, West Virginia, Maryland, and Washington, DC.). The large, medium, and small city categories used in Table 4.1 are based on Metropolitan Statistical Areas (MSAs) that are delineated by the United States Office of Management and Budget. These categories indicate that large metro areas have a population of at least one million people; medium areas have a population of 250,000 to less than one million; small metro areas have a population of 10,000 to less than 250,000; and rural areas are defined as non-MSA areas.

There were two participants who qualified as practicing in a large metro area (DC is listed as the seventh largest metro area in the country). Two qualified as medium metro area practices (Richmond is listed as number 44 on the metro list) and the last four practitioners also qualified as medium metro practices (number 36 on the metro list in Tidewater, Virginia). All participants worked actively in private practices. I define private practice as non-public agencies owned by one or several individuals and providing mental health services for a fee. All practitioners worked with at least one other mental health professional and were able to offer or refer for services as needed by the client. If the focus of the practice is on ADHD services only, then the practice would be listed as ADHD only. If the clients receive a variety of services and do not go somewhere else for psychotherapy or neurofeedback (for example), I listed them as

integrated.

Table 4.2 presents the participants' professional information as well as their years of experience, number of adult clients and number of adult ADHD clients. All participants were actively involved in training students from a number of mental health disciplines. They offered a variety of services to adult clients with and without ADHD.

**TABLE 4.1**  
**DEMOGRAPHIC OVERVIEW OF PARTICIPANTS**

Participant	Race	Gender	Type of Area	Type of practice
Lydia	Caucasian	Female	Large Metropolitan	Integrated
Stuart	Caucasian	Male	Medium Metropolitan	Evaluation ADHD only
Miranda	Caucasian	Female	Medium Metropolitan	Integrated
Tessa	Caucasian	Female	Medium Metropolitan	Integrated
John	Caucasian	Male	Medium Metropolitan	Integrated
Gregory	Caucasian	Male	Medium Metropolitan	Integrated
Adrian	Caucasian	Male	Large Metropolitan	Integrated
Carmen	Caucasian	Female	Medium Metropolitan	Coaching ADHD only



**TABLE 4.2**  
**DEMOGRAPHIC OVERVIEW OF PARTICIPANTS: PROFESSIONAL**  
**INFORMATION**

CTI = Coach Training Institute  
 DO = Doctor of Osteopathy  
 LCP = Licensed Clinical Psychologist  
 LCSW = Licensed Clinical Social Worker  
 LMFT = Licensed Marriage and Family Therapist  
 LPC = Licensed Professional Counselor  
 MD = Medical Doctor  
 PedMD = Pediatric and Adolescent Psychiatrist  
 PsycMD = Psychiatrist  
 PsyD = Doctor of Psychology

Participant	License or Certification	Highest Degree	Years of mental health practice	Years of Adult ADHD practice	Average number of clients per week
Lydia	DO	MD	20	20+	80-90
Stuart	LCP	PsyD	20+	12	15
Miranda	LCP	PsyD	5	4	45
Tessa	LCP LMFT LPC	PsyD	22	10	35
John	LCP	PsyD	26	20	45
Gregory	PedMD	MD	40	43	25
Adrian	PsycMD	MD	30	24	40
Carmen	LCSW	MSW CTI	29	5	15

Participants' years of psychotherapy practice ranged from 5 to 43 years with a mean being 20.25. The number of clients they saw each week ranged from 12-90 clients with a mean of 33.38. The number of ADHD adults seen in a week ranged from 3 to 72 clients per week with a mean of 14.35.

### **Individual profiles**

This section includes an individual profile for each participant. The identity of the participants was protected by giving pseudo first names. Each profile includes a narrative description of the major themes and subthemes that emerged in the face-to-face interview, the follow-up emails and phone calls. A chart depicting themes, subthemes and supporting information is presented in a condensed format table.

#### **Participant # 1: Lydia**

##### **Practitioner**

Lydia is a female in her late 50s who specializes in anti-aging medicine. She describes herself as a Doctor of Osteopathy. She is a board certified Psychiatrist who has been in practice for over 20 years. She states that she sees between 80-90 adults per week. She also notes that 20-30% of those clients are adults with ADHD. She is married to a man whom she describes as "having terrible ADHD." Her husband has others who help him to function. She describes her own issues with motivating her husband to perform day to day tasks and points out that he is highly successful at his work where he has work associates to "turn the crank" and assist him with his work tasks. Lydia shares that she is unable to give her husband two-step commands but, with simplified communication, their domestic life is more productive. She is a lifetime learner and describes herself as relationship oriented.

**Theoretical orientation**

Lydia describes herself as holistic. She dislikes the “medical model” which she feels “pigeon holes” people into categories that can be inappropriate. As a psychiatrist, she practices in a medical model environment seeking to identify ADHD adults and place them into one of the six categories identified by the clinic’s research.

**Therapeutic process**

Lydia shared that her early experience with ADHD was more negative than positive. She didn’t have much faith in medication and felt that medication for ADHD was overprescribed. She was able to view and get involved in the work at the clinic making her a believer in brain scan technology (brain scans show physical evidence of ADHD). The scans are called SPECT (single photon emission computerized tomography) and are a special photograph of the brain that helps the practitioner to diagnose and treat the type of ADHD that the scan identifies. The practitioner is able to use the clinic scan protocols to note patterns in the brain scans which indicate one of six different types of ADHD. The scan patterns suggest six corresponding treatments. Adult ADHD clients are given a brain scan to “view the dysfunctional part of the brain” and then educated on the type and its effects on their functioning levels. Lydia believes that once she and the client see the scans and treat the person for the type of ADHD that they have, they will be encouraged (as she has been) in her work with the ADHD types and the evidence of the brain scans. Lydia also notes that many adults with ADHD are anxious, depressed, etc. and often have comorbid conditions. She works to identify these conditions and treat them in conjunction with the ADHD. She also believes that medicine and supplements are the keys to treatment for ADHD. She follows up with

clients, meets with their families, educates clients as to self-care, and develops agreed-upon treatment plans.

### **Clients**

Adults with ADHD must be highly motivated to work with a professional to identify one of the six clinically researched types of ADHD. Brain scans are usually recommended and viewed by clients who can see progress as they understand the information produced in the scan. Clients must also agree to approach their ADHD with holistic vigor: taking medication, vitamins and supplements, watching their diets, and exercising as a means of maintaining their health. Lydia states that her approach is to present a “lifestyle” change for her clients.

### **ADHD orientation and perceptions**

Lydia approaches her diagnosis and treatment holistically believing that the medication (“nothing works better than medication”) and the supplements are primary in her treatment approach with ADHD adults. Personal and professional experiences tell her that ADHD is complex and often involves comorbid conditions such as depression and anxiety. Lydia is intent on helping adults find new approaches to lifestyle issues including better coping techniques, alliances, and support with others. She also counsels adults to engage in continuing education and to learn self-advocacy. Lydia also notes that ADHD is a lifetime issue. She believes that there are numerous factors that could lead to an adult ADHD diagnosis including head trauma. Lydia expressed a desire to be in the research study by having her staff contact me to set up an interview. She stated that her policy is to be involved in any research that involves ADHD that might further the field of study.

## Summary

Lydia is relationship driven. She uses her ability to convince and encourage her clients to succeed. In her personal and professional life she shares that “ADHD is hard,” meaning that she realizes that the client must “buy in” in order for real change to occur. She is passionate about her work and believes that the brain scans are proof that ADHD adults can be successfully treated and helped with their attention and memory problems. If you ask the right questions, “they have had ADHD their whole life,” but she also notes that ADHD can be caused by trauma. She is also a holistic practitioner and believes that health (for ADHD and other conditions) is related to numerous factors and can be improved by improving body health.

As a mental health professional and a physician, Lydia presents with valuable personal experience. She is aware of her personal and professional strengths and is unafraid to discuss her personal issues about her ADHD spouse. Her professional boundaries are intact leading her to use her personal knowledge to help her clients. She believes that her work makes a difference in the lives of her clients. The themes that emerged in the interviews with Lydia are displayed in Table 4.3.

## ANALYSIS OF PARTICIPANT #1: LYDIA

TABLE 4.3

## THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life-long learner Risk-taker Relationship oriented Commitment	“a lot of ADHD out there” “hard to categorize human beings” “You always treat the patient.”
Theoretical Orientation	Holistic Multi-phasic medical model Educate families	“Nothing works better than drugs.” “When people see the brain scans, they believe.”
Therapeutic process	Education Emotional & social support Medication, vitamins, diet, exercise School & work strategies	“You have a complex issue there.” “Part of the treatment is to help (the client) with lifestyle issues.”
Client	Identifying 6 types of ADHD Motivated Wants Education	“Coming from ‘a-natural’ like me, they don’t want to take drugs.” “Brain scans are very persuasive.”
ADHD orientation/perceptions	Comorbid confusion Need management help Personal experience with spouse’s ADD	“He has staff that turns the crank.” “It’s very hard to live with somebody with ADD. You want to kill them. You just want to kill them.” It’s very hard to live with.”

**Participant #2: Stuart****Practitioner**

Stuart is a Board Certified Clinical Psychologist who has practiced for 20-plus years. He is a male in his late 40s. He stated that he sees 12-15 clients per week. Stuart noted that about 5-6 of them are ADHD adults. Stuart is clinical in his approach to clients believing that his primary work is to assess their needs and then refer to other practitioners. He is the only Cog-Med provider in the Tidewater area. Cog-Med ([Cogmed.com/research](http://Cogmed.com/research)) is a peer reviewed cognitive re-training system. He sees the benefits of Cog-Med but reports limited success with the program (due, he believes, to the lack of advertising by Cog-Med). Stuart is dedicated in his constant search for new testing protocols. He is very knowledgeable about testing and has studied what he believes are the most effective methods of determining which tests to choose to diagnose ADHD in adults.

In advance of the interview, Stuart was personable and open chatting about mutually recognized colleagues. When the interview began, Stuart seemed to assume a clinical distance during most of the interview. When I remarked on the impressive view from his office windows that were large and sweeping, he stated, "People have to look at something." It was not until the very end of the interview (when he revealed that he had done a qualitative research project for his own dissertation) that he seemed more open and personable again. He is committed to setting appropriate boundaries and is highly disciplined in his work.

**Theoretical orientation**

Stuart thinks of assessment measures as a research project. "When I do a research

project, you have a literature review in a clinical assessment as the person's history. Then you have a methodology that you are formulating to test the hypothesis and in a research project, you have a null hypothesis. My assignment is to determine if this person has a problem. My clinical assessment is the methodology of my test."

Stuart states that he is the advocate for the data rather than the advocate for the person. Stuart believes that he needs as much reliable information as possible but doesn't think that self-report is reliable for a diagnosis. Stuart believes that a part of his job as an evaluator is to be as objective as possible. That is, his "work is a gift to his clients." Stuart often receives clients from other practitioners and professionals who are asking for an objective assessment for ADHD. He described how he has been contacted on numerous occasions to determine whether accommodations should be offered for professional testing like MAT, etc. Stuart states that he feels the weight of those kinds of decisions and wants to make good decisions for clients and professionals.

### **Therapeutic process**

The initial interview is self-report, screening tools, and interview. Stuart chooses testing based on the first visit. Stuart follows a medical model: diagnosing and then referring for treatment. He is also engaged in brief therapy techniques.

Stuart states that his reputation is "on the line" to decide about ADHD and reasonable accommodations for testing or school. He uses a triangulation of method. Stuart asks the questions, "What is going on at home? What is going on at work? Does anyone else notice this?"

Stuart says that he looks at frequency, duration, and intensity to determine what the diagnosis might be. He asks, "Does this affect you in different settings? If it only



occurs in one setting, it is probably not ADHD. It is probably contextual or situational.”

Stuart reveals, “I do my interview. It’s a typical mental status exam. Then I decide on a battery of tests, and for an adult that testing could be limited to a computerized test which I like a lot. I use the CN’s Vital Signs.” Stuart employs testing and objectivity factors to attempt to make the testing as objective as possible.

“I always like to see prior reports,” Stuart says. “That’s revealing. Where they may say they don’t have a problem, whereas someone else says they’ve got significant problems. I don’t really meet with people more than two visits, at most three. I just list accommodations, strategies of approach and then refer them out.” Stuart doesn’t really see his office as a place to receive therapy but rather as a place to receive a diagnosis. Stuart states that he offers a research-based cognitive retraining program to clients. He believes that it is underused but points out that many clients cannot afford it or don’t want to take the time indicated (over 20 visits) for optimal cognitive restructure. It is not usually eligible for insurance payment.

“I have become a Cog-Med provider. Cog-Med is a cognitive training program which has been researched as an effective method of cognitive retraining. I do have some clients that go through Cog-Med training. It is a coached training program. The key to a program like Cog-Med is to really just open up and let it be absorbed. So you are taking it all in.”

### **Clients**

“So again, I don’t really approach everybody the same way.” Stuart takes into account what he is being asked to assess and the specifics of each potential client. People who are “older and people who are younger get less testing. Younger get less because

they are less stable and older because their stamina is narrow.” Stuart wants to test all clients on one day believing that he will get the most valid results in one day. He believes that things change across time. He also notes that poor sleep patterns and anxiety all contribute to testing results. “A training program (like Cog-Med) doesn’t replace medication.” He believes that medication is very helpful to aid functioning for ADHD adults. He receives referrals from doctors and mental health professionals whose patients are seeking diagnostic services or who want to document their eligibility for other services.

### **ADHD orientation and perceptions**

Stuart states that he uses scales from Russell Barkley ([www.russellbarkley.org](http://www.russellbarkley.org)) for executive function information. “I use them basically to get a self and other report from home that I cannot get otherwise. It is important to get that information.” Stuart talks to clients about Cog-Med and medication. This is the best use of brain training methods. Stuart sees himself as an educator of adults with ADHD. Stuart does an extensive history and gathers early school experiences to determine ADHD-like behaviors. He doesn’t enjoy long-term therapy with any group of clients and this includes ADHD adults.

### **Summary**

Stuart sees himself as an educator, but he has limited engagement with clients over time. He attempts to limit his involvement for the “sake of objectivity.” His practice has one of the only research validated cognitive training programs in the area, but he believes it isn’t as successful as it should be due to the company marketing techniques. Stuart has had limited success with Cog-Med but sees its potential. He

worries about his objectivity with those who want to prove their ADHD in adulthood (for accommodations, etc.) and remains distant as a result. He primarily provides testing services to clients who want a diagnosis of adult ADHD. He believes that he is providing an important service for adults who were never diagnosed or for adults who were diagnosed in childhood and are no longer connected to what it means to be ADHD. This service enables them to seek treatment for their ADHD symptoms. The themes that emerged in the interviews with Stuart are displayed in Table 4.4.

## ANALYSIS OF PARTICIPANT #2: STUART

**TABLE 4.4**

### THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life-long learner Objectivity important Educator Testing/evaluator	“Advocate for data, not the person” Educator of ADHD adults “work as gift to clients”
Theoretical Orientation	Assessment Null hypothesis as “word picture” for testing Medical model	Research project “wants objective opinion” “They are applying for accommodations.”
Therapeutic process	Testing Interview Objectivity Brief therapy	Cog-Med is “taking it all in.” Brain retrain Short term diagnostic intervention
Client	Motivated Searching Referrals	Sleep patterns and anxiety contribute to poor testing results” Seeking diagnosis
ADHD orientation/perceptions	Diagnosis needs a triangulation of method. Medication Needs education	Doesn’t replace medication Needs for services Need for objectivity

**Participant #3: Miranda****Practitioner**

Miranda is the youngest provider in the study. She is in her late 30s and is a Licensed Clinical Psychologist. She started working as a neurofeedback provider by taking a certification course through the EEG Information Institute. She has been working with adult clients for five years. Miranda states that she sees approximately 45 clients per week and 5-8 of them are ADHD adults. She works in two offices (one in Hampton and one in a small practice in Williamsburg) on the Peninsula and has within the last few years begun her work with ADHD adults using neurofeedback. She states that her motivation to involve herself in this work was “to help people.” Miranda indicated that because of her very encouraging background, she wanted to give back and encourage others. She shared that she always felt that she would “maybe have a career as a missionary or in ministry or as a teacher.”

She went to a small college for undergraduate school and took a psychology course that she believes changed her life path. She found it amazing and she “loved it.” She started out in mental health as a social worker and found that she wanted more training and education. She noted that she is particularly interested in trauma work. Miranda entered the PsyD degree program, and because trauma work is often tied to the use of neurofeedback, she became interested in neurofeedback. “I guess it all started with feeling like I’m supposed to help people somehow.” She describes herself as a “school person,” and is a life-long learner. “I think that circumstances and God’s leading all kind of funneled me into this role of clinical psychology which I actually love and adore.” Miranda noted that she started with “children, and it evolved into working with children

and adults. I came across neurofeedback, which ended up with me being trained in 2010 so that I could offer neurofeedback and actually neurofeedback is one of the best supported, evidence based practices for ADHD for children and adolescents. I don't think that holds that title for adults quite yet. There is plenty of research showing its effectiveness with attention and focus. Because most of my referrals actually come with some sort of attention and focus problem that includes well, I will say that most adults that I do provide neuro-feedback for aren't strictly (or only) ADHD diagnosis. Most of them have some sort of mood disorder, trauma history and usually they don't have PTSD or they may have anxiety. So it is pretty complex working with adults as to what we can treat" (with neurofeedback).

### **Theoretical orientation**

Neurofeedback is very holistic. "The brain is involved in every decision that we make. All actions that we take, everything that we feel, every choice that we make, it all starts with the brain. So they come into the office and some have been diagnosed as ADHD and many have not. Maybe as a child they were diagnosed with ADHD, and maybe they were on Ritalin for a period of time, but they stopped it. But now as an adult in the working world maybe for a decade or so, they are coming in and saying, 'Like, I can't focus. I'm having trouble at work now, and I just always assumed that, you know, that I would have outgrown the ADHD.'" So we know that some people have symptoms as adults. It hinders their relationships and work life, and they are seeking answers to try to deal with the disruptions. There are other adults who come in, and it is not focus and attention that is the main issue. For these adults they want relief from an underlying mood or anxiety disorder. Clients are asked to complete an in-depth structured interview

and many health related questions. They are sometimes asked to take a series of tests (like the Conners Continuous Performance Test known as the CPT) to determine the appropriate diagnosis.” Behavioral interventions for ADHD summarize the neurofeedback approach of treatment because “neurofeedback is very symptom driven as opposed to diagnosis driven.”

### **Therapeutic process**

Neurofeedback fits best into the medical model. It is brain retraining at its core. It is person-centered, because it is geared toward the individual client and is holistic. The purpose of the neurofeedback is to “stabilize and kind of normalize the functioning in various parts of the brain. There are multiple things going on which is the case of many clients who have ADHD and comorbid conditions as well. Neurofeedback is a wonderful option because I can treat the underlying anxiety (comorbid condition) which will then help with the other distressing symptoms, like focus for example. Through a cycle of learning how your brain functions, you can learn to monitor brain activity. Brains are chemical and electrical, so given time, your brain will produce electrical impulses which are measurable through the EEG machine.” People see the feedback and can learn how to interpret the brain activity that they see. ADHD adults are practicing maintaining attention, and they can get immediate feedback as to how they are doing in real time. In “neurofeedback we are going directly to the source (the brain) so it’s the brain that is making the adjustments, not the conscious level.” The therapist is able to educate the client as to how their brain is functioning and offer feedback and incentive to clients. In this capacity, the neurofeedback therapist is a coach and encourager.

## Clients

Clients will be appropriate for neurofeedback if they are presenting with memory, attention, and focus issues. Clients will also report that “they always had a hard time in school. They never liked school or that they always got into trouble for talking or not staying still. They might talk about these things in the structured interview and then discuss their functioning now. It would be apparent that regardless if there is a true diagnosis, there is some sort of focus and attention deficiency that needs to be addressed.” Miranda refers to an adult male who came into therapy for other reasons and discovered that he was an undiagnosed ADHD adult. “He was having difficulties because of the unstructured nature of a new job and the lack of external structure that his old job offered. In the new environment he was much more in charge of his time, and he was really struggling. So he discovered that he needed help with this in his new job environment. He came in because of his daughter (who was diagnosed with ADHD) and decided to try neurofeedback for his own newly diagnosed ADHD.” Miranda believes that clients who are the most successful with neurofeedback are highly motivated to change, have a high level of distractibility, and experience difficulty staying focused on more detailed oriented tasks. They also have problems with time management and organizational skills. “The major reason for seeking treatment is because they are experiencing some sort of negative impact on their work performance or maybe they are in school or college.” They also tend to have comorbid conditions like anxiety and depression. Clients must be self-motivated and be willing to continue for at least 20 sessions of neurofeedback. Since insurance plans generally do not cover neurofeedback payments, clients must be willing to pay for the program “out of pocket.”



## **ADHD orientation and perception**

Painful symptoms of ADHD may be the determining factor why clients enter into neurofeedback treatment. “Like, I cannot focus. I am having trouble at work.” Adults might say “I have always had trouble in school.” Some adults receive their diagnosis due to another family member’s diagnosis. Some adults learn about treatment because they are seeking help to improve their focus and concentration. Often adults are having work related issues that bring them in for consultation. Insurance doesn’t cover neurofeedback at this time, so clients have to be motivated to engage and continue the retraining of the brain. Neurofeedback is evaluated by asking about day to day performance abilities. “How is your working memory? Can you remember when someone tells you to do something? Are you remembering to follow through on that thing that your wife asked you to do?” Clients are asked to pay attention and be mindful of its effectiveness. “I remind them that neurofeedback is like physical exercise. You won’t attain any level of physical fitness if you don’t continue to exercise. Neurofeedback is similar. If you do it a few times, great, but you won’t be able to hold onto the new level of functioning very long without, you know, repetition. So it takes 20-25 sessions for the brain to really get that new level of functioning locked in so that becomes the new normal.” ADHD clients have problems with persistence, and this may affect their ability to follow-through to gain their greatest good from neurofeedback training. Problems with families and marriages also draw adults into treatment. ADHD adults may seek treatment for underlying issues like anxiety and depression. Trauma may also be effectively treated through neurofeedback and is sometimes associated with untreated ADHD.

**Summary**

Miranda is zealous about her neurofeedback practice and the possibilities inherent in this treatment. Although her role in neurofeedback is to monitor and educate clients as their “brain does the work,” she is anything but quiet regarding the benefits that she feels clients will encounter in this therapeutic method. She is a cheerleader for brain activity that leads clients to understand themselves and become more successful in their ability to monitor attention and focus activities in their personal and work life. Miranda requested involvement in the research study due to her emerging work with adults and a desire to engage in evidence based research studies that may bring validation to neurofeedback. Her insights are summarized on Table 4.5.

### ANALYSIS OF PARTICIPANT #3: MIRANDA

**TABLE 4.5**

#### THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life- long learner Committed to service Faith oriented Motivated	Social work background “. . . feel that God led me to this work” Religious orientation
Theoretical Orientation	Behavioral Physical evidence of brain work Medical model	“Neurofeedback is very symptom driven as opposed to diagnosis driven.”
Therapeutic Process	Referrals Evaluation for brain retraining 20-25 sessions are average Monitor and interpret	“The brain is involved in every decision.” Uses technology to show brain retrain
Client	Learning to regulate Disorganized Poor memory Motivated to change	Monitor and practice brain activity Mindfulness
ADHD orientation/perceptions	Focus issues Disorganized Unhappy with current functioning	“Can’t focus” “Trouble at work” Encourage more action in the brain

**Participant #4: Tessa****Practitioner**

A Licensed Clinical Psychologist in her mid-40s, Tessa is the director of a private, Christian counseling center on the Peninsula. The practice has three locations. She stated that she has been in practice for 22 years and sees 35 clients per week. She also noted that she sees 10 clients per week that are diagnosed as ADHD adults. She is the daughter of missionaries and grew up in several foreign countries before returning to the United States to attend college and graduate school. This influenced her ability to relate to people of many races and nationalities. She stated that in order to get licensed she “worked with any population in her zeal to get started.” She worked with a lot of different groups, all ages and all issues. “I found that I was doing testing, and I realized that psychologists do testing, and that there was a need for accurate diagnosis so the best treatment could be applied for ADHD (for example).” Tessa noted that she uses a variety of psychological tests. She also explained that she is a life-long learner, and that she continues to read about developments in the field (executive function issues with ADHD was mentioned). She incorporates new emphasis and approaches into her counseling practices. Tessa is interested in growing her practice and offering options of treatment to potential clients. Tessa shared her experiences of a failed first marriage and a successful (and happy) second marriage. She related that she uses her learned life lessons to relate to the issues that clients face and has drawn strength and encouragement from overcoming personal challenges. Tessa is deeply religious and believes that clients should be given the option to explore their spirituality as a therapeutic intervention.

