

Parents' Experience and Needs After ADHD Diagnosis

Moriah Boggs

College of Social and Behavioral Sciences

Northwest University

Author Note

I have no conflicts of interest to disclose.

Leihua Edstrom, PhD, Dissertation Chair. Grant Martin, PhD, Committee

Member. Elisa Peterson, PsyD, Committee Member.

Date of Dissertation Defense: April 11, 2022

Correspondence concerning this article should be addressed to Moriah Boggs at Northwest University, College of Social and Behavioral Sciences, 5520 108th Avenue NE, Kirkland, WA 98033. Email: Moriah.boggs@northwestu.edu

Acknowledgments

This journey would not have been possible without the encouragement, support, and guidance from my family, friends, and committee. I would like to specifically thank my husband, William Boggs, and my children, Jasmine and Kaleb Boggs, for giving me grace, love, and understanding throughout this process. It took a toll on my ability to be fully present at times, and I am eternally grateful for your continued support! In addition, my friends Kristen Lowe and Michelle Baker offered unending encouragement that gave me the fuel I needed to continue moving forward. Thank you both for loving me well and always believing in me. Last by not least, my committee Drs. Leihua Edstrom, Grant Martin, and Elisa Peterson. I want to thank you all for your knowledge and guidance throughout this process. I always felt supported and confident knowing I could go to you for your expertise and encouragement.

Table of Contents

Acknowledgments.....	2
Abstract.....	5
Chapter 1: Literature Review.....	6
Overview of Attention Deficit Hyperactivity Disorder	6
Defining ADHD.....	7
Standards of Assessment and Diagnosis.....	10
Impacts of Attention Deficit Hyperactivity Disorder	13
Familial Considerations	14
Academic Performance.....	17
Effects of Attention Deficit Hyperactivity Disorder Across the Lifespan.....	19
Post Diagnosis.....	22
Psychoeducation	22
Treatment of Attention Deficit Hyperactivity Disorder.....	23
Rationale, Purpose, and Research Questions.....	27
Chapter 2: Qualitative Methodology	28
Purpose Overview.....	28
Design Strategy and Philosophical Worldview	28
Participants.....	30
Research Methodology	30
Data Collection Procedures.....	30
Protection of Human Subjects	32
Data Analysis	33
Promoting Study Reliability, Credibility, and Validity	33
The Researcher’s Role and Reflexivity	33
Reliability and Validity.....	34
Summary	35
Chapter 3: Findings.....	37
Data Analysis and Procedures	38
Description of Participants.....	40
Findings of Group Experiential Themes.....	41
Theme 1: Realization Help Was Needed	41
Theme 2: Diverse Experience in the Diagnostic Journey.....	53
Theme 3: Putting It All Together - Moving Forward After the Diagnosis.....	63
Chapter 4: Discussion	76
Experience in the Diagnostic Journey.....	76
Understanding the ADHD Diagnosis.....	80
Parental Role.....	81
Implications of Research Findings.....	82
Study Strengths and Limitations.....	85
Recommendations for Future Research	86
Conclusion	87
References.....	88

Appendix A.....97
Appendix B.....99

Abstract

With a focus on exploring how the mental health field could better assist parents throughout their journey in raising a child with attention deficit hyperactivity disorder this phenomenological study comprised six study participants that had children diagnosed with ADHD. In addition, this study's objective was to gain a deeper understanding of the challenges parents face throughout the process. This included what they experienced prior to, during, and after their child was diagnosed with ADHD. Using an interpretative phenomenological analysis approach, this study captured the unique challenges parents' faced in each stage. In addition, this study demonstrates significant importance in the parental role throughout the diagnostic process. Clinicians would benefit from designing their approach considering how parents process, make meaning of, and assign their role in helping their child. Further research needs were identified in both the areas of academic influence in the diagnostic process and barriers to treatment that may be linked to understanding the diagnosis.

Chapter 1: Literature Review

Overview of Attention Deficit Hyperactivity Disorder

A large body of literature pertains to the neurodevelopmental condition (Ahmed et al., 2014) known as attention deficit hyperactivity disorder (ADHD). ADHD is the most common pediatric psychological condition treated by both primary care physicians (PCP) and mental health practitioners (DeNisco et al., 2005). It is a chronic and pervasive condition (Dopheide et al., 2009) presenting with attention difficulty, hyperactivity, and impulsivity (Evans et al., 2006). It is thought to affect between 3%–8% of school-age children (Blaney & Millon, 2009); although, these statistics continue to be a source of debate (Hamed et al., 2015). Although there are many controversies surrounding this diagnosis, it is typically agreed upon that ADHD is a multifaceted condition (Kanarek, 2011), with a complex etiology stemming from both environmental and biological factors (Curatolo et al., 2010), often persisting into adulthood (Halperin et al., 2012).

Research has made many advances to help practitioners, educators, parents, and individuals alike; however, there is still a great need for research on both stigmatization and disability (Garland-Thomson, 2012; Lebowitz, 2016) to further explore aspects of ADHD that can be adaptive rather than impairing (Sedgwick, 2018). The field of psychology has continued to seek new and better ways to treat ADHD, and although the literature has been plentiful to date, there also has been discussion surrounding the need for more strength-based approaches to care and treatment (Sedgwick, 2018). Frequently, the focus of ADHD research has been to understand the cause and effect of ADHD, often with a deficit perspective in mind (Sedgwick, 2018). Recently, a shift in perspective has led some researchers and clinicians to adopt a strengths-based approach, highlighting

attributes or aspects of ADHD that benefit the individual (Sedgwick, 2018). This distinction between a deficit lens and strength-based perspective is an important ingredient to consider when working with parents. The way the child learns to view the world and themselves begins first with the parents' attitudes and beliefs (Grusec, 2014). Therefore, the aim of this research was to understand the parents' journey of having their child diagnosed with ADHD, with a focus on understanding how the mental health field can better serve parents from the beginning, ultimately to benefit the child. To understand why research about this disorder is complex, a brief history of ADHD and an overview of the diagnostic process will be offered.

Careful and calculated intension was given throughout this paper not to add to the deficit perspective pervasive in ADHD literature. It was important to the author to take a balanced perspective to articulate research results clearly while pointing out, where appropriate, the need for a strengths-based perspective in research to help families and children have a holistic outlook on the possibility for a well-adjusted future.

Defining ADHD

The history of ADHD in the medical literature dates to the late 1700s (Barkley, 2015b; Lange et al., 2010). Although, the recognition of ADHD, then labeled a "defect of moral control" (Lange et al., 2010, para. 16), took hold in the early 1900s when a British pediatrician named Sir George Still offered his research of what he found to be an abnormality in an otherwise intelligent child's ability to control their behavior (Barkley, 2015b). In its infancy, the literature of the developing syndrome was expanded in 1932 when German physicians Kramer and Pollnow termed what they viewed as an issue marked by increased motor activity as a hyperkinetic disease caused by minimal brain

damage (Lange et al., 2010). The effects of ADHD were thought to diminish with age, and it was categorized as a disorder of childhood (Lange et al., 2010). Both these historical accounts of the behavioral challenges in children closely align with today's diagnostic criteria of ADHD; although, current research has been able to offer more succinct and detailed understanding of the etiological factors and neurological underpinnings.

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013), ADHD is categorized as a neurodevelopmental condition, in which causes are known to go beyond the surface level of attention, behavior, and emotional elements central to the diagnosis. Historically, there was little understanding of what causes ADHD, and as new information becomes available, science continues to challenge the beliefs that ADHD is merely a label for difficult children or the result of poor parenting (Nigg, 2012). Over the past 20 years, research has uncovered etiological factors that allow for a more in-depth understanding of the neurological, biological, and genetic variances (Nigg, 2012). Through advanced brain imaging, researchers can now identify both the structural and functioning differences that exist in individuals with ADHD, as well as several specific gene markers (Nigg, 2012). Furthermore, it has been found that ADHD often runs in families, tends to persist throughout an individual's lifetime, and has environmental sensitivities (Nigg, 2012). Armed with this basic understanding of the biological basis of ADHD, the next foundational component is to understand how the medical community classifies this complex syndrome.

ADHD is diagnosed using the classification system known as the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013). The DSM-5 offers that ADHD is “a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development” (American Psychiatric Association, 2013, p. 59). To qualify for an ADHD diagnosis, an individual must display several inattentive or hyperactive-impulsive symptoms prior to age 12 and across multiple settings (American Psychiatric Association, 2013). The symptoms must be noted to interfere with overall functioning, which cannot be better explained by another mental disorder (American Psychiatric Association, 2013). In addition, it must be specified as one of the three presentations: (a) combined presentation, (b) predominantly inattentive, or (c) predominantly hyperactive/impulsive, with severity ranging from mild to severe (American Psychiatric Association, 2013). It is important to note that the well-being of the entire family can be disrupted by the symptoms of ADHD (Peasgood et al., 2016). This nomenclature system, although imperfect, gives clinicians a concise way to communicate about ADHD.

The guidelines for diagnosis are clear; however, the objective nature of the diagnosis process, and debate about what ADHD really is has continued to cause confusion and controversy in the literature. Gualtieri et al. (2005) offered that ADHD is a psychiatric disorder, but not a mental illness. They suggested ADHD is a “constellation of personality traits and cognitive styles” and “like most mild impairments people can learn to adjust to it” (Gualtieri et al., 2005, para. 11). To adapt functionally, Gualtieri et al. (2005) pointed out the necessity to improve the problematic way ADHD is diagnosed and subsequently treated.

Standards of Assessment and Diagnosis

The assessment and diagnosis process, although standardized, is often adjusted by the clinician depending on the setting (Lange et al., 2010; Visser et al., 2015), and although ADHD is classified as a neurobiological disorder at the time of this research, there is not a valid way to use the neurological information to diagnose ADHD (Nigg, 2012). In a 2015 literature review titled “Why the Diagnosis of Attention Deficit Hyperactivity Disorder Matters,” Hamed et al. offered a synthesis of the research, highlighting the complexities that arise throughout the diagnosis and treatment planning process. At the forefront of the findings, it was indicated that a proper diagnosis allows children and their families to obtain the assistance they need for long term success (Hamed et al., 2015). However, several barriers and considerations stood out that may hinder the process. For this study, these barriers were divided into two distinct categories: (a) family level barriers and (b) clinical level barriers.

Within the family unit, these barriers stretch from the time leading up to diagnosis, to choosing from and adhering to treatment plan options. It is important to understand that prior to deciding whether to have a child evaluated for ADHD a family has unique factors and fears about stigmatization that may mediate the decision to seek support. Specifically, Hamed et al. (2015) found cultural factors in the family unit, parental view of behavior, and the level of trust between parent and teacher, aid in the resolve to seek support. In addition, it is important to recognize that a diagnosis of ADHD can be viewed as a highly stigmatized diagnosis with negative connotations (Lebowitz, 2016). This, taken with the dominant view that having a disability is limiting (Garland-Thomson, 2012), can deter parents from having their child assessed or seek

treatment (Lebowitz, 2016). Sensitivity and awareness of these barriers may allow clinicians to better support families throughout each stage of the process.

Additionally, research has offered that barriers exist in the evaluation process itself. These include access to mental health providers, subjectivity in the diagnosis tools, and controversies surrounding treatment (Hamed et al., 2015; Lange et al., 2010). With limited access to mental health clinicians, most children are diagnosed and treated by their primary care physician (Hamed et al., 2015). Although the evaluation through a medical practitioner is found to be efficacious, the diagnostic complexity and time constraints can hinder management of ADHD through a pediatrician (Gualtieri, 2005). Partially due to these factors, Hamed et al. (2015) illuminated disparities with proper protocol and evaluation standardization exist, that can lead to poor management and long-term success in the treatment of ADHD. The task to make an objective diagnosis for a seemingly subjective disorder and design an individualized treatment plan, can be a daunting task without proper training and adherence to best known protocols.

Diagnostic assessment and evaluation of ADHD has been problematic throughout history. In the 1960s, it was recommended that an ADHD diagnosis come from a psychologist with direct observation of the child's behavior in the classroom or activity room (Gualtieri et al., 2005). Another approach, still used by some in 2022, includes a double-blind trial of stimulant medication with behavioral observations (Gualtieri et al., 2005). These suggestions were subjective in nature with several limitations. It is common practice in 2022 for clinicians take on a more systematic approach to assess children for ADHD.

There is no single test used to diagnose ADHD, and depending on the setting, the recommendations for assessment may differ (Gualtieri et al., 2015). However, clinicians are advised to rely on a variety of tools to assist in the evaluation process. These include a combination of direct observation, questionnaires or rating scales, school reports, developmental history, and psychological testing (Gualtieri et al., 2005; Hamed et al., 2015; Visser et al., 2015). Additional medical tests, such as sight, hearing, and blood tests, may be offered to rule out other medical conditions (Gualtieri et al., 2005). With this comprehensive process, clinicians can provide a symptom analysis instead of a one-size-fits all diagnostic categorization.

