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Living With Attention Deficit Hyperactivity Disorder

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LIVING WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

A THESIS SUBMITTED IN PARTIAL FULLFILLMENT
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Abstract

Attention Deficit Hyperactivity Disorder is a commonly diagnosed disorder for both children (and today adults). The literature discusses how ADHD is defined as research continues, the symptoms demonstrated by those diagnosed, how it has been known to affect their main life areas e.g. home, school, social relationships, and how it is assessed, diagnosed and treated. However, reading the literature does not give the reader a sense of the real life perception of ADHD. Children with ADHD and parents of children with ADHD participated in an interview consisting of nine open ended questions. The results were found to be consistent with the literature and the commonalities among each of the participants. Similarities that emerged in the findings were the ages the children were when they began to show similar symptoms that led to the diagnosis, the participants' personal views on medication and therapy, and their efforts of coping with ADHD exhibiting that life with the disorder is not an easy life but an ongoing process that gets better with time.

Living with Attention Deficit Hyperactivity Disorder

Persons with ADHD are not only affected by the disorder themselves, but everyone in their life is affected. From home to work to school to their social life, ADHD changes the lives of those diagnosed and those in their lives. "Current evidence clearly defines ADHD as a clinical syndrome associated with impairments in multiple domains including academic difficulties, impaired family relationships, social difficulties and increased rates of conduct problems" (Kooij, Bejerot, Blackwell, Caci, Casas-Brugué, 2010, p. 8). In order to gain the real life perspective of ADHD, I researched literature ranging from ADHD being defined in the many years of research and the symptoms, to

the roles of the people involved in the person's life who were diagnosed with ADHD, how it affected them and the ongoing research for assessment, diagnosis and treatment in order to compare the previous research to the real life perspective of ADHD.

Attention Deficit Hyperactivity Disorder Defined with Criteria

Kelly and Ramundo (2006) define "ADD (or ADHD) as a disorder of the central nervous system (CNS) that is characterized by disturbances in the areas of attention, impulsiveness and hyperactivity" (p. 14). Hallowell and Ratey (2005) refer to these areas as "excessive distractibility, impulsivity and restlessness" (p. 5). Kelly and Ramundo (2006) believe that it is better to break down the problems with attention into components of the process of attention. These components include focusing on the right stimulus, remaining focused over time, dividing focus between relevant stimuli and shifting focus to other stimuli. A person with ADHD may have more trouble in one area of attention than in another. Kelly and Ramundo (2006) define impulsivity as a "failure to stop and think" (p. 19). Things are done hastily without thinking about the consequences. Kelly and Ramundo (2006) state that hyperactivity can be looked at as a deficit or an asset depending on the behavior shown. Hyperactivity is not just shown by physical action but in a number of other ways; for example talking excessively. For a motivational speaker with ADHD, hyperactivity can be looked upon as an asset (Kelly & Ramundo, 2006). Hallowell and Ratey (2005) look at ADHD as an asset as well. People with ADHD have special gifts; such as an unusual sense of humor, charisma, creativity, energy, liveliness, intellectual brilliance and spunk (Hallowell & Ratey, 2005, p. 4).

The most recent term used to describe the condition is ADHD, "defined as a clinical syndrome characterized by the presence of developmentally inappropriate levels

of inattention, hyperactivity and impulsivity, starting in childhood and leading to impairment" (Kooij et al., 2010, p. 5). The World Health Organization (WHO) defines ADHD in the International Classification of Diseases (ICD-10) in a more conservative manner using a subgroup of people with severe symptoms which meet the criteria for the ADHD combination type. Both the Diagnostic and Statistical Manual (DSM-IV) and the ICD-10 acknowledge that ADHD continues from childhood into the adult years, but they do not take into account how the symptoms of ADHD show in adults or the age-dependent changes in regard to the number and severity of symptoms. The revised DSM-V, currently being prepared to be released in 2013 and the ICD-11 in 2015 may still follow the previous criteria but with the following changes:

1. Symptom thresholds: For older adolescents and adults (aged 17 and above) only 4 symptoms in either the inattentive or hyperactive-impulsive domain are required.
2. The list of hyperactive-impulsive symptoms has been increased to 13 to include 'uncomfortable doing things slowly or carefully', 'is often impatient', 'difficult to resist temptations or opportunities' and 'tends to act without thinking'.
3. Descriptions of symptom items have been elaborated to include more specific descriptions of behavior, some of which are more applicable to adults.
4. The age of onset criteria has been broadened to include 'noticeable inattentive or hyperactive-impulsive symptoms by the age of 12 years'.
5. The requirement for clear evidence of impairment from the symptoms is a key part of the diagnostic criteria, but is no longer required before the age of 12 years or younger.

6. Autism spectrum disorder is no longer listed as an exclusion criterion (Kooij et al., 2010, p. 5).

These criteria changes specify that ADHD symptoms may not be able to be clearly identified until adolescent years and acknowledge that impairment from the disorder can develop later in life. This is the case with the Inattentive type of ADHD, that for example, an adult does not show symptoms until moving out on their own from their parents and experiencing anxiety related to the organization and the demand of attention involved with employment and gaining a higher education (Kooij et al., 2010). According to Jeffery Halperin's developmental hypothesis, ADHD is linked to an early-appearing and enduring subcortical dysfunction (weak arousal mechanisms), while symptom remission is dependent on the extent of maturational changes in executive control, emphasis being on the interaction between these two processes, with remission or persistence of ADHD symptoms related to the emerging balance between cortical and sub-cortical function (Kooij et al., 2010).

The diagnostic criteria as defined in the DSM-IV-TR are:

> The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the Predominantly Inattentive Type (Criterion B). Some impairment from the

> symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder (Criterion E) (American Psychiatric Association [APA], 2000, p. 85).

There are currently three subtypes of ADHD. The Predominantly Inattentive Type should be used if six or more symptoms of inattention but less than six symptoms of hyperactivity-impulsivity persist for 6 months. The Predominantly Hyperactive-Impulsive Type should be used if six or more symptoms of hyperactivity-impulsivity but less than six symptoms of inattention persist for 6 months and the Combined Type should be used if six or more symptoms of both inattention and hyperactivity-impulsivity persist for 6 months (APA, 2000, p. 87).

Probable Causes of Attention Deficit Hyperactivity Disorder

ADHD is a disorder in the nervous system caused by biological, genetic or metabolic factors. (Shillingford, Lambie, & Walter, 2007). Environmental risk factors include drug, alcohol and nicotine use, high blood pressure and maternal stress while pregnant, as well as pre-term birth and low birth weight (Kooij et al., 2010). Some researchers have reported that ADHD can also be caused by a head injury, too much television and video games, a high lead level, allergies to food, and a lack of oxygen at birth (Hallowell & Ratey, 2005).Sometimes environmental factors are masked by genetic factors which

complicate the primary cause of ADHD. An example of this would be prenatal exposure to nicotine being masked by genetic effects as opposed to the effects of the nicotine and/or other toxins that make up tobacco smoke. Data from numerous twin studies, of parent and teacher rated ADHD in children and adolescents indicate an average heritability (the variance explained by additive genetic factors) of around 76%, indicating that molecular genetic studies are expected to confirm some genetic associations found in childhood ADHD samples and find other genes that cause ADHD to persist and go into remission in adult years. This information may lead to new ways to prevent the progression of ADHD into the adult years (Kooij et al., 2010). Adults with ADHD had parents and/or siblings with the disorder (Kelly and Ramundo, 2006; Kooij et al, 2010).According to Hallowell and Ratey (2005), if one parent has ADHD; there is a 30 percent chance one of their children will get it and a 50 percent chance if both parents have it (p. 7). Parents also influence their children through their parenting styles and behavior. Children therefore tend to pick up characteristics from their parents; especially while imitating the parents (Kelly & Ramundo, 2006). Around 20% of parents with children with ADHD have the disorder themselves and are not fully able to implement the strategies to assist with behavior issues with their children, part of it due to poor parent-child relationships (Kooij et al., 2010).

Brain scans show evidence of biological factors causing ADHD. Researchers found four brain regions to be smaller for children with ADHD in comparison to children without ADHD. These four brain regions are the frontal lobes, the cerebellum vermis, the basal ganglia and the corpus callosum (Hallowell & Ratey, 2005; Kelly & Ramundo, 2006). The frontal lobes are essential to the functioning of the brain helping with

decision-making, time management and organization. Damage to the frontal lobes can cause hyperactivity, impulsivity, mood swings and unrestrained behavior. The cerebellum vermis is responsible for rhythm, language, balance and motor coordination. The basal ganglia control outbursts and regulate moods. Lastly, the corpus callosum connects the left and right frontal lobes enabling communication between them (Hallowell & Ratey, 2005; Kelly & Ramundo, 2006).

Who Is Affected and How?

ADHD is known to affect a person's personal, social and academic life. These negative effects can lead to promiscuity, delinquency and substance abuse. Based on statistics from the National Health Interview Survey for 1998-2009, the percentage of children age 5-17 years diagnosed with ADHD increased from 6.9% for 1998-2000 to 9.0% for 2007-2009 (Akinbami, Liu, Pastor, & Reuben, 2011). Approximately 37% of school aged children receiving special education services have been diagnosed either primarily or secondarily with ADHD. Students with ADHD show a significantly different dropout rate and have lower grades and scores than their peers. Attention Deficit Hyperactive symptoms are ongoing through adolescence in 70% and to adulthood in 65% of those diagnosed with the disorder (Shillingford et al., 2007, p. 1). By puberty, 30 to 40% of adolescents no longer show symptoms of ADHD (Hallowell & Ratey, 2005). Hallowell and Ratey (2005) state that out of 10 million adults in the United States; only 15 percent have been diagnosed and treated (p. 5).