**Theoretical orientation**

ADHD is treatable. Tessa believes that with proper treatment, the weakness of clients can become strengths. Tessa chooses testing that gives information to client and family. She recommends cognitive-behavioral therapy, both individual and family. She also identifies and encourages treatment for comorbid conditions like anxiety and depression. Depending on the severity, Tessa also recommends books to read or workbooks to master and the engagement of the adult to “do homework” towards their own treatment. Tessa recommends neurofeedback and group therapy for some clients. “I am a firm believer in talk therapy” for the adult and family members. Tessa suggested weekly therapy and setting treatment goals to develop coping techniques and normalize issues with ADHD. Tessa believes that faith is an enhancing and healing tool for spiritual clients. It helps them to be strong in the process and project the future as positive while viewing their progress as not all on them to “get better alone.” Tessa stated that a community of faith can provide “social support and encouragement, particularly the Christian client who looks to a church family for some of that.” She also points out that faith and a community of faith can bring structure “to the person’s life and routine that is needed to function in a healthy manner.” Tessa believes that her approach to ADHD adults is holistic in nature. “Just a healthy life from nutrition, exercise, getting outside but also having an accountability partner which would provide routine and accountability for the adult with ADHD.”

**Therapeutic process**

Tessa states that she recommends what is best for each adult client. Medication management and interfacing with a medical doctor is usually prescribed for the ADHD

adult. Individual therapy is recommended to cope with issues, and neurofeedback to be more aware of ADHD and its physical effects on client. “I usually do a kind of behavioral work with some insight oriented psychodynamic approaches in the therapy. It matters how much dysfunctional thinking has become a part of the adult’s mind set before they come to therapy. So, of course, with the comorbid conditions, there is trauma that is going to take a little longer to uncover. For me, spending some time in therapy to look back and determine how to identify and manage those lies that the client believes about him/herself; that is helpful and meaningful work for the ADHD adult.”

### **Clients**

“I enjoy meeting with clients with ADHD because I think that I can see progress in that population. I feel that you can help people who have been underachievers. Those who cannot get things right and feel that they have been a hostage all of their life now can be freed from those things.” Tessa believes that this really helps her clients to accept treatment with great relief. “It is interesting, I think, the responses that people have when they are given test results. When I first started out, I didn’t realize how life changing for this person some results could be. I now realize that even if a person came in on the initial interview and said, ‘I think that I have ADD,’ it is different when they see it in black and white. It has been rare, for an adult to be surprised by the diagnosis. Now parents of children that is a different story. So I make a diagnosis, and they receive it.”

“I usually say, ‘This is new information. It is very treatable. More treatment options than ever before. Why don’t you come in for therapy?’ We will work on adjustment.” Tessa engages in cognitive behavioral therapy with adults with ADHD. She believes in combating negative and debilitating mental messages that are crippling

for ADHD clients.

### **ADHD orientation and perceptions**

Tessa believes that 80-85 % of people diagnosed at ages seven and eight will go on to be ADHD adults. It is “treatable, and after treatment you resource it. So to be able to build on success in therapy and help them develop a new door as they move forward is healing.” Tessa also identified ADHD as a factor leading to trauma in the ADHD adult. Tessa especially pointed out the adult who has gone untreated for many years. “There are some common themes, and one of them is a kind of failure mentality. Other people can get it and I can’t, and I am frustrated with myself. This can develop into why even try or a defeatism. It is these themes that, I think, lead you to seeing the grief work that is needed and how adults with ADHD show signs of trauma.” Tessa gave an example of a man who was returning to school after many years and stated to her, “I might have gone a different career route. I might have tried this back when I was 21, if I had had the treatment for ADHD in place.” Tessa said this is grief. Tessa also noted that many adults with ADHD have self-esteem issues and describe themselves as “being harmed and not knowing what happened to themselves.”

### **Summary**

Tessa is a very positive, encouraging practitioner, and counseling center director. Her views on clients are inspiring and encouraging. She uses the extent of her resources to guide people into healing. She wants to see clients “resource” their ADHD and embrace who they are in their diagnosis. Tessa is a woman of faith who believes that the fellowship of believers (in any faith experience) would be beneficial to a person struggling with a need for accountability, structure, and life balance (as many ADHD

adults are). It also lends itself to a sense of something greater than self that arrests aloneness and loneliness. Tessa used an analogy that expresses someone walking “through their recovery or healing process journey with ADHD. One client said, ‘Now it’s a resource.’ Now that I have come through looking at how it was kicking me and going through the treatment for this (ADHD) whether it is talk therapy or medication or neurofeedback what it is she used for treatment, she was at a place where she could see God’s redemption in ADHD.” Tessa elaborated, “I try to tell people that ADHD is a gifted brain. You are distressed because you are seeing all the dysfunction that it has brought into your life. After treatment you’re going to be able to see something very redeeming. I am not sure what that will be, but it will be clear and redemptive to you.” Tessa is a former coworker of this researcher who through a series of events was able to establish her own counseling business taking with her a number of clinicians who were interested in continuing their work on the Peninsula and affiliating with the new practice. Because of our shared work experiences and positive past interactions, Tessa was willing to engage in the interview and offered many personal insights as well. The insights that evolved from the interview are found in Table 4.6.



## ANALYSIS OF PARTICIPANT #4: TESSA

TABLE 4.6

## THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life- long learner Positive Faith	Reads to keep up on research “Freed from hostage.”
Theoretical orientation	Cognitive/Behavioral Case management Referrals	“Firm believer in talk therapy.” Encourager ADHD is very “treatable”
Therapeutic process	Testing to identify Medication management Group Neurofeedback Family and individual therapy Faith as structure	“Confront lies that client believes about self” “. . . manage dysfunctional thinking” “. . . being harmed and not knowing what it was that hurt them”
Client	Faith to grow Support system needed Guide in healing process	“ God’s redemption in ADHD” Build on success Higher power important
ADHD orientation/perceptions	Adults are ADHD. Negative thinking patterns Multiple comorbid conditions including grief/trauma	“Treatable” “Resource it.” Client suffering “defeatism”

**Participant #5: John****Practitioner**

John is a male Licensed Clinical Psychologist in his early 50s. He has been in practice for 26 years. He stated that he sees 45 clients per week and approximately seven of them are adult ADHD clients. John noted that many of his referrals are from the local colleges seeking evaluation for adult ADHD or seeking accommodations for college students. He also sees many families with numerous ADHD members. John described himself as starting out evaluating ADHD children and then having parents and family members turn to him when “there was no one else in the book for ADHD adults.” He explained that he began to work with adults due to a need in an emerging field. John described himself as “always learning” and wanting to educate his clients about ADHD and to “demystify” the issues related to ADHD. John is in practice with several others including his wife who he describes as “an excellent life coach.” He is very friendly and outgoing and offers many personal antidotes regarding his practice and his interest in working with ADHD adults.

**Theoretical orientation**

John likes to “figure out what is going on” in his approach to a diagnosis. He stated that he asks questions like, “Why are you calling?” and “Is he/she ADD?” He related that he uses many of the same diagnostic techniques with adults and children. For example, John said that he often asks similar questions of adults and wants to get “old school records and interview family members, if available.” He also noted that he wants to determine if the adult’s distress levels are causing life problems. John recommends a battery of tests as a means of diagnosis and a trial of medication. He recommends short

term psychotherapy (to review and learn coping techniques), possibly coaching and engaging in a support group. He claimed to be interdisciplinary with his approach to ADHD adults helping them to access the services that they need to be successful. He engages in short-term cognitive behavior therapy with individuals and families and then assesses what other services are needed. John interfaces with other professionals working as a case manager to include coaches, medical doctors and psychotherapists.

### **Therapeutic process**

“I’ve seen plenty of adult clients, who once they get diagnosed with ADD and get on medication, they are not anxious because they can get things done. The things that they need to get done, they can now do.” John sees his process as holistic. He feels confident in his diagnostic skills that he utilizes to develop a treatment plan with adults. John engages in short-term therapy and referrals to other professionals or support groups for continued services. John also emphasizes “three legs of treatment which is therapy, accommodations, and medication.” He believes that there is a fourth leg for ADHD adults which is coaching services. The psychological evaluation is “for you to understand what we are talking about and you see where it all fits in. Where the story is right, you get the story from this end all the way over here so they get a much better understanding of themselves. I’m very much into them understanding what the ADD is all about and the effects on them in particular.” John believes that one of his roles as a therapist is to educate his client and their family members. He thinks that ADHD is largely misunderstood, and that the more that his clients and their loved ones understand ADHD, the better for everyone involved.

## **Clients**

ADD is “normal. It’s not abnormal behavior. It’s things that most people do, but the rating scale is looking to see if you do it more than other people, and is it causing you problems in your life?” John noted that often there are comorbid conditions like depression and anxiety. He believes that there are levels of ADD (bimodal distribution of symptoms.) Some people have learned coping techniques or adaptive behaviors that work better for them than for other people.

John thinks that all adult ADHD clients need to feel successful. He stated, “It’s not like I want them to change themselves but (to ask themselves), how am I going to work through this?” John also suggested that clients with ADHD must develop strategies that work for them and that they understand themselves and what affects them in particular. He recommended self-awareness and perfecting strategies that work for them. John suggested that ADHD is treatable and manageable with appropriate interventions.

## **ADHD orientation and perceptions**

John believes that most practitioners are poorly educated in adult ADHD. He suggested that knowing when to refer is very important for all professionals. He also pointed out the comorbid conditions that can mask ADHD from diagnosis. John indicated that ADHD may run in families. He noted that it seems to be a lifetime issue and that continued support and assistance with various individual issues is an on-going problem. He noted that ADHD affects people in different ways and that accommodations and advocacy training is a task of ADHD adults and family members. He advocates medication. He also noted that “you have to work around their expectations. Medication, some medication, doesn’t fix anything. Medication can help manage ADD,

but it's not going to fix ADD.” He advocates support groups and has been very active in the local chapter of CHADD ([www.chadd.org](http://www.chadd.org)).

### **Summary**

John is primarily an evaluator and an educator. He is very interested in teaching advocacy and self-awareness of ADHD. He is also involved in case management activities for individuals and families with ADHD. His cutting edge work with adults with ADHD enrolled in local colleges is well known in the community. He is actively engaged in working with individuals and families and reported that his role is uncovering needs and educating clients about ADHD. John stated that a large part of his practice is “to help clients manage and understand what is going on with them.”

John was nominated in the snowballing stage by numerous mental health professionals in the Tidewater area and willingly agreed to be a part of the dissertation project. John made a teasing comment to me following the interview that he would like to hear “that his interview was the very best in the dissertation process!” He seemed very open and willing to engage in the research project. John suggested that any research regarding ADHD was important research which is why he wanted to contribute with his professional experiences. The themes that emerged in the interview with John are displayed in Table 4.7.

## ANALYSIS OF PARTICIPANT #5: JOHN

TABLE 4.7

## THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life- long learner Educator Passionate Kids who brought parents Demystify	“Demystify everything.” “I’m always learning.” “Who does an adult call when there is no one in the book for ADHD adults?”
Theoretical orientation	Testing Evaluation Work with families	“So I evaluated him.”
Therapeutic process	Coaching Interdisciplinary Organization Counseling and medication	“It’s not forever; get a person to a point.” “Medication can be helpful.” “Organizational help out there.”
Client	Lifetime ADHD Education Advocacy Need Success Gain support	“It’s not going to fix ADD.” “Helping them manage and understand what’s going on.” ADHD is “normal”
ADHD orientation/perceptions	Know how to refer for evaluation Consider ADHD for adults Family link Advocacy training Support	“This person may need evaluation.” “People treated for ADHD and not just anxiety and depression.”

**Participant #6: Gregory****Practitioner**

Gregory is a male Pediatric and Adolescent Psychiatrist in his early 70s. He has been in practice for 40 years and stated that he has been counseling adults for 43 years. He sees about 25 clients per week and notes that 80% of them are ADHD adults. Gregory is the medical director of a health center in Richmond. He is also the director of an outdoor experience center which serves both adolescents and adults in middle Virginia. Gregory has served on numerous boards, councils, and task forces most of which have addressed delinquency, drug and alcohol treatment, and mental health concerns. He stated that his program “incorporates psychology and counseling. We have an educational consultant who is a coach and advocate. We also have an artist on our staff.” Gregory was very proud of his life work and offered well-thought-out and comprehensive information about his programs and how treatment is appropriate for ADHD. His personal beliefs about treatment are heavily invested in utilizing the challenges of the outdoors to guide clients towards success. His office is representative of his love of hunting, wild life (especially ducks), and the creative arts. He has a wall of bookcases that hold many representations of these pursuits and art work representing creativity and challenge events.

**Theoretical orientation**

All ADHD clients are viewed holistically as needing medical, psychological, and emotional evaluation before entering the program. His clients generally have had a series of life issues. Complete medical review of systems and a physical exam are given to each client. Psychological screening for ADHD is provided, and also the center screens

for psychosocial consequences. Gregory believes that ADHD is an all-encompassing disorder. Gregory mentioned that they make note of any comorbid conditions. Medication management and home management go hand in hand. He views his work with ADHD adults as a “partial meaning,” believing that the effects of ADHD are experienced in a lifetime. He and his treatment team include families and spouses in their treatment plan.

### **Therapeutic process**

Gregory pointed out the importance of family and its healthy or unhealthy influence. He discusses with ADHD clients the need for a cognitive restructure of family. “Family therapy is essential to promote healing. In an adult, we find that normally there is dysfunction either vocational, social or emotional within the home that needs to be addressed. That’s why counseling is so important for the family.” He urges his adult clients to receive psychotherapy for a period of time, to develop coping techniques and also to enhance self-awareness skills.

By late adolescence, there is a need for accommodations due to “hyperactivity and impulsive symptoms that have decreased, but accommodations are needed for good functioning.” Gregory stated that there is a need for adults to learn how to cope with anxiety and develop strengths in cognitive skills. Gregory pointed out that referrals to counselors are made for this reason. “Pharmacotherapy and social support are needed.” This is the underpinning of the therapy that the center provides.

“College students get more accommodations than high school ADHD students.” This relates to the need for help with executive function during early adulthood. It also reflects Gregory’s responses to the needs of adults with ADHD. Some of Gregory’s



clients follow the traditional individual and family therapy model using cognitive therapy techniques. Some of Gregory's clients (especially those with comorbid conditions that include impulsiveness and addiction) are referred to the outdoor experience program. The program is open to older teens and young adults up to 27 years old. In this program, the clients are challenged to live outdoors with counselors for a number of weeks facing challenges and using teamwork to deal with stressful situations. The center also includes the family in de-programming later and uses the experiences "outside" to help teach and encourage the ADHD adult participants.

### **Clients**

"We help them build strengths. We feel that without looking for the asset and building on the asset and using accommodations for the relative weakness, they will certainly continue the destructive path." Gregory believes that the program is a "testing place for young adults who want to change with encouragement and the limits that the outdoors provides to individuals."

Gregory believes that many ADHD adults self-medicate. His experience is that "90% of young adults in his program have substance abuse problems along with ADHD." The outdoor program that he runs is equipped to deal with both of these issues. The program includes parents or spouses in family work to discuss their success in the field and to have a written treatment plan with goals and objectives identified and agreed upon as a family. "The success of this program is immense in terms of self-esteem, self-concept, and getting in touch with what they have been self-medicating and prescribing about. Many of them have been treated as criminals rather than young people who are very distressed over the fact that they have not been successful in any area. They have

gone from job to job. They don't get things done in a timely fashion, because they cannot focus. This is about a chance to change and succeed." This is a heavily male population, 80-20, (80% male, 20% female). "The out-of-doors is the ultimate limit setter."

### **ADHD orientation and perceptions**

Gregory pointed out, "There is no one approach that is going to be for everybody." Gregory stated that he recognizes that ADHD is unique to each individual. He has noticed and attempted to address a self-control issue inherent in ADHD (impulsivity) and a tendency toward self-medication. He noted, "In the field of ADD, primarily the work is prevention and intervention."

Gregory has also recognized the "creativity of many ADHD adults and the sensitivity of the right brain and the ability to visualize." He lamented the loss of art and creative arts in schools and cultural settings and attempts to reinvent their impact by placing them into his work with adults with ADHD.

### **Summary**

Gregory is a dynamic and creative mental health provider who has spent many years focusing on treatment for adolescents and adults. He is highly accomplished in his work and has established some landmark treatments for drug and alcohol offenders as well as adults with impulsivity issues. He believes in the power of the environment to bring about positive outcomes for participants. He is also holistic in his approach to treatment wanting to influence the client with external as well as internal treatment options. He views his approach as highly successful and has been interviewed by numerous newspapers and magazines regarding his treatment programs. He has many of

these interviews displayed in his waiting room. He also pointed out numerous paintings that grace his waiting room and office produced by former clients. These works of art represent successful completion of the program. Gregory was highly recommended by other providers who knew of his work in the Richmond area. He welcomed the opportunity to interview regarding his unique approach to ADHD treatment. The insights in the interview with Gregory are summarized in Table 4.8.

# ANALYSIS OF PARTICIPANT #6: GREGORY

## TABLE 4.8

### THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life- long learner Passionate Community engaged Problem solver	"The out-of-doors is the ultimate limit setter."
Theoretical orientation	Medication management Identify self-control Hone management Holistic Life changes	"Dysfunction is social, vocational, emotional." "These changes are life changes."
Therapeutic process	Medication Accommodations Comorbid conditions	"Counseling is so important to the family." Referral to counselor Wilderness program/creativity outlets
Client	Motivated to change Make life changes Medication	"There is no one approach going to be for everyone." "personal responsibility"
ADHD orientation/perceptions	Hyperactivity and impulsivity decreased Tendency toward poor self-control Job changes Cannot function	"Prevention and intervention." "Creativity and visualization are healing."

**Participant # 7: Adrian****Practitioner**

Adrian is a male, Board Certified Psychiatrist who is in his early 50s and trained in psychoanalysis. Adrian described himself as practicing with adults for 30 years. He stated that he sees 40 clients per week and that approximately 20 of them are ADHD adults. He is the head psychiatrist for a clinic in Washington, D.C. Adrian stated that he was “surprised and startled” by what he saw of client care during his internship. He felt that it was “dehumanizing and mechanical.” Adrian also noted that “he probably had some personal issues to work out” so he entered psychiatry.

He also noted that he “had people in his family with ADD and began to think more about it.” He became involved in the clinic because of his relationship approach to mental health and the helping profession. He was drawn to the family friendly approach of the clinic and maintains that that is one of the strengths of the clinic’s work.

**Theoretical orientation**

“At the clinic we are looking for correlation of ADD and brain scans. We gather an extensive history. We do brain scans and correlate with ADD. We don’t rely on the computer tests in that we don’t believe that they correlate very well. We give our clients a boring task and take a snap shot of their brain when it is working. We use six areas of ADD brain functioning. I also do an extensive functional capacity. If I don’t detect it in life, then I determine that they don’t have it. The scans give us lots of information. ADHD symptoms could be trauma also.” He follows the medical model which drives diagnosis and influences treatment. He stated that he is holistic and person-centered with his treatment options.

## **Therapeutic process**

“I determine if the client is ADHD or has a type of ADHD.” Adrian noted that making that determination is the first step in determining ADHD type and then determining treatment. “You cannot just throw a stimulant at somebody.” Adrian takes a holistic approach to the treatment of adults with ADHD. “If they have a diet that is not healthy, we try to help them improve their diet. I’m recommending to a lot of people a gluten-free, dairy free diet or the cave man diet.” Adrian also pointed out that they are giving numerous nutritional supplements to clients. Lots of fish oil is usually recommended as well. He noted that almost anyone with ADD can benefit from fish oil. He believes that “reprogram your brain waves so you gain better control of brain waves” is more than a slogan; it is a lifestyle change that is the underpinning of his work with ADHD adults.

Lifestyle changes are recommended and encouraged by the treating doctors. After treatment is completed, Adrian pointed out that many clients return for follow-up or to “tweak” their treatment plan with a trusted doctor.

## **Clients**

Adrian pointed out that most clients are motivated to change, because they have been to many doctors without success. The clinic offers physical evidence of ADD (brain scans before and after treatment) and encompasses traditional medications and supplements as healing.

Adrian explained that there is “no quick fix” for lifetime issues like ADD. He does believe that many clients with ADD have detoxification issues, and that food and diet can affect them adversely. Adrian noted that he always tries the natural approach

first, possibly neurofeedback, supplements, etc. and then “we’ll go to medication.” The client and his needs are the focus of this approach to ADHD treatment. He also noted the family connection, i.e., that “there is almost always one parent who has ADHD, and if the family (parent) doesn’t get treatment, then they are not going to be in a good position to help their loved one.” Adrian pointed out that “you have to meet the clients where they are.”

### **ADHD orientation and perceptions**

Adrian pointed to a “sense of stigma” about ADD. We “need education and early intervention before there are a whole series of failed relationships, failed marriages, jobs lost, and substance abuse. Self-medication is always a possibility. They have waited so long for treatment that they feel so bad about themselves, that their self-esteem is crushed, and it’s so difficult.”

Many of the symptoms of childhood ADHD have changed by adulthood; according to many experts. Adrian explained that, for example, instead of hyperactivity there is something called “psychic hyperactivity.” This treats emotions like “a bunch of wild horses. They just go wild and go where they want to go. If you are lucky you can set some reins on them, and maybe you can’t make the horse go exactly where you want, but pull the reins and try to divert a bit.” This is how ADHD changes in adulthood and becomes emotional deregulation.

Brain evolution occurred and inhibits the lower levels of inhibition allowing for more flexibility of behaviors. This is also part of executive functioning ability as a non-ADD adult. ADHD adults have less ability to organize themselves due to a deficit in executive functioning.

**Summary**

Adrian is a practical psychiatrist who attempts to regulate his treatment to the patient needs. Adrian noted that all clients are different and, therefore, require differing treatments. He emphasizes holistic treatments for adults but places emphasis on brain scan information, medication, and supplements as primary treatments recommended. He enjoys being available to clients even after treatment is completed. He is very open and at ease with others and feels that his work really helps adults with ADHD.

Adrian contacted me concerning the dissertation interview. I had already interviewed a psychiatrist from the clinic when Adrian contacted me and wondered if I would be interested in gaining more insight into the clinic by interviewing him. I agreed and felt honored by the invitation. The insights in his interview are summarized in Table 4.9



## ANALYSIS OF PARTICIPANT #7: ADRIAN

TABLE 4.9

## THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life- long learner Relationship oriented Personal ADD connection	“Saw dehumanizing approach/mechanical approach.” “Personal issues to work out.”
Theoretical orientation	Medical model Brain scans Supplements	“Snapshot of the brain.” “If I can’t detect it in life, they don’t have it.”
Therapeutic process	Lifestyle changes Coaching/restructure Counseling Medication management	“You cannot just throw a stimulant at someone.” “Reprogram your brain waves.”
Client	Patience Motivated Executive functions off	“No quick fix.” “Meet the client where they are.”
ADHD orientation/perceptions	Family connection Stigma on ADHD Poor self-control Emotional	“Emotions are like a bunch of wild horses.” .