In a statistical report conducted in 2015, Visser et al. described the diagnostic experience of children in the United States. Drawing from the 2014 National Survey data, this report indicated that age 7 was the median age children were diagnosed with ADHD (Visser et al., 2015). In addition, the diagnostic clinician included a variety of health care providers, such as physicians and specialists; primary care physicians being the main source for diagnosis (Visser et al., 2015). Interestingly, if a child was diagnosed prior to age 6, the diagnosis typically came from a psychiatrist; whereas, if a child was diagnosed after age 6, the diagnosis was more likely to come from a psychologist (Visser et al., 2015). The concern for diagnosis typically came from a family member, and secondary were school and daycare providers (Visser et al., 2015). Methods (listed most common to least common) used to assess for ADHD included a combination of clinical parent interviews, behavior rating scale or checklists, neuropsychological testing, and neurological imaging or laboratory tests (Visser et al., 2015). Pairing with these statistics, Spencer et al. (2007) reported 50% to 75% of children are diagnosed with combined type,

20% to 30% are diagnosed with inattentive type, and less than 15% are diagnosed with hyperactive-impulsive only presentation. The Centers for Disease Control and Prevention (CDC, 2020) statistical data from 2019 reported 8.8% of children aged 3 to 17 are ever diagnosed with ADHD; among that statistic, 11.7% are boys and 5.7% are girls.

Historically, a deficit model has been used to understand ADHD. Clinicians and researchers that ascribe to a positive or strength-based perspective question if this method allows for a holistic approach to case conceptualization and treatment planning (Sedgwick et al., 2018). Although things have shifted slightly, ADHD has been viewed synonymously with problematic behavior throughout history, perpetuating the deficits perspective. This offers little in the way of embracing a positive outlook for parents as they begin to conceptualize their role in raising a child with ADHD.

Impacts of Attention Deficit Hyperactivity Disorder

Armed with an understanding of the history, symptoms, etiology, diagnostic, assessment, and statistical data, the next domain that is important to understand is how ADHD symptomatology is thought to impact the family, school system, and long-term outcomes for the individual (Evans et al., 2006). This is an important domain to explore when considering why research on ADHD is so heavily employed and still so tremendously needed. Much of the research covering ADHD in these domains focus on the effects or impacts ADHD can cause; however, for this study, the review of the research offered an overview of the types and purpose of prior studies that are most prevalent.

Familial Considerations

The literature on ADHD has often cited the difficulties families face in raising a child with ADHD (Coghill et al., 2008; Cunningham, 2007; Harpin, 2005; Johnston & Marsh, 2001). Having a child with ADHD in the home impacts marriages negatively, causes an increase in family stress, and affects siblings (Coghill et al., 2008). These consequences are discussed as common knowledge; however, care is often given to acknowledge the gap that exists in understanding these complexities (Cunningham, 2007; Johnston & Mash, 2001). Furthermore, research on families has focused typically on the family environment with a cause-and-effect lens, neglecting the mechanisms that underlie these associations (Johnston & Mash, 2001). In addition, Johnston and Mash (2001) pointed out research on families of children with ADHD has lessened, mostly since the 1970s, and has argued that many questions remain unanswered. Although a search including “family and ADHD” returns many results, the type of research and age of the study are important factors to consider.

One focus of ADHD and family research has looked at intervention outcomes and the family’s perceived view of usefulness. In a European study, Coghill et al. (2008) surveyed parents of children with and without ADHD to understand the impact of ADHD on everyday activities, general behavior, and family relationships. Groups were further broken down by those currently receiving medication, with specifiers of 12- and 6-hour stimulants. Compared with the normative sample, the parents of children with ADHD reported that there was more disruption in their homes, such as disorganized, noisy, and impulsive behaviors (Coghill et al., 2008). In addition, this survey found parents reported difficulties in relationships between the child with ADHD and their parents, siblings, and

peers (Coghill et al., 2008). Outcomes of the study offered that although medication can mediate disruptive behaviors, the relationship dynamics were not changed with medication use. Although this study pointed out areas where families may have felt the impact of ADHD symptomatology, the focus was on psychopharmacological interventions and outcomes.

Another realm of ADHD and family research has focused on the need for better ways to capture family dynamics and perceptions of ADHD. Using a family-centered approach to interventions, Cunningham (2007) looked at what can be drawn from research on ADHD and families. It is offered that not all families of children with ADHD report difficult relationships or family functioning, and caution should be taken to be careful to view the relationship between dynamics in the family and ADHD as causality when the interactions are not understood (Cunningham, 2007). This research offered the need for better measures to allow parents, children, and other stakeholders to provide more useful information and greater understanding of overall functioning in ADHD research (Cunningham, 2007). Although this research has not necessarily added to the understanding of family dynamics and ADHD, it has highlighted the need for more utility of the family in research. After all, the claim could be made that the family has a lot to offer outside of the clinical understanding of the effects, both positive and negative, of ADHD (Sedgwick et al., 2018).

Furthermore, reviews of prior literature have been conducted to understand the consensus of ADHD in the family unit. Johnston and Mash's (2001) review has often been cited in subsequent research (Cunningham, 2007; Harpin, 2005), but the recount has often excluded the inconsistencies that were mentioned 26 times throughout the article.

The evidence gathered in this 2001 review indicated an association exists between children with ADHD and disturbances in family functioning. This includes marital discord, increased stress, and relational difficulties (Johnston & Mash, 2001). Although Johnston and Mash (2001) clearly found evidence that parent-child dynamics do influence one another, they also offered two “striking revelations” (p. 199) discovered from their review. First, tremendous inconsistencies were found in the research that was reviewed, and second, there was a gap in understanding the observed associations between family dynamics and childhood ADHD (Johnston & Mash, 2001). When claims are taken out of context, and without proper extraction, the results can be viewed as causation, when indeed what is offered is correlational in nature. Although this review aimed to gain a better understanding of ADHD and the family, what was offered is the need for more research to understand the mechanisms that underly the associations.

What can be seen in a review of the literature on the family of children with ADHD is that many questions remain unanswered. To this point, the literature has been full of research looking at interventions in relation to ADHD and family function, pointing out ways in which families are struggling, but offering little regarding understanding the complexity of the family dysfunction. With a desire to understand what is causing the interfamilial discord, Glatz et al. (2011) focused on how ADHD symptoms may contribute to parents’ view on parenting and subsequently affect their behavior towards their child. It was hypothesized that parents’ feelings of powerlessness may directly influence parents’ display of warmth toward their child (Glatz et al., 2011). The results uncovered that parenting a child with ADHD may indeed lead to parents’ feelings

of powerlessness, affecting the way a parent relates to and guides the child through challenging circumstances (Glatz et al., 2011).

There is not a debate that parents of children with ADHD experience increased difficulties in their parental role. However, understanding the mechanisms that underly these difficulties is often overlooked and blames the child inadvertently (Glatz et al., 2011). This does little to help the parent or child after the child is diagnosed with ADHD. Glatz et al. (2011) offered a shift in focus to develop theoretical models to understand family dynamics and ADHD. Having this type of framework could be used by clinicians as they work alongside parents struggling to understand their role in raising a child with ADHD. In addition to family considerations in the research, academic challenges are an important domain in ADHD research.

Academic Performance

Children with ADHD have a variety of challenges throughout their academic career directly linked to ADHD symptomatology. Due to high rates of comorbid learning disabilities, and pervasively low test scores of children with ADHD, research has focused on understanding the relationship between ADHD and academic performance to help educators, parents, and children learn to compensate, often with school-based accommodations. Difficulties at school can be seen academically, socially, and behaviorally (Evans et al., 2006). For this study, data from the research cited will focus on the academic challenges, and behavioral and social challenges will be addressed later in this paper.

ADHD affects children at school in several ways. Mainly, ADHD can affect a student's ability to pay attention (American Psychiatric Association, 2013). This

translates into difficulty listening to instruction, following along with the teacher, and the effort put into schoolwork (Hart et al., 2010). In the classroom, it is not uncommon for students to submit incomplete work, lose assignments and books, or avoid tasks that require sustained attention. These difficulties can lead to low academic performance with low grades on assignments and tests (Hart et al., 2010). Although poor grades can often be a struggle for students with ADHD, this is not due to an inability to learn (Hart et al., 2010). However, math and reading are two areas often associated with extreme difficulty (Hart et al., 2010). This is thought to be due to processing speed, memory, or executive functioning deficits (Curatolo et al., 2010; Hart et al., 2010).

Research on ADHD in the classroom offers a broad view, depicting the struggles that children with ADHD may face. Although the information on the challenges is plentiful, how to assist children with ADHD remains somewhat elusive. Loe et al. (2007) offered an in-depth review of the educational challenges and outcomes of children with ADHD. Great strides have been made to provide accommodations to offset the characteristics of ADHD; however, there is still very little known about the long-term effects of such interventions (Low & Feldman, 2007). Several suggestions have been offered as considerations for future directions in the classroom, such as alternative method of discipline, increased physical activity, smaller class size, and reducing distractions (Low & Feldman, 2007). Furthermore, it has been suggested that future research needs to include large-scale studies using modern statistical methods, such as hierarchical linear modeling to tease apart the impact of various treatments on outcomes (Low & Feldman, 2007).

Although the common consensus is that children with ADHD may have a lower overall intellectual functioning, or slower cognitive functioning, a selection of students with ADHD may be more properly described using the term *twice-exceptional* (Foley-Nicpon et al., 2011). The term twice-exceptional was developed to capture the gifted child with specific learning disabilities or ADHD (Foley-Nicpon et al., 2011). In a review of the past 20 years, Foley-Nicpon et al. (2011) found support for academically gifted students can indeed have ADHD; although, the rates of cooccurrence are unknown. The difficulty, as they pointed out, is that proper assessment and testing is needed to capture these children (Foley-Nicpon et al., 2011). Although many children with ADHD do not meet these qualifications, it is important to point out that although ADHD does pose educational challenges, the reason for these challenges can be influenced by a variety of factors, including giftedness.

A brief overview of the challenges, misconceptions, and direction for future research is offered to understand the way a child with ADHD may be impacted academically. An overlapping difficulty in most academic literature pertaining to ADHD is the behavioral and social component. These constructs are thought to be directly linked to self-esteem and future trajectory, including comorbidities.

Effects of Attention Deficit Hyperactivity Disorder Across the Lifespan

Much of the research offered thus far has focused on how others view and experience the child with ADHD. Even though that view is imperative in conceptualizing ADHD holistically, it is also important to look directly at how a child with ADHD learns to view themselves in relation to the world. This self-conceptualization includes the

research that is frequently offered regarding long-term prognosis and high rates of comorbidities.

In a literature review focused on understanding what research has uncovered about different stages of development and ADHD, Harpin (2005) provided a breakdown of how ADHD may affect an individual from preschool to adulthood. As little has been referenced about the preschool years because ADHD and typical preschool behavior can be difficult to tease apart, Harpin (2005) suggested the most important part of this stage has to do with parent-child interactions. Without parenting intervention and strategies to help parents cope with the emerging symptoms of ADHD, the child may begin to internalize messages of frustration from parents and caregivers (Harpin, 2005). In the primary school years, several negative impacts begin to emerge. These include struggles with self-esteem, and educational and social difficulties (Harpin, 2005). During these years, it is important for a child to have a thorough assessment to understand the development of comorbid disorders, such as learning disabilities and oppositional defiance disorder. Early intervention can equate to more adaptive outcomes (Harpin, 2005). In the adolescent years and beyond, the difficulties can extend from problems in school and work, to substance use and criminal behavior (Harpin, 2005).

Within the social domain of functioning, research evidence has suggested ADHD may impact relationship satisfaction (Pollock, 2017). This includes social impairment in the family and with peers (Wehmeier et al., 2010). Reduced ability to detect emotional stimuli, deficits in emotion regulation, executive functioning deficits, and inattentiveness are thought to be some of the core contributing features (Pollock, 2017; Wehmeier et al., 2010). With a focus on these difficulties, Pollock (2017) isolated emotional intelligence

to moderate the effects of ADHD symptomatology on relationship satisfaction. The term emotional intelligence is used to capture an individual's capacity for recognizing and controlling the expression of emotion. It was hypothesized that greater emotional intelligence would be positively correlated to relational satisfaction (Pollock, 2017). The results suggest relationship satisfaction was higher when individuals with ADHD also have high emotional intelligence (Pollock, 2017). These findings add to the literature on possible therapeutic treatments, in this case increasing emotional intelligence, that may be beneficial in enhancing overall life satisfaction for individuals with ADHD.

It is also common for ADHD to be associated with comorbid diagnoses (Barkley, 2015a; Evans et al., 2006). Research has shown between 30% and 50% of youth (Dopheide et al., 2009) with ADHD also have oppositional defiant disorder (Evans et al., 2006), and 25 to 35% of those with a diagnosis of ADHD have a comorbid diagnosis of an anxiety disorder, suffer with a mood disorder or depression (Dopheide et al., 2009). Despite the fact that the comorbid diagnosis is important, it is also alarming to understand the many serious outcomes linked to ADHD such as increased risk for substance abuse, difficulty maintaining employment, and relational issues (Evans et al., 2006).

As noted, the symptomatology of ADHD can be associated with many internal characteristics. This brief overview is by no means an exhaustive list. Instead, the intent was to offer a broad range of dynamics to point out the rationale for why more research efforts need to be made. Viewing ADHD as a syndrome, without a one-size-fits-all presentation, can make the complexity of ADHD research more digestible. No one person experiences ADHD the same, but overall, the effects can be felt in many areas of one's life. With an understanding of how ADHD can be experienced on an individualized level,

the next important aspect of research to consider is what happens after a child is diagnosed with ADHD.

Post Diagnosis

A discussion and background of ADHD was offered to give context to what parents and children may experience prior to and during the diagnostic process, and the way they may be experiencing the symptoms of ADHD in many areas of their lives. The next section will address the pertinent post diagnosis topics. This section is important as it aids in the understanding of what parents' experience after diagnosis and why this research is necessary to know how to aid parents during this stage of their journey.