The behaviors caused by the inattentive and hyperactive types of ADHD can cause a child to have low self-evaluations of competence and bring them to be referred for psychological help. Owens and Hoza (2003) conducted a study using Harter's model

of the Self-Perception Theory that children who experience success are more likely to develop and maintain healthy competence beliefs and an internal locus of control, whereas children who experience repeated failure are likely to develop low competence beliefs and an external locus of control. For this Study, Owens and Hoza used children diagnosed with ADHD who each possessed one of the dimensions of ADHD. The purpose of the study was to analyze the children's perception of their competence. The concept used was the positive illusory bias in which children rated themselves with higher levels of self-competence in order to escape the truth of an actually low level of effort. The children with the hyperactivity/impulsivity dimension definitely possessed positive illusory bias as well as reporting higher self-perceptions in the behavioral conduct domain than the control group of children and the inattentive dimension children. The inattentive children reported lower self-perceptions than the hyperactivity/impulsivity children in the scholastic competence domain of the study. Owens and Hoza also concluded that a positive illusory bias, while it may help a child with ADHD's self-esteem, may become a source of denial for the child to shield from criticism from authoritative figures around them for improvement within themselves (Owens & Hoza, 2003).

The basic setting of the classroom may be difficult for the student with the inattentive type of ADHD. A student diagnosed with the inattentive type of ADHD may find it hard to sit still and pay attention for a prolonged time, listen to detail in instruction or even stay focused during the task they were instructed to do. The level of hyperactivity experienced by a student with ADHD varies. Based on the level of hyperactivity, a student may not be able to complete tasks or be quiet during play, may call out answers to

questions before the question is completely asked, may not be able to wait for their turn - therefore being rude and more than likely intruding on others. These types of behaviors can cause the students to be rejected socially by their peers (Shillingford, et al., 2007).

Children with ADHD are more likely to fail grades twice or three times as often as a child without ADHD. They also are more likely to be suspended or expelled often and score low in various subjects (Schwiebert, Sealander & Dennison, 2002).

ADHD is more prevalent in boys than girls (Heiligenstein, Guenther, Levy, Savino, & Fulviler, 1999). The National Health Interview Survey for 1998-2009 reports the prevalence of ADHD increasing in boys from 9.9% in 1998–2000 to 12.3% in 2007–2009, and for girls, from 3.6% to 5.5% for the same years (Akinbami, Liu, Pastor, & Reuben, 2011). More boys are diagnosed during childhood with ADHD than girls due to boys showing a more aggressive, hyperactive nature while girls have a more inward, inattentive disposition (Kooij et al, 2010). Females are more likely to have ADHD without hyperactivity or impulsivity (Hallowell & Ratey, 2005). The comparison of boys without hyperactivity to girls approaches a one to one ratio (Kelly & Ramundo, 2006). Girls are diagnosed usually in their adult years, especially as they may seek help for anxiety and depression (Kooij et al., 2010).

ADHD, said to affect five percent of children under the age of eighteen, is usually misconstrued to be grown out of by that age (Glass, 2001). In fact, people of all ages are affected by ADHD. Teenagers, as they age and are called upon for a greater sense of social maturity, are overwhelmed with certain issues of relationships, sex, dating, puberty, etc. Adults, too, may have poor memories (losing and forgetting things, appointments, and assignments, etc.) and complications with school and careers

(Schwiebert, Sealander & Dennison, 2002). According to Heiligenstein and colleagues (1999), in their study of college students with ADHD from the University of Wisconsin-Madison, these students gave reports of poor academic functioning, low grade point averages and academic probation. Challenges like these began during childhood (Heiligenstein et al., 1999). According to Kooij et al. (2010), in a majority of cases, ADHD falls among the most common psychiatric disorders that continue from childhood to adulthood. Numerous studies of children with ADHD show that two thirds persist into adulthood (Kooij et al., 2010).

According to the study done by Kooij et al. (2010), ADHD is under-diagnosed. One reason is due to the change and showing of symptoms as it relates to a child as opposed to an adult. Where a child may be hyperactive and impulsive, adults can be disorganized, inattentive and restless. For example, children with ADHD may not be able to play quietly or may run and climb when inappropriate while adults may not be able to relax due to an inner restlessness, have over-talkativeness, may fidget a lot in places that would normally call for sitting for a long time e.g. church, movies, dinner (Kooij et al, 2010). Starting relationships and jobs on an impulse, and spending impulsively are just a few examples of impulsivity in adults (Kooij et al, 2010). Being easily distracted, stressed, bored, tardy and having a difficult time making decisions are characteristics of inattention in adults. Adults can also experience frequent mood changes and break downs, up at times, down at times, and have short tempers (Kooij et al, 2010). A person with ADHD's behavior can change on a constant basis with his/her emotions being unsteady (Hallowell & Ratey, 2005; Kelly & Ramundo, 2006). When his/her temper is rising, it can take something miniscule to cause an outburst. The outburst or display of

emotions, however, is also surprising to the person with ADHD; leaving them questioning why they were upset as they were to begin with (Kelly & Ramundo, 2006). They are more likely not to settle down after the age of thirty due to short relationships and jobs due to being fired. Break-ups in relationships are attributed to the ADHD adults being bored with the companion and their inability to listen to their companions (Kooij et al., 2010). Friendships and relationships do not last due to the amount of attention and affection never being sufficient (Kelly & Ramundo, 2006).

Due to inattention and impulsivity, young adults with ADHD are more prone to car accidents, being bitten by dogs and burns. Other unhealthy lifestyles may include interaction with alcohol, drugs, risky sexual behaviors, gambling addictions, unbalanced rhythm due to lack of sleep and structure and criminal lifestyle due to ADHD combined with bad conduct and anti-social personality. ADHD patients are more likely to be arrested, convicted and incarcerated. Due to inattention, adults with ADHD are more likely to underachieve because of their difficulties with performing independent tasks (Kooij et al, 2010). People with ADHD have trouble staying on task until the task is complete. People with ADHD tend to look at time differently than those without ADHD. A person with ADHD may miscalculate how much time it can take to complete a task and rush to complete things at the last minute (Hallowell & Ratey, 2005; Kelly & Ramundo, 2006). A child with ADHD may turn in assignments late, miss curfew, and be late for school while an adult may be late for work or completing a project for work (Kelly & Ramundo, 2006).They often have trouble with organization; children organize by putting things into bags and closets while adults with ADHD put things in piles. They may have a hard time putting their ideas into action and appreciating their strengths or

recognizing their shortcomings (Hallowell & Ratey, 2005). Due to irregular attention and a wandering mind, a person with ADHD may interrupt or change the subject in a conversation giving the perception that they are rude or weird (Hallowell & Ratey, 2005; Kelly & Ramundo, 2006). This issue and difficulty processing information can cause academic problems and issues in the workplace. A positive aspect of a person with ADHD's wandering mind may be his/her ability to notice things that others may have missed. Unlike the person without ADHD who is able to focus on primary stimuli and shift his/her attention to other stimuli if needed, a person with ADHD is overwhelmed and has to continually attempt to focus on one stimuli and ignore other distractions. As a result of this very intense effort, a person with ADHD may become "overpersistent" and it can become very hard to get his/her attention otherwise. This type of focus can be an advantage for completing things or a disadvantage putting the person with ADHD in a harmful situation; for example, not hearing the smoke alarm (Kelly & Ramundo, 2006). Many adults with ADHD shy away socially and feel lonely and isolated, even if they themselves have a high IQ. Studies show that adults who have not been treated for ADHD are more prone to an increased risk of having substance use disorders, are not as social, have few friends, low levels of academics, low job status accidents (Kooij et al., 2010, p. 11).

ADHD & Parenting

Parents are affected in a major way since they are the main caregivers for the child with ADHD. The child trusts and depends on the parent. The parent often becomes the person receiving the backlash when the child is frustrated. Having a child with a disability is considered to be a permanent stressor for one's family. Parents with children

with disabilities have a lower psychological well-being. That is why it is important to have a balance between the parent's feelings of vulnerability due to the disability and their access of support in dealing with the disability and to treat the child with the disability, also providing support to the family in order to maintain the balance of psychological well-being (Hallberg, Klingberg, Reichenberg, & Moller, 2008).

For families with a child with a disability, the indulgence in social activities is usually minimal. The parents of such families tend to work fewer hours and are forced to take recurrent sick leaves. Parents find themselves not able to work or leave too far from home for having to deal with the issues involving their child. Many parents mentioned the child constantly calling and upon the parent not answering, the parent having to leave work or where they were to comfort the upset child (Hallberg et al., 2008). In the study by Hallberg and colleagues (2008), the phrase coined by the parents in the study regarding their life as a result of having a child with ADHD was "living at the edge of one's capability" (Hallberg et al., 2008). The parents interviewed in the study identified their life as being strained; as being more than they could handle. Parents mentioned not being able to sleep nights due to constant monitoring of their children. Threatened attempts of suicide and medicine overdose by the child caused the parents sleepless nights. Some of the children abused alcohol and/or drugs which caused bigger issues of the children being abusive to the parents sometimes to the point of the parents calling the police to deal with the issue (Hallberg, et al., 2008).