**Participant # 8: Carmen****Practitioner**

Carmen is a female Licensed Clinical Social Worker in her mid-50s who has worked in several mental health fields before coming to ADHD coaching. She was working in the Richmond area as a social worker (LCSW). She became aware of a corporate based coaching business and became interested in coaching as a means of helping clients. She has been a mental health professional for 29 years. She started receiving coaching training and has completed approximately 180 hours of coaching education. Carmen is certified in ADHD training and attended a national coach training institute. She has been counseling adults since 1991 and sees approximately 10-15 clients per week. Carmen stated that she coaches 4-5 ADHD adults per week. She and her husband, who is also a life coach, own a coaching business which is directed at individuals, non-profit organizations, and business and government partnerships. They also provide leadership coaching, conflict coaching, and performance management that they call “360 Assessment.” She meets clients either at an agreed upon location for personal or corporate coaching or coaches over the phone or internet. She stated that much of her ADHD coaching has been college-oriented. Carmen shared about meeting her husband following the death of his first wife. She suggested that grief (and their handling of it together) has had much to do with their ability to deal with the issues of others. Carmen shared her passion for coaching and helping clients to be successful. She pointed to the strength that this type of experience brings into a professional’s life. She gave me a guided tour of her husband’s first wife’s garden that Carmen re-purposed as a gift to her husband and their new life together.

**Theoretical orientation**

“Folks come to me because they know that I am a coach. And most folks with ADHD come to me because they know that I do ADHD coaching in addition to leadership and conflict coaching. So they have to be referred. Usually they have gone through a process in which they have been formally identified. They then use a web-based instrument to screen which takes about five minutes to fill out.”

Carmen is clear with her clients that she is a coach and not a clinician. She sets boundaries and identifies the differences between coaching and clinical work. Carmen stated that she uses her clinical skills to identify issues and set goals with clients. “I would say that it’s a meshing of using the skills. I use the skills diagnostically for myself.” She wondered about how coaches without clinical skills can adequately provide the services she can. Carmen sees herself as a case manager developing an individualized action plan with each coaching client. She forms an alliance with her clients and describes it as “two people on a tandem-bike who are riding this thing together.” She said, “I am not the expert.” Carmen described her coaching as a form of brief therapy that is person-centered.

**Therapeutic process**

Carmen described coaching as “action forward.” Therapy,” she said “is looking back.” Carmen sets goals with ADHD clients and agrees to monitor their progress. Carmen develops a mindfulness mindset with clients. She establishes a check-in time frame-work using phone calls or e-mails and sometimes face-to-face meetings. Carmen sets the boundaries and reviews the coaching documents (which includes discontinuation if services become unsatisfactory and are not needed). She refers clients who may need

medical or therapeutic services. Carmen explained that she believes that the best treatment for ADHD adults is an “integrated approach with other professionals.” She described this with an analogy of her work as a case manager in clinical work. “I would say that, not for all my clients but for some, that the general integrated case management services with the appropriate professional is one of the keys to making, to helping adults with ADHD. If someone can be identified (a coach, a psychiatrist, a social worker, a psychologist or the disability office of a college), if someone is helping to pull together the pieces and make sure that each professional is doing their appropriate role, then I think that it can work. It can work extremely well. I am really talking about wrap-around services. I guess it could also be called long term care. I was going to call it case management, but it doesn’t fit the clinical definition in the mental health field.”

### **Clients**

“I always start where the client is.” Carmen’s client and coaching skills are available to help the client identify his or her issues. The client must be motivated to contact the coach when help is needed and meet with coach as prearranged. The ADHD client must be committed to his or her own self-care (i.e., follow-up on other health needs, following through on referrals). Carmen stated that coaching is a shorter and more personal agreement with the client than is often the case in traditional therapy. The client “is whole and complete within themselves, and you can help them figure it out.”

### **ADHD orientation and perceptions**

Carmen stated that the need for executive function assistance and coaching are a good fit. “When you get an ADHD client, you know that executive function is more likely to be a challenge...not always; high functioning ADHD clients are more

overwhelmed. They have learned to compensate for a lot of their executive function weaknesses already.” Carmen also noted that many comorbid issues must be addressed, and she engages in emotional checking to identify anxiety and depression.

Carmen noted that many of her ADHD clients are “very, very bright and creative.” They are often in gifted programs and have learned to compensate. ADHD adults are often disorganized and in need of case management services (i.e., tracking). Carmen believes that coaching is a positive opportunity to help ADHD adults to be successful. Coaching services in employment and school environments are her primary experiences.

### **Summary**

Carmen is a life-time learner who is passionate about her work with ADHD adults in coaching. She is able to set appropriate boundaries with ADHD adults allowing her to target what she does best in conjunction with the clients primary coaching needs. She has a strong background in mental health services, and while she quickly points out that coaching and therapy are not the same thing. It is essential to note that she often uses her counseling skills to help her clients. Carmen pointed to coaching as an opportunity to “help (clients) with whatever they need help with. With coaching, it is always their agenda.” She expressed joy in helping clients get to where they want to go in the coaching relationship. She also enjoys using her mental health skills to set boundaries, to formulate alliances with clients, to refer, when needed, and to create and assess goals.

The Edge Foundation (an ADHD oriented web-based referral service) referred me to Carmen when I contacted them regarding an ADHD coaching referral. Carmen is in a network of providers who refer to life coaches. She was very pleased to explain coaching

for the benefit of the research and agreed that she wanted to be involved in treatment methods for adults with ADHD as a result of her beliefs in the benefits of coaching. The themes that emerged in the interviews with Carmen are displayed in Table 4.10.

## ANALYSIS OF PARTICIPANT #8: CARMEN

TABLE 4.10

## THEMES, SUB-THEMES, AND SUPPORTING INFORMATION

THEME	SUB-THEMES	SUPPORTING INFORMATION
Practitioner	Life-long learner Passionate Boundaries Commitment	"I'm not going to be a clinician." "Meshing skills" "To have knowledge of what is going on."
Theoretical orientation	Coaching Case management Tracking progress Brief therapy	"Continued long-term care" "I keep a notebook with tabs."
Therapeutic process	Boundaries Referrals Coaching services/case management	"Professional and ethical standpoint." "Red flag for counseling." Support people
Client	Start where the client is. Motivated and compliant Gain perspective of problem area Need for success	Wellness model Develop an action plan. Shorter and personal agreement
ADHD orientation/perceptions	Wrap-around services Checking/guiding Disorganized Energy to pursue and remain teammates	"Case management." Contacts consistent Emotional checking "Individualized Action Plan" "Two people riding this together."

## **Participant Themes**

### **Introduction**

In the previous section entitled, Participant Profiles, a group profile of all participants as well as an individual profile for each of the eight participants in the research study was included. A thick description of each participant provides a rich background for comparison of the themes that emerged from interviews with the participants. This section entitled Participant Themes describes common themes that appeared across participants in the process of axial coding. Prominent themes were selected based on research team agreement and not solely on the number of times that a theme appeared in the coding process. These themes surround the five major questions that were asked during participant interviews.

Research participants were identified following a nomination process and snowball sampling. The data collection consisted of a face to face interview with each participant in their office environment (with the exception of the life coach interview that was held in her home office). The interviews took place between September 2012 and February 2013. The second contact with participants was a follow-up interview that occurred between November 2012 and March 2013 (one of the eight participants did not respond to the second telephone interview request). The final data collection consisted of an e-mail follow-up that took place between December 2012 and March 2013 (one of the eight participants responded by letter as opposed to e-mail). Interviews were transcribed and analyzed by the research team and myself as they were completed. The team and I wrote notes and memos that were discussed and evaluated during team meetings. The research team and I met on a regular basis to reach consensus on themes that were



emerging from the interview transcripts.

As a part of the reflective process, I prepared five concept maps, one for each interview question. I asked research team members to respond to the emerging themes giving immediate and later e-mail insights into participant themes. The concept map was merged as identified themes and interactive process evolved. A chart showing the merged themes of participants is presented in this chapter.

### **Interview Themes**

The central research question for this study was, “What are the Experiences and Perceptions of Mental Health Professionals Considered Effective in the Diagnosis and Treatment of Adults with Attention Deficit Hyperactivity Disorder?” The interview questions, the format of the questions, and the interview location were all designed to capture the factors and processes of the mental health professional and his/her expertise.

### **Practitioner**

The majority of the participants interviewed were in their 50s. One was in his 70s (Gregory). They were business owners and entrepreneurs (Gregory, Carmen, Tessa, and John). They were engaged in the community on mental health boards, performed volunteer work in churches, edited journals on ADHD, and were support group chairmen. They were trendsetters and educators (Lydia and Stuart). They believed in themselves and the change that therapeutic interventions can make in the lives of their clients; as Tessa pointed out, “ADHD is treatable.” The eight participants were encouragers. “We can help the client build on their success” (Tessa).

They all were cheerleaders for their clients believing that the therapeutic process involves personal endorsement. Tessa believed that ADHD is highly treatable and that

her work with adults can lead to the client finding ways to “resource their ADHD.” Participants expressed themselves as willing to make referrals for the benefit of their clients, but each participant also demonstrated highly developed boundaries. Stuart and John emphasized the need for competency within the boundary of their identified job description. Carmen was careful to identify the boundaries of her life coaching arena accessing her skill sets from past work experiences without venturing into what she called “counseling.”

I assumed that I would learn therapeutic techniques most often used by this very experienced and diverse group of practitioners which I did. I also assumed that I would learn their therapeutic orientations, and I did. I did not, however, anticipate the depth of commitment and the dedication to excellence as a mental health professional that each of the eight participants exhibited. Each of the participants spoke of their desire to continue to grow and learn for the sake of their clients. They were life-long learners. They continued to grow in their field through reading and study. They wrote materials and shared with consumers and other professionals. No matter their age, participants sought to further their education in the field. Case management skills were evident in each participant. Not content to offer their services alone, most of the participants were engaged in referrals to other professionals and to programs and services that they believed might enhance their clients’ options for successful treatment. Stuart, John, and Gregory were all engaged in offering services to the adult ADHD client who might need or want to explore other services.

They were passionate about their work. Lydia noted that “when people see the brain scans, they believe!” Lydia revealed that she was skeptical about the validity of the

ADHD diagnosis until she viewed the brain scans. She noted that the scans made a believer of her. John immersed himself in many aspects of ADHD treatment. He was motivated to “demystify” ADHD for his clients. He edited a professional journal that is geared toward professionals, worked with clients and their families individually and in groups. John was engaged in a local chapter of a nationally recognized support group as a leader and board member.

They showed concern for the whole person or treating the “adult with ADHD holistically” (Gregory). All eight participants pointed out that referrals were essential due to the multifaceted nature of ADHD and encouraged what Stuart called “triangulation of methods.” Several of the participants noted that they have had personal and family connections with an ADHD person. Lydia identified her husband as an ADHD adult, and Adrian said, “Someone in my family was ADHD” causing him to want to learn more. For many of the participants, their work with ADHD was personal and professional.

Their presumed motivation for choosing the field of mental health services (and especially their work with ADHD adults) was as varied as they were. Tessa and Miranda claimed a deep religious motivation to serve others because of their commitment to a higher power. Gregory cited his satisfaction with natural settings and the challenges he had experienced personally as valuable and repeatable. Gregory called his motivation to engage in the work with ADHD adults as “prevention intervention.” He also noted that for ADHD clients, “providing creativity and visualization was healing.” While diverse, the participants were united in their efforts to provide diagnosis, treatment, and successful interventions for their clients.

## Theoretical Orientation

In the preface of their second edition of *Theoretical Models of Counseling and Psychotherapy*, Fall, Holden and Iarquis (2010) stated, “What seems apparent to me, now more than ever, is that learning about theory is the most important step in learning about change.” Change is the goal of most therapeutic approaches. “Psychotherapy is a remarkably effective healing practice. Yet the mechanism by which psychotherapy creates change are not well understood” (Wampold, 2007, p. 858).

Professionally trained mental health providers would have engaged in at least one course concerning theoretical identification and orientation. Deciding on therapeutic orientation is generally required of professionals during internship and before practicing solo. Considering the experience of the participants in this study and the average length of practice being 20 years, the practitioners chosen for the study were seasoned and well versed in their theoretical orientation and diverse in their practice styles. Participants identified the theoretical orientation that they most closely associated with but also expressed eclectic style orientation utilized as the need arose with client issues. All participants emphasized utilizing client-centered principles in making case management decisions. Adrian trained in psychoanalysis early in his career but reported that he “saw it as dehumanizing and mechanical” and wanted to be more involved with his clients.

Gregory developed a wilderness program for ADHD young adults believing that the “outdoors is the ultimate limit setter.” Even though his treatment approach was unique, Gregory employed a medical model of treatment techniques for his clients. Stuart’s Cog-Med and Miranda’s neurofeedback provided physical brain retraining opportunities for clients but was also based on the medical model. Lydia and Adrian

worked in a cutting edge clinic whose emphasis were brain scans that “show ADHD.” Lydia noted that “when people see the brain scan, they believe.” They both employed a medical model of treatment. Tessa referred to herself as a cognitive-behavioral therapist and added emphasis by stating, “I am a firm believer in talk therapy.” She also placed emphasis on faith-based interventions saying, “Faith is a strategy for success. Looking to a higher power builds structure that can lead to success in an adult’s life.” Miranda and Tessa both espoused the incorporation of spirituality in treatment. While Carmen presented herself as a life coach who was “not going to be a clinician,” she also noted that many of her theoretical interventions were a combination of coaching and brief- therapy. Carmen stated that coaching worked best when kept to “a shorter and personal agreement.” Carmen explained that she develops with her clients an individualized action plan that she uses as a guideline to aid the client in mapping coaching progress. John also employed a medical model approach with clients emphasizing appropriate diagnosis and treatment as essential. He, like most of the participants, noted that ADHD in adults requires a multimodal approach to treatment. “People must be treated for ADHD and not just anxiety or depression.”

It was interesting to note that six of the eight participants referred to the medical model as the basis of their treatment style (Adrian, Lydia, Gregory, Miranda, John, and Stuart). According to McLeod (2008) the medical model supports “symptoms to be outward signs of the inner physical disorder. If symptoms are grouped together and classified into a ‘syndrome,’ the true cause can eventually be discovered and appropriate physical treatment administered.”

## **Therapeutic process**

All participants agreed that ADHD work involved careful evaluation and diagnosis. Gregory noted that the dysfunction of ADHD was “social, vocational and emotional.” Lydia explained, “You have a complex issue there” (pointing to the ADHD diagnosis). Most participants pointed out the comorbidity of ADHD and included the following conditions: drug addiction (Gregory), trauma (Tessa and Miranda), and anxiety and depression (John). Stuart noted that he was an “advocate for the data, not the person,” believing that a scientific approach with objectivity as central to his engagement with clients produced the most accurate testing results. Miranda pointed out that while neurofeedback is symptom driven instead of diagnosis driven, adults engaged in neurofeedback would benefit from being “quizzed by significant others as to the practice of mindfulness that the feedback requires to be successful.” The participants each have developed an intensive interview protocol. Reclaiming past school records, questioning employers, engaging relatives of adults to provide information, etc. were all suggested as possible avenues to “fill in the gaps” for the diagnosis of adult ADHD.

All participants were in agreement regarding the benefits of medication as a treatment option for adults. Wender (1995) wrote, “Drug treatment of ADHD with stimulants and with other medications is of both practical and theoretical importance. Long term treatment of patients often produces major changes in scholastic, vocational and personal functioning,” (p. 153). Adrian explained that while an effective component in treatment, medication treatment was best used in conjunction with other treatments. He said, “You cannot just throw a stimulant at someone.” Medication treatments effective for children with ADHD have been found to be as effective for adults as they

are for children with ADHD (Barkley et al., 2008).

All the participants urged the use of testing or comprehensive intake evaluations to determine diagnosis and treatment options. According to their orientation of treatment, each participant might recommend varying treatments, but all emphasized a careful diagnosis. Stuart expressed a concern regarding his objectivity in testing of adults. Stuart believes that non-objective testing could skew results and invalidate the results. Adrian noted that careful evaluation was needed to diagnose adults with ADHD. Gregory observed that his treatment protocol was geared to “life changes.”

Each practitioner emphasized the need for “wrap-around services,” (Carmen) as well as case management. The participants emphasized the need for an interdisciplinary approach to help educate, organize, and track the adult with ADHD while providing appropriate services. Carmen noted that she is an “advocate of consistent contacts, emotional checking, and developing an individualized action plan.” Gregory stated, “Counseling is so important to the family and that referrals are needed for family counseling services.” John explained the need for “helping them manage and understand what’s going on.”

### **Clients**

All participants explained the importance of meeting the client’s physical and emotional needs from the time they arrive until they leave. Lydia said, “It is hard to categorize human beings. You always treat the patient who shows up.” Adrian said, “You meet the clients where they are.” Gregory noted, “There is no one approach going to be for everyone.” Carmen stated, “You start where the client is.”

Each participant emphasized their belief in the client and the client’s ability to

make changes. Gregory stated that each client had a “personal responsibility” towards personal change. Stuart described ADHD adults who came to his practice as only “seeking diagnosis.” Adrian, Lydia, and Miranda stated that clients must be motivated to change.

John stated that ADHD is “normal, not abnormal.” While John noted that ADHD is a lifespan diagnosis, he did not think that it should be treated as an abnormality. He urged mental health professionals to “get people to a point, that it (ADHD) should not be viewed as a forever treatment plan.” He noted that, in his view, this approach devalued the individual strengths of the ADHD adult.

Participants described the need for education as pivotal for the success of the ADHD client. The need for education was interpreted in several ways by participants. Gregory proposed personal self-awareness as education. He stated that “creativity and visualization are healing.” John also encouraged continued education. Carmen explained that adults could be challenged to educate themselves and “gain perspective of the problem area.” Lydia and Adrian both described the need for identification of the type of ADHD experienced by the client and then gaining the education needed to manage it. Stuart’s diagnostic work was described by him as “a gift to clients.” He further explained the benefits of good diagnosis and how it could aid in the treatment of an ADHD adult. He noted that he took time to explain his process so his clients could be better educated regarding their diagnosis.

Carmen described education of her coaching clients as pivotal to a successful working arrangement. She described reviewing forms, contracts and agreements to aid the client in understanding the roles of the coach and the client. Carmen explained that



she believed that this approach was more likely to produce a successful outcome for her coaching clients.

Miranda also emphasized education for neurofeedback clients. She stated that “neurofeedback uses technology to show the brain how to retrain.” She educates clients and helps them monitor and understand the feedback that they are receiving. Tessa stated, “ADHD clients can resource their ADHD.” She explained further that clients with ADHD can learn and educate themselves to duplicate outcomes that benefit themselves and discontinue outcomes that do not benefit themselves.

### **ADHD orientation and perceptions**

All participants pointed to the complex nature of ADHD. All acknowledged that most clients have ADHD and at least one comorbid condition. This lends itself to being misdiagnosed or over diagnosed by service providers and mental health practitioners. Negative thinking patterns can occur as a result. Tessa noted she “attempts to confront the lies that clients believe about self.” She further noted that “ADHD causes harm. It is being harmed and not knowing what it was that hurt them.”

While they did not agree on the treatments for ADHD, they all agreed on the need for services across the lifespan. Treatment, according to Adrian, is “reprogramming of the brain waves.” Adrian suggested that the emotions tied to ADHD are “like a bunch of wild horses.” Adrian and Gregory both identified further that ADHD represents poor emotional control. Miranda and Gregory emphasized unhappiness with functioning levels especially in the work environment. Tessa explained that “ADHD is highly treatable” and that many clients are suffering from “defeatism” due to a lifetime of failures and low self-esteem.

Currently, many mental health professionals are identifying a deficit in executive function as pivotal to understanding many of the issues inherent in ADHD adults. Researchers have identified a group of developmental tasks in adulthood that have been termed executive function. There is much disagreement as to what tasks make up the components of executive function, but there is agreement that ADHD adults suffer with impaired ability in many adult life-function areas. In several studies (Barkley, 2007; Beckett, 1994; Nigg, 2001), executive function is identified as organizational skills, self-sufficiency, personal reflectivity, planning, and projection of future events. This cluster of behaviors allows for independence and higher functioning in adults. Participants in the study also noted deficits in these areas.

Adrian believes many of the issues of poor self-control lie in what he called “psychic hyperactivity.” Carmen described chronic disorganization and low energy to pursue goals as executive function failure. Lydia explained that school and work strategies are on her list of executive function dysfunctionality. Lydia reported that her husband (an ADHD adult) was able to work in an environment that provided staff workers who “turned the crank “or aided him in task completion. This, she explained, afforded him a successful career. John identified the need for organizational assistance. Carmen identified issues such as the inability to focus as well as problems holding and maintaining jobs. Adrian pointed out a stigma regarding ADHD that clients experienced. Lydia reacted when asked about her experiences with an ADHD husband by exclaiming, “It is hard to live with somebody with ADD. You want to kill them. You just want to kill them!” Tessa believed that ADHD contributed to being traumatized. Miranda noted the unhappiness of clients with ADHD stating they “were unhappy with current

functioning levels.”

All participants expressed the desire to offer understanding, hope, and advocacy to adults with ADHD. Lydia and Adrian explained that “brain scans were very persuasive” toward understanding and treating ADHD. They both agreed that this approach to treatment gave hope to clients. John supported giving advocacy training to his clients. He also encouraged clients to engage in support groups. John reported that he wanted to “demystify” ADHD and help clients to view their diagnosis as “normal” rather than abnormal. Stuart described himself as “a gift to his clients,” explaining that he wanted to provide educational opportunities and hopefulness. Tessa wanted to encourage her clients and “free them from being a hostage” (to ADHD). Carmen described her coaching as a wellness model and identified her support as “two people riding this together” (as a tandem bicycle). Miranda encouraged more action in the brain and urged clients to practice neurofeedback, thus improving focus and memory. Miranda saw her role as monitoring and coaching clients to be more successful at the brain retraining efforts. Gregory saw his efforts with clients as “life changes.”

### **Interviewer reflection**

I began to notice a trend of comments after the tape recorder was turned off. In Chapter 3, I indicated that I raised a son who was diagnosed with ADHD at age seven. Like most parents, my husband and I did the best we could in the unknown territory of child rearing taking into account the impact of ADHD. I noticed that I was clinically interested in the insights of the research participants regarding their work with adults with ADHD. I also noticed that after the tape recorder was off, I was personally interested in sharing a small issue regarding my own experiences and gaining feedback from this

amazing group of interviewees. I wrote in my journal that when asked by a participant for my motivation in choosing ADHD as my study topic, I decided to share briefly about my personal journey with the disorder. I shared a brief personal accomplishment regarding my adult ADHD son and felt affirmed when the participant said, “That’s terrific. You must have done things right.” I continued in each interview to mention my years of experience as a Licensed Professional Counselor and my personal affiliation with ADHD. I believe these references to my personal experiences accomplished four things. First, the interviewees were all asked to share their personal motivation for engaging in work with ADHD adults, and it seemed appropriate to model the level of disclosure requested of them. Second, it provided a link of association that could quickly be established both professionally and personally. Third, linking with the interviewees helped me to contain my anxiety within manageable levels. I noticed that interviewing professionals, finding new places, and even using recording equipment all lent themselves to high anxiety levels for me. I wrote in my journal “anxiety about interview, again!” As I settled into the interview with each participant, my anxiety seemed to diminish. I believe that the personal demeanor of quiet acceptance that each exhibited gave rise to this positive action.

Finally, I noticed that as my anxiety decreased, I really listened to the interviewees. I was enthralled with the professionalism, warmth, and graciousness that each interviewee offered to me. I realized that I was engaged in more than an interview, I was being honored. I realized that these professionals were sharing of themselves as much as sharing their work. It was humbling as well as enlightening.

## **Summary**

This section contains prominent themes that emerged following three rounds of data collection and refinements for this research study. The themes represent the experiences and perceptions of mental health professionals considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder.

## **Grounded theory**

The first section of this chapter, Participant Profiles, included thick description of the participants and prominent themes that emerged from three rounds of data collection. The second section, Participant Themes, emerged as participants were described. These themes compose the factors and processes that contribute to diagnosis and treatment outcomes of ADHD adults. The third section, Grounded Theory, describes a potential theory to explain how these factors and processes interact and show how diagnosis and treatment outcomes are influenced. This section provides a summary of the central research question and the five research sub-questions that comprised the focus of the research study.