Psychoeducation

To understand the informational needs of parents after diagnosis, several studies have looked at information disbursement, including primary source, as well as discrepancies between professional recommendations and parents' evaluations of appointment helpfulness. In an exploratory descriptive study using focus groups, Bussing and Gary (2001) found information given to parents came mainly from their PCP. Following the professional practice guidelines of recommending a multi-modal treatment approach, the information given was not congruent with what parents felt they needed (Bussing & Gary, 2001). Parents expressed the need for less medicine-focused, comprehensive information, tailored to their child's individual needs (Bussing & Gary, 2001).

Furthermore, Ahmed et al. (2014) looked at 11 studies consisting of 335 parents of children with an ADHD diagnosis. Aimed at understanding the factors which influenced the decision to use stimulant medication, it was also found that treatment

options presented to parents came mainly from the PCP; information was filled with medical jargon, lacked individualized recommendations, and conflicted with information that came from other sources, such as media outlets (Ahmed et al., 2015). This study found similar results as Bussing and Gary's (2001) study, but added parents also felt they needed resources for support groups and unbiased information (Ahmed et al., 2015).

Psychoeducational interventions are being considered a first line of intervention in ADHD treatment (Lantz et al., 2021). Research has found psychoeducation has a positive impact on parent-reported ADHD symptoms and behavioral problems (Dahl et al., 2020). An indication regarding positive outcomes stems from parents having gained increased knowledge about ADHD and how the symptoms influenced their children's behavior (Dahl et al., 2020). The authors theorized having a clearer understanding about ADHD also increases the likelihood of adhering to the treatment (Dahl et al., 2020). Furthermore, Lantz et al. (2021) looked at group intervention finding that most parents responded well to group programs offering psychoeducation.

Treatment of Attention Deficit Hyperactivity Disorder

To meet the information and support needs highlighted above, DeNisco et al. (2015) stressed the need for a multidisciplinary approach to treatment by utilizing a comprehensive collaboration with healthcare providers, parents, educators, and mental health practitioners. This theory was developed to include the family's educational needs surrounding treatment options, including home-based strategies, adverse effects of medication, psychoeducation (DeNisco et al., 2015), and strength focused approaches (Healey et al., 2006). A large aspect of this type of multidisciplinary approach stresses the need for communication between parents, educators, and medical field practitioners

to support a child fully and ensure they reach their full potential (DeNisco et al., 2015). Just as there is not a one-size-fits-all treatment plan for ADHD, this collaborative team approach encourages parents to seek support from multiple avenues to meet their child's needs.

This wraparound approach for support begins with an understanding of the role parenting can have on positive outcomes. Through a narrative review of the literature, Tarver et al. (2014) looked at how parenting interventions may impact outcomes associated with ADHD, such as academic and social functioning. They found that parenting behaviors directly impact ADHD symptomatology and parent-child relationships (Tarver et al., 2014). Furthermore, a psychoeducational approach emphasizing the parent-child relationship and mitigation of aversive interactions has also been shown to improve ADHD symptomatology, leading to less externalizing behavior (Bell et al., 2018). Within this multidisciplinary treatment approach, parents are connected with various types of support to understand what their child needs, what role they play as parents, and it stresses the importance of working with specialists to provide a complete benefit to the child.

As the history and understanding of ADHD has progressed, a link between the known neurocognitive liabilities (Curatolo et al., 2010) and the impacts on academic and social domains have emerged, highlighting a need for intervention (Hinshaw et al., 2014). Research has shown that a multimodal treatment approach produces great efficacy in managing ADHD (Barkley, 2015a; Hinshaw et al., 2015). This multimodal treatment approach includes a combination of medication, psychotherapy, psychoeducation (Hinshaw et al., 2015) and naturalistic/dietary options (Rojas et al., 2005). It is important

to recognize that this approach, although deemed the gold standard, requires an individualized plan to best meet each child's needs (Hinshaw et al., 2015).

In a longitudinal follow-up of the largest study conducted on ADHD, the multimodal treatment study of children with ADHD (MTA), Hinshaw et al. (2015) found that the multimodal/combination approach resulted in optimal outcomes for treating the functional impairments of ADHD. The results showed improvements in academic achievement, social and familial relationships, as well as internal and external traits (Hinshaw et al., 2015). However, it was also highlighted that in the multimodal treatment approach, several variables should be considered when designing the best approach for each child's unique circumstance. The need for an individualized plan lead researchers to question, "which intervention strategies, delivered at which time intervals and at what levels of intensity, are optimal in promoting maintained change for different subgroups of youth with ADHD?" (Hinshaw et al., 2015, p. 47). The challenge parents experience in choosing the best treatment approach for their child with ADHD manifests through this complex question.

Within each treatment modality, there are numerous options to choose from (Barkley, 2015a). These include, but are not limited to, the decision to use stimulant versus non-stimulant medication, understanding which form of psychotherapy and/or psychoeducation is needed, and which of the numerous dietary/naturalistic options to try (Barkley, 2015a). With a diverse range of interventions in this multimodal treatment approach, it is important to understand parents' informational sources, and other factors, such as views and/or stigma about diagnosis, which may influence their decisions about treatment. Prior to diagnosis, parents' knowledge about ADHD may be limited and

information sources post diagnosis vary (Ahmed et al., 2014) leading to question how and by whom they are receiving this valuable information.

Medication

Understanding the main informational sources and the recommended treatment approach, Ahmed et al. (2013) conducted a systematic review focusing on the factors contributing to parental decision about psychopharmaceutical use. Themes and individual level factors influencing the decision to medicate children with ADHD were identified, and both the approach the clinician used in delivering information and attention to parental concerns were addressed. They found that the way parents confronted the diagnosis and the impact of external influences, such as contradictory information from media sources, type of concern about stimulant therapy, and general experience with professionals in the medical field, played a role in determining the use of medication as a treatment option (Ahmed et al., 2013). Consistent with the prior two studies, commonly expressed concerns included: (a) a need for more comprehensive and unbiased information, (b) limited consultation times, and (c) lack of avenues for support after diagnosis (Ahmed et al., 2013).

The expansive research on ADHD offers evidence-based treatment options, parents' opinion on informational sources, and data supporting the use of a comprehensive collaborative approach. There are numerous areas of concern that can be highlighted throughout the literature when it comes to treating ADHD, but what remains elusive is whether the recommendations from research are being used. Acknowledgement and inclusion of this type of information is an essential area for future research. To aid in the understanding of ADHD that is offered in the literature, the research question of this

study focused on parents' experience in seeking and finding support for their child with ADHD with a slightly different lens than prior studies have offered. This study looked at empirical treatment options beneficial in treating symptoms of ADHD, in conjunction with information disbursement after diagnosis, and parents' experience in accessing appropriate support and interventions. By including the parents' experience and first-hand accounts of what it is like to raise a child with ADHD, the mental health field could benefit from a more holistic view of this complex syndrome. Ultimately, the goal is to uncover better ways to serve the needs of this vulnerable population.

Rationale, Purpose, and Research Questions

The purpose of this study was to understand the parents' journey of having their child diagnosed with ADHD, with a focus on understanding how the mental health field can better serve parents from the beginning. The rationale for focusing on the parents was to better understand their experience as the caretakers, an important role that may impact the long-term outcomes for children with ADHD. In this qualitative study, I posed research questions directly related to these three overarching questions to parents of children with ADHD:

1. What is the experience like for parents prior to, during, and after their child is diagnosed with ADHD?
2. How do parents understand the ADHD diagnosis?
3. What meaning do parents ascribe to their role in parenting their child with ADHD, including their role in treatment implementation?

Chapter 2: Qualitative Methodology

Purpose Overview

This study was designed to understand a parent's experience after having a child diagnosed with ADHD, but specifically it focused on what factors prompted parents to seek an assessment, the overall experience of having their child evaluated, and how the diagnosis assisted in finding the right kind of support for their child. Through semistructured interviews, the goal was to uncover how parents process, make meaning of, and understand their role in helping their child. Ultimately, the focus was to expose how the mental health field could better assist parents after diagnosis. At the time of the study, to my knowledge, there have not been any studies published to specifically address the current gap that may exist in understanding the parents' journey in helping their child after being diagnosed.

The following section describes the relevant underpinnings and procedures that were used during this study. This includes the design strategy, philosophical worldview, research methodology, sample characteristics, participant recruitment procedures, methods of data collection, and analysis. In addition, procedures will be described to ensure credibility, reliability, validity, and protection of the study participants.

Design Strategy and Philosophical Worldview

A phenomenological qualitative research design was used to gain a rich understanding of the parents' experience finding support for their child with ADHD. Qualitative research, originally developed by philosopher Edmund Husserl (Wertz, 2005), is a method of study that uses an inductive style of exploration to ascribe a deeper meaning to a particular human experience (Creswell, 2014). In qualitative research, the

researcher is the main instrument, producing a product that is rich and descriptive (Merriam et al., 2016). Phenomenological design allows the researcher to identify and gain understanding of a phenomenon through the lived experience described by the research participants (Creswell, 2014; Wertz, 2005). The purpose of the phenomenological approach in research is to illuminate, identify, and ultimately come to a greater understanding of phenomena through how they are perceived by individuals impacted by a situation (Creswell, 2014). This normally translates into gathering deep information and perceptions through inductive, qualitative methods such as interviews, discussions, and participant observation, and representing it from the perspective of the research participant(s). Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity and emphasize the importance of personal perspective and interpretation (Merriam et al., 2016). As such, this worldview was useful in understanding the subjective experience of parents, to gain insights into people's motivations and actions in the treatment of ADHD.

In addition, a transformative worldview was embodied in this study with a focus on making a difference in the lives of children diagnosed with ADHD. This worldview was developed to broaden issues examined by researchers to include societal issues of power, social justice, discrimination, and oppression (Creswell, 2014). Further, it has been described as being a lens used for advocacy (Sweetman, 2010); thus, this study examined access to support for a class of children protected under the Americans with Disabilities Act. More specifically, in the transformative worldview, a disability inquiry lens guided the study in a way that focused on a need for change in the mental health field (Creswell, 2014; Sweetman, 2010). Great effort was taken throughout this study to

avoid adding to the deficits lens that often coincides with literature on ADHD. The goal of using this worldview was to understand the challenges in treating children with ADHD to better understand and serve this vulnerable population.

Participants

A small sample of six participants was selected for this study. Participants were recruited from word-of-mouth marketing, snowball sampling, and an online post submitted through Facebook asking people to share the post to others to find volunteer participation for this study. Contact information was gathered and interested individuals were contacted and screened to insure they met eligibility. Once inclusion criteria were determined, interested participants were given a brief description of the study and asked to schedule a time to meet. Prior to our scheduled meeting, participants were asked to read and sign an online consent form giving permission to include their information in this study. The inclusion criteria for this study required that participants were parents of a child between the age of 5 to 15 years old with ADHD, living in the same home. This inclusion criteria were created to capture the most common age group of children diagnosed with ADHD and to ensure participants had a more recent experience with the diagnostic process. Volunteers were not offered any incentives to participate.

Research Methodology

The following section outlines the data collection procedures, interview process, and participant protection protocols that were followed.

Data Collection Procedures

Informed consent forms (see Appendix A) were used containing a description and purpose of the study, benefits, and risks of participating, offered information about

gathering support, voluntary participation, and contact information of the researcher. Prior to the interview, electronic consent forms were signed through Qualtrics, a data software program, and both the researcher and the participant were given access to a copy. Meetings were scheduled with participants and held virtually through Microsoft Teams, a secure online meeting platform. Interviews were video recorded, and participants were given opportunities to ask questions throughout the interview.

Interviews

The tele-interview began with a demographic questionnaire asking for basic information about the family (see Appendix B), followed by four central research questions inquiring into participants' experience having their child diagnosed, finding support to understand the diagnosis, and their experience with different treatment options (see Appendix B). Both questionnaires were specifically designed by me for this study. The interviews lasted between 60 and 90 minutes, and were administered in a semistructured, open-ended question format. This semistructured format allowed me, as the researcher, to inquire further or go in a different direction with questions as needed, or where appropriate (Merriam et al., 2016). I took notes throughout the interview on specific things participants said that I felt held significance. The focus of the interview was to understand the participants' experience in the journey of having their child diagnosed, the meaning-making process of understanding what the diagnosis meant for them, and their role in parenting and treatment implementation for their child. All questions asked had that focus in mind.

Field Notes

After the interview, I compiled reflection notes. Reflection notes are important in qualitative research to assist in documentation and analysis (Maharaj, 2015). These notes included participants' behavioral characteristics, such as appearance, demeanor, and my own feelings and interpretations of what was said during the interview (Maharaj, 2015). I also documented overarching themes I extracted from the interviews.

Member Checking

In addition, member checking was completed several times throughout the interview to ensure highest reliability and validity of the data collected (Creswell, 2014). The member check was used to determine accuracy by allowing the participants to determine if the report accurately depicted their story (Koelsch, 2013). At the conclusion of each interview, I reviewed my notes and extracted themes with participants. This was done by restating or summarizing what was discussed to ensure accuracy by checking that summaries and interpretation were correct. Participants were given an opportunity to correct misinformation or add to the discussion at this time.

Protection of Human Subjects

To ensure study participants were well protected, approval was obtained through the institutional review board prior to execution of the study. Each interview was video recorded with participants' information deidentified and kept securely to maintain their confidentiality. Participants were also given a pseudonym to ensure their real names were kept private.