The child's constant need for attention kept the parents from developing or having relationships and not having a private life leading the parents to not enjoy being parents but feeling a sense of resignation. The parents were tired, wanting someone else to take

over the responsibility while at the same time wishing the child would get better. The parents had to find information themselves regarding ADHD. School staff were not being supportive, leading to their children being suspended or dropping out. The mothers in the study developed stress related diseases such as psychosomatic and\or physical symptoms and chronic pain (Hallberg, et al., 2008).

Teachers & Counselors

It is rather difficult to work with a person with ADHD when you are not knowledgeable about ADHD. This happens to be a recurring issue in the education system. The lack of knowledge about ADHD develops the cause and effect relationship between people diagnosed with ADHD and academic failure. Uninformed teachers are less likely to use certain teaching strategies that aid in the academic success of children with ADHD (Schwiebert, Sealander & Dennison, 2002).

According to a study by Glass (2001), other factors that may affect how teachers work with students with ADHD include the teacher's beliefs, age and years of working experience; beliefs that the strategies would not help the children or benefit the entire class. Other factors include age being due to the teacher's knowledge of teaching learned early on in his/her career and years of experience in general life issues causing them to be more flexible in utilizing different teaching strategies as opposed to a younger teacher's use of strict class rules to maintain order in the classroom. Kindergarten to Fifth grade teachers in Southeastern Virginia were given a survey for the teaching strategies used if they perceived that a student exhibited ADHD behaviors, whether the student had been diagnosed or not. As a result of the study, the percentage of teachers who were made knowledgeable of ADHD and who had used the teaching strategies tripled in comparison

to teachers who had used the teaching strategies but were not made knowledgeable about ADHD (Glass, 2001).

Miranda, Presentacion, and Soprano (2002) developed a study in which they informed teachers about ADHD and trained them in strategies and interventions more likely to aid students with ADHD in academic success. In the study they used the most common interventions: contingency management and cognitive-behavioral strategies. Contingency management involves strategies such as the token reward, losing privileges, and timeouts, etc. Cognitive-behavioral strategies, found in the study to be more beneficial than the former mentioned strategy, allow the student to control their own behaviors by using strategies such as self-monitoring, self-reinforcement, and self-instruction, etc. The experimental group was composed of teachers trained to use the above mentioned strategies and children with ADHD and the control group was composed of teachers who had not received the training and children with ADHD. The results showed a decrease in problems usually associated with ADHD such as learning problems, disruptive behavior and underachievement in math and science. Other results showed that a limited number of children no longer fit the diagnosis of ADHD after the study (Miranda, et al., 2002).

It is important to find ADHD in a person during childhood in order to start interventions. It is important for the parent and school personnel, including the counselors, teachers, psychological and special education staff to interact in order to help the child by providing him or her with all the necessary resources needed to not only make it through a normal school day but through everyday life. Counselors play a key role in the life of a child with ADHD because counselors create the pathways to the

child's transition in life. It is the counselor's responsibility to be the bond between the school personnel, the parent and the child. It is the counselor that makes sure that the child is obtaining all of his or her resources such as more time on tests and providing distraction-free environments. The counselor has to make sure the child obtains the resources in elementary and high school. The keeping of records is a key part in the above statement. Counselors need to include a summary report in the child or adolescent's records as well as I.E.P.s or assessments; records that show that the child needs specific resources to succeed. Counselors are responsible for observing the child and making sure that the child stays on task and makes transitions easily. It is these types of interventions that help the child with ADHD to handle other issues later in life. As the years go on and the child ages to be an adolescent in high school, the counselor needs to play work related roles with them to help them in their careers and social interactions with others. Interventions such as showing them the advantages of audio-taping or finding a note-taker, mnemonics, reading and writing essays, and vocabulary building play key roles in assisting in the success of persons with ADHD. A most definite role that counselors must play is in providing information (Schwiebert, Sealander & Dennison, 2002).

Due to the effects of ADHD and the responses from the peers of students with ADHD, school-based interventions began to be implemented when the American School Counselor Association asserted that professional school counselors begin to use an integrative, cognitive-behavioral, systemic approach in order to take the lead in assisting students with ADHD and close the gaps between the school and the family (Shillingford et al., 2007). Among these interventions was Bowen's Systems Theory. Bowen believed

that the Systems Theory is surrounded by several aspects; the differentiation of self, or the student's ability to stay calm in the face of pressure, the nuclear family emotional process, which is the process through which symptoms develop in a family and the I-position, an individual's ability to determine one's own behaviors, thoughts and decisions without imposing on the rights of others (Shillingford et al., 2007, p. 3).

Examples of techniques taught to and implemented by the students diagnosed with ADHD are Meichenbaum's cognitive self-instructional training model and Beck's restructuring techniques. Meichenbaum's training model was made to assist the child with ADHD with impulsivity. Instead of conducting impulsive behaviors, Meichenbaum's model teaches the child with ADHD to speak quietly to himself/herself before acting. Steps to the model include: the student becoming aware of their maladaptive thoughts, the counselor modeling appropriate behaviors while verbalizing effective action strategies, and the student practicing the targeted behavior while saying appropriate self-instructions and rehearsing them (Shillingford et al., 2007, p.2). For example, where as a student would usually blurt out answers, they would recognize the bad thought to call out the answer, say to themselves that they can wait their turn or say to themselves in a positive manner " I know the answer, but I will wait on my turn." Beck's restructuring techniques were designed to help those with irrational thoughts that affect their behaviors negatively. This method also encourages the student to identify automatic thoughts and correct them before acting on them. For example, if a student has an automatic thought that they are not liked by their peers; instead of acting out on that thought, the student would identify that automatic thought and question the evidence for the thought. This may cause them to look into themselves to see how maybe their

interactions with their peers caused the issue or how they think when the situation occurs, so they will know how to think when a situation regarding this issue happens.

In order to implement motivation, organization and direction, Beck encouraged that the student has a daily schedule or plan; this was usually in the form of a behavior chart. The goals for the behavior chart were goals for developing and improving social skills, organizational skills and being better able to focus. The teacher is responsible for the behavior chart, making it always visible to the student by maybe keeping it on the student's desk - allowing them to see when they have progressed with a behavior. The chart is sent home at the end of the day for the parent. The counselor also reviews the behavior chart and meets with the student on a consistent basis in an effort to update the student's plan. Seeing the chart motivates the student to reach the goals and develop an inward feeling of increased self-worth and acceptance. Students also can receive rewards for their progress as decided when the plan is constructed by the professional school counselor, parent, administration and teachers. (Shillingford et al, 2007).

When the student is referred for counseling services, the plan begins by an evaluation being done of the student's academic and social skills based on classroom observations, the student's assessments of his/her self and consultation from the teacher. After an evaluation, the parent is contacted and a plan is constructed based on the needs of the student (Shillingford, et al., 2007).

In the family systems theory, the family is encouraged to focus on the students' strengths rather than their weaknesses. The parent or caregiver is involved along with the counselors, school administrators and staff in setting the goals necessary for the student to have a better academic life. Other than the school behavior matters, the parent provides

much necessary information to the counselor regarding the student's behavioral symptoms and functioning. For example, information about how the student acts at home can be integrated into a behavior chart. Often, a student feels good when perceiving that a parent wants to be involved, good parenting skills can assist the ADHD student to want to do better, by increasing their self-worth and confidence in themselves, although it is often seen that parents do not want to work with their children in an effective manner when it comes to discipline issues and behavior. It can be overwhelming to the parent, due to the ADHD student not cooperating at home by not completing chores or behaving as the household rules suggest and therefore affecting their siblings (Shillingford et al., 2007).

After the plan is formulated, there is regular consultation between the professional school counselor, the parent/care-giver, the student and any other person who is academically significant to the student. The counselor can introduce the family to the different techniques that the student is engaged in at school such as self-monitoring through their daily behavior chart, social skill building done in small group meetings, self-talk in positive I-statements and role-playing rational and irrational thoughts regarding behaviors. For example, a student may say they cannot complete their homework because they are stupid; role playing changes the irrational thought and negative behavior of not completing the task to the student saying the homework is difficult but they are going to try their best to complete it. The parent may also be able to participate in parent training to increase parental skills such as discipline, rewards and chores. The counselor can also give the parent literature and refer them to community linkages to further assist in the family's growth (Shillingford et al., 2007).

Assessment and Diagnosis of ADHD

The diagnosis of ADHD is based upon behavior. The overall understandings are that the atypical behavior should impair the child's functioning to the point that it is noticeable (Schaughency & Rothlind, 1991). People with ADHD are usually diagnosed during childhood as certain behaviors are more apparent e.g. failing as mentioned above, the lack of turned in and completed assignments, and definitely inattention when the child cannot remain in his or her seat long enough to complete an assignment or receive the information being taught. It is when these behaviors are noticed, that parents, teachers and other school personnel refer the child for a psychological evaluation with the assumption that the child has ADHD (Schwiebert, Sealander & Dennison, 2002). Observation of the child's life domains remains very critical. Interviews with those who are significant to the child's life are very important; e.g. peers, family, teachers. In fact, the more interviewees, the better. At least two people should be interviewed (Hallowell & Ratey, 2005).