## **Central Research Question**

The central research question for this study was, “What are the experiences and perceptions of mental health professionals considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder?”

The purpose of this grounded research study was to discover and conceptualize the experiences and perceptions of mental health professionals. Grounded theory techniques lend themselves to using systematic and careful analysis in the construction of a theoretical explanation of the phenomenon studied (Denzin & Lincoln, 2000). This

section provides a narrative explanation of the potential theory that emerged from the interviews with eight practitioners nominated as experts in diagnosing and treating adults with ADHD.

Successful diagnosis and treatment with ADHD adults begins with the mental health professional. Study practitioners who are successful tend to be committed to excellence in their work. They are life-long learners and continue to build their knowledge of ADHD through interactions with other professionals, education, and knowledge of research in the field. They stay active in professional organizations, participate in continuing education, and engage in professional networks. It is through their personal dedication to continue to learn that they stay abreast of all aspects of ADHD in adults. The practitioners have a comprehensive understanding of ADHD: trends in diagnostic interventions, treatment options, and emerging research in the field. Because there is limited research on adults with ADHD and no best practice guidelines, practitioners have communicated with one another with more vigor than perhaps in more established fields. They have followed relevant research more closely and piloted programs and interventions to fill the gaps.

Gregory, for example, developed a teen wilderness program for substance abusers. He noticed that many of his early clients were diagnosed with ADHD. Recognizing that the outdoors afforded opportunities for success and self-awareness (two treatment elements needed in work with ADHD), he began a program for young adults (ages 18-26) who were ADHD.

They maintain professional relationships with clients and offer understanding and hope based on their professional training and personal courage. The practitioners have

rich life experiences that they utilize to engage and teach clients practical life skills.

Lydia noted that her personal relationship with her husband is a life lesson and a source of learning that she can integrate into her work with clients. “It is very hard to live with someone with ADD. It is hard to live with,” Lydia shared. Adrian, though trained in psychoanalysis, decided that he wanted to be less “mechanical and dehumanizing” with future clients and changed the direction of his practice.

Practitioners have a passion for the field rooted in their therapeutic orientation and techniques. Each practitioner, although utilizing different approaches, showed enthusiasm for their interventions and a confidence that they could successfully diagnose and/or treat ADHD clients. They were able to build a therapeutic relationship with clients who came seeking help for themselves or other family members. Therapeutic skills included building confidence and trust and engaging in a nurturing relationship with the client.

Participants explained that many ADHD adults were undiagnosed or untreated. Several practitioners reported that adults realized their childhood/teen experiences with inattention and focus was ADHD when engaging with a family member who was diagnosed with ADHD. In the case of many clients, they entered mental health services following an introduction while others were receiving services. Study practitioners recognized that relationships with family and friends often enabled the ADHD adult to become aware of their own need. Therefore, most practitioners offered family and group services in conjunction with individual services.

The process of diagnosis of an ADHD adult began with a complete assessment. Miranda explained, “Neurofeedback is very symptom driven as opposed to diagnosis

driven,” and that she evaluates physical evidence of brain work, client self-report of troubling symptoms, and motivation to make changes. John indicated that he included any records (school, work) or reporting agents (parents, spouse, self-report) that were made available to him for evaluation. Most practitioners reported that they valued all sources of information past or present that would aid them in their evaluations. Most practitioners reported that the adults were open to this type of report seeking.

The practitioners also reported that adults were highly motivated to be evaluated, and that this was essential toward making a good diagnosis. All the research participants agreed that the mental health professional was more likely to make an appropriate diagnosis and treatment plan if the adult client was fully engaged in the process.

Most practitioners used some form of physical testing (brain scans, working memory) or psychological testing (Barkley, 2011 & Conners, 2009) or assessment tool (internet based World Health Organization) to make an accurate assessment of the client. All of the study participants emphasized “careful diagnosis.” Since ADHD is now considered a lifetime diagnosis, participants were even more careful to indicate that a diagnosis would include not just “lifestyle changes” but also, as Gregory put it, “These changes are life changes.” All research participants noted the comorbidity of ADHD. Lydia called it “comorbid confusion” indicating that a diagnosis of ADHD often carries one or two coexisting conditions that cloud or hinder the diagnosis. Lydia and Adrian adhere to an evaluative process that employs brain scans and a concise history to diagnose ADHD naming one of the six subtypes in the diagnosis. Stuart reported that objectivity was important in diagnosis since he was tasked with making accurate diagnosis of ADHD for clients to receive disability services.



The participants of this study underscored the need for accurate diagnosis in order to provide good treatment. The two exceptions were neurofeedback and coaching. Two participants engaged in “diagnostic theorizing” or holding a possible diagnosis in the back of one’s mind based on a set of symptoms that resemble a possible diagnosis. Miranda pointed out that since neurofeedback is more “symptom driven rather than diagnosis driven,” the diagnostic step wasn’t as essential for her work. Miranda’s social work and clinical psychologist background gave her an edge on “diagnostic theorizing.” Carmen’s coaching clients were less influenced by having no diagnosis for service than other mental health clients. Carmen’s background in more traditional mental health services (social work, special education) gave her an edge on “diagnostic theorizing” that aided her in assessment and service to clients with ADHD.

Each participant admitted that their treatment choices may or may not be appropriate for all clients. They were careful to refer to other providers, if needed. Most study participants noted that several types of therapy might be needed to treat ADHD. Stuart termed the combination of services as “triangulation of methods.”

All study participants realized that the need for services for the ADHD adult reached into many areas of life requiring various services and treatments over time. The research participants agreed that treatment options for adults with ADHD is limited. Each interviewee noted that there is much research needed to determine what types of treatment for adults with ADHD are most effective.

The medical model, brief therapy, and cognitive behavioral therapy were the three therapeutic approaches represented by the participants. Client-centered techniques were employed to develop a therapeutic relationship with clients. Research participants

expressed the “cafeteria nature” of treatment to adults with ADHD. Most of the interviewee’s explained that as the need arose (or was recognized), treatment could be engaged, discontinued, and re-engaged as needed. They noted that practitioners were engaged in “prevention and intervention” treatment services. John pointed out that ADHD adults were “normal” and that treatment should involve time-limited or issue-limited mental health services. Adrian explained, “There are no quick fixes.” Although all participants were aware of the disability status of the disorder, there was limited agreement as to acceptance of the possible negative implications. The lifespan nature of ADHD was universally accepted; however, disability as incapability, was rejected.

While study participants were realistic about the facts of a disorder, they were believers in self-actualization and human potential. Tessa described herself as an encourager. She identified her work as “confronting lies that clients believe about themselves.” She also added that ADHD clients “suffer from defeatism.”

Coaching services, like the other treatments, were individualized (no matter the treatment orientation) and goal directed. Carmen called her coaching work a “wellness model.” Emphasis is placed on support, encouragement, and case management services.

Participants agreed that support, advocacy, and education were important aspects to assure success in reaching treatment goals with clients. Tessa described the need to help clients build on success and find ways to “resource their ADHD.” She seemed to suggest that finding a way to accept and view positively the earmarks of the disorder were keys to accepting the diagnosis of ADHD.

Tessa remarked that ADHD was “treatable.” All research participants agreed that medication is an effective treatment measure for adults. All interviewees projected the

belief that ADHD took a toll on the individual and the family, and that with treatment those clients could be more successful and productive in their lives.

Participants pointed out their availability to clients at “pressure points.” The self-advocacy of the individual that John emphasized and the courage reinforced in a wilderness program like Gregory utilizes was all seen as valuable and therapeutic in nature. Carmen coined the phrase “wrap-around services” as a term to describe periodic need for services and referrals to other providers as well. All participants noted that “case management” was needed by ADHD clients, and from their treatment perspective, each was willing to engage in treatment that included that management aspect.

Participants agreed that mental health services were a combination of personal dedication to helping others and business. The research participants had each followed a path of training and preparation to enter human services that they described as “intriguing;” others noted that they “had personal issues to work out.” Stuart explained that his work was a gift to his clients, while Miranda described her work as a spiritual experience saying, “I feel that God called me to this work.” Each participant was highly engaged in their work with clients and had deeply personal motives for choosing mental health. Carmen’s early attraction to her husband and later coaching business partner was his grief management following the loss of his first wife. She explained that her interest in coaching was primarily personal and secondarily business. Tessa described her faith as very important to her and espoused a belief that clients could benefit from a structure and support system that faith might offer to an interested client. John described himself as a businessman as well as an educator. All study participants had worked in multiple mental health settings and were able, over time, to determine their personal and

professional strengths. Adrian and Lydia were private contractors in an upscale cutting edge mental health clinic; the other participants were working in small private practices as entrepreneurs and clinicians. All participants presented as savvy businessmen and women who possessed multiple skills in marketing, salesmanship, and business management.

### **Research Sub-question 1**

Research sub-question 1 states the following: Would you talk about working with the adult ADHD population? What drew you to this work?

Participants were asked to discuss their perceptions and insights pertaining to the adult ADHD population. Although adult ADHD is almost completely ignored in the *DSM-IV* (APA, 2000) manual, practitioners were universally in agreement that adult ADHD not only exists but is largely underdiagnosed. Practitioners indicated that their work with adults was rarely initiated due to the recognition of ADHD but generally as a result of other mental health needs. Many adult clients recognized their own potential ADHD as a result of a family member's diagnosis. Other adults were diagnosed with ADHD when seeking treatment for other mental health conditions. All participants agreed that this phenomenon might also be explained by comorbid clinical conditions that, more often than not, could hide the symptomology of the disorder. Research practitioners pointed out that when adults were diagnosed, they tended to be very glad to know that their symptoms, hitherto unknown as a disorder, explained their behaviors. In this study, the participants noted that when adults were diagnosed with ADHD, they tended to choose short term and specific services. Coaching, brain scans, psychological testing, disability accommodations, and wilderness adventure experiences were listed as

attractive short term treatment options. Less attractive to the clients were longer term traditional therapy approaches like, for example, open-ended individual therapy.

Participants gave a variety of reasons for their chosen field of work. Many stated personal and emotional reasons for their work with adults with ADHD; others pointed to spiritual reasons for their choice of clientele. The study participants explained their motivation to work with this population as being emotionally and professionally challenged to engage with a population that was, in their view, neglected and ignored by other practitioners. The participants all agreed that they entered the field of adult ADHD due to the shortage of providers offering services for this population. They were willing to “fill the mental health gap.” Most research participants agreed that it was good business to offer services to adults when they were already working with a child/teen population of ADHD clients. They all believed that they were capable of offering services in a new and emerging field and were willing to challenge themselves to stay abreast of the latest developments and offer new programs, etc. to meet the needs as they presented themselves.

### **Research Sub-question 2**

Research sub-question 2 states the following: The *DSM-IV* (APA, 2000) includes limited information about ADHD adults. What criteria do you use to make this diagnosis?

Participants described the creation of criteria to make an appropriate diagnosis. Many referenced established testing and interview criteria as foundational to their diagnosis. All study participants combined a number of tests, interviews, etc. that they felt worked well with their personal evaluative resources. All participants used a format

that included intensive background questions, collaborative materials (school records, work reports), client self-report, and a collaborative individual's report (parent, employer, friend). The study participants valued psychological testing and utilized it as collaborative documentation.

Participants also acknowledged the criteria established in the *DSM-IV* (APA, 2000) as essential to appropriate diagnosis. They were also aware of the limited references identifying adult diagnosis criteria and offered their personal insights into any changes that might occur with diagnosis of the disorder in the 2013 edition of the *Diagnostic and Statistical Manual*.

Each research participant recalled that the criteria of the *DSM-IV* (APA, 2000) diagnosis of adult ADHD must follow a childhood diagnosis of the disorder. All participants asserted that at least some of the clinical confusion regarding the diagnosis of adult ADHD was directly related to the lack of clarity in the diagnostic manual.

Participants noted that their "careful evaluation" included uncovering trouble in school, or, for example, inattention factors in a training program. Believing that many adults were either not diagnosed or treated for ADHD as children, study participants tended to interpret the diagnostic manual mandate loosely. They stated that not receiving a diagnosis in childhood did not, in their estimation, preclude the adult client from being diagnosed with ADHD. Several practitioners noted that ADHD-like symptoms might be developed later in life. Participants took into account any childhood diagnosis or ADHD-like behaviors that would agree with a possible childhood history of ADHD. Childhood criteria listed in the diagnostic manual was also taken into account before the diagnosis was made. Addiction evaluation was used by all participants as a screening tool for

ADHD. Screening also included any criminal activity and driving problems. Participants all agreed on the individualized nature of diagnosis. Each client was treated with respect and careful consideration of their individual symptoms and needs.

### **Research Sub question 3**

Research sub-question 3 states the following: What symptoms convince you that the correct diagnosis is adult ADHD?

ADHD is a disorder that includes three major criteria of dysfunctionality: impulsivity, hyperactivity, and concentration or focus. During the discussions and revisions proposed in the newly published (2013) version of the diagnostic manual, ADHD symptomology was reviewed. Many scholars have proposed that symptoms of ADHD change in appearance and function in adults. The term executive function skills (skills that are needed by most American adults to organize and function in day to day life) were brought up by the study participants. While there is limited agreement as to the scope of executive function skills, participants were aware of and using life-skills as part of their evaluative process. One interviewee noted, “Impulsiveness allows for susceptibility to addictions.”

All participants pointed to adults with internal and external disorganization as an indicator of ADHD. Participants noted that adults with ADHD were often self-denigrating. They reported numerous lost jobs, poor relationships, and unsuccessful endeavors as representative of the disorder. ADHD clients tended to have at least two comorbid conditions which contributes to the difficulty in diagnosis and the management of the disorder. Participants described clients who were lacking in focus and unhappy with current functioning levels. All participants described adult hyperactivity as “psychic

hyperactivity” or intense inability to “turn off the brain’s merry-go-round” activity.

Hyperactivity was also identified in adults as irritability or impatience.

Emotional liability was described by the participants as an earmark of ADHD.

One interviewee described ADHD, “Emotions are like a bunch of wild horses.”

Participants also universally agreed on the need for evaluation of personal, work, and other relationships. Disrupted relationships are often an indicator of poor self-control and impulsivity.

#### **Research Sub-question 4**

Research sub-question 4 states the following: Currently, there is no best practice treatment for ADHD adults. How do you overcome the lack of clinical information and make choices that drive your therapeutic interventions?

Participants use their knowledge of childhood diagnosis and treatment to work effectively with adult clients. They employ well established principles of work with childhood ADHD to maximize their work with adults. Study participants educate themselves regarding ADHD adults. Participants are unafraid to take risks and work with a clientele that is new and clinically untried. Research participants are mindful of the childhood diagnostic manual guidelines and use their professional training to assist them in devising programs and interventions that they believe would be effective for the adult client. Participants use referrals to enhance the interventions and work as case managers to provide a roadmap piecing together services as needed for clients. Participants described a variety of methods to engage clients and provide opportunity for personal responsibility. A research participant said (when asked to describe her role with the client), “It is like two people riding a bike together.” Research participants are able to



develop a healthy therapeutic relationship with their adult clients. All participants are respectful of clients' gender, ethnicity, race, and religion. Their drive to provide (or refer for) services is to help the client develop an action plan that can be carried out by the client. All participants noted that they feel successful when clients report remediation of negative symptomology and identify improved management of their life.

One research participant called his involvement with clients as "prevention and intervention." Most participants view their mental health services as "wellness" driven. Participants are motivated to assist in a healing process. They described themselves as educators and guides.

All participants described their work as holistic. They pointed to the desire to help a client make life changes. One research participant said, "These changes are life changes."

### **Research Sub-question 5**

Research sub-question 5: What do you feel has been the most effective means of treatment for ADHD adults?

Participants pointed out that due to the number of adults with ADHD and the current limited number of providers, a major stumbling block for effective treatment of adults will be finding a skilled provider. All study participants noted that medication was the most effective treatment for adults. All reported a positive outcome as a result of a trial of various medications used effectively with children and teens.

Participants noted that a multimodal approach was most often employed. A research participant called this type of service "a triangulation of method."

In this study, the medical model which includes diagnosis, treatment and follow-

up is practiced by the majority of the interviewees. This treatment model includes medication management and short term brief therapy or coaching. Client- centered techniques are employed by all participants during diagnostic and treatment stages. Treatment options for adults are described by the interviewees as “cafeteria-like.” They described the needs and choices available to clients as driving treatment.

ADHD is now understood to be a lifespan disorder. The options for treatment reflect life stages and needs relating to, for example, marriage and childbearing issues, employment concerns, etc. This approach is driven by the adult client and is based on client perceived needs. Research participants described client’s possible future need for an alliance with a mental health professional. Short term treatment approaches were mentioned: neurofeedback, coaching, brief family therapy, and brain scans.

A healthy and positive relationship with a mental health provider, all agreed, is essential for a good treatment outcome. Trusting the provider to be client-oriented and confidently working in conjunction with the client is key according to the study participants.

### **Research Sub-question 6**

Research sub-question 6 states the following: What would you like to add to your statement?

They answered with the following comments:

- “We have found that many people do not have the encouragement or the opportunity to really develop themselves. We feel that without looking for the asset and building on the asset, our work will not be successful.”
- “Learn the six areas of ADHD diagnosis.”

- “I am teaching self-advocacy.”
- “I would like to have a supplement that really works.”
- “Mental health professionals should educate themselves regarding ADHD.”
- “My background allows me to connect with MDs, and I can make referrals as a result.”
- “Pursue your dreams and move forward. Share this with clients!”
- “Training your brain is possible and good!”

### **Researchers’ experience as credible and coherent**

“Once the researcher has asserted her presence, she also has to make her presence worthwhile and meaningful ... she must also make herself a credible presence” (Holliday, 2002, p.139). “Qualitative research focuses on exploring, examining, and describing people and their natural environments. Yet researchers may find that their roles as researchers and as clinicians may be in conflict. Qualitative studies are frequently conducted in settings involving participation of people in their everyday environments” (Orb, Eisenhauer & Wynaden, 2008, p. 93).

In every interview, I revealed personal orientation by sharing mental health credentials or a story from past experience to connect and establish credibility with the participants. I also shared “snap shots” of personal history with ADHD in my immediate family. It was hoped that this sharing would explain my interest in the topic and also provide coherent integration of the researcher and the research topic. Participants responded in some of the following ways:

“How much does adult ADD, you know, go into substance abuse and addiction? It also leads to financial mismanagement, overeating, and health stuff. I mean we could

just go on . . . I guess that explains your interest in the field?”

“I share that. I know that sometimes you want to kill them.” She is married to an ADD husband and relates a personal story. She recommends a clinic workbook for relationship building.

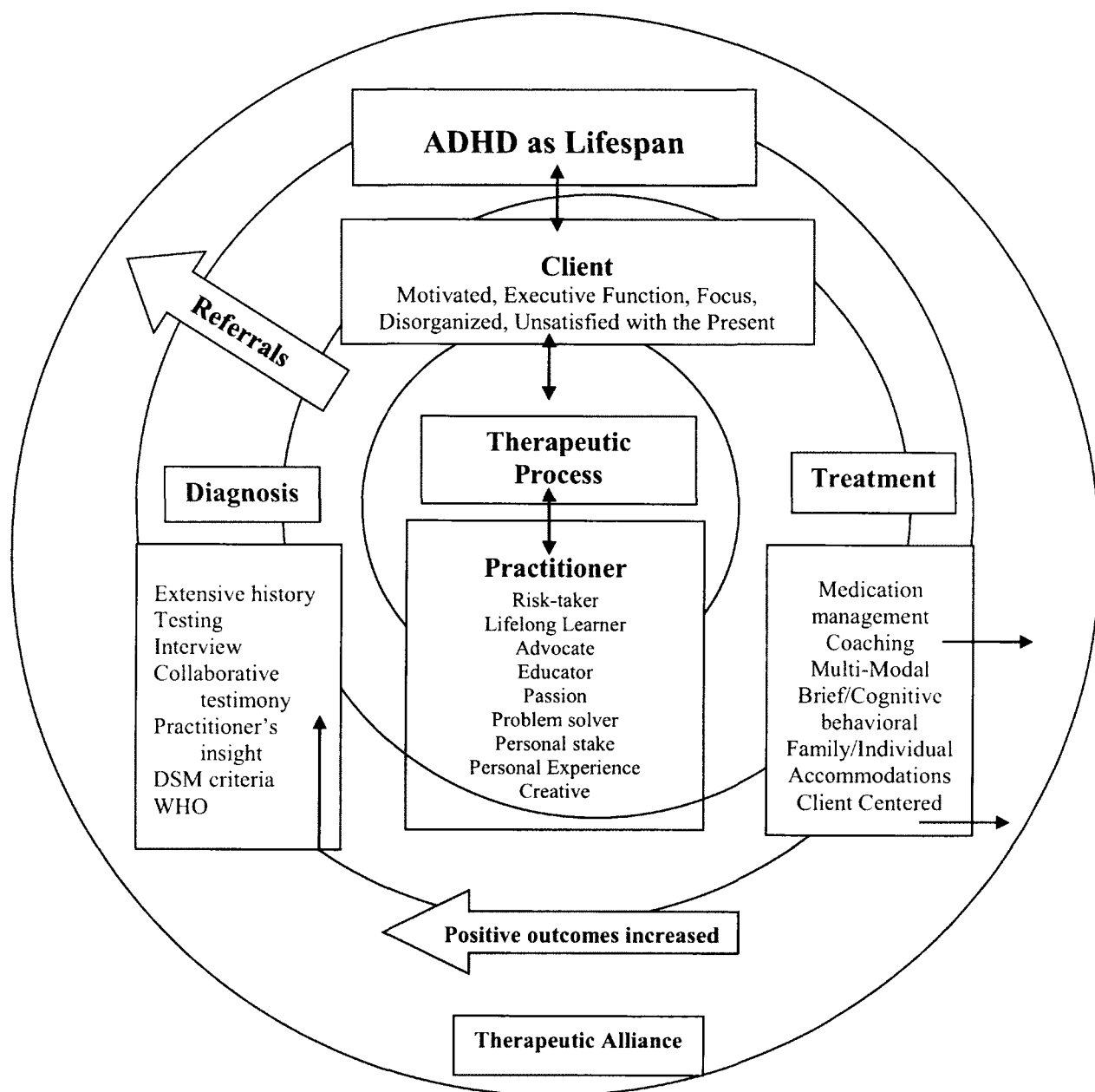
After finding out that I was an LPC in Tidewater, one interviewee stated, “If you have people who are interested in our outdoor program, we would be happy to work with you”

### **Summary**

The results of this study indicate that ADHD practitioners play a central role in treatment outcomes of adults with ADHD. There was an atmosphere of trust and therapeutic alliance that created a place of safety and hope for clients. It was also theorized that future mental health needs might be addressed by the practitioner who developed an alliance with clients. ADHD providers were creative businessmen and women. Providers were undeterred by the lack of clinical information regarding ADHD. They developed and utilized existing diagnostic materials reinventing them for adult market. Study participants used careful diagnostic techniques to make appropriate diagnosis. They provided mental health services to adults, producing materials that would uniquely meet their needs. The participants were pioneers in clinical work choosing to accept clients who needed their expertise, first, working with ADHD children and then expanding into work with adult clients. Treatment was identified as primarily following the medical model with brief therapy in conjunction. Client multicultural factors of race, ethnicity, gender, and age were not perceived as negatively effecting treatment outcomes. In accordance with grounded theory tradition (Corbin & Strauss,

2008), a visual representation of this theory is depicted in a final concept map in Figure 4.11.

**FIGURE 4.11**  
**FINAL CONCEPT MAP**



## CHAPTER FIVE

### DISCUSSION

The purpose of this grounded theory qualitative study was to explore the experiences and perceptions of licensed mental health professionals considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder. Licensed mental health professionals were identified as effective in diagnosis and treatment through a snowball sampling method. I requested that fellow graduate students, mental health professionals, ADHD support group affiliates, physicians, a national coaching clearinghouse, an internet brain retraining program, and an ADHD pharmaceutical representative nominate qualified mental health professionals. I received 36 nominations of ADHD adult practitioners (19 males and 17 females) perceived as experts in the field. Of that group of nominees, I contacted all 36 nominees. Twelve nominated practitioners responded positively to the request to participate in the study (six women and six men) and from that group, I received positive responses from eight participants who composed the study participants. Four men and four women ranging in age from the 30 to 70 years old were interviewed. All participants were Caucasian.