Data Analysis

Before analysis began, data were first organized, reviewed, and then coded (Creswell, 2014; Smith & Nizza, 2022). In qualitative research, codes or themes are used to summarize or condense data and are often a short phrase or word (Saldaña, 2009). Transcribed interviews went through a series of analysis, first using the Atlas Ti qualitative data analysis software and then utilizing the structure and tables outlined by Smith and Nizza (2022). The Atlas Ti program was used in the initial analysis stage to organize the data, and to manage the data during the next transitional phases and processes.

Promoting Study Reliability, Credibility, and Validity

The following section will discuss the protocols that were followed to ensure the utmost reliability, credibility, and validity.

The Researcher's Role and Reflexivity

For this study, I was the main data collecting instrument used as the researcher. Although this was a beneficial part of qualitative research, personal values, assumptions, and biases need to be noted (Creswell, 2014). My perception of access and support after a parent receives an ADHD diagnosis for their child was shaped by my personal experiences. Raising a child with ADHD, I am aware of the tremendous amount of education and support needed to help offset the broad range of symptoms of ADHD. The information given to me by my child's primary care physician (PCP) did not come close to answering the unending questions I had as I learned about ADHD, and without a one-size-fits-all treatment plan I was often confused about how to help my child. Furthermore, locating services, such as coaching and therapy, and professionals who

specialize in ADHD proved difficult. This experience has motivated me to seek out others' experience and find solutions to better assist parents along their journey in finding support. I believe this firsthand account increased my ability to understand the vast challenges participants faced as they recounted their own stories.

Reliability and Validity

Validity strategies incorporated throughout this research project include triangulation of the data, member checking, peer debriefing, and reliability coding. Triangulation was used to bring a holistic approach to the process and incorporate checking different data sources (Creswell, 2014). Data triangulation was achieved through close consideration of not only what the participant said, but also the tone and expressions used, and through using the field notes collected by the researcher.

Member checking is the process of clarifying meaning to insure internal validity (Creswell, 2014). This process included a discussion with participants after the interview to review the big picture results prior to coding the transcript to check my initial analysis. This process allowed participants the opportunity to provide feedback on the themes that were extracted, and my overall understanding of their journey.

Peer debriefing checks for accuracy of the researcher's account, offering unbiased opinion on the study outcomes, and provides validity to the themes and subthemes (Creswell, 2014). For this study, one peer debriefer reviewed three of the transcripts to determine if the extracted themes accurately represented the findings. The peer debriefer was a counseling psychology doctoral student who had experience working with children and their families. The debriefer understood the research aims of this study but was not given an account of the specific procedures used in the analysis framework process. The

themes and subthemes, as well as the direct quotes, were discussed to check that the data extracted were accurate and captured the essence of the participant's journey. The debriefer noted some areas in the analysis that may have reflected a slight bias based on my experiences of raising a child with ADHD. These comments were considered and the analysis was refined to minimize any potential biases.

In addition, intra-rater reliability was used to measure the degree of consistency in analyzing and coding the data (O'Connor et al., 2020). To conduct the intra-rater reliability analysis, I recoded a transcript after several months after the initial analysis and compared the results. Based on the initial coding and recoded transcripts, a weighted kappa analysis was performed that yielded an intra-rater reliability coefficient index of $\kappa = 0.93, p < .001, 95\% \text{ CI } [0.827, 1.04]$. This value indicates a strong intra-rater reliability agreement.

Summary

This study was designed to understand a parent's experience after having a child diagnosed with ADHD, but specifically it focused on what factors prompted parents to seek an assessment, the overall experience of having their child evaluated, and how the diagnosis assisted in finding the right kind of support for their child. A phenomenological qualitative research design was used to gain a rich understanding of the parents' experience finding support for their child with ADHD. In addition, a transformative worldview underlies this study with a focus on making a difference in the lives of children diagnosed with ADHD. A small sample of six participants who met the inclusion criteria was selected for this study.

Informed consent forms (see Appendix A) were used containing a description and purpose of the study, benefits, and risks of participating, offered information about gathering support, voluntary participation, and contact information of the researcher. Tele-interviews were conducted using the Teams platform and were video recorded and transcribed. Participants were given opportunities to ask questions throughout the interview. The tele-interview began with a demographic questionnaire asking for basic information about the family (see Appendix B), followed by four central research questions inquiring into participants' experience having their child diagnosed, finding support to understand the diagnosis, and their experience with different treatment options (see Appendix B). After the interview, reflection notes were compiled. In addition, member checking was completed several times throughout the interview to ensure highest reliability and validity of the data collected (Creswell, 2014).

To ensure study participants are well protected, approval was obtained through the institutional review board prior to execution of the study. Before analysis began, the data was first organized, reviewed, and then coded using both the Atlas Ti software and the procedural steps described by Smith and Nizaa (2022). For this study, the researcher was the main data collecting instrument used. Although this is a beneficial part of qualitative research, personal values, assumptions, and biases have been described, as my perception of access and support after a parent receives an ADHD diagnosis for their child is shaped by my own personal experiences. Validity strategies incorporated throughout this research project include triangulation of the data, member checking, peer debriefing, and reliability coding.

Chapter 3: Findings

The purpose of this study was designed to understand a parent's experience after having a child diagnosed with attention deficit hyperactivity disorder (ADHD), but specifically it focused on what factors prompted parents to seek an assessment, the overall experience of having their child evaluated, and how the diagnosis assisted in finding the right kind of support for their child. The rationale of doing such a study was ultimately to uncover how parents process, make meaning of, and understand their role in helping their child. Ultimately, the goal of this study was to expose how the mental health field could better assist parents throughout their journey in raising a child with ADHD. This was accomplished by applying a phenomenological qualitative research design, guided by the following research questions:

1. What is the experience like for parents prior to, during, and after their child is diagnosed with ADHD?
2. How do parents understand the ADHD diagnosis?
3. What meaning do parents ascribe to their role in parenting their child with ADHD, including their role in treatment implementation?

This chapter presents a summary of the findings of this qualitative study looking at six parents' experience having their child diagnosed with ADHD. The small sample size allowed for a deeper analysis of experiences and enabled the researcher to identify common or divergent themes that represent the lived experiences of the parents (Smith & Nizza, 2022).

Data Analysis and Procedures

Phenomenological qualitative research designs commonly use a variety of data analysis strategies to pull themes from the data (Saldaña, 2015). This study used an interpretative phenomenological analysis (IPA) framework to focus on the participants' lived experience and how they made sense of a major life event (Pietkiewicz & Smith, 2014). IPA is an approach that draws on three philosophical principles to establish a set of procedures that guide the analysis and examination of the data provided by participants (Smith & Nizza, 2022). The three theoretical underpinnings of IPA include phenomenology (i.e., the study of human experiences), hermeneutics (i.e., the theory of interpretation), and ideography, which is a focus on the particulars (Smith & Nizza, 2022). Instead of offering a single summary of the group experience, IPA focuses on case-by-case analysis of each interview to produce patterns or themes where experiences of a single phenomenon converge or differentiate (Smith & Nizza, 2022). More specifically, I applied the four-phase approach to IPA analysis as outlined by Smith and Nizza (2022).

Using a case-by-case analysis structure, the first phase of applying the IPA strategy requires the researcher to read through the transcript while relistening to the recorded interview and making notes of initial reactions or thoughts in the margin (Smith & Nizza, 2022). During this phase, the data was managed and organized using the coding software, ATLAS.ti. These expository notes included descriptive notes (i.e., summaries of explicit meanings), linguistic notes (i.e., the actual words and how they were expressed), and conceptual notes which were used to formulate questions about the data (Smith & Nizza, 2022). The next phase in IPA is to develop experiential statements

(Smith & Nizza, 2022). During this stage I used a table to organize the data, which included corresponding quotes from the participant. Experiential statements were formulated by analyzing the series of expository notes and required a condensing effort to capture important aspects of the participants' experience (Smith & Nizza, 2022).

The third phase, "finding connections and clustering experiential statements" is a process of refining the statements to clarify the key features in the phenomenon (Smith & Nizza, 2022, p. 55). To do this, I made groupings or clusters of statements that were conceptually similar and that linked back to overarching research questions. Once the clustering was significant, I compiled a table of participants' personal experiential themes and corresponding quotes in the fourth phase (Smith & Nizza, 2022). The title of each experiential theme was developed by capturing the essence of the themes that were brought together (Smith & Nizza, 2022). These four phases of analysis were completed individually for each interview. Additionally, although the research questions ultimately guided this study, I remained open to themes that were not directly relevant to the established research questions (Pietkiewicz & Smith, 2014).

The final process in IPA was to complete a cross case analysis combining all individual themes together (Smith & Nizza, 2022). The focus with this process was to identify connections, similarities, or differences between the participants' experiences (Smith & Nizza, 2022). This process required continued analysis of individual themes to ensure they adequately fit in the developing combined themes. The results of this analysis allowed me to combine themes into three overarching group experiential themes (GETs) and associated subthemes (Smith & Nizza, 2022). The final output yielded three main themes, each having three to four subthemes (see Table 1). The titles I gave to the main

themes were designed to capture the essence of participants' stories specifically: The Realization That Help Was Needed, Diverse Experience of the Diagnostic Journey, and Putting It All Together – Moving Forward After the Diagnosis. Table 1 offers an overview of the themes and subthemes.

Table 1

Group Experiential Themes and Subthemes

Theme	Subtheme
Realization That Help Was Needed	1a. Perceiving behavior as neurodivergent 1b. Presupposing viable diagnoses 1c. Acknowledging the impact
Diverse Experience of the Diagnostic Journey	2a. Seeking the assessment rationale 2b. Varying sense of clinical support 2c. Understanding the whole picture
Putting It All Together – Moving Forward After the Diagnosis	3a. Making meaning from the diagnosis 3b. Learning to adapt 3c. Reflecting on the positive changes 3d. Relating to interpersonal dynamics

Description of Participants

To be eligible to participate in this study, individuals had to be parenting a child with ADHD currently living in their home. In addition, I required the children with ADHD be between 5 and 15 years of age. These requirements allowed me to capture a specific period in a child's development, while the experience having them diagnosed would still be recent in the parents' minds. All participants met eligibility requirements and completed all required components of this study. Regarding gender, all participants identified as women, and all but one was married. Four participants lived in the Pacific Northwest, one participant lived in the Southwest, and one lived in the Southeastern

region of the United States. Each participant had between one and three children, and four of the children were boys, three were girls. The age at which the children were diagnosed ranged from age 5 to age 15. One parent had two children who were both diagnosed with ADHD. All but one participant answered “yes” to having an immediate family member (other than their child) diagnosed with ADHD. Table 2 presents basic details about each of the study participants.

Table 2

Description of Participant Attributes

Pseudonym	Education	Marital status	Total # of children	Child's sex	Age ADHD diagnosis (time elapsed)	ADHD type	Others in faculty diagnosed with ADHD
Jessica	BA student	Married	1	M	5 (1 yr)	Combined	Husband
Kim	BA	Married	2	F	8 and 10 (5 yrs)	Inattentive	Self
Hannah	BA	Married	2	F	9 (1 yr)	Inattentive	Nephew
Grace	BA	Single	1	M	15 (3 mos)	Inattentive	n/a
Hailey	Some college	Married	3	M	7 (7 yrs)	Combined	Child's father
Kelly	Some college	Married	3	M	6 (7 yrs)	Combined	Child's father

Findings of Group Experiential Themes

The results of the analysis yielded three overarching themes. The following section offers an in-depth analysis of each of these themes and corresponding subthemes.

Theme 1: Realization Help Was Needed

At the beginning of the interview, participants were asked to describe what difficulties or challenges they witnessed their child facing prior to their child being diagnosed. This question captured how the parents experienced parenting their child and

what things stood out to them as they recalled this formational period. During this time, they each worked to formulate a sense of what was happening for their child and offered a variety of observations, ultimately, leading them to the realization that they needed to get help for their child that went beyond what they could offer as a parent.

Within this overarching theme, three subthemes emerged that best captured the individual and varying experiences, both highlighting similarities and dissimilarities. One area of concern expressed by all parents was viewing their child's behavior as neurodivergent. Although some parents focused more on how they were unsettled by the negative external behavioral characteristics their child displayed, others offered specific traits they perceived as concerning. In addition, each parent shared how they began to make sense of the divergent behaviors and traits by presupposing variable diagnoses. At some point along their journey, all but one of the parents began to suspect ADHD identified, with varying degrees, their comorbid diagnostic suspicions as well. Finally, a subtheme was created to capture the parents' emotional response and how they each went through a stage of grief in response to the impact these behaviors were having on their child, themselves, and their families. This acknowledgement was often paired with fear about what it would mean for their child to have a diagnosis. Participants' unique and individual journeys prior to diagnosis, and the different ways they made sense of their experiences are reflected in the following sections.

Perceiving Behavior as Neurodivergent

Participants reflected a dialectic reflection on how they viewed their child's difficult behavior while taking care to not denigrate their children. Jessica's story was filled with confusion over the behavioral intensity her son displayed at times that she felt

were inappropriate. These challenges began from a very young age and included angry outbursts that were in opposition to how she viewed her son's overall temperament. The description she offered of her son was that he was filled with love and warmth, which modeled the type of home environment she and her husband felt they created as well. As the intensity and her son's age grew, Jessica began to see the extremes in his behavior as something of a concern, offering, "There was a lot of anger, really hyper, just not listening at all. Which was different than normal 4 year old 5 year old behavior."