In combination with the teacher and observer rating on the Child Behavior Checklist, the child's behavior should be looked into with peers' evaluations that the child cannot pay attention, sit still or wait their turn. In another study involving children diagnosed with ADHD, children diagnosed with both ADHD and Conduct Disorder and children who were not diagnosed with ADHD, McCone and Schaughency (1990), found that children with a diagnosis of ADHD and Conduct Disorder tend to fight more than the other groups who did not differ. Children in the ADHD group and combination of ADHD and Conduct Disorder received more nominations of inattention, not sitting still and being liked the least than children without ADHD. This study showed that peers are able

to recognize behavior matters in children referred for adjustment difficulties and externalizing behaviors in their classmates and that their nominations can help in the observation of behavior for ADHD.

For the professional, there is an advantage in being able to observe the child in their natural environments. Observation gives a more objective view as opposed to the subjective view given by interviews and rating scales. However, the method of observation is more costly due to professional time and the behaviors to be observed not occurring in the time the child is observed. An example of behaviors being exhibiting during some observational times and not others was shown in a study where observations obtained using the Direct Observation Form were compared to observations obtained using teacher ratings and sociometric nominations. Made like the Child Behavior Checklist, the Direct Observation Form has a rating scale format. The child is observed for three to six 10 minute sessions, and the ratings completed at the end of each session are averaged. Another more in depth observational measure is the Interactive Behavior Code which records discreet behavioral codes during five 3 hour playground sessions and three home observations. These observations are more specific and give a better time limit to observe specified behaviors are better than those obtained using the Direct Observation Form. It is important to be able to observe whether a child is exhibiting behaviors out of the normal scope of behaviors (Schaughency & Rothlind, 1991). Research shows that ADHD will show changes in impulsiveness, the level of activity and the child's attention span. Rating scales can be used as tools for the home and school. Sociometric measures can assess the child's social life domain. Other important sources of information targeting the child's development, past and present include grades, the

child's participation and awareness in the classroom, referrals the child may have gotten as a result of atypical functioning, etc. so that by the time a child is referred for assessment, all the tools and needed information can be in place. In researching these entities of the probable child with ADHD, the diagnostician looks to see if these behaviors are exhibited in a problematic way showing developmental issues and severity. These same tools and instruments can also be used to evaluate whether goals are being reached in treatment (Schaughency & Rothlind, 1991).

There are many ways to interview the child with ADHD and these include the Diagnostic Interview for Children and Adolescents, the Diagnostic Interview Schedule for Children, the Interview Schedule for Children and the Child Assessment Schedule (Schaughency & Rothlind, 1991, p. 5). Each of these interview instruments revolve around the Diagnostic and Statistical Manual criteria. Questions are asked on the basis of symptoms meaning some instruments can take longer if a child has multiple matters. For example, the Diagnostic Interview for Children and Adolescents (DICA), Diagnostic Interview Schedule for Children (DISC) and the Child Assessment Schedule (CAS) are sectioned according to the different life domains of the child while the Schedule for Affective Disorders and Schizophrenia for Children (K-SADS) and the Interview Schedule for Children (ISC) focus on a single diagnosis. Due to informants disagreeing at times, it is best to have a combination of the interviews along with other information such as teacher rating scales. Teacher's rating scales are a good way to provide information at a low cost. They are also a good way to find objective information about the child and the severity of the symptoms and the impairment caused by these symptoms. The Conners parent and teacher rating scales, the SNAP Checklist, the parent and teacher forms of the

Child Behavior Checklist, the Revised Behavior Problem Checklist and the Comprehensive Behavior Rating scale are behavior rating scales that are commonly used. Just as with the interviews, the rating scales are different in their structure. For example, the Hyperkinetic Index of the Conners rating scale contains a look at noncompliance and aggression. The Child Behavior Checklist asks a number of the same questions appearing on more than one scale based on hyperactivity and aggression and some rating scales such as the Comprehensive Behavior Rating scale for Children look at separate matters, for example hyperactivity and attention problems while others do not like the Child Behavior Checklist. Even though both methods of obtaining information are good to use, a diagnosis should only come after looking into comprehensive multi-method assessments (Schaughency & Rothlind, 1991).

Other tests including the qEEG (Quantitative Electroencephalogram), SPECT scan, and neuropsychology testing can help in diagnosing ADHD. The qEEG is a brainwave test which is about 90 percent accurate. The SPECT scan can be used in the case of head trauma, head injury or the question of already existing conditions. Neuropsychological testing can also assist in the finding of the diagnosis of ADHD as well as other existing conditions (Hallowell & Ratey, 2005).

The following questions need to be answered for a clinician to properly use the criteria in the Diagnostic and Statistical Manual: Does the child meet the diagnostic criteria for ADHD, does an alternative diagnosis account for the child's difficulties, does the child display the behaviors to a developmentally inappropriate extent and do these behaviors affect the child's functioning within the child's important life domains, e.g. school, home and social relations (Schaughency & Rothlind, 1991, p. 12). In order to

answer the first two questions, clinicians must be knowledgeable of the diagnostic criteria for ADHD as well as other disorders (Hallowell & Ratey, 2005; Schaughency & Rothlind, 1991). Structured interviews are useful tools for discerning between whether a child has ADHD or another disorder. With structured interviews along with the child's developmental history, the clinician may be able to determine whether the child primarily has school learning difficulties or ADHD (Schaughency & Rothlind, 1991).

Norm based behavior rating scales can be used to help find information relating to a child's age and the level at which they are functioning. Due to the fact that some rating scales can lead to a diagnosis, other than ADHD, item composition of scales is key to the correct diagnosis (Schaughency & Rothlind, 1991).

Adults with ADHD are more likely to be diagnosed after reporting current symptoms or recalling symptoms from childhood. However the tool used in order to assess may not be the best tool due to adults under reporting their symptoms because they are not good at accurate recall of their childhood. Due to this matter, it is desired to obtain the reports of the adults' parents as well as their partners regarding the severity of the symptoms (Hallowell & Ratey, 2005; Kooij et al., 2010, p.8). It is useful to question the symptom pattern of ADHD symptoms as well as co-morbidities throughout the family in order to look into the familial aspect and inheritability. One should obtain the family's history of psychiatric and neurological problems within the family as well. The second matter to look into is the age of onset (Kooij et al., 2010).

Schaughency and Rothlind (1991) express that children who are suggested to have ADHD are more likely not to actually have the suggested disorder. This conclusion is based upon three reasons; one, there could be numerous other reasons why a child may

display lack of attention and hyperactivity; including their level of ability verses the demand of the task instructed, emotional matters or other developmental disorders. Another reason remains that there are others disorders that come frequently with ADHD but are more pervasive such as learning disorders and conduct disorders and lastly, these suggested children with ADHD can behave differently altogether. These reasons share the fact that most children suggested to have ADHD may be misdiagnosed. This means that psychologist need to understand the behaviors associated with ADHD and be ready to look into other alternative causes for the displayed symptoms, and thereafter be ready to refer for the necessary matters or make plans if it in fact is ADHD (Schaughency & Rothlind, 1991).

The misdiagnosis of ADHD in adults can be due to the lack of accurate recall by the adult and even the bias of the parent when it comes to recalling the symptoms and the age of onset. Therefore it is recommended by the National Institute of Health and Clinical Excellence in the UK to use a broader onset criterion ranging from early to mid-adolescence. That is why it is good to refer to the adults' school records to obtain more precise information as to the age of onset and symptoms. Another important criterion to look at in the assessment of ADHD in adults is the severity of impairment along with the symptoms; impairments including behavioral problems, personal distress from the symptoms, problems with self-esteem, social interactions and relationships and the development of co morbid psychiatric syndromes (Kooij et al., 2010, p. 8). Impairments are looked at in at least two of the four domains: home, work, school and/or social. It is also good to look at any history of somatic and psychiatric treatments (Kooij et al., 2010). There are different scales and instruments that can be used to diagnose adults with

ADHD, including the six item World Health Organization Adult ADHD Self-Report Scale (ASRS) Symptom Checklist and the ADHD rating scale based on the DSM-IV criteria, self-report questionnaires such as the Brown ADD Scale Diagnostic Form (BADDS) which measures executive functioning and inattention based behavior, the Wender Utah Rating Scale (WURS) which takes into account symptoms of other co morbid disorders and the Conners' Adult ADHD Rating Scale (CAARS) which like the ADHD rating scale includes the DSM-IV criteria and comes in different versions suitable for patients and their significant others. The latter CAARS and the ADHD rating scale outcomes can be totaled together to screen for ADHD and evaluate the outcome of treatment (Kooij et al., 2010).

In 2003, the European Network Adult ADHD was founded to increase awareness of the disorder and to bring forth knowledge and better patient care regarding adults with ADHD. The European Network consists of 40 professionals from 18 countries across Europe, that have come to the conclusion that because many adults with ADHD have not been treated effectively due to being misdiagnosed for reasons listed as follows; 1. The adult psychiatrists misunderstanding of ADHD as more of a childhood disease, 2. The fear of causing addiction to stimulants, 3. People being labeled as lazy, aggressive or having a mental or behavior issue and lastly, those not familiar with the logistics of the disorder, misdiagnosing it for a mood or personality disorder. Therefore the individual, their family and those in their surrounding environments, e.g. work, school, etc. suffer. As a result of three meetings between 2003 and 2009, trials and clinical presentations of adults with ADHD, a consensus statement was derived in order to not only assist

psychiatrist, but help in the referral of treatment, care and follow up for other health care providers (Kooij et al., 2010).