All were actively engaged in private practice in two states representing large and medium metropolitan areas. The study included two practitioners who offered one primary service to ADHD adults (with some brief therapy included), and the remaining six participants offered integrated services. All participants declared a willingness to refer to other services or practitioners as needed. Participants included licensed professionals from several branches of mental health professions: social work, counseling, clinical psychology, and psychiatry.

Participants ranged from 5-43 years of experience in mental health practice with the mean experience being 20.25 years. The number of clients that were seen each week ranged from 12-90 with the mean average case load of 33.38 clients per week. The number of ADHD clients seen in a week by the providers ranged from 3-72 clients per week with a mean of 14.35 ADHD clients seen per week.

Data collection took place in three rounds over a seven month time period. The first round consisted of a face-to-face semi-structured interview with eight participants held at their place of business. The second round consisted of a telephone interview designed to provide clarification of any areas that the face-to-face interview neglected or in which there might have been a misunderstanding of the interview content or meaning. This member checking served to establish research validity. The third round was an e-mail follow-up contact.

A ninth participant was interviewed but did not meet the research study criteria of being a mental health professional. Therefore; the interview was eliminated and utilized as collaborative research data.

Nonspecific documents were collected from participants to add depth and detail to analysis. This is physical trace evidence or "*footprints in the snow*" (Creswell, 2009). A reflexive written and drawn journal was utilized as a means of self-study and auto-ethnographic expression (Pithouse, Mitchell, & Moletsane, 2009). Memos and notes were also written both *on the spot* and during coding to link theory and data. I individually trained each research team member. The team met both physically and digitally to code the transcripts. The first three interviews were audio and video taped. The last five interviews were audio taped only. The transcripts (audio and video) were



transposed by a research team member. The research team and I analyzed the data as the transcripts were available. The research team met in small groups, always including myself in each meeting. We met regularly to reach a consensus and identify themes that emerged from the data. Creswell (2009) pointed to peer examination, participatory research, and clarification of researcher bias as methods to establish internal verification.

## **Findings**

### **Practitioners**

The results of this study indicate that the practitioners themselves play a central role in the positive diagnostic and treatment outcomes of ADHD adults. The interviewed practitioners were individuals who maintain a high level of professional and ethical standards and provide accurate empathy that is supportive and unconditional toward clients. The research study interviewees were non-defensive and respectful of personal and cultural needs. Practitioners included in the research study had already met the research criteria to be considered experts in the field of adult ADHD. Each practitioner, by the nature of his or her mental health licensure, met the criteria of competence in his or her discipline. Interviewees engaged in deliberate practice techniques that pushed past limits of training and experience into creativity that enhanced their ability to understand clients and conceptualize treatment goals. They embodied advanced counseling skills and techniques. They were master therapists. Interviewees identified their motivation for entering the field of adult ADHD as meeting an unmet need and viewed their work largely as an *agreeable challenge*. As one practitioner queried, “Who does an adult call when there is no one in the [phone] book for ADHD adults?”

The interviewed practitioners set the framework for the therapeutic process by

creating a place of safety, inspiring clients to hope and gain confidence in the process. Adults presented their issues to a mental health professional who would then begin a thorough assessment.

ADHD as a lifespan disorder is newly recognized therapeutically. Because ADHD has only recently been considered a lifespan disorder, practitioners employ complex methods of identifying the root causes of the client's presenting problems. Many adults with ADHD were never diagnosed in childhood and have never experienced an explanation of their symptoms. A practitioner described her experience of identifying ADHD as "clients being harmed and not knowing what it was that hurt them."

When ADHD was identified with or without comorbid conditions, all practitioners communicated a treatment plan that included planning with the client. One of the interviewees reported that she tells clients, "It is hard to categorize human beings, and you have a complex issue there!" The practitioners screened out clients who may not have benefitted from a treatment protocol and, if needed, referred clients to other services. There was much diversity of therapeutic interventions espoused by each practitioner, but respect for the client's diagnosis and subsequent therapeutic need guided services and referrals.

Participants utilized advanced counseling skills by employing process and movement strategies. Many adults who presented for service were identified by the interviewees as needing "help in management and understanding what was going on" (i.e., education about ADHD). Others were unhappy with current functioning levels, experiencing self-defeating negative thinking and behavior patterns. The practitioners described helping clients identify obstacles prohibiting change. Using reflective thinking

skills, the practitioners explored options and possibilities with clients. Being aware of the characteristics of ADHD that are defeatist and overwhelming, research interviewees validated positives including strengths of the individual.

### **A Summary of Research Findings Concerning Practitioners**

#### **Creative**

The interviewed practitioners were creative. When a document or educational aid was unavailable for work with ADHD clients, the interviewees created documents, forms, and procedures to meet the presented needs. An assortment of nonspecific documents was gathered at each interview site. Some of these materials included psychoeducational hand-outs, clinic-specific interview intake forms, a coaching tracking guide for ADHD college students, and a guide recommending nutritional supplements.

Many of the treatment interventions were creative themselves. Wilderness as a setting for adults to learn limits and test skills is an example of one of the creative approaches to ADHD treatment. As one of the interviewees put it, “Creativity and visualization is healing.”

#### **Lifelong Learners and Reflective Thinkers**

The practitioners were life-long learners. Several participants stated, “I am always learning.” They were open to new ideas and were constantly seeking to improve their clinical skills and challenge current treatment procedures and practices.

Practitioners were engaged in reflective thinking. Reflective thinking makes the assumption that knowledge is gathered from a number of sources and understood in the context of the client’s issues. Interviewees were able to identify facts, formulas, and theories relevant to the unique complexity of adults with ADHD. They then engaged in

problem solving related to the information gathered.

### **Passionate**

While all of the mental health professionals in the study had training and experience with other populations, all demonstrated focused therapeutic attention to this population. Several practitioners identified their passion for ADHD work as a result of personal relationships that included family or friends with the disorder. Others described a perceived injustice to an under-served population and wanted to be a person who “righted that wrong.” Still other participants identified a sense of duty related to personal faith and a desire to “give back through service to adults with ADHD.” No matter the differences attributed to their motivations, participants as a whole were committed to making authentic connections that could potentially facilitate change in a client’s therapy experience. As one provider stated, “My work is freeing clients from bondage.”

### **Committed to Clients Reaching Personal Goals**

Participants in the study displayed a positive attitude regarding a client’s potential for success. This positivity was rooted in the participants’ therapeutic competencies, their knowledge of adult ADHD, and the client-counselor alliance. Practitioners described themselves as holistic, practicing from a particular theoretical orientation but engaging in treatment that includes the whole person. All of the interviewed participants were dedicated to using their skills to improve the lives of others. They were willing to go beyond the basic requirements of mental health professionals and used personal experiences and resources to form alliances with clients.

The research interviewees were genuine with clients responding with sincerity and congruency. It is the genuineness of the practitioners that lends itself to acceptance

of the client's life story, providing the ability to give unconditional positive regard to struggling ADHD adults. Interviewed practitioners proved to be highly invested in their work.

### **Client-Counselor Alliance**

Practitioners were aware of the challenges that adults with ADHD face. Interviewees acknowledged that clients are greatly affected by their ability to utilize strength gained in the client-counselor relationship. One practitioner put it this way, "Working with ADD clients is like starting where the client is and doing whatever they need to have done to help them. It is always their agenda. You have a personal agreement, so to speak, when designing your alliance. Clients are complete within themselves. Your job is to help them figure that out."

A diagnosis of adult ADHD may indicate years of unsuccessful relationships, employment problems, or failed educational efforts. Adult clients are in need of support and encouragement that motivates them to change unsuccessful behavior patterns. One of the research practitioners explained that she developed an "individualized action plan" for adult clients. Her plans were modeled after individual education plans used by special education departments in public school systems. One research interviewee described her plan as a means to help adults create a contract agreement that acts as an organizational guideline for behavior change. The practitioner visualizes this idea as "two people riding this [as a tandem bicycle] together" as an example of the therapeutic alliance.

### **Educators**

Research participants were educators. One participant said, "My work is a gift to

clients.” From understanding the impact of brain scans, learning how to monitor and practice brain activity, or identifying reasonable accommodations, interviewees engaged in psycho-education for their clients. Research interviewees all acknowledged that ADHD is a lifespan disorder. They agreed that each adult client had a responsibility to engage in personal self-care and to learn self-advocacy. Because of the pervasive nature of ADHD, several practitioners explained that ADHD causes “dysfunction in social, vocational, and emotional life” arenas. One research participant described the task of education in this way: “Part of the treatment is to help [the client] with lifestyle changes.”

Most research participants identified the need to include other professionals, family, and others who would aid in services to the adult with ADHD. One participant noted, “Counseling is so important to the family.”

### **Comparison to Existing Literature**

Several factors contribute to psychotherapy outcomes that have been identified in the literature. The results of this study indicate that the practitioner is central to positive treatment outcomes among experts working with adults with ADHD. “A common denominator in the literature places emphasis on the skill of the therapist. Emphasis should be placed on the therapist or counselor rather than on a particular therapy” (Ahn & Wampold, 2001, p. 255). Research literature contains significant findings related to the characteristics of expert practitioners. The literature describes these mental health practitioners as master therapists.

### **Master Therapists**

Jennings and Stovholt (1999) pointed to a set of characteristics of mental health

professionals whom they termed master therapists. Their research was summarized in an article entitled, “What do Master Therapists have in Common?” Master therapists are enthusiastic learners. They want to learn about clients and new interventions. Master therapists draw on their own experiences to aid clients. They are emotionally open and able to accept the feelings of clients and their own emotional reactions. Master therapists are mentally healthy and take care of their own emotional well-being. Finally, master therapists cultivate working alliances and therapeutic relationships that lead to healing.

Jennings and Stovholt (1999) noted that master therapists also value complexity and ambiguity. In this research study, participants indicated that their reasons for choosing adults with ADHD as their therapeutic focus was as diverse as having an ADHD family member with the condition (Adrian and Lydia), desire to “help people somehow” (Miranda and Tess), attempt to diagnose ADHD from an objective/biological point of view (Stuart), and meet needs for an underserved population (Carmen, John, and George). Participants indicated that they were motivated by the inherent challenge of the ADHD population. They were intrigued by clients that are under-served, undiagnosed, and largely untreated. The practitioners identified the desire to go beyond competency. The challenges of improving skills that the practitioners had already mastered and extending the reach and range of a skill set was identified by Ericsson, Prietula, and Cokely (2007) as representative of experts in a field.

### **Deliberate Practice and Reflective Thinking**

Deliberate practice is a “particular type of practice to develop expertise. When most people practice, they focus on the things that they already know how to do.

Deliberate practice is different; it entails considerable, specific, and sustained efforts to

do something you can't do well or even at all. Research across domains shows that it is only by working at what you can't do that you turn into an expert you want to become" (Ericsson, Prietula, & Cokely, 2007, p. 3). The participants committed themselves to deliberate practice with adults: trying new approaches; writing materials, etc. in an attempt to challenge their own skills; modeling persistence; and finding ways to carve out treatment pathways for adults with ADHD.

The study participants were reflective thinkers. Dewey (1933) pointed to the importance of reflective thinking defining it as "active and persistent allowing for careful consideration of any belief or supposed form of knowledge in light of the grounds that support it and the further consequences to which it leads" (p. 9). "The highest level of reflective thinking assumes that knowledge is gained from a variety of sources and is understood in relationship specific context. Although it is impossible to achieve perfect understanding of certain problems, some judgments are more accurate than others ... [this provides] conceptual soundness, coherence, meaningfulness, usefulness, and parsimony. These allow for reasonable conclusions and the knowledge of the criteria on which the decisions are based" (King & Kitchener, 1994, p. 17).

### **Client-Counselor Alliance**

The psychotherapist has been the focus of many studies indicating that the therapist-client alliance is a critical factor in successful therapeutic outcomes. According to Wampold (2001), "All therapies involve the relationship of a client and a therapist each of whom believes in the efficacy of that treatment" (p. xii).

In *The Great Psychotherapy Debate: Models, Methods and Findings*, Wampold (2001) identified two competing and broad theories of psychotherapy practice. He



indicated that while there are literally hundreds of therapeutic approaches, they fall into two categories. The medical model contains ingredients that contribute to what he calls “the medicalization of psychotherapy.” The contextual model is the category that places emphasis on the commonalities among therapists, not therapeutic interventions. In Wampold’s estimation, the relationship between the client and therapist is the driving force in treatment, not the treatment techniques (p. xii).

While the medical model emerged as consistent in the training of all the mental health professionals, the practitioners adhered to eclectic treatment practices, ultimately rejecting the medical model of treatment in favor of client-centered treatment choices. Frank and Frank (1991) defined a psychotherapist as “a person trained in a socially sanctioned method of healing believed to be effective by the sufferer” (pp. 1-2). “My position is not that technique is irrelevant to outcome. Rather, I maintain that the success of all techniques depends on the patient’s sense of alliance with an actual or symbolic healer” (p. xv).

### **Diagnosis**

Adult ADHD has emerged only recently as a lifespan disorder. It was considered a disorder primarily affecting children. ADHD, it was assumed, would be “outgrown” subsequent to childhood.

Unlike many mental health disorders, ADHD is diagnosed by a variety of professionals including counselors, family care practitioners, developmental pediatricians, neurologists, psychologists, and psychiatrists who each approach diagnosis from their particular orientation. This leads to diagnostic differences. Adults may be over-diagnosed or undiagnosed. The validity of the diagnosis is not in question when

appropriate guidelines are used. If guidelines are not consistent from professional to professional, inconsistencies in diagnosis may emerge.

It is well documented that ADHD is often comorbid with other mental health conditions. Practitioners recognize the importance of diagnostic discernment regarding ADHD symptoms and their correlation to other psychiatric conditions. Practitioners were aware that an ADHD guideline in the *DSM-IV* (APA, 2000) refers the diagnosing professional to childhood symptoms and diagnosis criteria providing limited assistance to the clinician.

ADHD is a neurobehavioral disorder. It is diagnosed as a result of behavior patterns that persist. The behavior patterns that make up ADHD are inattention, hyperactivity, and impulsivity. To meet the criteria, ADHD must be identified in two or more settings and be more severe than typically seen in other people at a comparable developmental levels (APA, 2000). The examples and wording of the criteria are largely directed towards children. It is currently recognized that adults manifest symptoms of the disorder in differing ways from children and adolescents. Mental health professionals in the study indicated that they followed the guidelines in the *DSM-IV* (APA, 2000) but also utilized other resources to aid their diagnostic assessments for adults.

Research interviewees placed emphasis on the importance of a complete and accurate diagnosis. One practitioner in the study engaged in diagnosis only. The practitioner visualized the diagnostic process as “a research project” wanting to make his diagnosis procedure as unbiased as possible. Two practitioners engaged in diagnostic screening to determine special accommodation services for adults in educational settings.

All practitioners advised a lengthy intake interview. This might include

comprehensive questions regarding past and current functioning levels; medical history; school or work performance; and interpersonal relationship issues. An interviewee said, “Start where the client is and gain a perspective of the problem areas.” Another practitioner reported, “The information gleaned from the psychological assessment also includes a one hour diagnostic interview by the psychologist prior to the administration of the test materials that we feel are important to establish ADHD and/or ruling out other concurrent problems.”

The practitioners all agreed that appropriate psychological testing is useful in providing more information towards diagnosis. A research interviewee explained, “Many clients wanted answers, so I evaluated them.”

### **A Summary of Findings Concerning Diagnosis of ADHD**

#### **Accurate Diagnosis is Challenged due to Comorbidity**

ADHD is comorbid with many other psychiatric conditions. Most often, anxiety, depression, oppositional defiant disorder, and obsessive compulsive disorder complicate an accurate diagnosis. Comorbidity and its complications are a diagnostic concern for all research practitioners.

#### **Accurate Diagnosis is Challenged due to Adult Symptom Presentation**

Research interviewees understood the problematic nature of accurate diagnosis for adults with ADHD. Practitioners identified three areas of concern regarding accuracy when diagnosing adults. Interviewees stated that identifying symptoms in adults that appeared different in adults than in children was the first step toward accuracy. In addition, practitioners identified the inherent problems of using guidelines designed primarily for the diagnosis of children. Finally, practitioners noted that the presentation

of ADHD symptoms from person to person in different settings is unique to each individual client and therefore more challenging.

### **Accurate Diagnosis is More Assured with Comprehensive History**

All research study participants agreed that a comprehensive history was necessary for accurate diagnosis. A variety of diagnostic tools were used by interviewees as a means of improving their ability to accurately diagnose adult ADHD. Two practitioners utilized an expanded six-type identifier of ADHD developed by the founder of their clinic to isolate ADHD into specific types. The same practitioners relied on brain scans as diagnostic tools. Based on their treatment approach, some practitioners approached diagnosis as an “individual action plan” providing a diagnosis-in-action that was viewed as a “shorter and personal agreement surrounding a [clinical] action.”

An example of a mental health diagnostic form was a comprehensive, 25 page document provided by one interviewee. It included a payment agreement and an essay intended to gain the main reason the client was seeking service. The Current Life Stresses Form covered birth events, diet and exercise history, sleep behavior, school history, and employment history. It addressed legal problems, alcohol and drug history, and sexual history. The Family History Form covered those living in the home with the client. The Adult General Symptom Checklist included a rating scale of 118 symptoms and was rated by the client and someone else. There was also a Learning Disability Screening. An adult client filled out this packet in advance of meeting with a mental health professional.

### **Accurate Diagnosis is More Assured with Collaborative Testimony**

Research interviewees reported that they included family members, spouses, and

even workplace supervisors and associates to provide collaborative testimony for the adult client. Many practitioners also recommended that the diagnosis include school records, other psychological records, work assessments, driving records, and an alcohol and drug assessment. The practitioners agreed that adults with ADHD are poor self-reporters and, in order to diagnose appropriately, they felt the need to gain collaborative testimony from people or records that could document or add to perceptions presented by clients.

### **Comparison to Existing Literature**

#### **Diagnostic Complexities of Adult ADHD: Comorbidity and Symptomology**

“The persistence of ADHD symptoms into adolescence and adulthood in many patients strongly supports the concept that ADHD is a lifelong disorder for many patients. Although the symptoms of ADHD seen in pediatric patients may drift as patients enter adulthood, the consequences of adult symptoms of ADHD are no less serious” (Goodman, 2009, p. 46).

Diagnosis of ADHD in adults is challenging because “like all psychiatric disorders, no objective medical or neuropsychological test can be used to make or confirm the diagnosis, and there is no established consensus on the specific symptoms cluster for ADHD adults” (Goodman, 2009, p. 42). A current clinical dilemma surrounds how adult symptoms manifest themselves and differentiate from childhood diagnostic symptoms. Some researchers have suggested that symptoms transform and manifest differently in adults with ADHD. “Ninety-two percent of adults who are diagnosed with ADHD remain untreated until age 18 or older” (Chen, 2009). Chen listed the following symptoms of adult ADHD: difficulty concentrating or reading unless interesting; easily

irritated; difficulty following conversations in groups; speaking without thinking; difficulty planning; running or racing thoughts; difficulty finishing tasks; and daydreaming. Still more symptoms of adults with ADHD include the following: “disorganization and failure to plan ahead; misjudging available time; difficulties at work; and problems with social interactions” (Shire US, Inc., 2012, p. 2). Wolf and Wasserstein (2012) stated, “One significant problem for our field is the upward extension of child-based models and approaches without proper adaption to adults. With adults differing patterns of comorbidity and symptom heterogeneity pose new conceptual, diagnostic and treatment challenges” (p. 396). “Accurately diagnosing ADHD is critically important, as highlighted by the findings of Barkley and colleagues and Biederman and colleagues. These studies demonstrate that missed diagnosis and the absence of treatment were associated with educational, occupational, and social implications in adaptive functioning, as well as increased risk of substance abuse disorders. Because of the high prevalence rate of ADHD relative to other Axis I psychiatric disorders, clinicians should be aware of the symptoms and adult manifestations of ADHD and include screening in every adult psychiatric evaluation” (Goodman, 2009, p. 46). Barkley (2010) estimated that most adults with “ADHD have at least two disorders: 80-83% have ADHD and one disorder, and more than half may have three psychological disorders” (p. 15).

Barkley (2010) also theorized that since ADHD could be confused with other comorbid conditions and due to the current belief that it is a lifetime condition, earlier diagnosis might have been misdirected allowing adults to go undiagnosed until later in life. Adults with ADHD may present for mental health services with interpersonal,

emotional trauma, and work-related problems, as well as physical maladies and engagement in risky behaviors leading to trauma (Barkley et al., 2008). Wender (2000) theorized that ADHD was a medical condition producing trauma associated with other debilitating medical conditions.

### **Comprehensive History and Collaborative Testimony in the Diagnosis of Adults**

“Every adult with ADHD had ADHD as a child. If the adult did not have ADHD symptoms, some other psychological problem is present” (Wender, 1995, p, 8). Barkley, DuPaul, and McMurray (1990) established in their study that under-reporting by ADHD adults of childhood symptoms was well documented. ADHD clients are poor self-reporters, and diagnostic decisions rest on childhood-laden symptoms and diagnosis. Diagnosis of children usually involves parents and teachers who are intensively engaged with children for long periods of time. Adults, however, do not always have others who have oversight regarding their behaviors. Wolf and Wasserstein (2010) noted “*DSM-IV* criteria for ADHD subtype and symptom is often not specified. As pointed out elsewhere, strict adherence to the *DSM-IV* criteria may not be the most appropriate for diagnosing and identifying potential ADHD subjects in adulthood” (p. 398). The careful review of history “by the clinician that integrates self-reports and other information recommends for a valid assessment of symptoms and impairments may be difficult to obtain from the adult patient” (Goodman, 2009, p. 42).

Goldstein and Ellison (2002) described an adult ADHD pilot study that was modeled after a childhood study produced by the American Academy of Childhood and Adolescent Psychology (AACAP). The research results demonstrated that parental recall is a more valid measure of a clinical diagnosis for ADHD than that of the client with

ADHD. This study led researchers to conclude that an effective way of diagnosing ADHD adults should include interviews with family members or others with a past knowledge of the client as much more reliable for diagnostic purposes (Goldstein & Ellison, 2002). A combination of psychosocial and cognitive evaluation appears to be an effective method to identify ADHD adults who have difficulty sustaining attention and inhibiting impulsive behaviors (Wilens, Farone, & Biederman, 2004).

### **Highlights of Diagnostic Changes from *DSM-IV-TR* to *DSM-5***

The *DSM-IV* (APA, 2000) was the diagnostic standard used and discussed by the research study participants during the majority of this research study. In May, 2013, near the end of the data gathering for this study, *DSM-5* was released culminating a 14 year revision process. The diagnostic changes that have been implemented and will affect ADHD diagnostic decisions are as follows:

1. “Examples have been added to the criterion items that facilitate application across the life span application.
2. The cross-situational requirement has been strengthened to ‘several’ symptoms in each setting.
3. The onset criterion has been changed from ‘symptoms that caused impairment were present before age 7 years’ to ‘several inattentive or hyperactive-impulsive symptoms were present prior to age 12.’
4. Subtypes have been replaced with presentation specifiers that map directly to prior subtypes.
5. A comorbid diagnosis with autism spectrum disorder is now allowed.



6. A symptom threshold change has been made for adults to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff at five symptoms instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity.
7. ADHD was placed in the neurodevelopmental disorders chapter to reflect brain developmental correlates with ADHD and the *DSM-5* decision to eliminate the *DSM-IV* chapter that includes all diagnoses usually first made in infancy, childhood or adolescence” (APA, 2013, p. 2).