Kim described the differences she saw in her younger daughter as concerning, when comparing the attitudes and behavior to her older child. She believed her daughter acted younger than was developmentally appropriate for her age, noting that she had a big imagination. This concern continued to grow when her daughter entered school. Kim's analysis was confirmed during the first few years of school, and she became painfully aware that these characteristics, that she viewed as special and unique, were beginning to set her daughter apart from other kids her age. She offered a summary of the behavioral concerns that she saw as much younger than her daughter's actual age. Kim said:

Impulsive behavior, a lot of destructive. Not like big things, but little things. And really emotional, very quick to get angry and like just not knowing how to handle big feelings. Those were a lot of the main things. Super chatty at school all the time. Couldn't wait, always had to be like get further into the front of the line.

Couldn't wait her turn up. Kind of just always moving around.

Hannah's experience differed in very specific ways. It was not until her son was 14 that he began expressing concerns. In his younger years, she described her son as average,

both developmentally and academically. Although she noticed he began struggling during the pandemic, when his schoolwork became a virtual endeavor, she felt her son kept his struggles private. This created a unique challenge for Hannah as she struggled to know how to help her son. As the concern in his behavior became more closed off, and his grades began to suffer, she reflected that it was difficult for her to know what was going on and that he became really “closed off.” Although some of this behavior could be explained as developmentally appropriate for his age, the change in his academic performance could not be ignored. Hannah stated:

Up until COVID he was always a total straight A student and then. . . they were completely remote and then [he] kinda hit a wall. . . and just stopped turning stuff in and started like being on the brink of failing classes. It definitely took a pretty significant toll, and this year has been a struggle.

Grace, a homeschooling mom of two, offered her experience in having both daughters diagnosed with ADHD. When the girls were younger, she recognized similar traits she experienced personally in learning and made the decision to homeschool. Overall, she described her girls as being “normal kids” who just struggled with following directions and were easily distracted. Her description of these behavioral traits was offered in a nonchalant yet acknowledged manner. Throughout her story, Grace continuously described their ability to manage things, although the following concerns were apparent:

We can't give like multiple step instructions because they get through the first step and they're like, 'well, wait, what're what's next? What am I supposed?' Even if it's . . . brush your teeth, put your pajamas on and get ready for bed.

Simple tasks, you know cleaning up a room, put stuff away - they shouldn't be very hard, but it was.

Hailey, a young first-time mom, recounted with great sentiment how challenging her experience was with her son from the beginning. Feeling judged by others, and not knowing how to navigate daycare, social challenges, and concerning dangerous behaviors, she offered a holistic narrative fraught with emotion and turmoil. Although she did not discount the severity of the behavioral issues, she also felt a deep need to defend and understand her child. With profound love and concern for her son, Hannah gently shared:

He was constantly being kicked out [of daycare] or I was getting phone calls to come get him. And for things just like he can't stop moving or just not following rules. He was doing things that the other children weren't doing . . . he was doing things like jumping off of things or the weird thing he was doing was he would like pick things and stick it up his nose. We were constantly at the pediatrician for sinus infections, and they were having to pull stuff out of his nose.

Kelly was a single mom for the first few years of her son's life. She remembered the early years with her son as chaotic and desperate. Her story offered a unique perspective on trying to navigate coparenting with a child exhibiting dysregulated behavior.

Specifically, she focused on how her son exhibited both internalizing and externalizing patterns, and how she felt these set him apart from other children his age. Kelly said the following about her son's behavior:

I knew pretty early on something was different . . . when I compared him to preschool peers and family cousins . . . he's either the sweetest, most loving and

kind kid, or he's completely out of control. But another thing that I noticed was [that] he wasn't malicious. He couldn't control himself, but it wasn't his goal to hurt somebody or make somebody mad.

Presupposing Viable Diagnoses

All the mothers had come to suspect their child was exhibiting behaviors to a degree that may warrant a diagnosis and offered both their initial suspicions and related feeling. Jessica and Kelly both suspected ADHD but were more concerned about the possibility of a different diagnosis. They had a shared sense of fear in how these diagnoses may be difficult to manage and affect their child long term. Jessica suspected her son was displaying traits found in autism spectrum disorder (ASD). Jessica offered, "We would still love him," but assumed the challenge with ASD would be extensive. Kelly suspected her son's mood swings may reflect a bipolar diagnosis, stating:

I literally thought we're going to be dealing with bipolar. And like in those cases, it feels like you have to medicate to live a normal life right? With a lot of those more serious types of mental disorders. I was terrified.

Kim and Grace had heightened concerns for their child's academic abilities and focused on understanding how possible learning disabilities could be a factor that needed to be addressed. Although the behavioral components identified by each were challenging at times, they seemed to take a backburner to the challenges with learning. There also seemed to be a sense that they could handle the behavioral tendencies but felt ill equipped to help offset the learning challenges, without a deeper understanding of why their child was struggling academically. They each expressed feeling deeply exasperated and

eventually decided to look beyond the issues being simply explained by a learning disability alone. The following reflections were offered. Kim said:

[She was] actually denied for any kind of service at school, even though they admitted that there were issues . . . there was fine motor delays. . . . She needed occupational therapy and she needed help with writing . . . written expression. We were getting really frustrated with kind of some of the challenges at school. I started kind of researching . . . academic challenges . . . and a lot of the ADHD stuff came up.

Grace shared:

School work, it just took forever to get through. It was probably first grade and I just I couldn't put my finger on what it was that wasn't working. A lot of this stuff is really common with dyslexia as well as the ADHD, so there's a lot of overlapping in there.

Hannah's story was unique from the others. At age 14, her son expressed concerns he thought he could be autistic and asked to have an evaluation done to help him determine the cause of his self-identified struggles. Hannah, wanting to support her child, did not rule out the possibility; however, she suspected his symptoms could better be explained as anxiety and/or depression. ADHD was not on either of their radars. Hannah offered the following reflection:

As far as what was going on with him . . . I didn't know what would be the diagnosis. But definitely, in my opinion, something that they were ruling out . . . to appease his thoughts, 'cause he decided that he thought that he could be autistic

. . . but my impression was just anxiety and depression. But that was as much as I was really aware of or that's kind of where my thoughts were centered.

Hailey's story was filled with both fear and concern about what a diagnosis could mean for her son. With trepidation, she avoided having him evaluated to protect him from the stigmatization she felt would come with a label. She suspected her son's behavior matched what she knew about ADHD and had slight concern about autism as well. Emotion was apparent as she reflected on the internal battle she experienced during this time. Hailey stated:

Also almost like not wanting to . . . accept it . . . because you hear it so much and it's almost like there's a stigma around it. And so I'm just being afraid of . . . what would come with that, like the judgement. So I kind of honestly avoided it for a little while. I was really worried about this stigma with ADHD, so that was probably the biggest thing for me.

Acknowledging the Impact

Each participant recognized the impact being uninformed was taking. Prior to coming to a place of acceptance, and without conscious awareness, the parents' stories were inundated with grief. There was a range of impacts parents described as they recounted this part of the journey. Jessica, wanting desperately to understand what was causing the assortment of difficulties for her son, experienced a substantial degree of anxiety. As she described this transitional time, she also expressed being scared and nervous. She was able to articulate the difficulty she was having but placed more importance on how she saw her son being socially and emotionally affected. She reflected on times her son was yelled at because adults lost their patience with him, and

how his difficulty with communication kept him from connecting with peers. Witnessing the way her son was being impacted, her focus began to shift until she felt armed with a determination that she would do whatever her child needed. Jessica provided the following dialogue with a sadness in her tone:

Whenever there's something wrong with your child, you get all these worst-case scenario thoughts that come into your head. So we were just really scared. He didn't have many friends because he was different, and kids are mean and he just didn't talk. He didn't communicate with people at all.

Similarly, Kim placed high importance on acknowledging that her daughter was suffering and made that her focus. Although the recognition of how she personally was being impacted was minimized, it was apparent how difficult things had been for her as well. Determined and desperate to help her daughter, she described the exhaustive methods she employed at bedtime, how she struggled to adjust her parenting to meet the individual needs of her two children, and the lack of support she felt at the beginning of her journey for answers. The following was an example of that outward focus, and inward acknowledgment. Kim said, "She was getting to the point where it was hurting her confidence and that was what was killing me."

Hannah, on the other hand, felt she was being left out by her son and what he was experiencing. This created an uncomfortable level of confusion and the realization that her ability to understand her child had changed. She was left making assumptions about what was or was not affecting him and had to turn to outside support from his counselor to fill in some of the gaps. Working to address some of my questions proved difficult and was captured in the following response, followed by Hannah's reflection on how things

had changed: “I don’t really know . . . it’s hard for me to say, actually. Yeah sorry, I take that back I don’t know. When they’re little they run your whole life and then they won’t tell you what’s going on.”

Grace leaned heavily on her own experience of having been diagnosed with both dyslexia and ADHD. Although she acknowledged the difficulty that came with the realization that her daughters were experiencing similar struggles, she focused on how she could use this information to offer appropriate support. As she quickly described how she processed the impact, it was apparent she had adapted by focusing on what she could control while staying open about receiving outside support. Although there was a brevity and lack of depth offered at times, there was a sense of desire in not focusing on the past as they had already worked to move forward. Her analysis stemmed from the idea that if she could work to understand herself, then she could understand her girls. The following reflection from Grace shows how her brief acknowledgement quickly turned to a need to understand and accept their situation: “We just finally got to where we’re like, OK, we need some assistance . . . I felt I understood them because they’re a lot like me.”

In the beginning, Hailey described feeling a great deal of ambivalence. She openly described the challenges both she and her son were experiencing but struggled to accept the full impact and described a period of avoidance. She offered that it took some time to process the range of emotions she was experiencing as she continued to be unable to address the concerning behavior her son exhibited. During this time, she recognized she began to blame herself. As a young mom, she felt she had something to prove and did not want herself or her child to be judged. The following reflection from Hailey best captures this processing:

It was hard . . . I knew something was up but you just don't ever know exactly what it is. I felt a little bit defeated, I guess. I feel I'd tried everything and almost like I had failed in a way. Even though I know that's not something that we can . . . I know that now, but at the time I felt very defeated. I was just afraid of what would come with it, like the judgment and the stigma of ADHD.

Kelly second guessed herself and what she thought she knew about how ADHD affected children, which became a difficult thing she had to process. Closely linked to this was a fear that her child would be misdiagnosed, and she openly acknowledge the impact that this significant hurdle had in her journey. A unique challenge she also faced was that her son's father was not on board with her suspicion of ADHD. This made her more cautious and doubtful causing her to question if what her son was experiencing could be better explained by something more "serious." The following passage from Kelly helps illustrate these challenges:

I for sure thought that was what was going on, but almost because [ADHD is] so commercialized. I don't know if that's the right word, but you know what I mean? Like there's your kid . . . [he] acts like that. He's ADHD. But I really wanted to know if it is . . . I think it's right. But you know how people throw things around. I needed his dad to be on board because we're 50/50 with medical decisions. I was scared. I thought for sure he had some serious mental health disorder.

Each participant shared what experiences, thoughts, and feelings they had that ultimately helped them come to the realization that additional support was needed. The three subthemes were chosen to best capture the nuances of each story, while making cross-connections allowing the experiences to be categorized. Table 3 shows the three

subthemes and a direct quote from each participant in the first broad theme: Realization That Help Was Needed.

Table 3

Theme 1: Realization That Help Was Needed

Subtheme	Participant quote
1a. Perceiving behavior as neurodivergent	His behavior was way intense. (Jessica)
	She acts a little bit younger. (Kim)
	He's just really closed off. (Hannah)
	Things were just so much harder for them. (Grace)
	He was doing things with the other children weren't doing. (Hailey)
	I knew pretty early on something was different. (Kelly)
1b: Presupposing viable diagnoses	We thought he had autism. (Jessica)
	I suspected ADHD, dysgraphia, and learning disorders. (Kim)
	He thought that he could be autistic ... my impression was just anxiety and depression. (Hannah)
	We suspected ADHD and learning disorders. (Grace)
	We were worried it was Autism as well as ADHD. (Hailey)
I thought for sure he was Bipolar, but also suspected ADHD. (Kelly)	
1c. Acknowledging the Impact	Whenever there's something wrong with your child, you get all these worst-case scenario thoughts that come into your head. (Jessica)
	She was getting to the point where it was hurting her confidence and that was what was killing me. (Kim)
	When they're little they run your whole life and then they won't tell you what's going on. (Hannah)
	I felt I understood them because they're a lot like me. (Grace)
	I was just afraid of what would come with it, like the judgment and the stigma of ADHD. (Hailey)
	I was scared. I thought for sure he had some serious mental health disorder. (Kelly)

Theme 2: Diverse Experience in the Diagnostic Journey

After examining the essential background information, the focus of the interview shifted to explore how parents experienced the diagnostic process. The questions asked in the next section of the interview, were specifically designed to capture both positive and negative elements in each participant's story. The opened-ended questions were asked with care and intention, not to be suggestive or assumptive in nature. As details emerged, it became clear that the process, for most, was not a linear experience. Due to this complexity, follow-up questions and reflections were used when clarification was needed. Unlike the prior section, which was remembered with memorable distinction, the diagnostic process itself seemed to be less remarkable.