Treatment

According to Hallowell & Ratey (2005), ADHD should be treated with an individual comprehensive plan that is suitable for the person diagnosed with ADHD. The plan should include eight areas:

1. Diagnosis and identification of strengths and talents (Identifying the individual's strengths and talents is a very important part of treatment.)
2. Execution of a five step plan that promotes the strengths and talents. The five steps include connecting (to positive people), playing (allows he/she to find their strength and talents), practice, mastery (other people recognize their achievement) and finally recognition (which connects he/she to the people who recognize their value.)
3. Education about ADHD and the individual's strengths and talents
4. Lifestyle changes including exercise, quality time with family and friends, less time spent watching television and/or indulging in electronics, diet, sleep and prayer or meditation
5. Structure
6. Therapy suitable for the needs of the person diagnosed with ADHD such as psychotherapy, career counseling, couples therapy, coaching and family therapy

7. Other therapies such as an exercise program, occupational therapy and nutritional interventions that may increase the effectiveness of the medication or replace it
8. Medication (p. 12)

The symptoms of ADHD are able to be treated; usually with atomoxetine or stimulant medication. Studies have shown similar responses to the medicine in adults and children (Kooij et al, 2010).Medicine being the single most effective treatment for ADHD works for 80 to 90 percent of those taking it. Ritalin, Adderall and Concerta are the most commonly used stimulants while amantadine, bupropion and Strattera are nonstimulants that are used as well (Hallowell & Ratey, 2005). Psychological treatments in the form of cognitive behavior therapy, psycho-education, and supportive coaching and/or assisting with daily life organization help adults depending on their level of development and ADHD (Kooij et al., 2010).

Treatment for an adult with ADHD can assist with the psychosocial impairments caused by ADHD symptoms by improving certain properties such as:

- psychological functioning and self-confidence
- family/relationship functioning
- interpersonal (broader than family) functioning
- professional/academic functioning
- cognitive deficits
- driving performance
- risk of substance use disorders (Kooij et al., 2010, p. 11)

As with treatment of children with ADHD, a multimodal approach is also taken with adults for treatment. As with children, the adult's significant other, family and friends may be involved and the client's co-morbid disorders are integrated as well in the treatment. Examples of such multimodal approaches include family therapy, pharmacotherapy for ADHD and co-morbid disorders, cognitive behavior psychotherapy (individual and group) and coaching (Kooij et al., 2010, p. 11). Depending on the severity of the co-morbid disorder, treatment may vary. For example, if depression and anxiety are severe, they are treated first and then the ADHD. Whereas if the co-morbid disorder is mild, the ADHD is treated first, this usually causes the mild co-morbid disorder to be resolve. For example, patients with ADHD may have turned to alcohol and drugs in order to help with the symptoms of ADHD and/or the anxieties of it. Treating the ADHD may cease the need to indulge in such activity or reduce it. This order of treatment with ADHD and Substance use disorder may be good if there is an understanding of the treatment, however depending on the severity of the substance use disorder, it is up to the doctor's discretion as to whether substance use disorder may need to be treated first. All treatment is based on the severity of the ADHD and co-morbid disorders and the discretion of the doctor (Kooij et al, 2010).

Psycho-education is usually the first step in the treatment plan; teaching the patient, significant other and family about the different things involved with ADHD such as inheritability, co-morbid disorders, the brain dysfunctions and impairments, symptoms and, of course, treatment. This information usually brings comfort to the patient and close ones, causing negativity in relationships to decrease and bringing understanding to past neglects and situations. Because of this comfort, a patient's self-worth can increase and

cause better social relationships as with the information about self-help groups regarding ADHD allowing the patient to share their feelings and experiences with others (Kooij et al, 2010).

When dealing with pharmacotherapy, based on effectiveness and safety, methylphenidate and dexamphetamine are the first choices for treating ADHD with atomoxetine coming second. Other non-stimulants include guanfacine, modafinil, bupropion and tricyclic antidepressants. Depending on the study design and maximum dosage, according to studies, these stimulants prove to be 70% effective; improving not only ADHD symptoms but related issues as well. To name a few, outbursts of anger, social relationships, family matters, low self-worth are improved (Kooij et al, 2010). Side effects caused by stimulants include appetite suppression, nausea, tics or twitching, jitteriness or anxiety, depression, paranoia, agitation, mania, headache, elevated blood pressure, elevated heart rate, vomiting and insomnia (Hallowell & Ratey, 2005). Along with these side effects, Kooij et al (2010) mention difficulty falling asleep, dry mouth, weight loss meaning, therefore patients should be assessed prior to, and monitored during treatment (p. 12).

> Stimulants are not advised during pregnancy or breastfeeding and are contraindicated in psychotic disorders up to now; although some specialists have treated ADHD successfully in stable patients with schizophrenia maintained on antipsychotics. Relative contra-indications are hypertension, cardiac problems including angina, hypertrophic cardiomyopathy and arrhythmias, hyperthyroidism and glaucoma. For these disorders, first referral to and treatment by a specialist are needed before starting a stimulant. Stimulants may be used in autism with

> generally positive effects, although in some cases autistic features may worsen. A recent meta-analysis indicated that treating ADHD in children with tic disorders is safe and effective. Stimulants have little impact on seizure threshold and may be used in epilepsy (Kooij et al., 2010, p. 12).

In order to better treat adults with ADHD, pharmacotherapy is usually accompanied by coaching and cognitive behavioral therapy for treatment. Coaching and Cognitive behavioral therapy offer such improvements as:

- acceptance of the disorder
- learning to deal with time management
- learning to limit activities to 'one goal at a time'
- organizing home, administration, finances
- dealing with relationship and work difficulties
- learning to initiate and complete tasks
- understanding emotional responses associated with ADHD (Kooij et al., 2010, p. 14)

These tools, coaching and cognitive behavior therapy provide more structure through therapy, whether it is individual or group therapy in order to help adults with ADHD resolve the issues of calculated problems from years of developed impairments or their responses to the disorder. Relationship matters, low self-worth and esteem, as well as co morbid disorders in conjunction with ADHD can be treated by psychosocial or family therapy. Combinations of these treatments seem to benefit adults with ADHD in order to get them on the road to a better life; especially when they are open to self-growth and new ways of handling life issues and situations (Kooij et al., 2010).

In October of 2011, the American Academy of Pediatrics published clinical practical guidelines regarding treating ADHD. These guidelines were made up by a subcommittee of developmental-behavior pediatricians, primary care pediatricians and representatives from the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, the Society for Pediatric Psychology, the National Association of School Psychologists, the Society for Developmental and Behavioral Pediatrics, the American Academy of Family Physicians, and Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), as well as an epidemiologist from the Centers for Disease Control and Prevention (CDC) (American Academy of Pediatrics [AAP], 2011).

Five Key Action Statements regarding the monitoring of ADHD in children and adolescents, evaluation, diagnosis and treatment were developed as a result:

First, for children 4 to 18 years of age who exhibit behavioral or academic issues and show symptoms of impulsivity, hyperactivity or inattention, it is recommended that primary care physicians begin an evaluation for ADHD (APA, 2011).

Secondly, in order to make a diagnosis of ADHD, the child must meet the criteria for the DSM-IV and have impairment in more than one major life setting documented. All other alternative causes for the symptoms should be excluded by the primary care physician. Reports from those involved in the care of the child (parent, guardian, mental health clinician, teacher and other necessary educational staff) should be obtained (APA, 2011).

The third key action statement recommends that other conditions (physical, developmental, emotional and behavioral) that may exist with ADHD be assessed by the

primary care clinician. The assessments of these conditions are to be included in the evaluation for the ADHD (APA, 2011).

The fourth key action statement recommends that the primary care physician acknowledge ADHD as a chronic condition; therefore considering children with ADHD as having special health care needs. As a result, the medical home and chronic care model should be utilized (APA, 2011).

The fifth key action statement gives recommendations for treatment and varies according to age. For children (4-5 years) attending preschool, the primary care clinician "should prescribe evidence-based parent and/or teacher-administered behavior therapy" (APA, 2011, p. 2). If therapy does not elicit improvement in the child's functioning or if evidence-based behavior treatment is not available, the primary clinician can prescribe methylphenidate as treatment and an effort to avoid delay in diagnosis and treatment. Along with evidence-based parent and/or teacher-administered behavior therapy, elementary school children (6-11 years) should be prescribed US Food and Drug Administration-approved medications for ADHD. Adolescents also should be prescribed US Food and Drug Administration-approved medications for ADHD by their primary care clinician if the adolescence agrees to it with behavior therapy also as treatment (APA, 2011).

Lastly, it is recommended that the primary care clinician titrate the dosage to accomplish maximum success with minimum adverse effects (APA, 2011, p. 2).

Co-morbidity

Clinical and epidemiological research show that mental health is a common aspect in 10-20% of those with ADHD with examples of people in addiction as well as

personality disorder clinics showing the need to research and access these populations for ADHD (Kooij et al, 2010) .