### **Treatment**

All research study interviewees agreed that treatment for adults with Attention Deficit Hyperactivity Disorder is critical. ADHD is a complex issue dictating the need for treatment in a variety of areas. A practitioner noted, “You normally find that in adults there is some dysfunction, vocational, social, or emotional, or within their home that needs to be addressed.” Scholars have pointed to the potential damage done to adults who were undiagnosed until adulthood (Barkley, 2005, Wender, 1995 & 2000). They have noted that for many adult clients, there are years of academic, vocational, and relationship failures that might have generated self-blame, a sense of helplessness, anxiety, and fear of continued failure. The study interviewees agreed there is a unique challenge to overcome these barriers. There are significant hurdles in identifying the need for treatment, continuing in treatment, and the subsequent success of treatment.

Practitioners were aware that adult ADHD currently has no best practice treatment protocol. The interviewees were trained in a variety of theoretical orientations. While none of the interviewees practiced from a traditional medical model approach,

practitioners were influenced by their training in the medical model. They utilized their considerable therapeutic skills, creativity, and insight to choose treatment that was most advantageous for clients. They were eclectic in their therapeutic choices. Generally, interviewees identified brief therapy techniques coupled with an emphasis on wellness and holistic interventions. Practitioners who practiced more traditional therapy (i.e., talk therapy for individual, family or group) tailored their approach by limiting the sessions to the needs of the clients.

All participants reported that their goals in treatment were to “get a person to a point” to reach their goals. They realized their limitations stating that they knew that most treatment was “not forever.” The participants identified short-term, brief therapeutic interventions as most effective treatment options. As a group, they were realistic about the effectiveness of each treatment protocol and communicated that “ADHD is a complex issue.” Therefore, the treatment would be assumed to be multidimensional as well. One research interviewee described ideal treatment as a “multi-phasic medical model.”

The interviewees described a case management style of treatment delivery. Clients with ADHD tend to be disorganized and scattered and so benefit from an external management system. Practitioners understood the executive function failings of this population and made alterations to accommodate them within their chosen treatment protocols. ADHD treatment requires motivation from the adult client. Providers described treatment as an alliance relationship.

Each practitioner described utilizing assessment, treatment intervention goals, and a contract agreement between the mental health professional and the client. The

practitioners agreed that medication is the most often utilized and recommended treatment for adults with ADHD both by themselves and other mental health professionals.

One practitioner stated “ADHD is normal,” yet all study participants recognized that as a disorder, ADHD is pervasive. Treatment for ADHD is complex and generally involves addressing more than one clinical issue. Practitioners agreed that the feedback they received from many adult clients indicated that being diagnosed as ADHD was “bittersweet.” Some research interviewees embraced ADHD as a disability, feeling that the label provided positive service possibilities for clients. Other practitioners dismissed the label as negative and further debilitating for clients. Most interviewees were uncertain how clients viewed themselves in the disability debate but were hesitant to use a disability label themselves unless they felt comfortable that it would provide needed services (i.e., ADHD disability services in colleges and universities) for their clients.

The study participants did agree on the need for ADHD clients to identify and practice self-advocacy skills. All participants identified a client’s ability to self-advocate as a positive outcome of treatment. Several interviewees described clients as “being freed from being a hostage [to ADHD] when diagnosed.”

### **A Summary of Findings Concerning Treatment of ADHD**

#### **Effective Treatment Utilizes Case Management, Holistic Integration, and Brief Therapy**

Practitioners described treating ADHD adults using holistic treatments. An interviewee said, “Starting where the client is, gaining motivation and compliance, and aiding the client to gain perspective of the problem area, ultimately [they will] resolve the

issues for themselves.” Another participant stated, “Coaching is a wellness model.”

In all the treatment venues, practitioners advised short term, brief therapy goals as most effective with ADHD adults. Neurofeedback treatment, for example, might be suggested for a specified number of weeks. Following the course of neurofeedback treatment, a re-evaluation would take place and a decision would be made to continue the treatment for another prescribed number of weeks or discontinue. Other research interviewees recommended a combination of approaches intended to enhance therapy and offer clients short term add-ons. One participant stated, “I usually refer to a support group. [I tell clients] You should go hear at least a few times what other people are saying; you’ll find out that you’re not that different.”

Practitioners were case managers. Due to poor self-management skills, ADHD adults benefit in treatment from counselors who assist with executive function deficits. An interviewee pointed out, “I would say that it’s an integrated approach with other professionals. This is my big challenge, because I don’t get paid for all those hours that I spend outside the coaching, the time I actually spend with a client. I do a lot of what I would call clinical case management. In general, it is called integrated case management services. With appropriate professionals, it is one of the keys to helping the adult ADHD client.”

### **Effective Treatment is Eclectic and Multimodal**

While practitioners did not agree on the type of treatment, each approached treatment from a variety of protocols keeping in mind the needs of the adult client. They were multimodal, using insight and flexibility to provide treatment that was tailored to the ADHD adult.

The interviewed practitioners were eclectic in their therapeutic choices leaning on the techniques that they believed worked best and made referrals for clients as needed. The study practitioners represented numerous treatment approaches including traditional individual, family and group talk therapy, neurofeedback, brain scans, nutritional supplements, brain retraining, wilderness experience therapy, and coaching.

### **Effective Treatment includes Medication**

All research participants identified medication as the most recommended treatment for adult ADHD. The providers agreed, with one exception, that while medication for children has been studied and utilized in the United States for 70 years, research exploring medications for adults is in its infancy. Regardless, medication is often requested by adults for ADHD-like symptoms and given by family doctors, psychiatrists, and other physicians who prescribe medications for adults. Participants reported good treatment results when adults combined medication with other treatment options. No interviewee indicated a discomfort with appropriately prescribed medication for ADHD symptoms.

One of the research interviewees, who is a psychiatrist, stated, “In terms of medication management, there are two choices. The two classes [of medications] are methylphenidate and amphetamines. The methylphenidate line consists of Concerta, Ritalin, Daytrana patch, Focalin XR, and Focalin TR. My preference is always to start with an amphetamine. In looking at the research, and also in my clinical experience in doing studies, we were looking at Adderall XR compared to Ritalin XR. Much research [regarding medication use] is now geared towards adults. By late adolescence many hyperactive impulsive symptoms have decreased, but accommodations are still necessary

in order for the person to function evenly in society ... when you look at chronic medical problems the successful experiences are with two things, pharmacotherapy and social support regardless of the type of diagnosis that relates to the chronic illness.”

### **Effective Treatment may Produce Self-Advocacy**

Identifying and improving self-advocacy was an important indicator of health for the study practitioners. Interviewees described treatment as successful when clients understood their symptoms, recognized and addressed their needs, and engaged in actions and attitudes that were self-actualizing. One of the practitioners stated, “Many students who are over the age of 18 in college with ADHD are not aware that every college doesn’t provide accommodations. They don’t realize that they can get disability services either. College students can get a great deal more in the way of accommodations than do high school students.” A practitioner put it this way, “So I am teaching them how to advocate for themselves.” Other research interviewees noted that “they [ADHD adults] were applying for accommodations [in colleges and universities]” and in receiving the diagnosis, they were able to receive the “help they needed to be successful.” Another practitioner stated, “Diagnosis could demystify” ADHD leading to improved self-awareness.

## **Comparison to Existing Literature**

### **Holistic Integration, Case Management, and Brief Therapy Treatment**

A wellness, holistic treatment approach with clients was embraced by all practitioners. Hettler described the six dimensions of wellness as occupational, emotional, spiritual, physical, social, and intellectual. Hettler (1976) explained, “Wellness is an interconnection of each dimension and how they contribute to healthy

living. It is a holistic model and is a pathway to optimal living” (pp. 1-2).

Several studies (Barkley, 2007; Beckett, 1994; Nigg, 2001) identified areas of dysfunction that are termed executive function. This includes organizational challenges, self-sufficiency, ability to plan, and project into the future. Wolf and Wasserstein (2010) identified the need for adults with ADHD to improve social skills, improve future oriented planning, and become more independent. Counselors, they point out, might use a case management approach to provide appropriate services. While research studies are scarce regarding the effective treatment of ADHD adults, cognitive behavioral, medication management, and a few other brief therapies are most often mentioned in the literature as beneficial and advantageous to this population (Ramsay, 2010; Young & Amarasinghe, 2010). Weiss and Weiss (2004) cautioned that traditional insight oriented nondirective psychotherapies may not be as effective as structured, directive, short term therapy approaches.

### **Eclectic and Multimodal Treatment**

“Although psychotherapeutic methods have existed since time immemorial and a vast amount of accumulated experience supports the belief in their value, some of the most elementary questions about them remain unanswered. Despite decades of effort, no one has shown convincingly that one therapeutic method is more effective than any other for the majority of psychological illnesses. This suggests that, for these conditions at any rate, the specific efforts of particular healing methods may be overshadowed by therapeutically potent ingredients shared by all” (Frank & Frank, 1991, p. 2).

Medication is one treatment option, for example, in a multimodal approach for adults with ADHD. Weiss (2008) recommended multimodal interventions as effective

therapeutic interventions in his research on practice guidelines for adults with ADHD.

Wilens et al. (2004) noted that there is a lack of formal guidelines for the treatment of ADHD in adults. No single treatment strategy has emerged as the most efficacious in the treatment of adults (Weiss & Weiss, 2004), but guidelines for treatment inclusions have been developed. Components that might enhance therapeutic approaches are the following: empowerment strategies that focus on the management of cognitive and behavioral manifestations of a neurological disorder dealing with relationship issues; teaching coping skills; management of mood swings; and anxiety identification and management (Weiss & Weiss, 2004). Hallawell (1995) concluded that adults with ADHD may need assistance in treatment to re-conceptualize their self-identity and reframe past failures in light of the disorder.

### **Medication**

Medication treatments for children with ADHD have been found to be just as effective for adults with ADHD (Barkley et al., 2008). Barkley reported, “We know that ADHD medications can normalize the behavior of 50-65% of those with ADHD and result in substantial improvements, if not normalization, in another 20-30% of people with this disorder” (Barkley, 2010, p. 109). Research on medication is primarily devoted to children with ADHD. Controversy regarding the current efficacy of medication use for adults currently is unresolved. Clients, mental health professionals, and researchers disagree on medication as an effective treatment choice. Participants reported good treatment results when adults combined medication with other treatment options. No interviewee indicated a discomfort with appropriately prescribed medication for ADHD symptoms.



The effectiveness of medication in the treatment of adults with ADHD is not well established (Spencer, Biederman, & Wilens, 2004). Counselors should be aware that stimulant medication is an ineffective treatment for approximately 30% of adults diagnosed with ADHD, because individuals do not respond adequately to treatment or cannot tolerate stimulant medication. In a controlled trial, Spencer et al. (2004) found that trials of non-stimulant medications among adults with ADHD reported tricyclic antidepressants, bupropion, and cholinergic agents might be the most effective alternatives to stimulants among adults. More short term and long term research is needed to confirm safety and efficiency of treatment of stimulants and non-stimulant medication in adults (Spencer et al., 2004).

### **Self-Advocacy**

Adults diagnosed in childhood may be aware of eligibility for special education services. This eligibility allows for “reasonable accommodations” as provided by the Rehabilitation Act of 1973, Section 504. This is a national law that protects qualified individuals from discrimination based on their disability. It also includes adults with ADHD who are employed or engaged in education or training programs. Since ADHD is considered a disability for adults as well as children, adults are also eligible for services and protections that the law suggests.

Patton (2009) noted that in a broad definition of ADHD, employed adults with the diagnosis should be given reasonable accommodations in the workplace. It is the employee’s responsibility to disclose the condition to the employer. Joachim and Acorn (2000) in their research found support that ADHD adults who disclosed their disorder were benefited by preventing social consequences such as social rejection due to the

personal disclosure. Mental health professionals who diagnose and treat adults with ADHD are uniquely poised to teach and train clients about their disorder and encourage advocacy, specifically self-advocacy. Treatment and education might lead to self-advocacy skills in adult clients.

### **Limitations**

There are a number of limitations to this study that should be noted. Limitations that involve me as the lead researcher includes my personal and professional biases and assumptions. I attempted to bracket my biases and assumptions by sharing them in my journal (written and pictorial) and shared with my research team in notes, written electronic messages, and verbally during research team meetings and communication. My research team assisted me in balancing these personal biases and offered perspectives that would have been missed without their insights. Even accounting for these safeguards, it is possible that I missed important factors or processes that should have been included in the course of the research process. My inexperience with qualitative research is also a factor that may have led to my missing important aspects in the data and the research process.

Another set of limitations includes the participants selected for the study. They were nominated through a snowball sampling method. I attempted to obtain a representative mix of participants who diagnose and treat adults with ADHD. The study focused on mental health practitioners who are currently in practice with adult clients; this proved to be limiting due to an emerging field of practice. There is a lack of ethnic diversity in the group in that all were Caucasian. The participants were older practitioners (the majority 50 and above) although divided evenly between male and

female. This is not representative of contemporary demographics in the United States. This participant demographic skew may have adjusted themes and responses in unknown ways.

The eight participants in the study may not be representative of mental health providers as a whole. The snowball sample and the geographic limitations may have excluded expert practitioners just as effective in their practice and yet unknown to me and my resources.

Finally, the number of participants may also be considered a limitation. The research team and I agreed that the data seemed saturated at eight participants. No new themes were emerging, and there were variations and depth in the themes identified. It is impossible to know if other important information would have been added to the research with more participants.

### **Implications**

There are several implications inherent in the findings of this research study, especially for counselors and counselor educators. It seems clear that setting appropriate and consistent standards for counselors is necessary to promote the development of expert counselors. The research study places emphasis on the importance of the counselor in the counseling process. Counselors and counselor educators who are familiar with the Council for Accreditation of Counseling and Related Educational Programs (CACREP) will understand the value of an organized and regulated effort to assure counselor training programs maintaining high standards and continuing to promote excellence for counselor trainees and graduates. As stated in the introduction of CACREP standards, “When a program applies for CACREP accreditation, it is evidence

of an attitude and philosophy that in that program excellence is a fundamental goal” (CACREP, 2009, p. 2). Preparation and training for counselors that embraces consistent guidelines and opportunities to learn and practice with excellence will produce excellent counselors and will raise the standards of counseling professionals.

Another implication for counselors and counselor educators is in identifying diagnosis and treatment options with an ungrounded and unproven client population. Counselors in this study faced many challenges regarding diagnosis and treatment of adults with ADHD. Because ADHD adults are a newly recognized population in mental health, education endeavors regarding diagnosis and treatment of ADHD is essential to aid the improvement of client interactions and counselor competencies.

In accordance with the American Counseling Association Code of Ethics, counselors are charged with taking “special care” to provide proper diagnosis of mental disorders. Assessment techniques (including personal interview) used to determine client care, (e.g., focus of treatment, type of treatment or recommended follow-up) are carefully selected and appropriately used (ACA, 2005, E.5.a, p. 12).

The ACA Code of Ethics charges counselor educators with this mandate: “When counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation or without well-grounded theoretical foundation, they define the counseling technique/procedure as unproven or developing and explain the potential risks and ethical considerations of using such techniques/procedures” (ACA, 2005, F.6.f, p. 15).

Counselors in this research study were faced with an emerging population of clients requiring education and assistance in personal advocacy. Adults in employment

settings, ADHD adults in educational endeavors, and many other situations may find themselves unprepared to engage in self-advocacy efforts. The implication for counselors and counselor educators is the need for further training and preparation for all populations of clients with particular training in advocacy in under-served populations.

Challenging counselors to show awareness and engagement while providing client welfare is a necessary step toward teaching advocacy to clients. Advocacy is defined by CACREP (2009) as “action taken on behalf of clients or counseling profession to promote individual worth, dignity, and potential; to oppose or work to change policies and procedures, systemic barriers, long standing traditions or preconceived notions that stifle human development” (p. 58).

“As counselors, our role is not only to support individual clients in resolving their concerns but also to promote social change that can help ensure equality and inclusiveness ... counseling programs should continue to provide education and training in areas of multiculturalism, social justice, advocacy, and holistic well-being ... we can train counselors to empower people and contribute to a positive change at the individual, organizational, community, and policy levels” (Ostvik-de Wilde, et al., 2012, pp. 47-48).

Finally, findings in the study indicate that further research is needed in the field of adult ADHD. Participants in the study modeled a professional awareness of current research and participated in research projects at various points in their careers. CACREP (2009) encourages counselors to “use research to inform evidence-based practice” (p. 14). Counselors and counselor educators would benefit from undertaking research studies and remaining current in the practice field. Likewise, more research efforts regarding adults with ADHD would complement counseling and lead to best practice

solutions in the future. “While directly serving clients, we should also be researching solutions. It might be time for a unified professional effort to articulate our vision for advancing the future of counseling research by engaging practitioners in the identification of important research directions, designs, and implementations”(Ostvik-de Wilde et, al., 2012, p. 47).

### **Suggestions for Future Research**

The findings of this study indicate that the mental health practitioner is central to the treatment outcome of adults with ADHD. The ability of the practitioner to be creative, be a reflective thinker, and engage in the client-counselor alliance with adult ADHD clients might also be the basis of study. Future research might highlight the themes identified in the study that relate to the master therapist.

This research study focuses on mental health professionals and their point of view. A qualitative study from the ADHD adult point of view concentrating on what diagnostic and treatment interventions that they found the most beneficial is indicated. A quantitative study from the client’s point of view might provide balance to what is known from the mental health provider’s view of the process. There is very little qualitative or quantitative research available regarding the views of the adult client covering a variety of aspects of ADHD (Barkley et al., 2008). Little currently exists from the perspective of the adult with ADHD regarding diagnosis and treatment outcomes.

Another possibility for research might be a quantitative study regarding the efficiency of medication as a treatment for ADHD in adults. While there are literally thousands of studies and 70 years of documented medication use for children and teens, there are relatively few studies regarding adults and the use of medication as a treatment

intervention. At this time, medication is recommended most often as a treatment option for adults.

The idea that effective diagnosis and treatment of adults with ADHD might correlate with self-advocacy skills in a client population that is under-served and poorly identified is an area of research that would enhance the field. It would offer enlightenment in a newly emerging field giving direction to mental health professionals and educators alike.

### **Personal Reflection**

In his book, *Running with Ritalin*, Diller (1998) presented a cultural observation in the following example of two well-known fictional characters: “What if Tom Sawyer or Huckleberry Finn were to walk into my office tomorrow? Tom’s indifference to schooling and Huck’s oppositional behavior would surely have been the cause for concern. Would I prescribe Ritalin for them, too?” He went on to point out that “the rise of ADHD is a consequence of what otherwise would be considered a good thing: that the world we live in increasingly values intellectual consideration and rationality increasingly demanding that we stop and focus. Modernity didn’t create ADHD. It revealed it” (p. 84).

As noted earlier in this study, I have been a Licensed Professional Counselor (LPC) for over 20 years. I was a mental health professional for another 10 years before my licensure. I have had the opportunity to work in numerous settings: private practice; both state and city mental health agencies. I have learned a great deal about the work of providing services to people in a variety of circumstances. I knew that I would learn a great deal about ADHD and the providers of services to this population.

I did learn about ADHD and hope to bring new concepts and techniques to the private practice where I am employed. I am interested in writing training materials for adult ADHD clients and a client educational workbook for group work. I am interested in interacting with adults who have been diagnosed with ADHD through a web-site that is currently under construction. I would like to develop an interactive web presence that will engage adults who are seeking answers in the management of their disorder. I would also like to engage other professionals regarding the issues that face ADHD clients. I want to further my research regarding diagnosis and treatment of ADHD and perhaps, in the future, assist in a best practice model.

I met and interviewed a group of amazing mental health practitioners who were welcoming and totally engaged in their work with clients. I felt greatly honored to have met them and to have had an opportunity to listen to them. I was professionally challenged by their dedication and passion. They were generous with their time and their wisdom, and I was grateful to them.

I expected to learn about ADHD, but I did not expect to learn about myself as well. My journal reflects the connections that I have had throughout my life with ADHD. It wasn't a mistake that I choose this topic. ADHD has always been a part of my life.

Professionally, I have met with hundreds of clients and their families who are struggling with ADHD. They are seeking comfort and encouragement for their life journey, and I am glad, as a counselor, to travel with them. Personally, I believe that my father was an undiagnosed ADHD adult who suffered most of his life with underemployment and a low reading level. My son, diagnosed at seven with ADHD, and now a young adult, continues to struggle with the disorder. These two beloved



individuals have challenged me to ask questions and seek answers to comfort and encourage them as life obstacles arose. They, like so many of my clients, have faced life challenges with positive energy, not allowing ADHD to define them negatively.

I was reminded during this study that facing life with or without ADHD requires courage. The practitioners in the study respected their ADHD clients; they saw their courage and embraced it. The practitioners were prompted to engage in meaningful ways with people struggling with this disorder. I am inspired to do the same.

### **Summary**

The findings of this study agree with other previous studies that point to the therapist as crucial to positive treatment outcomes. The counselor's cognitive, emotional, and relational characteristics are all pivotal in the therapeutic process. Emphasis should be placed on the mental health professional rather than on a particular therapy or therapeutic approach (Ahn & Wampold, 2001). Frank and Frank (1991) pointed out that it is not the technique that is relevant to outcome, but rather that the success of the techniques depends on the client's sense of alliance with the counselor.

The study placed emphasis on a comprehensive history and collative testimony as important factors in identifying accurate ADHD diagnosis. Diagnosis is made difficult because of the newness of the field and complications due to comorbid conditions. Clinicians should make themselves aware of the symptoms and adult manifestations of ADHD and include screening for the disorder in adult psychiatric evaluations (Goodman, 2009).

The research study revealed that there is no best practice currently suggested for ADHD, and limited information is available regarding treatment options. Study

outcomes indicate that participants were eclectic in their therapeutic choices, generally choosing brief therapy techniques coupled with an emphasis on wellness and holistic interventions for adults with ADHD.

The findings in this study concurred with previous childhood studies that an effective treatment of ADHD adults might be medication management. There is current disagreement regarding the effectiveness of medication for adults, yet all study participants advised medication use as an important treatment option. It is unproven but believed to be most effective in conjunction with other brief therapies most often mentioned in the literature as beneficial and advantageous to this population (Ramsay, 2010, Young & Amarasinghe, 2010). More short term and long term research is needed to confirm safety and efficiency of treatment of stimulants and non-stimulant medication in adults (Spencer et al., 2004).

Finally, treatment and education might lead to self-advocacy skills in adult clients according to Joachim and Acorn (2000). As ADHD adults understand the impact of the disorder and embrace the role of self-advocacy, counselors may find that their services are in more demand in assisting clients to learn this valuable skill.

**CHAPTER SIX**  
**MANUSCRIPT SUBMISSION**

**EXPERIENCES AND PERCEPTIONS  
OF MENTAL HEALTH PROFESSIONALS CONSIDERED EFFECTIVE  
IN THE DIAGNOSIS AND TREATMENT OF ADULTS  
WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER:  
A GROUNDED THEORY STUDY**

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## ABSTRACT

**Objective:** The aim of this study was to explore the experiences and perceptions of mental health professionals considered experts who provided diagnosis and treatment to adults with Attention Deficit Hyperactivity Disorder (ADHD). Professionals in a variety of mental health disciplines with a number of differing approaches to ADHD provided insights into their methods, techniques, and practices. **Method:** Four male and four female experts from the Southern Atlantic region of the United States were interviewed using qualitative research methods. They were clinical psychologists, psychiatrists, licensed professional counselors, and social workers. **Results:** Findings suggest that practitioners' therapeutic skills are crucial to the treatment of ADHD adults. Other prominent themes from this study identified expert treatment and diagnostic practices including case management, brief therapy, medication, comprehensive and collaborative history taking, and self-advocacy. **Conclusion:** Expert practitioners may offer insight leading to appropriate diagnosis and treatment of adults with ADHD.