Within this overarching theme, three subthemes emerged. These themes helped to categorize the participants' experience in a way that would allow for an individual and cross-interview analysis. The first subtheme captured each participants' rationale behind seeking an assessment for their child. Three of the participants stated that their main goal surrounded accommodations at school, one parent offered that it was for her son's own self-exploration, and two discussed it as being a last resort with a focus on pharmaceutical intervention. Regardless of the reason given, each participant clearly articulated what they had hoped to gain from having their child evaluated. The next subtheme highlighted the drastic difference in the participants' perception surrounding the level of care and support offered by clinicians. There were a variety of clinicians and school staff reportedly involved in the process, and differing views about who should have been the focus—the parent or the child. Finally, as each parent worked to describe their experience, many offered that understanding any comorbid diagnoses played a

significant role in determining how to proceed. Although a few participants felt a holistic view of their child was originally captured, many others continued seeking understanding until the diagnosis given adequately matched their child's experience.

Seeking the Assessment Rationale

After coming to accept that they needed support to understand what was causing their child's divergent behaviors, the participants explained not only how, but why they proceeded in having their child evaluated. Jessica's story was multifaceted. With time in-between, she had two separate psychological evaluations, and reported that the first clinician misdiagnosed her son. In conjunction, she had her son evaluated at school for special academic accommodations. The more progress she saw him making, the more support she felt he needed. Armed with experience, she described how she learned to navigate her advocacy role and believed that a new evaluation and appropriate diagnosis, may allow her son to receive the full accommodations she felt he needed at school. With a desire to obtain the most comprehensive support for her son, Jessica offered the following: "We needed help from the psychologist and the teachers. He qualified for an IEP . . . but we knew he'd get more added on with an ADHD diagnosis."

Kim exhausted all academic avenues prior to seeking support outside the school system. After having her daughter evaluated at school, it became frustratingly obvious that the school was only equipped to help to a certain degree. Frustrated and concerned that they were wasting valuable time for her daughter, she made the decision to seek additional support. Kim stated the following:

We were getting really frustrated with some of the challenges at school and then what we were seeing at home. She was actually denied for any kind of service at

school, even though they admitted that there were issues. And so that's kind of what led us to further investigate it outside of the school system.

Hannah's story varied from the others in one significant way. Her son, with the support from his therapist, had prompted the evaluation. Although Hannah did not have a clear understanding about what her son was experiencing, she saw his grades slipping and that he became more and more distant with her. To support her son, she decided to help him in the way he would allow—finding the right clinician to do his evaluation. Hannah reflected: “He definitely wanted to figure out what was what and for self-exploration.”

Grace, armed with first-hand knowledge about ADHD, did her best to help her daughters manage their challenges without outside support. When things got to a point where her girls were struggling to an extent that warranted additional support, she decided to have them evaluated, specifically with the intention of having them try medication to help them focus. Grace reflected the following to communicate her focused intention: “Since we assumed it was ADHD, we decided to just work with it. Then we just finally got to where we're like, OK, we need some assistance. We need some medicine to help us get through this.”

Hailey felt that she had tried everything she could on her own, but her son's behavior was not improving. Her fear of having her son labeled was still present; yet, she began to see the evaluation as inevitable and necessary to get herself and her son the help they needed. Avoiding having him evaluated also meant she avoided the stigmatization she felt certain would be attached. In this way, she felt that she was protecting her son. She described how she battled herself throughout this stage of the journey and felt a degree of defeat along the way. Although this was not an easy decision to make, Hailey

offered the following reflection highlighting her decision: “I was at my end with everything. Getting him diagnosed was the last resort.”

Kelly’s story, like Hailey’s, offered insight as to why some parents wait longer than others once they suspect their child has ADHD. For her, the main fear she had was that she would be pushed to medicate her child. As an individual that strongly believed in naturopathic medical interventions, medicating her child was not an option. Her son was receiving some support through an occupational therapist, and she was managing things the best she could at home. At that time, she did not see the purpose in having him evaluated. Things began to change after she received some advice from a trusted teacher. Once she realized her son needed accommodations at school that were unavailable to him, the decision became clear that an evaluation would serve a greater purpose. Kelly offered the following reflection about this pivotal moment:

His teacher, at the end-of-the-year-conference, pulled me aside and basically was like, “you know he’s very smart, he’s the best reader in the class . . . but he is not going to thrive . . . you’re gonna have to get him diagnosed to get accommodations.”

Varying Sense of Clinical Support

After the decision was made, and the participants felt armed with a clear focus of what they hoped the evaluation would provide, they described their experience in having their child evaluated. To capture the essence of their stories, this theme was created to highlight the unique differences experienced in the process. The focus of these theme is not so much to understand the process itself, but to understand how the parents perceived the level of support along the way. A brief summary of each participant’s experience will

be offered to gain a deeper understanding of how and why they did or did not feel supported.

Jessica's story offered two different accounts of what it was like to have her son evaluated. Her journey began with a psychologist that she felt lacked integrity and inaccurately labeled her young son based on behavioral observation only. From what she remembered, there was no formal testing and very little time was spent with either her or her son. After this disappointing experience, some time passed before she felt a new evaluation was warranted. In the interim, she received support through the school system. She researched clinics in her area and found a new clinic she felt would offer a more comprehensive evaluation, but unfortunately was put on a long waiting list. Once her turn came, she described the process and reflected on the experience with great appreciation for the help she received. The things that stood out to her centered around the time and attention given to get to know her son and she felt that her family was treated with kindness. To this day she continues to have check-ins with this clinician. The following was offered by Jessica to capture the different experiences:

For the first one who just diagnosed him with autism, I did not feel any support at all. I felt like they were just trying to put a label on my son. The second one . . . she really got to know him . . . got to know us as a family and the whole staff. They were very supportive in the whole process. They're very kind and sweet . . . they were phenomenal.

Kim's story was laced with frustration and dead ends. After being told by the school that they could offer her little support without a full evaluation and diagnosis, she first turned to her pediatrician who referred her to a psychologist in the area and was put

on a long waiting list. Trying to speed things up, she searched for other options. After locating another office that had a shorter waiting list she was again met with disappointment. There was a miscommunication and the doctor she was scheduled with only saw adult patients. She described how she received the “run around” by the next clinic and was bounced around during the beginning of the pandemic. Finally, she received a personal referral of a specialist in her area. They did not accept her insurance, which created a financial hardship, but she decided to move forward in hopes that they would help her daughter. Finding this clinician was described as a huge turning point for her and she continues to work with them today. The following is a brief summary describing the lack of support Kim felt in the beginning:

The pediatrician ended up not being any help. There were lots of phone calls. Lots of tears. Lots of being pushed around back and forth to nobody knew who was doing what and who to go to and where and why . . . it was kind of a nightmare.

Hannah, unlike Jessica and Kim, described her experience finding a clinician for her son, as not being a problem. Throughout her reflection, she oscillated between being thankful that her son was receiving the care he needed to find answers, while struggling herself to feel included in the process. She felt that her son was being supported but offered the challenges she experienced stemmed from the privacy laws in Washington State which allow an adolescent the right to manage their own medical care. Hannah offered the following reflection: “It was a combination of help from his therapist and finding someone covered by our insurance. The main challenge was feeling like I was on the outside of the process.”

Grace's story highlighted the length of time it can take for a parent to feel they understand all the contributing factors affecting their child. Her experience could be described as having a piecemeal nature that caused specific challenges. From early on, she had assumed an ADHD diagnosis for her child and opted out of having that concern professionally assessed. Instead, she decided to enroll help from her local school district to rule out the possibility of a learning disorder. A brief evaluation was done, but because she went in with a particular focus, the results were not comprehensive enough to capture her daughter's dyslexia. A while later, she made the decision to try medication, and went to her pediatrician for the diagnosis. Although the medication proved helpful, it did not take long for her to realize there was still something they were missing. The final piece of the puzzle came after battling with the school district to evaluate her again, specifically for dyslexia. The following passage from Grace reflects these challenges:

It took us like 6 years to figure this out. It was frustrating. I felt supported by the first school but that didn't give us the whole picture. Then there was the doctor's office which was kind of a neutral thing. The last school I had to fight to have them do the dyslexia testing.

Hailey focused on describing her approach to finding a clinician, which proved helpful. As a social worker, Hailey reflected on hearing the challenges other parents had faced and knew if she was going to have her son evaluated, it was imperative that she find a clinician she felt would offer a thorough and comprehensive analysis of the factors affecting her son. She did her research and read online reviews before finding a child neuropsychologist, specializing in child evaluations. From there, she offered a detailed narrative of how this clinician not only offered her a deep understanding of how and why

her son was being affected, he also changed her overall view on ADHD. In time, and support from the neuropsychologist, she made the decision to try medication for her child. Again, she did her research and found a child psychiatrist, which she also described as being supportive, offering reassurance that she was making the right decision for her son. Hailey offered the following reflection: “He went through and broke down everything for me at a huge packet that ended up being sent to me which was helpful. We have been very lucky in the doctors that we have been working with.”

Kelly’s story was similar to Hailey’s but offered a unique way she felt supported by the clinician that completed her son’s evaluation. Hailey found the clinician she worked with through a personal referral of a friend. From the beginning, she felt supported by the clinician and trusted his interpretation that led to her son’s diagnosis. The thing that stood out to her the most, was the clinician’s willingness to work with their challenging coparenting dynamics. She described how he went the extra mile to support both parents which ultimately allowed their son to be better understood. Kelly reflected with appreciation that the clinician understood that they faced these specific challenges:

We just couldn’t be in there together; it wouldn’t have been cordial. We met with him one on one and he was nice enough to do it twice- he did it for me, and then he did it for his dad. That was nice. He was really good, and we felt very supported.

Understanding the Whole Picture

Although there were variations in the specifics, a commonality that all the participants discussed was that additional diagnoses or factors commonly found with ADHD that were discovered in the process. A brief description of these factors gave a

richness and depth to their journey that ultimately highlights why the evaluation proved helpful in gaining a holistic view of their child. A brief overview of each will be provided, with expanded information given in subsequent sections.

Jessica's son was diagnosed with ADHD with both cognitive and speech delays. She felt that this captured the difficulties her son had and allowed her to begin her research on how to proceed in finding the right support and treatment that would best suit his needs.

Kim knew her daughter was experiencing fine motor delays, but the evaluation uncovered that her daughter also met criteria for both ADHD and anxiety. With this knowledge, she began to see the full picture of how the combination of these things explained how and why her daughter was struggling.

Hannah was not surprised when her son's evaluation revealed he was struggling with ADHD, anxiety, and depression. She felt this answered her son's questions.

Grace's daughters were both given a diagnosis of ADHD, but her younger daughter also had challenges with dyslexia, a specific learning disability. This helped illuminate for Grace how she could better support each child with their homeschooling curriculum.

Hailey's son was diagnosed with ADHD with sensory processing dysfunction. This diagnosis not only matched what she felt her son was experiencing, it also gave her a label that allowed her to research ways to better understand and help her child.

Kelly was aware that her son experienced sensory processing dysfunction, but the evaluation further revealed a diagnosis for both ADHD and anxiety. With a clinical

understanding of what their son was experiencing, Kelly and her son's father could better communicate about their son's needs.

Each participant offered their experience in having their child diagnosed with ADHD. The three subthemes that were chosen captured their rationale or focused reasoning for seeking an evaluation, the perceived level of support offered to them, and the final diagnostic summary. These categories were designed to highlight both similarities, differences, and stages in this process. Table 4 shows the three subthemes and a direct quote, or diagnostic labels, from each participant in the second broad theme: Diverse Experience in the Diagnostic Journey.

Table 4

Theme 2: Diverse Experience in the Diagnostic Journey

Subtheme	Participant quote
2a. Seeking the Assessment Rationale	<p>We needed help from the psychologist and the teachers. He qualified for an IEP... but we knew he'd get more added on with an ADHD diagnosis. (Jessica)</p> <p>We were getting really frustrated with some of the challenges at school and then what we were seeing at home. (Kim)</p> <p>He definitely wanted to figure out what was what and for self-exploration. (Hannah)</p> <p>Since we assumed it was ADHD, we decided to just work with it. Then we just finally got to where we're like, OK, we need some assistance. We need some medicine to help us get through this. (Grace)</p> <p>I was at my end with everything. Getting him diagnosed was the last resort. (Hailey)</p>
2b. Varying sense of clinical support	<p>Having him diagnosed meant we could get him accommodations. (Kelly)</p> <p>For the first one who just diagnosed him with autism, I did not feel any support at all. I felt like they were just trying to put a label on my son. The second one ... she really got to know him (Jessica)</p> <p>The pediatrician ended up not being any help. There were lots of phone calls. Lots of tears. Lots of being pushed around back and forth to nobody knew who was doing what and who to go to and where and why. And it was kind of a nightmare. (Kim)</p> <p>It was a combination of help from his therapist and finding someone covered by our insurance. The main challenge was feeling like I was on the outside of the process. (Hannah)</p>

Subtheme	Participant quote
	<p>It took us like 6 years to figure this out. It was frustrating. I felt supported by the first school but that didn't give us the whole picture. Then there was the doctor's office which was kind of a neutral thing. The last school I had to fight to have them do the dyslexia testing. (Grace)</p> <p>We have been very lucky in the doctors that we have been working with. (Hailey)</p>
2c. Understanding the whole picture	<p>The doctor was really great, and we felt very supported. (Kelly)</p> <p>ADHD, Cognitive Delay, and Speech Delay (Jessica)</p> <p>ADHD, Fine Motor Delay, and Anxiety (Kim)</p> <p>ADHD, Anxiety, and Depression (Hannah)</p> <p>ADHD and Dyslexia (Grace)</p> <p>ADHD and Sensory Processing Dysfunction (Hailey)</p> <p>ADHD, Sensory Processing Dysfunction and Anxiety (Kelly)</p>

Theme 3: Putting It All Together - Moving Forward After the Diagnosis

The journey of receiving the diagnosis contained a variety of emotions and challenges, but ultimately granted each participant a degree of clarity. As their stories continued, a new shift in focus emerged. Now that they had a clear understanding of their child's overall diagnostic analysis, most of the parents shared how they used their new knowledge to continue to help their child moving forward.