Co-morbidity is a huge factor with ADHD usually being accompanied in 65% of children by other disorders such as oppositional defiant and conduct disorder, Tourette's, learning disorders, autism and anxiety and mood disorders. This remains true with 75% of adult ADHD patients as well. This is why care must be taken to distinguish between the symptoms that can occur with both ADHD (for example mood swings, impatience; not waiting in long lines in order to avoid frustration, nonstop mental activity) and bipolar disorder, personality disorder, anxiety or depression. Borderline personality disorder and ADHD share such symptoms as impulsivity, boredom, outbursts of anger and emotional instability, but suicidal ideation, mutilation, identity disturbances and feelings of abandonment are less with ADHD than borderline personality disorder just to name a few. "ADHD is also associated with increased rates of neurodevelopment traits and disorders including autism spectrum disorder, dyslexia and impaired motor coordination; which are thought to arise from overlapping genetic influences" (Kooij et al, 2010, p. 9). These particular traits and disorders are less likely to be studied with ADHD, however show up when ADHD is treated medically. One disorder that deserves special attention is Substance use disorder. There are high rates of ADHD within populations of those with Substance Use Disorder. Out of twenty five cases of ADHD, 45 to 55% misused substances, with marijuana and alcohol being the most used; cocaine and amphetamines following behind. Co-morbid cases of ADHD and substance use disorder are characterized by severe substance use disorder at an early onset, greater impairment, with a long time of substance use, a shorter time in going from use to dependency with

ADHD influencing the risk of suicide in those with substance use disorder (Kooij et al, 2010).

Purpose/Research Questions

The purpose of this study was to gain insight into the lives of people living with ADHD; to see ADHD from a personal perspective. While existing research clearly defines ADHD, the symptoms, and how they manifest and change from childhood to adulthood and also explores various potential causes, there exists little research that delves into how ADHD affects a person with ADHD and their loved ones. Literature presents suggestions for the various steps one may take after the diagnosis (e.g., therapy and medication); however questions remain as to the effectiveness of the treatments. This study was completed to answer four research questions:

1. How does ADHD affect parents?
2. How does ADHD affect the person who has been diagnosed?
3. How does ADHD affect a person's school, home and social atmosphere?
4. What are the effects of the medicine and/or therapy from the person taking the medicine and the guardian and/or parent who observes the child on a daily basis?

Method

Participants

The participants were four children (all male) with ADHD and four parents of children with ADHD (all female). The ages of the participating mothers were 35, 36, 54 and 56 years of age, while the ages of the children interviewed ranged from 13-17 years of age. All of the participants were of an African-American ethnicity. I utilized a sample of convenience by inquiring on Facebook of anyone who had children with ADHD, have

themselves been diagnosed with ADHD or knew of anyone and would be willing to be interviewed. The participants' knowledge of ADHD was gained from being diagnosed and as a result of experience with living with ADHD and the steps after being diagnosed. The study was conducted in the city of Chicago with participants residing within the inner city, south and one participant who originally lived in the inner city but had moved to a suburban area the previous year.

Measures

The questions for the interview were created in order to attempt to gain full knowledge of the personal experience of living with ADHD. Some of the questions consisted of the symptoms that led to the diagnosis, the next steps recommended after the diagnosis, how ADHD affected the life environments of the diagnosed ADHD person e.g. home, school, social life and how the person was coping with the ADHD. The interview questionnaire (see Appendix A) consists of nine open-ended questions giving the participant freedom to expand and possibly share life experiences. Some questions expand with A and B questions to gain more information.

Procedure

Rapport was established via telephone with an understanding of the purpose of the research, interviews and confidentiality. The times and the places of the interviews were established by the participants in the interest of their convenience. Seven interviews were conducted in the homes of the participants while one participant filled out her interview via e-mail and e-mailed it back to me. The interviews conducted in person ranged from 10 to 30 minutes depending on the source of the interview, the parent or the child and the experiences shared. For all the interviews, an understanding of the purpose of the

interview was established, followed by the participants reading the consent form (see Appendix B) and giving consent (the parent consenting for the child) for the interviews conducted in person. The consent was given by the participant who e-mailed her interview by her opening the e-mail and therefore sending it back to me. Upon consent of the interviews conducted in person, interview questions were asked while recorded with an audio tape recorder.

Analysis Steps

In order to analyze the data, the audio recorded interviews were first transcribed to written text. A three-level coding approach designed by Silverstein and Auerbach (2003) was used to analyze the data. The steps included were first to search the participants responses for text relevant to the research. After finding relevant text, consistencies and differences were grouped together as repeating ideas in order to obtain specific themes that answered the research questions and implications for future research (Auerbach & Silverstein, 2003). The themes were chosen as a result of the percentage of participants who responded in the same way; in this case 90 to 100 percent regarding the specific themes and the participants' reoccurring responses to the interview questions showing the importance of the specific themes. The themes are represented in the findings as well as the Theme-Based Participant Responses Table (Table 1).

Results

Findings

Emerging Themes

There were four themes that emerged in analyzing the participants' responses:

1. Symptoms
2. Medication

3. Therapy
4. Coping

Symptoms

All participants in the study reported the symptoms leading to the diagnosis to be consistent. The parents responded that the child beginning at an age as early as two years old was more hyper than the average child, that the child was not consistent in play; playing with one item for a few minutes and then moving on to another item. The parents mentioned that this was a normal form of play for their children. They mentioned having to constantly repeat things for the child to process the information or began to do something specific the children were being told to do. They also discussed issues of behavior and anger in school leading to the teachers or other members of the school staff recommending the children for professional advice. J.S., one of the child participants said that his symptoms began to show in Pre-kindergarten, "I threw a temper tantrum, and kick the teacher and start falling out." One of the parents talked about her child being hyper, "The first memory I have was he was always awake, never really slept and he still had a lot of energy." Another parent, K.E. mentioned,

> He kept having problems in school, constant suspensions and being separated from the other kids, parent conferences and calls. He was just really disruptive to the class so he suggested that I should get into counseling, and counselor said that I should do a test, and found that he had ADHD.

Medication

Medication, for the participants, depended on the level of symptoms shown for the disorder. Parents that mentioned there child being really hyper and anger as a symptom used medication as an aide in helping with the ADHD. One parent T.E.

mentioned after talking about how after moving, her children were not able to obtain their medication and failed the school year. She stated,

> That's another reason why I fought so hard to get them back on the medication, because I want to make sure that I gave them every advantage to not be able to come home and give excuses about I couldn't do this or why I failed. Because their concentration is shot.

Her two children acknowledge that the medicine helps them-A.E. stated, "I take the medicine so I can calm down…Sometimes it helps me focus" while his brother L.E. says, "I felt bored when I took the meds. It definitely helped cuz I was hyper already." One parent T.A. stated, "I believe the meds work because I stop them sometimes just to see the difference and there is a big difference."

Other parents did not use the medication. One parent G.E., after trying the medication, feeling that it did not help her child and the doctor changing the medication a few times in order to obtain the right one, and her child telling her that it made his heart beat too fast, ceased giving him the medication,

> It just made him too quiet, too withdrawn, into himself and then tired most times. And then also he was having problems, by them steady changing medication…Cuz I even actually took him to the emergency room to make sure he wasn't having a heart attack…they say he's alright, this might be a side effect of the medication. He hasn't been on it long enough; Let him take it for a couple of more weeks. I took him off of it.

Another parent K.E. who chose not to medicate her child stated, “Meds restrict kids from being kids...They told my mom that her kids were like zombies because the medicine was too strong and they have to keep tweaking it to find the right dosage.”

Therapy

While the parents of the children with ADHD felt medication was optional, the parents and the children agree that therapy is a great help in living with ADHD. It helps with the parents in having another authority; another voice that the children can listen to and trust. All participants agreed that it is helpful for the children to be able to talk about their experiences and the decisions they made during the week. It helps to receive feedback and/or advice as to how they could have done something differently or began to implement choices and actions in their life in a different manner. They agree that therapy helps in allowing the children to hear themselves discuss their feelings and actions and at the same time feel that there is someone else other than the parent that cares about them. One specific parent T.E., after moving and attempting to re-establish services, acknowledges the benefits of therapy when asked what resources would you like to have to help you deal with ADHD? (Question No. 7 in the interview) by stating,

> I would like to go back to the city or if not to the city, if there was a place out here where they can go on a regular basis, because people don’t realize it’s not all about the medication. The medication helps to slow them down, to try to give them understanding for what they need to do but at the same time, they need to be reminded on a daily basis, or weekly basis, they need to cover they week, what happen in they week with how they feeling, they need to talk about they feelings. They need to learn how to process they feelings and that’s where the therapy

> comes in at. Twenty minutes, you can't sit up and tell a person what happened the whole week in twenty minutes and expect to get enough feedback to teach you how to go next week and do it different.

See the Emerging Themes table for other specific comments made by the participants.

Coping with ADHD

ADHD first affects the mindset of the child who has been diagnosed with ADHD and their parents. Typically, children are not knowledgeable about ADHD and therefore when told they have it they may struggle to understand what they are being told. One of the research participants A.E., who is now 17 and was diagnosed at age 2, stated that he recently was given a paper defining ADHD, the symptoms and specific ways to cope with ADHD; for example being involved with activities. Before receiving this paper, he only knew what his guardian and therapist told him that he had a lot of energy that needed to be controlled. When asking the participants about the symptoms that led to them being diagnosed, the response was that they played a lot and could not focus. Being diagnosed made them feel afraid in a number of ways; not knowing what ADHD is, feeling that the situation was not something they could tell their friends because they felt already that they were not like any other child. One participant, J.S., mentioned that when he did not play like the other kids, they often taunted him; bringing up that he had ADHD while now older A.E. and L.E. feel that as they have gotten older that they have better control of the ADHD; of their energy and so forth. These participants show that there were many steps and assistance needed from outside resources from the showing of symptoms till now in their lives to help them to cope and have a better life with ADHD; that living with ADHD is an ongoing process. With symptoms showing up as early as

two years of age, the parent participants when asked, what resources would you like to help you deal with ADHD (Question No. 7 in the interview), responded that since they had been living with ADHD for the time that they had, that they felt that they were doing everything that could be done. They felt that it was hard to deal with in the beginning but as time passed and they found new ways to cope with ADHD, it has become easier. However they also stated that as a result of having a child with ADHD, you have no life; these responses being consistent with the ADHD & Parenting section in the literature review.