**Keywords:** Adult ADHD, ADHD Treatment, Diagnostic Issues, Comorbidity, *DSM-IV*

Attention Deficit Hyperactivity Disorder (ADHD) is listed in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5;* American Psychiatric Association, 2013) used by mental health professionals for the diagnosis and treatment of mental health disorders. The current diagnostic criterion for ADHD includes endorsing six or more symptoms of inattention or hyperactivity, or impulsivity that has persisted for at least six months to a degree that is maladaptive and inconsistent with developmental levels. The onset criterion has been changed from symptoms that caused impairment that were present before age 7 years to several inattentive or hyperactive-impulsive symptoms that were present prior to age 12. The current diagnostic criterion requires mental health professionals to diagnose adult ADHD after determining that symptoms were present when the client was a child or adolescent. One of the difficulties in diagnosing adults with the disorder, however, is that adult clients with ADHD may or may not have been diagnosed or treated in childhood. A symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity. The *DSM-IV* (APA, 2000) was the diagnostic standard used and discussed by the research study participants during the majority of this research study.

Current research suggests that in order to make a correct diagnosis, the mental health professional should include some of the following: a medical and social history, functional impairment testing, family history, any childhood diagnosis information, family member validation, school records, and comorbid conditions documentation (Wadsworth & Harper, 2007).

According to Goldstein and Ellison (2002), there has been controversy regarding the diagnosis; especially, they point out, the suitability of the current diagnostic criteria to identify adult ADHD. Some of the arguments these scholars have made against a diagnosis of ADHD in adulthood include the following: hyperactivity tends to disappear in adolescence; onset of the disorder in childhood cannot be proven; pharmacotherapy is less effective in adults; and other disorders can also account for many of the symptoms such as anxiety, depression, or personality disorders. Despite these concerns about diagnosing adults with ADHD, adults continue to be diagnosed and treated by mental health practitioners for this disorder.

There appears to be growing agreement that adult ADHD exists (Barkley et al., 2008; Goldstein & Ellison, 2002). However, diagnosis and treatment protocols for adults with ADHD are slow to garner agreement among researchers and mental health professionals (Goldstein & Ellison, 2002). According to Wilens, Spencer and Biederman, (1998), ADHD is highly likely to continue into adulthood with a large percentage of adults diagnosed in childhood. They stated a belief that ADHD is a chronic condition.

Barkley et al. (2008) cited recent research studies that have revealed that ADHD adults are more likely to suffer with comorbid psychiatric conditions (depression, anxiety, obsessive-compulsive disorder, etc.), interpersonal trauma, emotional and work-related problems, and physical maladies. Driving concerns, higher insurance risk, and risky behaviors are also noted as higher in probability for the ADHD population.

Multicultural issues surrounding the diagnosis have not been adequately addressed and may influence decisions regarding the diagnostic interventions devised for

ADHD adults in a diverse and multicultural population. Research shows that the diagnostic prevalence rates for ADHD indicate that at least three times more males than females receive the diagnosis. Adult ADHD research does not reflect the childhood ratio of more males than females with ADHD. There are no clear reasons for this phenomenon, but it seems to underscore the difference between adult and childhood populations of individuals with ADHD (Haavik, 2010).

Impairments of ADHD adults extend beyond inattention and impulsiveness (Goldstein, 2006). There is a growing consensus that ADHD is a fundamental disorder of executive function. According to Greene (2001), executive function includes cognitive skills, organization and planning, working memory, and the separation of affect from problem solving skills

While there is disagreement regarding the definition of executive function, it is largely agreed that there is an array of symptoms that the term identifies and that there are few reliable tools to diagnose adult ADHD. Barkley (2010) argued that “ADHD represents a developmental disorder of behavioral inhibition that interferes with self-regulation and organization towards the future” (p. 3). In order to treat ADHD in adults, it is essential to understand the multi-level approach that treatment must embrace simultaneously. ADHD is primarily neurological with secondary psychological features that coexist with other psychiatric conditions that must be addressed for treatment to be effective for adults (Goldstein & Ellison, 2002).

Given that prior research seems to support a strong neurobiological basis for ADHD, it is believed that the deficits of the disorder cause adults to be hindered in their ability to acquire coping strategies. Those deficits further add to their tendency to feel

overwhelmed, take on negative cognitions, reinforce the cycle of avoidance and failure, and develop maladaptive coping skills (Knouse & Safren, 2010). ADHD can affect multiple areas of life experiences including personal, interpersonal relationships, education, training, and adult employment.

## **Method**

Qualitative research lends itself to a fluid, evolving, and dynamic problem-solving approach as opposed to the more rigid and structured format of quantitative research methods (Corbin & Strauss, 2008). Qualitative research allows researchers to reach into the experiences of participants and discover meaning rather than a process that is confined to testing variables. It allows researchers to delve into the inner meaning of the experiences of participants and in so doing to determine how meaning is formulated (Corbin & Strauss, 2008).

## **Participants**

Mental health professionals considered to be effective in treating ADHD adults were identified through a nomination process using a snowballing sampling method. There were 36 nominations of ADHD adult practitioners (19 males and 17 females) perceived as experts in the field. This process produced eight participants for the research project (four women and four men).

Each participant met the criteria suggested by Adler and Ziglio (1996). These criteria included the following: knowledge and therapeutic experience with ADHD adults; willingness to participate in research; sufficient time to participate; effective communication skills; and nomination from mental health professionals who identified each as a person as having expertise in professional services to ADHD adults. The data



in this study consisted of audio and video recordings made in face-to-face initial interviews, notes from follow-up telephone interviews, and e-mail contacts. The first author spent approximately 49 hours in the field with participants.

All participants were Caucasian and ranged in age from the 30 to 70 years old. They were actively engaged in private practice in two states representing large and medium metropolitan areas. Participants included licensed professionals: one social worker, one professional counselor, three clinical psychologists, and three psychiatrists. Participants ranged from 5-43 years of experience in mental health practice with the mean experience being 20.25 years. The number of clients seen each week by participants ranged from 12-90 with the mean average case load of 33.38 clients per week. The number of ADHD clients seen in a week by the providers ranged from 3-72 clients per week with a mean of 14.35 ADHD clients seen per week. To preserve confidentiality and anonymity, participants were given a pseudonym.

Data collection took place in three rounds over a seven month time period. The research project was complete when saturation occurred; consensus was reached; and generalization about the research was possible.

We solicited agency/individual specific document(s): educational materials provided to clients that would further enhance the richness of data collection at each participant's location and other trace evidence materials. Creswell (2009) referred to examples of trace evidence included in the research trail as *footprints in the snow*. The data for trace evidence materials included 1,093 pages of written materials provided by ADHD providers, 285 pages of coding charts and memos, and 154 pages of notes. There were 39 pages of research journal notes and 39 pages of journal drawings. The external

auditor examined the audit trail which consisted of 1,598 pages of materials.

### **Data Analysis**

The research team consisted of four current students of the counseling master's degree program at Old Dominion University (ODU), one student in the counseling PhD program and one counseling master's degree graduate from ODU. The external auditor was a Masters of Education graduate from Regent University.

The first author spent approximately 29 hours meeting with the research team. She also spent over eight hours individually training team members and directing the research team in coding procedures and transcription procedures.

The team met both physically and digitally to code the transcripts. The research team provided a means to establish and re-establish validity, discuss emerging themes, review prominent quotations, and develop a codebook that would be pivotal in understanding the research results. Creswell (2009) pointed to peer examination, participatory research, and clarification of researcher bias as methods to establish internal verification.

The initial open coding process involved analyzing the individual interviewee's words or phrases, followed by axial coding in which the themes were categorized across the interviews of the participants. The interview questions, the format of the questions, and the interview location were all designed to capture the factors and processes of the mental health professionals and their experiences. Five concept maps were utilized by the research team to provide structure for emerging themes. The concept maps were merged as identified themes and the interactive process progressed. The prominent interview themes of the research were practitioner, theoretical orientation, therapeutic

process, clients, and ADHD orientation/perceptions.

A reflexive written and drawn journal was utilized as a means of self-study and auto-ethnographic expression (Pithouse, Mitchell, & Moletsane, 2009). Journaling and meeting with the research team to debrief, reach consensus, explore codebook entries, and modify the concept map all contributed to the identification of sensitivities and bias.

### **Trustworthiness**

Creswell (2007) pointed out that an important criteria for determining rigor of a qualitative study includes the amount of time the researcher spends in the field as well as the amount of data the researcher utilizes to formulate conclusions. The data in this study consisted of 22 hours of audio and video interview recordings, approximately 10 hours of telephone follow-up interviews, and numerous e-mail follow-ups.

The first author spent approximately 49 hours in the field with participants. Research involved interview preparation and entailed travel to the participants' offices, meeting them in several cities. The interviews totaled 280 pages of verbatim transcription and were transcribed from video and audio interviews by a research team member. Participants were given two opportunities to clarify their comments and perceptions from the recorded interview. Creswell (2009) has suggested that some follow-up interviews may allow for greater verification.

Checking after each of the three meetings with the experts to explore the accuracy of the data collected and to have the opportunity to explore the data in more detail or elongate the information into other directions was emphasized by Chamaz (2006). This process provided rich description of the data and increased accuracy of the collected data.

Nonspecific data was collected and reviewed from each participant. Trace

evidence documents included intake forms, general information, marketing materials, advertised ADHD services, and other nonspecific information offered by the experts as exemplary materials in their work with adults. This type of information can add depth, detail, and meaning to qualitative analyses (Patton, 2002).

## **Results**

The central research question for this study was, “What are the experiences and perceptions of mental health professionals considered effective in the diagnosis and treatment of adults with Attention Deficit Hyperactivity Disorder?” Five major themes, each with subthemes emerged from the research data.

The interview research sub-questions were as follows: (1) Would you talk about working with the adult ADHD population? What drew you to this work? (2) The *DSM-IV* (APA, 2000) includes limited information about ADHD adults. What criteria do you use to make this diagnosis? (3) What symptoms convince you that the correct diagnosis is adult ADHD? (4) Currently, there is no best practice treatment for ADHD adults. How do you overcome the lack of clinical information and make choices that drive your therapeutic interventions? (5) What do you feel has been the most effective means of treatment for ADHD adults? (6) What would you like to add to your statement?

### **Theme 1: The Practitioners**

The results of this study indicate that the practitioners themselves play a central role in the positive diagnostic and treatment outcomes of ADHD adults. Jennings and Stovholt (1999) pointed to a set of characteristics of mental health professionals whom they termed master therapists. Master therapists are enthusiastic learners who draw on their own experiences to aid clients. They are emotionally open and able to accept their

own and the feelings of others. Master therapists cultivate working alliances and therapeutic relationships that lead to healing. The interviewed practitioners were individuals who maintain a high level of professional and ethical standards and provide accurate empathy that is supportive and unconditional toward clients.

By the nature of their mental health licensure, they met the criteria of competence in their discipline. The social worker's pseudonym was Carmen. The counselor's pseudonym was Tessa. The three psychologists' pseudonyms were Miranda, Stuart, and John. The three psychiatrists' pseudonyms were Adrian, Gregory, and Lydia. Their presumed motivations for working with ADHD adults was as varied as they were. Tessa and Miranda claimed a deep religious motivation to serve others because of their commitment to a higher power. Gregory cited his satisfaction with natural settings and the challenges he had experienced personally as valuable and repeatable. While diverse in their approaches to intervention, they were united in their efforts to provide diagnosis, treatment, and successful interventions for their clients.

### **Sub-theme 1.1: Creative**

The interviewed practitioners were creative. They created documents, forms, and procedures to meet the presented needs. Many of the treatment interventions themselves were creative. For example, Gregory developed a wilderness program for ADHD young adults believing that the "outdoors is the ultimate limit setter."

### **Sub-theme 1.2: Lifelong Learners and Reflective Thinkers**

The practitioners were lifelong learners. John stated, "I am always learning." They wrote materials and shared with consumers and other professionals. No matter their age, participants sought to further their education in the field.

Practitioners were engaged in reflective thinking. Interviewees were able to identify facts, formulas, and theories relevant to the unique complexity of each adult client. Tessa believed that ADHD is highly treatable and that her work with adults could lead to the client finding ways to “resource their ADHD.”

### **Sub-theme 1.3: Passionate**

All demonstrated focused therapeutic attention on the ADHD adult population. Lydia identified her husband as an ADHD adult, and Adrian said, “Someone in my family was ADHD” causing him to want to learn more. For many of the participants, their work with ADHD was personal and professional.

### **Sub-theme 1.4: Committed to Clients Reaching Personal Goals**

Participants in the study displayed a positive attitude regarding a client’s potential for success. The positivity was rooted in the participants’ therapeutic competencies, their knowledge of adult ADHD, and the client-counselor alliance. The eight participants were encouragers. “We can help the client build on their success” (Tessa). They showed concern for the whole person or treating the “adult with ADHD holistically” (Gregory).

### **Sub-theme 1.5: Client-Counselor Alliance**

Practitioners were aware of the challenges that adults with ADHD face. Interviewees acknowledged that clients were greatly affected by their ability to utilize strength gained in the client-counselor relationship. Miranda urged clients to practice neurofeedback, thus improving focus and memory. Miranda saw her role as monitoring and coaching clients to be more successful at the brain retraining efforts. Gregory saw his efforts with clients as “life changes.”

Carmen put it this way, “Working with ADD clients is like starting where the

clients are and doing whatever they need to have done to help them. It is always their agenda. Your job is to help them figure that out.”

### **Sub-theme 1.6: Educators**

Research participants were educators. From understanding the impact of brain scans, learning how to monitor and practice brain activity, or identifying reasonable accommodations, interviewees engaged in psychoeducation with their clients. Carmen described the task of education in this way: “Part of the treatment is to help (the client) with lifestyle changes.” Not content to offer their services alone, most of the participants were engaged in referrals to other professionals and to programs and services that they believed might enhance their clients’ options for successful treatment. Stuart, John, and Gregory were all engaged in offering services to the adult ADHD client who might need or want to explore other services as well. John immersed himself in many aspects of ADHD treatment. He was motivated to “demystify ADHD for his clients.”

## **Theme 2: Theoretical Orientation**

In the preface of their second edition of *Theoretical Models of Counseling and Psychotherapy*, Fall, Holden and Jarquis (2010) stated, “What seems apparent to me, now more than ever, is that learning about theory is the most important step in learning about change” (p. vii). Change is the goal of most therapeutic approaches. “Psychotherapy is a remarkably effective healing practice. Yet the mechanism by which psychotherapy creates change are not well understood” (Wampold, 2007, p. 858).

Considering the experience of the participants in this study and the average length of practice being 20 years, the practitioners chosen for the study were seasoned and well-versed in their theoretical orientation and diverse in their practice styles. Participants

identified the theoretical orientation that they most closely associated with but also expressed eclectic style orientation utilized as the need arose with client issues. All participants emphasized utilizing client-centered principles in making case management decisions. Adrian was trained in psychoanalysis early in his career but reported that he “saw it as dehumanizing and mechanical” and wanted to be more involved with his clients.

Stuart’s Cog-Med ([Cogmed.com/research](http://Cogmed.com/research)) and Miranda’s neurofeedback provided physical brain retraining opportunities for clients and was based on the medical model. Lydia and Adrian worked in a cutting edge clinic where the emphasis was brain scans that “show ADHD.” Lydia noted that “when people see the brain scan, they believe.” Tessa referred to herself as a cognitive-behavioral therapist and added emphasis by stating, “I am a firm believer in talk therapy.” She also placed emphasis on faith-based interventions saying, “Faith is a strategy for success. Looking to a higher power builds structure that can lead to success in an adult’s life.” Miranda and Tessa both espoused the incorporation of spirituality in treatment. While Carmen presented herself as a life coach who was “not going to be a clinician,” she also noted that much of her theoretical interventions were a combination of coaching and brief-therapy. John employed a medical model approach with clients emphasizing appropriate diagnosis and treatment as essential. He, like most of the participants, noted that ADHD in adults requires a multimodal approach to treatment. “People must be treated for ADHD and not just anxiety or depression.”

**Sub-theme 2.1: Effective Treatment Utilizes Case Management, Holistic Integration, and Brief Therapy**



Practitioners described treating ADHD adults using holistic treatments. Miranda stated, “Starting where the clients are, gaining motivation and compliance, and aiding the clients to gain perspective of the problem area, ultimately [they will] resolve the issues for themselves.”

In all the treatment venues, practitioners advised short term, brief therapy goals as most effective with ADHD adults. Neurofeedback treatment, for example, might be suggested for a specified number of weeks. Following the course of neurofeedback treatment, a re-evaluation would take place and a decision would be made to continue the treatment for another prescribed number of weeks or discontinue. Other research interviewees recommended a combination of approaches intended to enhance therapy and offer clients short term add-ons.

Practitioners were case managers. Due to poor self-management skills, ADHD adults benefit in treatment from counselors who assist with executive function deficits.

### **Sub-theme 2.2: Effective Treatment is Eclectic and Multimodal**

While practitioners did not agree on the type of treatment, each approached treatment from a variety of protocols keeping in mind the needs of the adult client. They were multimodal using insight and flexibility to provide treatment that is tailored to the ADHD adult. Treatment for ADHD is complex and generally involves addressing more than one clinical issue. Adult ADHD currently has no best practice treatment protocol. The interviewees were trained in a variety of theoretical orientations. They utilized their considerable therapeutic skills, creativity, and insight to choose treatment that was most advantageous for clients. They were eclectic in their therapeutic choices. Generally, interviewees identified brief therapy techniques coupled with an emphasis on wellness

and holistic interventions. Practitioners who practiced more traditional therapy (i.e., talk therapy for individual, family or group) tailored their approach by limiting the sessions to the needs of the client.

### **Theme 3: Therapeutic Process**

All participants agreed that ADHD work involved careful evaluation and diagnosis. Gregory noted that the dysfunction of ADHD was “social, vocational, and emotional.” Lydia explained, “You have a complex issue there” (pointing to the ADHD diagnosis). Most participants pointed out the comorbidity of ADHD and included the following conditions: drug addiction (Gregory), trauma (Tessa and Miranda), and anxiety and depression (John). Stuart noted that he was an “advocate for the data, not the person,” believing that a scientific approach with objectivity as central to his engagement with clients produced the most accurate testing results. Miranda pointed out that while neurofeedback is symptom driven instead of diagnosis driven, adults engaged in neurofeedback would benefit from being “quizzed by significant others as to the practice of mindfulness that the feedback requires to be successful.”

#### **Sub theme 3.1: Accurate Diagnosis is Challenged due to Adult Symptom Presentation**

Research interviewees understood the problematic nature of accurate diagnosis for adults with ADHD. Practitioners identified three areas of concern regarding accuracy when diagnosing adults. Interviewees stated that identifying symptoms in adults that appeared different in adults than in children was the first step toward accuracy. In addition, practitioners identified the inherent problems of using guidelines designed primarily for the diagnosis of children. Finally, practitioners noted that the presentation

of ADHD symptoms from person to person in different settings is unique to each individual client and therefore more challenging

### **Sub theme 3.2: Effective Treatment includes Medication**

The providers agreed that while medication for children has been studied and utilized in the United States for 70 years, research exploring medications for adults is in its infancy. Regardless, medication is often requested by adults for ADHD-like symptoms and given by family and other physicians who prescribe medications for adults. Participants reported good treatment results when adults combined medication with other treatment options. No interviewee indicated a discomfort with appropriately prescribed medication for ADHD symptoms.

One of the research interviewees, who is a psychiatrist, stated, “By late adolescence many hyperactive impulsive symptoms have decreased, but accommodations are still necessary in order for the person to function evenly in society ... when you look at chronic medical problems the successful experiences are with two things, pharmacotherapy and social support regardless of the type of diagnosis that relates to the treating condition.”

Wender (1995) wrote, “Drug treatment of ADHD with stimulants with other medications is of both practical and theoretical importance. Long term treatment of patients often produces major changes in scholastic, vocational and personal functioning” (p. 15). Medication treatments effective for children with ADHD have been found to be as effective for adults as they are for children with ADHD (Barkley et. al., 2008).

### **Theme 4: Adult ADHD Clients**

All participants explained the importance of meeting the client’s physical and

emotional needs from the time they arrive until they leave. Lydia said, “It is hard to categorize human beings. You always treat the patient who shows up.” Adrian said, “You meet the clients where they are.” Gregory noted, “There is no one approach going to be for everyone.” Carmen stated, “You start where the client is.”

Scholars have pointed to the potential damage done to adults who were undiagnosed until adulthood (Barkley, 2005; Wender, 1995 & 2000). They have noted that for many adult clients, there are years of academic, vocational, and relationship failures that might have generated self-blame, a sense of helplessness, anxiety, and fear of continued failure. The study interviewees agreed there is a unique challenge to overcome these barriers. There are significant hurdles in identifying the need for treatment, continuing in treatment, and the subsequent success of treatment. Each participant emphasized their belief in the client and the client’s ability to make changes. Stuart described ADHD adults who came to his practice as only “seeking diagnosis.” Adrian, Lydia, and Miranda stated that clients must be motivated to change.

John stated that ADHD is “normal, not abnormal.” While John noted that ADHD is a lifespan diagnosis, he did not think that it should be treated as an abnormality. He urged mental health professionals to “get people to a point, that it (ADHD) should not be viewed as a forever treatment plan.” Adrian pointed out that ADHD can stigmatize an adult. Lydia reacted when asked about her experiences with an ADHD husband by exclaiming, “It is hard to live with somebody with ADD. You want to kill them. You just want to kill them!” Tessa believed that ADHD contributed to being traumatized. Miranda noted the unhappiness of clients with ADHD stating they “were unhappy with current functioning levels.”

#### **Sub theme 4.1: Accurate Diagnosis is more Assured with Comprehensive**

##### **History**

All research study participants agreed that a comprehensive history was necessary for accurate diagnosis. A variety of diagnostic tools were used by interviewees as a means of improving their ability to accurately diagnose adult ADHD. Lydia and Adrian utilized an expanded six-type identifier of ADHD developed by the founder of their clinic to isolate ADHD into specific types. The same practitioners relied on brain scans as diagnostic tools. Based on their treatment philosophy, some practitioners approached diagnosis as an “individual action plan” providing a diagnosis-in-action that was viewed as a “shorter and personal agreement surrounding a [clinical] action.”

An example of a mental health diagnostic form was a comprehensive, 25 page document that included a payment agreement and an essay intended to ascertain the client’s reasons for seeking service. It also included a life stresses inventory covering birth events; diet and exercise history; sleep behavior; school history; employment history; a family history; a general symptom checklist rated by the client and someone else; and a learning disability screening.

#### **Sub theme 4.2: Accurate Diagnosis is More Assured with Collaborative**

##### **Testimony**

Gregory reported that he included family members, spouses, and even workplace supervisors and associates to provide collaborative testimony for the adult client. Many practitioners also recommended that the diagnosis include school records, other psychological records, work assessments, driving records, and an alcohol/drug assessment. The practitioners agreed that adults with ADHD are poor self-reporters and,

in order to diagnose appropriately, they felt the need to gain collaborative testimony from people or records that could document perceptions presented by clients.

All research study interviewees agreed that treatment for adults with ADHD is critical. ADHD is a complex issue dictating the need for treatment in a variety of areas. Lydia noted, “You normally find that in adults there is some dysfunction, vocational, social, or emotional, or within their home that needs to be addressed.”

The interviewees were trained in a variety of theoretical orientations. They utilized their considerable therapeutic skills, creativity, and insight to choose treatment that was most advantageous for clients.

#### **Theme 5: ADHD Orientation/Perceptions**

All participants pointed to the complexities inherent in ADHD. All acknowledged that most clients have ADHD and at least one comorbid condition. This lends itself to being misdiagnosed or over diagnosed by service providers and mental health practitioners. Negative thinking patterns can occur as a result. Tessa noted she “attempts to confront the lies that clients believe about self.” She further noted that “ADHD causes harm. It is being harmed and not knowing what it was that hurt them.”

While they did not agree on the treatments for ADHD, they all agreed on the need for services across the lifespan. Treatment, according to Adrian, is “reprogramming of the brain waves.” Adrian suggested that the emotions tied to ADHD are “like a bunch of wild horses.” Adrian and Gregory both identified further that ADHD represents poor emotional control. Miranda and Gregory emphasized unhappiness with functioning levels especially in the work environment. Tessa explained that “ADHD is highly treatable” and that many clients are suffering from “defeatism” due to a lifetime of

failures and low self-esteem.