The four subthemes that emerged were organized in a way that would allow impactful moments to be captured and shared. This cohesive structure offered enough flexibility to show both common and divergent concepts between stories, while gaining a sense of why this time period was meaningful. The first subtheme focused on the emotional experience and thoughts that the participants shared after they received the diagnosis. This transitional time was filled with mixed emotions for most of the participants, and solidified suspicions. The next subtheme looks at how the participants used the insights gained to make changes, seek specific treatments, or pursue academic accommodations. This section highlights how parents and children learned to adapt after the diagnosis. The following subtheme emerged to capture the positive outcomes of

finding solutions that worked and the emotional experience tied to these successes. Finally, the last subtheme proved important as each participant's story was filled with descriptions pertaining to their relationship with their child. This subtheme allowed for a space to illuminate how participants viewed their role over time and the meaning they ascribed to this role throughout this journey with their child.

Making Meaning From the Diagnosis

Parents were asked to offer a reflection of what emotions they felt after receiving their child's diagnosis. For Jessica, she reported that there were mixed emotions right away. She felt a sense of relief that her son did not have ASD, but simultaneously worried about what it meant for her son to have ADHD. As she described this process, she stated that an ADHD diagnosis felt more manageable because her husband had also been diagnosed and she felt comfort knowing he would help both her and her son manage whatever came their way. Jessica reflected: "It's kind of like a relief but scary at the same time. I guess I had my husband who has it so he knows how to deal with it on a daily basis."

For Kim, this knowledge brought a sense of relief and clarity, helping her understand her daughter in way that was hugely impactful. Kim offered: "I think it just kind of solidified some of our thoughts and explained why certain things were different or harder for her. Some of the challenges that we had made a little more sense."

The more Kim felt she understood, the more she felt empowered to help her daughter combat the challenges she faced. Kim gave an example of what she learned about the correlation between sleep challenges, anxiety, and ADHD and how she used this information to make adjustments:

They all three work together and they all feed off each other. So if you're not getting sleep, your ADHD is going to be worse and your anxiety is going to be higher and same thing. If your anxiety is high, it's gonna affect your sleep and your ADHD. And so I'm trying to work on each of those and get them into a good place really became our focus and challenge.

Hannah shared that the diagnosis did not change anything for her personally, but it allowed her son to understand himself better. She recognized that as an adolescent, he was working to create a sense of identity and even though he was closed off with her, being supportive of his journey offered her a way to stay connected to him. She reflected, "It really didn't change anything for me, but it helped him understand himself more."

Without downplaying the importance of having the diagnosis, Grace stated that she was not emotionally impacted, although it proved helpful in tailoring her girls' academics. Specifically, she was able to conceptualize the girls' challenges better after she felt she had the whole picture. She described how each of her daughters experienced their symptoms and how she used her own first-hand experience of having ADHD to help them learn about themselves. She reported, "It was different for both of them.

Understanding to the degree that each was impacted made a big difference. I understand it really well because I get to have it too."

Hailey felt a huge sense of relief after receiving her son's diagnosis. Working with the clinician, she came to realize that having the diagnosis would not change the things she loved about her son, instead it allowed her to understand and appreciate his nuances more. The fear and avoidance that her son would fall victim to the stigma she felt surrounded an ADHD diagnosis was no longer a concern. Instead of being scared for

her son, she was able to be redirect her energy and enjoy her son's "quirks." The following brief summary from Hailey captures this process:

Learning about the unique way his brain works has always stuck with me. I think kids with ADHD are so special . . . they've got this quiriness about them and I didn't wanna lose that. I needed him to be able to focus and not be so impulsive but keep that little personality that he has that was really important to me.

Kelly described the relief she felt after receiving the ADHD and anxiety diagnoses for her son. She touched on the fear she felt over the possible bipolar diagnosis and felt that this was much more manageable, especially without medication. Once she was no longer questioning what it was, she was able to focus her attention on researching how she could help her son. Kelly stated:

I felt very relieved just to know because once I know what I'm dealing with, I can dive into my options and understand it. Before I felt like I was a bad parent because I didn't understand what my kid needed.

Learning to Adapt

As information and knowledge about the ADHD was gained, it created a learning curve or trial-and-error phase as they learned to adapt. Each participant described how they experienced this new challenge. Jessica focused her energy first on changing the way she parented her child. With accommodations now in place at school, she spent time researching different parenting techniques that would help her manage her son's behavior at home. She reported that the diagnostic clinician greatly helped her as she armed herself with new knowledge and things to try, although there came a point when she realized a custom approach would work best for their family. She described taking a calm approach

to parenting that her son responded well to. Taking bits and pieces from different sources, Jessica gave the following reflection and example:

Some things we do, some things we don't. So what we do usually or I do is I get down to his face level and kind of like tell him what he's doing wrong and what we need to do better next time kinda thing.

Kim felt the impact of not only trying to learn what she could about ADHD for herself, but also felt that it was important to teach her daughter about it as well. She accepted this challenge with an open mind, not expecting herself to be an expert, and found comfort knowing that they had options. She had a team of clinicians helping her and she learned to trust her parental instincts along the way. Although some things worked, and others did not, Kim described this flexibility in her approach while considering a medication trial:

It's new to me, right? And so I'm learning it and also trying to help her deal with it and learn it and understand. It helped to know that we didn't have to do it forever if we didn't like it.

Hannah's perspective explains how different it can be for a parent adjusting to a diagnosis with an older child. The adjustments she described were administrative in nature. She helped her son navigate appointments with both his counselor and physician and gave him the space to work with the experts regarding his concerns. Hannah shared her view on how her son was adjusting: "He's found that both counseling and medication have helped . . . he's had to adjust his medication a few times."

Grace felt that she had always been flexible with her girls and made continuous adjustments in their home. Following the diagnosis, this was no different. She tailored her focus for each of her daughters and reported the adjustments she made. Her matter-of-fact

approach to conceptualizing and solving problems allowed her to describe her thought process. Grace offered that her oldest daughter, “does not have an IEP or 504 plan, medication was what she needed.” She said, “[With] my younger daughter it smacks you in the face kind of obvious and other accommodations were needed.”

Hailey described another internal battle she experienced when deciding whether to try medication for her son. Although things were improving, his attention at school continued to be a struggle. She described the exhaustive list of options she tried, from supplements and dietary changes to attention gadgets and parenting techniques. At one point they even joined a research study being conducted at a local children’s hospital that used computer-based games to target attention. When they came to the realization that pharmaceutical intervention was the only thing they had not tried, she again felt that she had failed her son. As she recounted the adjustment period during her son’s medication trial, emotions welled in her eyes. Thinking back about this time still caused her to get emotional, but Hailey stated with effort that: “We did everything first. Deciding to try medication was one of the hardest decisions I’ve ever had to make as a parent.”

Kelly offered a unique perspective on how she worked with a variety of specialists and avoided using pharmaceutical interventions with her son. She described the endless research she conducted to arm herself with knowledge about both the behavioral and biological factors associated with ADHD. She felt this path was much more difficult but learned a great deal about her son’s specific dietary needs and found natural ways to supplement the biochemical challenges. Kelly stated, “It was challenging to find people to help in the way that we wanted to be helped. Which was not medicating. That’s a lot harder to find.”

Another challenge she faced during this adjustment period, was trying to stay on the same page with her son's father. In the beginning this proved difficult but she reported that he eventually came around. Kelly provided the following recount of what happened after she had her son tested for food allergies: "He came back highly allergic to dairy eggs and then moderately for gluten. So again, I removed the foods at my house. His dad did not remove the foods for quite some time."

In conjunction with her research and search for natural ways to help her son, Kelly also offered that she worked with a variety of clinicians that helped her understand how to manage her child's behavioral outbursts as well. It was important to her that she created "teaching moments" that were appropriate and allowed him to feel loved. Kelly reflected on one way she learned to adjust her parenting during a temper tantrum: "The best advice was let him do his own thing, then we would talk when he's done. You know it's like a love language."

Reflecting on the Positive Changes

Whether conscious or not, participants continuously placed an emphasis on telling their story in a balanced nature. They did this by offering not just the challenging aspects of the journey, but also reflecting on the things they saw as positive. This theme emerged towards the end of our interview when parents were asked to discuss what they perceived to be the biggest strides that they had made, which gave them an opportunity to capture these beneficial reflections. When Jessica spoke about her son, she did so with a tenderness that showed the deep care and concern she felt for him. Her son's speech challenges were a major concern from the time he was very young. When she reported

these changes, she had a large smile on her face. With excitement, Jessica offered the following story:

He's catching up fast! A couple weeks ago we got him from school and he goes, "Mommy, I have a girlfriend named Lucy and she has sparkly shoes" He's making a lot of friends. We even see it on his little reports every day that he's talking with his friends . . . and he's going out of his way to talk to other students in this class.

Kim was careful not to paint a picture of her daughter that was overly negative. There was a sense of protection woven throughout her story that stood out as she addressed each question. With emotion, and tears welling in her eyes, she openly discussed the heartbreak she experienced in watching her daughter's confidence being affected. When given the opportunity to discuss positive changes she's seen, Kim described how important it was for her daughter to feel proud of herself and shared the following report from her daughter: "She was going on and on about how great of a session they had and how well she was doing and I asked her about her focus and she said it was great. She gets proud of herself!"

Hannah, with little feedback from her son, reported that she was happy to know that the medication trial has been a positive experience. Hannah offered, "he reports that it's working!"

Grace placed a high emphasis on taking a strengths-based approach to helping the girls understand that just because they have a diagnosis, does not mean that they will not be successful in life. She discussed how she would work with the girls to find famous people who also had ADHD or dyslexia and learn about their lives and success. This was

an intentional exercise that she hoped would help her daughters see themselves as more than a diagnosis. Grace reported on a heartwarming incident with her daughter stating: “It was eye opening for her to say, ‘OK, I can succeed in life. This isn’t gonna slow me down.’”

Hailey spoke about her son’s quirky and fun-loving personality often. When asked about strides, she focused on how their relationship remains close and how she hopes things remain that way between them. Hailey reflected, “I’m so thankful he talks to me and I desperately want to keep that trust.”

Kelly had many positive things to say about her son throughout the interview, but perhaps the most comprehensive observation Kelly offered was when she stated: “But seriously, he’s like a whole new kid. No one would ever pin him as ADHD.”

Relating to Interpersonal Dynamics

Each participant’s story was filled with descriptions pertaining to their relationship with their child. This subtheme allowed for a space to illustrate how participants viewed their role over time and the meaning they ascribed to this role throughout this journey with their child. Jessica saw herself as an important part of her son’s overall wellbeing, but specifically when it came to treatment options, she felt that her insight was an important consideration. Jessica reflected:

I feel like my role is really important because I know my kid best, so knowing what my opinions are and what would work best for him and what would not work for him was really like a critical part.

Kim described her role as being protective in nature and highlighted how she felt it was important to put her own needs aside when it came to helping her daughter. Kim offered the following summary:

My parenting role is a little bit more of a protective role with her. The important thing is just being able to provide that support for her. Taking care of her like that was really important for me. We focused on making sure we were handling things for her . . . I'll go cry by myself later and figure it out, you know? But, just feeling like we're giving her what she needs to be OK.

Hannah expressed a deep concern for the divide she currently felt in her relationship with her son. Although she saw her role being important, it was not the role she desired. With sadness Hannah reported, "We're kind of more in two different silos."

Throughout the interview, Grace continued to place importance on using her own experience to direct and guide her girls. It was important that she focused on what each of them needed. Grace offered, "It about just understanding them and understanding me." Hailey reported how going through this experience with her son created a strong bond between them. She adored his unique traits and didn't miss an opportunity to tell him why. Hailey offered the following reflection:

I feel like I've been there with him through all of this. And this really has made us closer and I hope that he sees that no matter what, I have his back. There's also this uniqueness, and in a way it makes him special, and so I really try to tell him that - make him know that. "Yes, it's different, but it also is what makes you special."

Kelly described two separate, but noteworthy interpersonal dynamics that were special in her story. The first, was the closeness she felt they had always shared and touched on how she saw her role and what she felt contributed to this closeness she felt. Kelly stated: “I have always just tried to be his biggest advocate, his biggest cheerleader. I think my biggest thing that’s been the biggest success two has just been keeping open communication.”

In addition, the theme that was present throughout Kelly’s story surrounded the complexity of coparenting and the challenges that they faced in the beginning. She described a turning point when they became a team, and felt that it was then that her son was able to have his needs fully met. Kelly reflected:

A big thing is the family dynamic of being this cohesive unit where we’re doing the same things together, we’re speaking the same kind of language and so there’s a consistency in their life. That has been a good thing for him.

Each participant explained what their journey entailed after they received their child’s diagnosis. The four subthemes that were chosen captured the meaning making stage and how they made sense of the diagnosis, the ways they learned to adapt, the positive strides in finding success, and how they viewed their relational role with their child. These categories were designed to provide an analysis of what happens after the diagnosis and how the participants learned to adjust. Table 5 shows the four subthemes and a direct quote from each participant in the third broad theme: Putting it all Together – Moving Forward After the Diagnosis.