T.A. stated,

> In the beginning I was called every day to the school to come get him. Meeting every day, doctors' appointments. It was really hard especially because I am a single mother, but now I'm dealing with it a lot better with support.

G.E. stated,

> You have to be there watching them so therefore you don't have a social life. Because you busy chasing that hyperactive child around the house, you don't have a social life. They don't have a social life because they can't keep still. They don't have any skills of interacting with other children.

T.E. stated,

> I had to be at home, I got calls from the school almost constantly. People don't understand cuz you at home every day you just sitting at home, you are not sitting at home. When you get through scheduling appointments for medication, appointment for therapy, appointments for the school you know that's a full time job.

One parent T.A. stated that “Everything has to be done the same way at the same time”, showing that one way to cope with ADHD is to be consistent. T.E. stated,

> When you dealing with kids with ADHD and all these other problems, thru all these years of counseling, the main thing I found out and they beat it in my head so much, till now I really really know this in my heart that it has to be consistent with them. I let them have freedom out here cuz I thought it was safer. I think I gave them a little too much freedom.

Another way to cope with ADHD, agreed upon among all participants was the need to keep the children busy and keep their “Energy up.” See the Theme-based Participant Responses Table (Table 1) for specific comments.

Table 1: Theme-based Participant Responses

Initials	Symptoms	Medication	Therapy	Coping
A.E. (Child) M	“Probably like when I was in school and I couldn’t stop like talking and stuff, couldn’t focus.”	“Like I’m playing basketball, I don’t take my medicine that day cuz I need the energy. But when I’m not doing nothing, I take the medicine so I can calm down.”	“Helps me deal with my anger.”	“Like running around, or making myself work with the energy. Like on the paper it says you have a lot of built up energy inside you and the best way to get it out is to be active. So I’m playing every sport I can.”
T.A. (Parent) F	“The first memory I have was he was always awake never really slept and he still had a lot of energy.”	“I believe the meds work because I stop them sometimes just to see the difference and there is a big difference.”	“Yes therapy also works he goes to Occupational therapy where he address his sensory needs, so he gets to do different obstacles where	“As a mother I had to do my research and find different ways to help my son. He is a good child he just have a disability that has affected him in a lot of different ways. I'm a proud

			he is constantly moving. He also goes to psychiatry where he can talk to his therapist about what's going on and why he does certain things and then he is allowed to find different ways to deal with his anger."	mother. I love him and I tell him everyday things will get better."
J.S. (Child) M	"Kept throwing tantrums and hitting teachers and rude behavior."	"Don't take meds."	"I get to talk about my problems and express how I feel."	"Controlling myself and expressing my feelings, talking to counselor, and playing football."
T.E. (Parent) F	"He was all over everything. Normally a kid don't live like that, but I mean he was just extra busy. But also at the same time, he had like this really really evil spirit where he was just mad all the time and at everybody."	"Have them to concentrate more"	"It was always weekly therapy and always family therapy… They need to learn how to process they feelings and that's where the therapy comes in at."	"I try to talk to them on a daily basis, when they come in from work, I have to pin them down and I want to hear about how was they day… They need to learn how to process they feelings and that's where the therapy comes in at"
G.E. (Parent) F	"When you ask him a question and then two three days later, you ask him the question again, he don't remember it, you gotta repeat it. They can	"But the thing with the medication, I took him off of it cuz I think because I seen some other signs and I really didn't see where	"Therapy once a week, outside and in-home therapy, helped for developmental and social skills."	"Find ways to keep them active, you have to do that with them because if they're not doing constructive then you gotta worry what are they doing."

	never be still, they constantly up and about moving around or doing something that you consider stupid and you know at their age, they know better than to do it, but they do it anyway, constant repeat.	the medication helped at all."		
K.E. (Parent) F	"He couldn't stay focused enough and everything was overwhelming and he had a lot of problems learning and stuff."	"Mom had cousins who were diagnosed with ADHD. When I saw them, they were like zombies, they didn't have any energy. They didn't play like normal kids so I was like I'm not giving them the medicine."	"The counselor worked wonders."	"Constantly learning skills to redirect him into positive actions, not getting offended when teacher corrects him, don't try to get hyper or if he get off focus, he constantly have somebody redirect him back to what he should be doing."
D.E. (Child) M	"Laughing and playing a lot."	"I started calming down, it helped me calm down more...Messing with my heart a little bit. My heart started beating fast. It kinda helped me focus. I felt kinda weird inside. It started giving me headache symptoms."	Yes, it taught me to learn how to focus more and pay attention to the teacher and not talk to other people and stay focused on my work."	"Sports, video games…reading."

L.E. (Child) M	"I was always hyper."	"I felt bored when I took the meds. It definitely helped cuz I was hyper already."	"Not really, cuz I was still the same way."	"After I got bored, I start thinking about doing different activities, like playing football, basketball, baseball, skateboarding."

Discussion

The purpose of this research study was to see ADHD from a personalized view, to bring life to the perception of ADHD as opposed to seeing it on paper. The research answered four questions:

1. How does ADHD affect parents?

2. How does ADHD affect the person who has been diagnosed?

3. How does ADHD affect a person's school, home and social atmosphere?

4. What are the effects of the medicine and/or therapy from the person taking the medicine and the guardian and/or parent who observes the child on a daily basis?

ADHD affects the parents'/guardians' stress level, time and schedule, job and life as a whole. Parents have to constantly observe their child with ADHD. If the child/children are not constantly observed, there is an underlying worry of what is or how is the child doing? Due to the child exhibiting behaviors of hyperactivity and impulsiveness, they may put themselves in dangerous situations. One parent G.E. stated that her son at the age of two would throw things (anything, soft or hard) in the air to see how it landed. The time spent by the child with ADHD has to be directed seeing as they move from one thing to the other. One parent T.E. stated,

> He would start off playing but if he there 15 minutes playing with that thing, it was a miracle. Because he went from one thing to another. Nothing ever caught his attention long enough. He would never stay there and continue to play. He was always like I played with this for a few minutes, done; let me go to the next one.

Each parent mentioned consistently having to make appointments for therapy and/or medicine, constantly having to go to the school for parent-teacher conferences, having to leave work and that is if they are able to have a job due to the level of severity of the ADHD. Parents have little or no time to do things that they themselves would like to participate in in life due to a constant thinking of how to help their child.

The third research question asks, “How does ADHD affect a person’s school, home and social atmosphere?” The home atmosphere is explained in the previous paragraphs discussing how ADHD affects the parent and the child. To further discuss the effects of ADHD for the child’s social atmosphere, it matters how the child uses his/her energy in social atmospheres. One common symptom associated with ADHD mentioned by the parents was an unexplained anger felt by the child. This anger as mentioned by the parents affected the child’s social atmosphere. T.E. mentioned that her one son L.E. would start off in a friendly game of basketball but due to anger issues would end up in an altercation. She stated that he had maybe one friend or two. When asked how ADHD affected his social life, he stated that it did not. Another parent K.E. mentioned that her son J.S.’s life was in the beginning affected at school as well as socially because nobody wanted to play with the ”trouble child”, while J.S. stated that he now has a lot of friends. The other child participants also stated that their social atmosphere was not affected; because they used their energy well, and therefore have a lot of friends. The school

atmosphere is mostly affected in the early years of the child with ADHD when symptoms first begin to show. The tantrums, fighting, disrupting the classroom and continuous calls to the parent/guardian affect the child, parent and educational staff involved. It is as help is sought, and understanding is gathered among the parents and educational staff that the educational atmosphere for the child with ADHD improves. The child participants each stated that they have okay to good grades. One participant J.S. is an honor roll student, he however is often sent out of the classroom keeping him from finishing his assignment in class. A.E. stated that elementary school came easy to him; it was math in high school that became hard to him. His mom T.E. stated that the counselor at the school said there was no point in an Individual Education Plan because A.E. and his brother L.E. do not stay in the classroom long enough.

I received many different responses regarding medicine from my research participants. One parent, K.E., uses therapy and multiple behavioral strategies with her son and has never used medication to treat his symptoms. She stated that, "Meds restrict kids from being kids." She has also observed her mother's foster children who are on the medication in "zombie-like states". Her mother informed her that the doctor said that the effects were a result of the different trials of the medication and that the dosage was going to be decreased. Another parent, G.E. stopped giving the medicine to her son due to reactions of his heart racing to the different trials of medication. Other participants reported that their medications help them calm down and focus. Parents and children that reported using medication believe that it helps. Those who choose not to use the medication have found solace in other methods such as therapy for the person with ADHD and the everyday counsel from the parents, guardians, educational staff etc. that

involves redirecting and advice to different ways of doing things when it comes to behavior for the child with ADHD.