Currently, many mental health professionals are identifying a deficit in executive function as pivotal to understanding many of the issues inherent in ADHD adults. Researchers have identified a group of developmental tasks in adulthood that have been termed executive function. There is much disagreement as to what tasks make up the components of executive function, but there is agreement that ADHD adults suffer with impaired ability in many adult life-function areas. In several studies (Barkley, 2007; Beckett, 1994; Nigg, 2001), executive function is identified as organizational skills, self-sufficiency, personal reflectivity, planning, and projection of future events. This cluster of behaviors allows for independence and higher functioning in adults.

#### **Sub theme 5.1: Effective Treatment may Produce Self-Advocacy**

Identifying and improving self-advocacy was an important indicator of health for the study practitioners. Interviewees described treatment as successful when clients understood their symptoms, recognized and addressed their needs, and engaged in actions and attitudes that were self-actualizing. John stated, “Many students who are over the age of 18 in college with ADHD are not aware that every college doesn’t provide accommodations. They don’t realize that they can get disability services either. College students can get a great deal more in the way of accommodations than do high school students.” Stuart pointed out, “They [ADHD adults] were applying for accommodations [in colleges and universities]” and in receiving the diagnosis, they were able to receive the “help they needed to be successful.” Practitioners agreed that the feedback they received from many adult clients indicated that being diagnosed as ADHD was “bittersweet.” Some research interviewees embraced ADHD as a disability, feeling that

the label provided positive service possibilities for clients. Other practitioners dismissed the label as negative and further debilitating for clients. Most interviewees were uncertain how clients viewed themselves in the disability debate but were hesitant to use a disability label themselves unless they felt comfortable that it would provide needed services (i.e., ADHD disability services in colleges and universities) for their clients. The study participants did agree on the need for ADHD clients to identify and practice self-advocacy skills. All participants identified a client's ability to self-advocate as a positive outcome of treatment. Several interviewees described clients as "being freed from being a hostage [to ADHD] when diagnosed."

## **Discussion**

The results of this study indicate that the practitioner is central to positive treatment outcomes among experts working with adults with ADHD. "A common denominator in the literature places emphasis on the skill of the therapist. Emphasis should be placed on the therapist or counselor rather than on a particular therapy" (Ahn & Wampold, 2001, p. 255). Research literature contains significant findings related to the characteristics of expert practitioners. The literature describes these mental health professionals as master therapists.

Jennings and Stovholt (1999) noted that master therapists value complexity and ambiguity. In the research study, participants indicated that their reasons for choosing adults with ADHD as their therapeutic focus was as diverse as having an ADHD family member with the condition or to meet needs of an under-served population. Participants indicated that they were motivated by the inherent challenge of the ADHD population. They were intrigued by clients who were under-served, undiagnosed, and largely



untreated. Practitioners identified the desire to go beyond competency. The challenge of improving skills that the practitioners had already mastered and extending the reach and range of a skill set is identified by Ericsson, Prietula and Cokely (2007) as a representative of experts in the field.

Diagnosis of ADHD in adults is challenging because “like all psychiatric disorders, no objective medical or neuropsychological test can confirm the diagnosis, and there is no established consensus on the specific symptom cluster for ADHD adults” (Goodman, 2009, p. 42). A current clinical dilemma surrounds how adult symptoms manifest themselves and differentiate from childhood diagnostic symptoms. Chen (2009) pointed out that 92 % of adults who are diagnosed with ADHD remain untreated until age 18 or older.

Accurately diagnosing ADHD is critically important, as highlighted by the findings of Barkley (2010). Because of the high prevalence of ADHD relative to other Axis I psychiatric disorders, researchers warn that clinicians should be aware of the symptoms and adult manifestations of ADHD and include screening in adult psychiatric evaluations (Goodman, 2009). Barkley (2010) estimated that most adults with ADHD have at least two disorders. “80-83% have ADHD and one disorder, and more than half adults may have as many as three psychological disorders” (p. 15).

Barkley (2010) theorized that since ADHD could be confused with other comorbid conditions and due to the belief that it is a lifetime condition, earlier diagnosis might have been misdirected allowing adults to go undiagnosed until later in life. Wolf and Wasserstein (2010) noted, “*DSM-IV* criteria for ADHD subtype and symptom is often not specified. As pointed out elsewhere, strict adherence to the *DSM-IV* criteria

may not be the most appropriate for diagnosing and identifying potential ADHD subjects in adulthood” (p. 398).

No research yet exists that embraces one treatment as more effective than another for adults with ADHD. Some important aspects of treatment have begun to emerge, however, including the role of the practitioner, and some suggested aspects of treatment that are currently advised to aid appropriate treatment options. “Although psychotherapeutic methods have existed since time immemorial and a vast amount of accumulated experience supports the belief in their value, some of the most elementary questions about them remain unanswered. Despite decades of effort, no one has shown convincingly that one therapeutic method is more effective than any other for the majority of psychological illnesses” (Frank & Frank, 1991, p. 2).

Medication is one treatment option that was agreed upon by all interviewees. Controversy regarding the efficacy of medication use by adults is currently unresolved. Clients, mental health professionals, and researchers disagree on medication as an effective treatment choice. Barkley (2010) advocated the use of medication as a treatment component for adults with ADHD, while Spencer, Biederman and Wilens (1994) urged more research for adult use of medications indicating a deficit of research showing efficacy and safety. Weiss et al. (2008) recommended multimodal interventions as effective therapeutic interventions for adults with ADHD.

Because of the lifetime status of ADHD, adults are encouraged to develop and practice self-advocacy. Patton (2009) noted that in a broad definition of ADHD employed adults with the diagnosis should be given reasonable accommodations in the workplace. It is incumbent, however, on the employee to disclose the conditions to their

employer. Joachim and Acorn (2000) in their research found support that ADHD adults who disclose their disorder were benefited by preventing social consequences such as social rejection due to their disclosure.

### **Limitations**

Limitations include the participants selected for the study. They were nominated through a snowball sampling method. Attempts were made to obtain a representative mix of participants who diagnose and treat adults with ADHD. The study focused on mental health practitioners who were currently in practice with adult clients; this proved to be limiting due to an emerging field of practice. There was a lack of ethnic diversity in the group, and all were Caucasian. The participants were older (the majority 50 and above) although divided evenly between male and female. This is not representative of contemporary demographics in the United States. This participant demographic skew may have adjusted themes and responses in unknown ways.

The eight participants in the study may not have been representative of mental health providers as a whole. The snowball sample and the geographic limitations may have excluded expert practitioners just as effective in their practice and yet unknown.

Finally, the number of participants may also be considered a limitation. The data seemed saturated at eight participants; no new themes were emerging; and there were variations and depth in the themes identified. It is impossible to know if other important information would have been added to the research with more participants.

### **Conclusions**

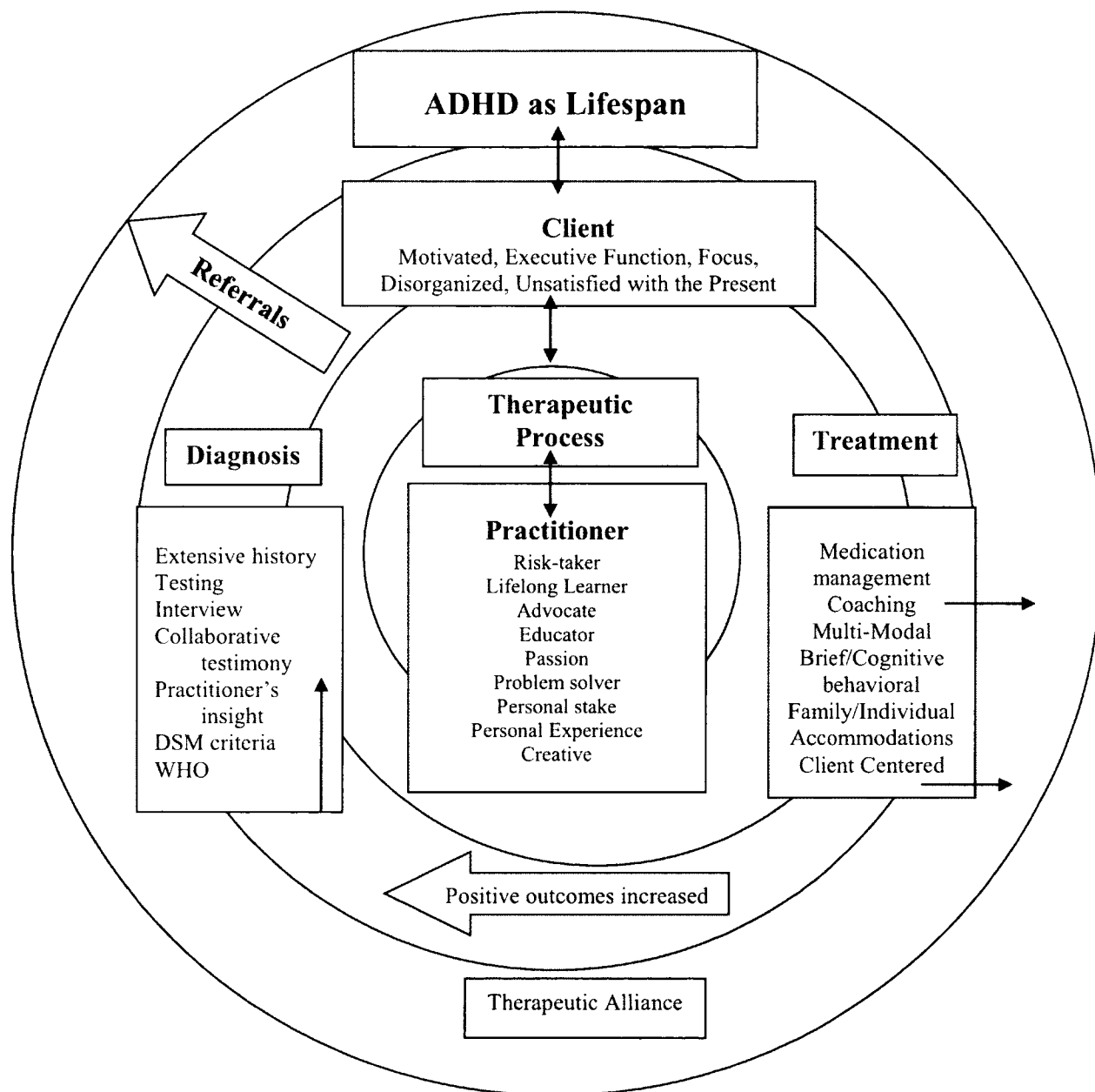
The findings of this study indicate that the mental health practitioner is central to the treatment outcome of adults with ADHD. Comprehensive and collaborative history

taking were identified as essential assessment tools utilized in diagnosis. Expert practitioners noted that treatment skills are crucial to effective work with adults with ADHD. Case management skills and brief therapy were also identified as needful for quality treatment of adult clients.

Medication as a treatment for ADHD in adults was advocated in this study. While there are literally thousands of studies and 70 years of documented medication use for children and teens with ADHD, there are relatively few studies regarding the use of medication as an effective treatment intervention for ADHD adults. Participants reported good treatment results when adults combined medication with other treatment options. No interviewee indicated discomfort with appropriately prescribed medication for ADHD symptoms.

Effective diagnosis and treatment of adults with ADHD, an under-served and poorly identified population, might correlate with self-advocacy skills. Expert practitioners may offer insight leading to appropriate diagnosis and treatment of adults with ADHD.

# FINAL CONCEPT MAP



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## **APPENDIX A**

### **LETTER TO MENTAL HEALTH PROVIDERS FOR NOMINATIONS PROCESS**

Dear Licensed Mental Health Provider,

I am a PhD candidate at Old Dominion University in Norfolk, Virginia. I am researching for my dissertation project the experiences and perceptions of licensed mental health providers who are engaged in diagnosing and treating adults with Attention Deficit Hyperactivity Disorder. In order to complete my study, I am interested in interviewing well-known experts in the field.

I would appreciate your help in identifying those professionals you feel would be most helpful in providing information on their work with ADHD adults. I am asking if you would be willing to suggest your choice of experts (someone that you might refer to a close friend or relative yourself).

I am limiting my study to the Commonwealth of Virginia. Any information received will be kept confidential. No nominations or persons nominated will be revealed to anyone other than the primary researcher.

Based on the licensed mental health provider's work with ADHD adults and/or their reputation of quality work with ADHD adults, I would be comfortable nominating the following providers as potential participants in your study:

Name, Address/e-mail contact address, Office telephone number

If you have questions, you may contact me by telephone at: 757-773-7805 or e-mail at: [berbx003@odu.edu](mailto:berbx003@odu.edu) or you may contact my Dissertation chair, Dr. Ted Remley, at Old Dominion University by phone, 757-683-6695 or e-mail at [tremlev@odu.edu](mailto:tremlev@odu.edu).

Thanks so much for your help in this study!

Bonita Erb, LPC, LMFT, NCC  
PhD candidate at Old Dominion University

**APPENDIX B****LETTER TO LICENSED MENTAL HEALTH PROVIDERS:  
REQUEST TO PARTICIPATE IN STUDY**

Dear

Because of your reputation and expertise in providing effective diagnostic and treatment services to adults with Attention Deficit Hyperactivity Disorder, other licensed providers have suggested that you would be an ideal candidate for in-depth, confidential interviews that I will be conducting for my dissertation research project. I am a PhD candidate in Counseling at Old Dominion University in Norfolk, Virginia. My qualitative dissertation research project is designed to learn about the experiences and perceptions of licensed mental health providers who provide effective diagnostic and treatment services to adults with Attention Deficit Hyperactivity Disorder. My intention is to interview 8-12 providers.

I hope that you will participate in the study. As a provider of services, you have received nominations by your peers who believe that your work with this adult population is effective and noteworthy. Your insights could be very helpful in the emerging field of diagnosing and treating adults who have ADHD. In addition, I hope that the information that I gather will provide a potential model that will increase the effectiveness of diagnosis and treatment for other providers of services to this population.

I am planning to begin arranging face-to-face interviews at the work sites of providers within the next 4-6 weeks. If you agree to participate in this study, I will be glad to arrange to meet at your convenience, whether inside or outside of normal working hours.

I will call you in the next week concerning my research project. Please feel free to call me if you have questions in advance of hearing from me.

You may also contact my Dissertation chair, Dr. Ted Remley, at 757-683-6695 or by email at [tremlev@odu.edu](mailto:tremlev@odu.edu) if you have questions.

Thank you!

Bonita Erb  
757-773-7805  
[berbxOO3@odu.edu](mailto:berbxOO3@odu.edu).

## APPENDIX C

### INFORMED CONSENT FORM

**Title:**

THE EXPERIENCES AND PERCEPTIONS OF LICENSED MENTAL HEALTH PROVIDERS CONSIDERED EFFECTIVE IN THE DIAGNOSIS AND TREATMENT OF ADULTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

**Introduction:**

I am a PhD candidate in Counseling at Old Dominion University (ODU) in Norfolk, Virginia. My qualitative dissertation research is designed to learn about the experiences and perceptions of licensed mental health providers who provide effective diagnostic and treatment services to adults with Attention Deficit Hyperactivity Disorder. This research project will be used for my dissertation and is being supervised by Dr. Ted Remley, Graduate Program Director of the ODU Counseling Graduate Program. I will provide you with information that will help you to decide whether or not you would like to participate in this research project.

**Criteria for participation:**

Based on your reputation and expertise in providing effective diagnostic and treatment services to adults with Attention Deficit/ Hyperactivity Disorder, other licensed providers have suggested that you would be an ideal candidate for in-depth, confidential interviews that I will be conducting for this dissertation research project. Other licensed professionals currently providing diagnostic and treatment services to adults with ADHD are also being invited to participate in this research project.

**Description of the study:**

Best practice clinical treatment follows good diagnosis. The current *DSM-IV* provides clinical criteria for childhood based symptomology and impairment. This limitation in the *DSM-IV* lends itself to confusion for the individual mental health professional attempting to diagnose and treat an adult with ADHD. Treatment options for this population are currently unexplored and largely under researched making diagnostic and treatment decisions for the adult population difficult. Since adult ADHD is an emerging field, mental health professionals may be more reliant on their training and diagnostic assumptions than on documented therapeutic treatment methods. There have been no qualitative studies exploring the experiences and perceptions of licensed mental health providers in diagnosing and treating adult ADHD clients.

After identification of participants, I will have one face-to-face appointment with each participant at a site where the professional provides services to ADHD adult clients. A second appointment will be held via telephone and a third contact will be via e-mail communication.

I anticipate interviewing 8-12 providers who emerge as the most frequently nominated providers of services to ADHD adults. You will be asked to complete a signed Informed Consent and Consent to Record form. Also, you will be asked to complete a



Demographic Information form. You will be asked to provide a resume (if available). You will also be asked to provide forms (non-specific and blank) that are used to assess clients; for example, intake forms, diagnostic forms that might enlighten the researcher as to materials gathered for initial/ongoing diagnosis.

I will audio record the interviews and delete any identifying information from the recordings. All interviews will be transcribed. You will be asked to review and comment on the accuracy of your individual transcribed interview. The collection and analysis of the data is expected to take place between June, 2012 and November, 2012.

**Confidentiality:**

All documents used in this research project will be kept in a secure file cabinet and all electronic responses will be maintained in a password protected computer. No identifiable client information will be used in the dissertation or in any subsequent publication. Summaries of this research project may be used in reports or publications, presentations, etc. Again, no identifiable information will be released at any time. At the conclusion of the research project, all data will be destroyed, including any recording, transcripts, nominations, etc., used for the analysis of data. Transcriptions of interviews will be given a pseudonym to protect the identity of the participant. The identity of each participant will be known only to me.

**Risks and Benefits:**

There are no foreseeable risks for participating in this research project. During the interviews, you will be asked to answer a number of questions. You may refuse to answer any questions that you do not wish to answer and you may terminate your involvement in the research project at any time without penalty. You may benefit from the body of research that this study intends to explore. Therefore, you may benefit from having helped with this dissertation project. You may contact the primary researcher at the e-mail address below if you have any questions.

**Withdrawal and payments:**

There is no cost to you and no compensation for your participation. You do not have to participate in this study. You can choose to withdrawal at any time. If you decide to withdrawal, there are no negative consequences.

If you have questions at any time, you may contact Dr. Ted Remley, at ODU, 757-683-6695 or by e-mail at [tremlev@odu.edu](mailto:tremlev@odu.edu). Feel free to send correspondence to: Old Dominion University, 110 Education Building, Norfolk, VA 23529.

By signing below, you agree that you have read and understand the explanations provided and voluntarily agree to participate in this study.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Researcher's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Bonita H. Erb, LPC, LMFT, NCC, (757) 773-7805 or [berbx003@odu.edu](mailto:berbx003@odu.edu)

**APPENDIX D****CONSENT TO RECORD FORM**

I, \_\_\_\_\_ (print your name), give my permission for Bonita H. Erb to conduct and record interviews with me in connection with her dissertation project. The interviews are taped to ensure that participants' observations and experiences are written in their own words to the degree possible and to ensure accuracy.

Recordings will be transcribed and any identifying information will be deleted by the researcher. Identification codes will be used for the purpose of tracking. Recordings will be destroyed after being transcribed and after verifying that a transcript is accurate.

Signed: \_\_\_\_\_  
Participant Date

Signed: \_\_\_\_\_  
Researcher Date

Bonita H. Erb, LPC, LMFT, NCC  
(757) 773-7805  
[berbx003@odu.edu](mailto:berbx003@odu.edu)

**APPENDIX E**  
**INFORMATION FORM**

Licensed Mental Health Provider of Services to ADHD adults

This form will be kept in a secure file by the researcher. Any information derived from it, for use in the dissertation research project or related to publication(s) will be identified by a participant identification code only, in order to preserve your confidentiality.

General information:

Name \_\_\_\_\_

Name of practice \_\_\_\_\_

Practice Address \_\_\_\_\_

Other Practice Address(s) \_\_\_\_\_

Number of Practices \_\_\_\_\_

E-Mail (practice or personal) \_\_\_\_\_

Educational Background:

In what field is your degree (choose one)?

Counseling

Psychology

Social Work

Psychiatry

Other: \_\_\_\_\_

Highest Degree completed?

Masters

Doctorate

Other: \_\_\_\_\_

List any licenses, certifications or other special training that you have received.

**Professional Experience:**

Number of years that you have practiced with adult clients. \_\_\_\_\_

In addition to working with adult ADHD, what other types of clients do you counsel?

How many years have you been counseling adults?

**Client information:**

Approximately, how many clients do you see per week?

Approximately, how many of your weekly clients are adults?

Approximately, how many of your adult clients each week have a diagnosis of adult ADHD?

**Other Comments:**

Thanks for your participation in this research study!  
Bonita H. Erb (757) 773-7805 or [berbx003@odu](mailto:berbx003@odu).

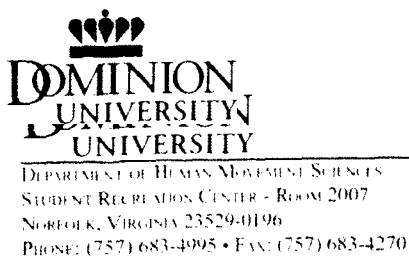
## **APPENDIX F**

### **INTERVIEW QUESTIONS**

#### **INTERVIEW QUESTIONS: FACE TO FACE INTERVIEW**

- The DSM-IV (American Psychiatric Association, 2000) includes limited information about ADHD adults. What criteria do you use to make this diagnosis?
- What symptoms convince you that the correct diagnosis is adult ADHD?
- Currently, there is no best practice treatment for ADHD adults. How do you overcome the lack of clinical information and make choices that drive your therapeutic interventions?
- What do you feel has been the most effective means of treatment for ADHD adults?
- Would you talk about working with the adult ADHD population? What drew you to this work?

## APPENDIX G -- IRB EXEMPT LETTER



May 31, 2011

Proposal Number 201002106**Professor Remley:**

Your proposal submission titled, **"The Experiences and Perceptions of Licensed Mental Health Providers Considered Effective in the Diagnosis and Treatment of Adults with Attention Deficit/Hyperactive Disorder: Grounded Theory Research"** has been deemed EXEMPT from IRB review by the Human Subjects Review Committee of the Darden College of Education. If any changes occur, especially methodological, notify the Chair of the DCOE HSRC, and supply any required addenda requested of you by the Chair. You may begin your research.

We have approved your request to pursue this proposal indefinitely, provided no modifications occur. Also note that if you are funded externally for this project in the future, you will likely have to submit to the University IRB for their approval as well.

If you have not done so, PRIOR TO THE START OF YOUR STUDY, you must send a signed and dated hardcopy of your exemption application submission to the address below. Thank you.

Edwin Gómez, Ph.D.  
Associate Professor  
Human Subjects Review Committee, DCOE  
Human Movement Studies Department  
Old Dominion University  
2021 Student Recreation Center  
Norfolk, VA 23529-0196  
757-683-6309 (ph)  
757-683-4270 (fx)

## VITAE

Bonita Erb earned a Bachelor's Degree in Social Work in 1973 from Virginia Commonwealth University, a Master's of Education degree in Counseling Studies from Old Dominion University in 1981, and is a member of the Omega Delta Chapter of Chi Sigma Iota. She is a licensed professional counselor, a licensed marriage and family therapist and a national certified counselor.

Mrs. Erb has been working for Eden Counseling Center in Norfolk, Virginia for 17 years and specializes in counseling children and adolescents. In the past, she has served as a client advocate for the disabled with a state rehabilitation department, investigated reports of child abuse and neglect as a case manager, and provided therapeutic and clinical services for families of abused children for a local department of social services.

Mrs. Erb has published a book on Attention Deficit Hyperactivity Disorder and has three articles published in national peer-reviewed journals. She has also been published in numerous nationally recognized magazines. She has presented at national, regional, and state level conferences on a variety of subjects. While attending Old Dominion University's Counseling PhD program, Mrs. Erb has taught master's level counseling courses, undergraduate human services courses, and supervised master's level counseling students.

Mrs. Erb is an active member of several professional organizations including American Psychological Association (APA), Virginia Counselors Association (VCA), National Association of Certified Counselors (NACC), and American Group Psychotherapy Association (AGPA).