The data suggest that real life is indeed consistent with the research. Kooij et al, (2010) state that "Current evidence clearly defines ADHD as a clinical syndrome associated with impairments in multiple domains including academic difficulties, impaired family relationships, social difficulties and increased rates of conduct problems" (p. 8). This definition of ADHD is consistent with the information and responses of the participants of the research. In the "Who Is Affected and How" and "Parenting and ADHD" sections of the literature review, the literature discussed how ADHD affects the child diagnosed and the parents of the child (Hallberg et al, 2008; Kooij et al, 2010; Owens & Hoza, 2003; Schwiebert, Sealander & Dennison, 2002; Shillingford et al, 2007). In the above discussion of the research questions, "How does ADHD affect parents" and "How does ADHD affect the person who has been diagnosed", examples are given showing validity to the literature in being compared to the research of the real life experience. In the section ADHD and Parenting of the literature review, it is mentioned how making appointments, parent-teacher conferences, calls from the school and having to make sure the children take their medication leaving the parents with little time for themselves; also showing consistency with the research (Hallberg et al, 2008). One parent T.E. mentioned it being hard with her teenagers and making sure they take their medicine,

> The older they get, the more little tricks they do to keep from taking it. I got a prescription filled for 30 pills, 5 mg that she started (A.E.) on. When we went back and they started on them 10 mg, (A.E.) still had 17 pills and it was over two

weeks. So it's summer, they out of school, they work four days a week. I have to get up in the morning at 7 o'clock. They have to leave by 7:30. I have to get up out my bed to make sure they took their medicine for the day.

ADHD is a disorder that has affected and is still affecting generations. Research is ongoing regarding ADHD resulting in changes in the Diagnostic Statistical Manual as to what guidelines to diagnose ADHD. The symptoms mentioned by each of my participants remain consistent with the symptoms mentioned in the literature affecting the person who has been diagnosed and their life environments (Hallberg et al, 2008; Kooij et al, 2010; Owens & Hoza, 2003; Schwiebert, Sealander & Dennison, 2002; Shillingford et al, 2007).

The treatment of the different options of therapy and medication and/or combination of medication and "Psychological treatments in the form of cognitive behavior therapy, psycho education, and supportive coaching and/or assisting with daily life organization" (Kooij et al, 2001) given after the diagnosis are helpful in coping with living with ADHD.

For the most part, my research showed to be consistent with the literature. The only matter I found inconsistent was the involvement of the counselor in the role of assisting in the diagnosis, records, weekly monitoring and behavior charts and assisting the child in transitioning during their school years as mentioned in the "Teacher and Counselor" section in the literature. This type of involvement has decreased in the school system, due to some schools not having counselors that deal with these issues. A lot of schools have a social worker that comes in to the school once or twice a week. This

shows a need for this type of interaction to improve; that the schools need to have these positions filled again in the schools.

As a result of interviewing, my research indicates that more knowledge regarding ADHD needs to be made known to all people, especially children, educational staff and parents. As research has grown, matters have improved in observing and diagnosing ADHD at a young age in order to begin to assist the person diagnosed with ADHD to live a more normal life as well as those in the life of that person. Resources need to be made more accessible and people need to be made more aware of these resources due to the mental and physical effect ADHD has on not only the person with ADHD but those in the life of the person. The fact that the close circle of those surrounding the child with ADHD tend to have little time due to constant observation of the child, being called to the school, constant appointments; medicine or therapy needs to be changed and therefore improved. With the existing knowledge and life experiences of those living with ADHD, it is possible that life can be maximized for those living with ADHD.

Limitations

Limitations for this study include the size of the sample of the participants, the age of the children participants, the bias of those with ADHD and the lack of ability to observe in order to gain a better perception of life with ADHD.

A small sample was interviewed with all participants of one race in one city. Thus the findings may not be generalizable to people of other races and cities where there might be different views based on different resources that are able to be obtained in other cities. As one of the parents (T.E.) mentioned, her children were able to have therapy on a

weekly basis in the city, but now can only talk to the therapist for twenty minutes due to an overwhelming need for him in a suburban area.

For my research, I interviewed the teenagers that were diagnosed with ADHD. Three of the parent participants had two or more children that were diagnosed. However, teenagers are able to voice their feelings and thoughts in a constructive way and therefore were interviewed for the study as opposed to the busy six year old that cannot collect his thoughts. This factor brings in the limitation of the lack of ability to observe. As stated in the literature review, observation is always the best way to research ADHD; however a convenient method had to be used for the research.

Lastly, the bias of the teenage participants is a limitation. They may not have wanted to fully divulge information to the researcher as the parents did with stories and experiences. Where one mom discussed her son's anger and because of his anger; a lack of peer relationships, when asked how ADHD affected him socially, the son stated that he had a lot of friends.

Suggestions for future Research

Three out of four of the parent participants were either guardian or foster parents of children with ADHD. Each of the three mentioned that the children with ADHD were drug-addicted babies. Future Research should be done on the relationship of drug usage during pregnancy and the child being diagnosed with ADHD.

The parents mentioned symptoms of acts of behavior on behalf of the children before they were recommended to seek understanding of the behavior and being diagnosed with ADHD. The symptoms included temper tantrums, kicking, biting, and fighting, etc. but the teenage participants later mentioning that they now have self-

control. One aspect of future research that should be looked into is behavior verses ADHD. I used to work with children with ADHD and found when going into the special education classroom that a lot of children were in the class room because of behavior. For example, there was only one parent in the research that stated that her child had an Individualized Education Plan (I.E.P). The other parents and children participants mentioned their level of intelligence, stating that school has been easy to them that they may act up and have to take the consequences because of their behavior but not because they weren't able to focus or showed symptoms of ADHD.

Anger was also mentioned with the symptoms of the children and should be researched. Two of the children participants mentioned that they were angry and didn't know why. Two parents mentioned that their child displayed anger or an evil, one parent said.

Lastly, better ways to find out the right dosage and medication type should be studied as opposed to the trials of children having to take a certain medicine for a time and then having the dosage increased or decreased or changed a number of times; also having to have blood work done each of these times. This issue too can add on the stress of living with ADHD.

With the above mentioned matters being further studied, the ability to cope with ADHD can be made easier. Progress can be made for the researchers and more importantly in the lives of those diagnosed and those in the person's life environments. Research must continue to explore ways to improve the lives of individuals and families that experience life with ADHD.

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Appendix A-Interview Questionnaire

1. At what age did you/your child first show signs of ADHD?
    A. Tell me about your first memory of an event that you think was a sign of ADHD? What happened, who was there, what made you think it had to do with ADHD?
    B. How long after the showing of symptoms were you or your child diagnosed, at what age?

2. What symptoms or events led to the diagnosis?
    A. How did you feel about getting diagnosed?
    B. Was there any fear?
    C. Relief?

3. Did the diagnosis answer any questions you might have had regarding you or your child's behavior or symptoms?

4. How did/does ADHD affect your/your child's life?
    A. Socially?
    B. Academically?
    C. At home?

5. What were the next steps or actions you were recommended to take after the diagnosis; e.g. therapy, meds?
    A. If meds were taken; did it help living with ADHD? If so, in what ways?
    B. If therapy was offered did it help living with ADHD? If so, in what ways?

6. How does living with ADHD make you feel about yourself?

7. What resources would you like to have to help you deal with ADHD?

8. Does living with ADHD affect your/your child's work?

9. If any, in what ways are you coping with/or managing ADHD to live closer to a normal life?

Appendix B

INFORMED CONSENT

Faculty/Adjunct Faculty/Staff/Student Form: Individual Participant

You are being asked to participate in a research study conducted by Chalonda Henry, student at National Louis University, Chicago, Illinois. The study is entitled **Living with ADHD** (Attention Deficit Hyperactivity Disorder.) The purpose of the study is to gain a perspective from a personal view of the life experience of living with ADHD.

Participants will be interviewed and recorded for accuracy of responses.

With your consent, you will be interviewed for about 20-30 minutes with a possible second, follow-up interview lasting 20 minutes. Upon request, you will receive a copy of your transcribed interview at which time you may clarify information.

Your participation is voluntary and you may discontinue your participation at any time without penalty. Your identity will be kept confidential by the researcher and will not be attached to the data. Only the researcher will have access to all transcripts, taped recordings, and field notes from the interview(s). Your participation in this study does not involve any physical or emotional risk to you beyond that of everyday life. While you are likely to not have any direct benefit from being in this research study, your taking part in this study may contribute to our better understanding of Living with ADHD.

While the results of this study may be published or otherwise reported to scientific bodies, your identity will in no way be revealed.

In the event you have questions or require additional information you may contact the researcher: Chalonda Henry, National Louis University, 122 S. Michigan, Chicago, Illinois 60603; (773) 727-0515; chenry6@my.nl.edu.

If you have any concerns or questions before or during participation that you feel have not been addressed by the researcher, you may contact Judah Viola, Judah.viola@nl.edu, (312) 261-3527: Chalonda Henry's advisor or the chair of NLU's Institutional Research Review Board:

Dr. Kathleen Sheridan, Ph.D., National Louis University, 122 South Michigan Avenue, Chicago, Illinois 60603; 312.261.3149; email: kathleen.sheridan@nl.edu

_____

Participant Name (Print)

_____ _____

Participant Signature Date

_____

Researcher (Print)

_____ _____

Researcher Signature Date