Table 5*Theme 3: Putting It all Together - Moving Forward After the Diagnosis*

Subtheme	Participant quote
3a. Making Meaning From the Diagnosis	<p>It's kind of like a relief but scary at the same time. My husband has it so he knows how to deal with it on a daily basis. (Jessica)</p> <p>I think it just kind of solidified some of our thoughts and explained why certain things were different or harder for her. Some of the challenges that we had made a little more sense. (Kim)</p> <p>It really didn't change anything for me, but it helped him understand himself more. (Hannah)</p> <p>It was different for both of them. Understanding to the degree that each was impacted made a big difference. I understand it really well because I get to have it too. (Grace)</p> <p>Learning about the unique way his brain works has always stuck with me. I think kids with ADHD are so special... they've got this quirkiness about them and I didn't wanna lose that. I needed him to be able to focus and not be so impulsive but keep that little personality that he has that was really important to me. (Hailey)</p> <p>I felt very relieved just to know because once I know what I'm dealing with, I can dive into my options and understand it. Before I felt like I was a bad parent because I didn't understand what my kid needed. (Kelly)</p>
3b. Learning to Adapt	<p>Some things we do, some things we don't (Jessica)</p> <p>It's new to me, right? And so I'm learning it and also trying to help her deal with it and learn it and understand. It helped to know that we didn't have to do it forever if we didn't like it [medication]. (Kim)</p> <p>He's found that both counseling and medication have helped... he's had to adjust his medication a few times. (Hannah)</p> <p>[Oldest daughter] does not have an IEP or 504 plan, medication was what she needed. [With] my younger daughter it smacks you in the face kind of obvious and other accommodations were needed. (Grace)</p> <p>We did everything. [trying medication] was one of the hardest decisions I've ever had to make as a parent. (Hailey)</p> <p>It was challenging to find people to help in the way that we wanted to be helped. Which was not medicating. That's a lot harder to find. (Naturopath, therapy, OT, dietary changes). The best advice was let him do his own thing, then we would talk when [he was] done. You know it's like a love language. (Kelly)</p>
3c. Reflecting on the Positive Changes	<p>He's catching up fast (Jessica)</p> <p>She gets proud of herself. (Kim)</p> <p>He reports that it's [the medication is] working. (Hannah)</p> <p>It was eye opening for her to say, OK, I can succeed in life. This isn't gonna slow me down. (Grace)</p> <p>We used medication for awhile and now I'm helping him learn to advocate for himself. (Hailey)</p> <p>But seriously, he's like a whole new kid. No one would ever pin him as ADHD. (Kelly)</p>

3d. Relating to Interpersonal Dynamics	<p>I feel like my role is really important because I know my kid best, so knowing what my opinions are and what would work best for him and what would not work for him was really like a critical part. (Jessica)</p> <p>My parenting role is a little bit more of a protective role with her. The important thing is just being able to provide that support for her. Taking care of her like that was really important for me, was making sure we were handling it for her and I'll go cry by myself later and figure it out, you know? But. Just feeling like we're giving her what she needs to be OK. (Kim)</p> <p>We're kind of more in two different silos. (Hannah)</p> <p>It about just understanding them and understanding me. (Grace)</p> <p>I feel like I've been there with him through all of this. And this really has made us closer and I hope that he sees that no matter what, I have his back. There's also like the uniqueness, and in a way it makes him special, and so I really try to to tell him that make him know that. Yes, it's different, but it also is what makes you special. (Hailey)</p> <p>A big thing is the family dynamic of being this cohesive unit where we're doing the same things together, we're speaking the same kind of language and so there's a consistency in their life. That has been a good thing for him. (Kelly)</p>
--	--

Chapter 4: Discussion

Prior to this study, there was a lack of qualitative understanding of the parents' experience after having a child diagnosed with attention deficit hyperactivity disorder (ADHD). To narrow that gap in research, this study focused on what factors prompted parents to seek an assessment, the overall experience of having their child evaluated, and how the diagnosis assisted in finding the right kind of support for their child. This study demonstrates significant importance in the parental role throughout the diagnostic process to assist in understanding how parents process, make meaning of, and assign their role in helping their child. This was accomplished by applying a phenomenological qualitative research design, guided by the following research questions:

1. What is the experience like for parents prior to, during, and after their child is diagnosed with ADHD?
2. How do parents understand the ADHD diagnosis?
3. What meaning do parents ascribe to their role in parenting their child with ADHD, including their role in treatment implementation?

Experience in the Diagnostic Journey

Approximately 8% of children in the United States are diagnosed with ADHD between the ages of 3 and 17 years old (CDC, 2020). Although the assessment and diagnosis processes are standardized (Lange et al., 2010; Visser et al., 2015), the complexities that arise throughout the process can be challenging (Hamed et al., 2015). Consistent with the literature, the findings from this study suggest that participants experienced challenges leading up to the diagnosis, in the evaluation process itself, and knowing how to proceed after diagnosis (Hamed et al., 2015). Whereas most studies

currently focus on the child and the exhibited behavior, this study adds to the existing literature by exploring the perspective of the parent, focusing on the process, not the child.

When discussing factors that lead participants to seek an evaluation, there were specific sequencing or phases that each parent described, highlighting the complexity that exists in the early stages of the diagnostic journey. Each participant described a phase of recognition and concern about their child's behavior, followed by a period of trying to make sense of what could be causing the behaviors. The age of the child at time of diagnosis was a factor that stood out as noteworthy. When a child is younger, the parents' role was much more involved, whereas, with an older child, the parent had to take a less active, albeit still supportive stance. These phases were experienced uniquely among participants, although they contributed to the realization that more help was needed. This builds on previous research conducted by Visser et al. (2015) that described the intricacy that exist in the diagnostic experience of children in the United States. Just as there is no one-size-fits-all treatment for ADHD, the journey to the diagnosis is an individual endeavor and the results of this study indicate that there are a wide range of special considerations that families endure.

Further, the results specify barriers that can deter parents from having their child assessed or seek treatment (Lebowitz, 2016). Specifically, several participants expressed fearful thoughts about having their child diagnosed with ADHD, viewing it as a highly stigmatized diagnosis with negative connotations (Lebowitz, 2016). Taken with the dominant view that having a disability is limiting, participants worried how their child would be viewed by others (Garland-Thomson, 2012). Judgements in the family system

also created barriers, which was unique to this study. Specifically, when separated parents have differing views, the coparenting dynamics add an extra layer of complexity. Societal views, stigmatization, and fear of judgment are considerations that may deter parents from seeking care.

Furthermore, all participants offered statistical information pertaining to the diagnostic process that can be seen elsewhere in the literature. Participants reported the median age for diagnosis was 8 years old, ranging from age 5 to 15, which coincided with the current data on ADHD offered by the Centers for Disease Control (2020). In addition, the diagnostic clinician used by the participants included a variety of health care providers, such as physicians and psychologists (Visser et al., 2015). The evaluation process was described as standard practice by all participants and included a combination of direct observation, questionnaires or rating scales, school reports, developmental history, and psychological testing (Gualtieri et al., 2005; Hamed et al., 2015; Visser et al., 2015).

Although the findings of this study aligned with prior research on basic elements in the diagnostic processes and statistical data, the rationale for seeking the assessment and choosing a specific clinician helps illuminate aspects of these parents' diagnostic process. Participants chose the clinician to work with based on three categories: exploration of symptomatology, medication, or academic support. For example, Kelly reflected:

We didn't take him to our doctor to get the diagnosis . . . I wanted feedback from the doctor, and it just feels like a general pediatrician is not gonna be able to give

you a full rundown of what's going on. So, we chose to work with a pediatric neuropsychologist.

Conversely, Grace, suspecting ADHD and wanting to try medication offered that she decided to go straight to her child's pediatrician, knowing they could offer a prescription. These findings add to the existing literature, and highlights the importance placed on choosing specialized clinicians and having a specific focus or reasoning for seeking the evaluation.

Prior research documented children with ADHD commonly experience academic difficulties (Evans et al., 2006; Hart et al., 2010). When experienced, these difficulties provided an additional layer of complexity that must be maneuvered. The participants offered a variety of unique challenges their children experienced academically, and for a few participants, these challenges were the reason and focus for the evaluation, which adds a degree of depth to the current literature. At the forefront of the findings, it was indicated that a proper diagnosis allows children and their families to obtain the assistance they need for long term success (Hamed et al., 2015).

There is a willingness in parents to exhaust all efforts to have their child's needs fully addressed. Participants often felt defeated when trying to help their child without knowing exactly what factors needed to be considered. As indicated, misdiagnosis or partial understanding creates confusion, mistrust in clinicians, and prolonged receiving treatment and support (Ahmed et al., 2013). Once parents had a thorough understanding, they began to move forward in understanding the diagnosis and treatment options available.

Understanding the ADHD Diagnosis

Factors such as comorbid diagnosis impacted the study participants' ability to understand the diagnosis. All the participants indicated additional factors such as anxiety, depression, and specific learning disabilities, requiring focused and individualized attention. This correlates with research findings that those with a diagnosis of ADHD likely have a comorbid diagnosis (Dopheide et al., 2009). Having two daughters diagnosed with ADHD and dyslexia, Grace was tasked with a unique challenge in differentiating how each impacted them, offering things were different for both of her children and learning to understand those differences were important. Knowledge about ADHD alone is not enough for parents seeking to understand both the big picture and the contributing nuances.

Once participants felt satisfied with the comprehensive summary offered through the evaluation feedback, they were armed with the information they needed. Most participants felt the evaluation gave them a sufficient baseline understanding, allowing them to conduct further research. This finding is congruent with the current literature on the importance of psychoeducation after the diagnosis (Bussing & Gary, 2001), but adds to the literature on how parents use this information. In many ways, the evaluation served as a starting point they could build on to gain a deeper understanding.

Furthermore, participants reported making strides with their children as they began to understand the multifaceted links between internal and external facets of ADHD. Parents see the outward behavior including struggles with self-esteem, educational and social difficulties (Harpin, 2005). Big changes occurred when participants began to make sense of their child's internal world and were able to adapt

their parenting accordingly. Parents realized the behavior communicated ways in which their child was internally struggling. Prior to finding interventions that worked for her son, Jessica reflected how hard it was for both her and her child. As their understanding grew, their ability to conceptualize the complex dynamics that affected their child also grew. Making important connections of internal and external factors offer parents a deeper understanding and awareness of why their child was exhibiting specific behaviors.

In addition, psychoeducation calmed the participants' fear and anxiety. Preconceived notions and stigmatization about ADHD existed for most participants prior to diagnosis. The clinician played a large role in extinguishing these fears, allowing parents to begin viewing the diagnosis with a strengths-based perspective (Sedgwick et al., 2018). As the parents' view on ADHD shifted, they were able to articulate the positive attributes their child possessed. Acceptance and knowledge were key aspects needed to move forward after the diagnosis.

Parental Role

Most participants had the attitude that the way a child learns to view the world and themselves begins first at home. This directly correlates with the literature pointing to the importance and perception of the parental role (Grusec, 2014). Parents learned to make sense of their role in several distinct categories including their role as protector, advocate, and guide. With each role, the child's needs were highlighted as the focus. For example, the protector role came from a place of deep concern for their child's well-being.

Furthermore, parents described their changing role as an advocate. When children are younger, the sense was that a parent knows best, and decisions were made on the

behalf of the child. As children grow older, participants described how that role shifted and they began to teach their child to advocate for themselves. The advocacy role, although dynamic and changing, offered parents a way to use tools and resources needed to assist their child in a variety of domains.

Research has indicated that parenting a child with ADHD may lead to parents' feelings of powerlessness, affecting the way a parent relates to and guides the child through challenging circumstances (Glatz et al., 2011). In the present study, although parents expressed feeling discouraged at times, only one participant indicated feeling powerless in their relationship with their child. Although the literature often points out the interpersonal challenges parents experience in raising their child with ADHD (Coghill et al., 2008; Pollock, 2017; Wehmeier et al., 2010), participants in this study described a sense of closeness they felt with their child. For example, Hailey stated:

I feel like I've been there with him through all of this. And this really has made us closer, and I hope that he sees that no matter what I have his back. There's also like the uniqueness, and in a way, it makes him special, and so I really try to tell him that, make him know that. "Yes, it's different, but it also is what makes you special." That created a closeness between us.

There was a sense of unity gained in navigating difficulties together.

Implications of Research Findings

Findings from this research study may assist clinicians when they encounter parents looking for answers. If clinicians understand the challenges that parents have endured leading up to finding a clinician, they may be able to offer a more supportive stance and gentle approach. Ultimately, clinicians who are sensitive to the challenges

faced by parents may be able ease parents' fears from the beginning, promoting productive parent-clinician interactions (Brinkman et al., 2011). Prior to their child's evaluation, there was a universal fear that resided in each participant. It could be useful to remember that although the evaluation may focus on the child, the parent plays a large role in shaping the long-term outcome for the child (Grusec, 2014). Modeling a strengths-based approach (Sedgwick et al., 2018) at the onset may assist parents in achieving both acceptance and understanding.

In addition to setting the stage for a positive experience, it would be helpful for clinicians to offer comprehensive evaluations from the beginning. Although some of the "runaround" parents received was in the school system, a few parents reported the child being underdiagnosed or misdiagnosed by clinicians. It would be helpful for the school system to offer clear expectations, appropriate supports, and early interventions to limit the time parents spend trying to find answers. This would include close home-school communication. If early and subsequent interventions are not successful or marginally effective, and concerns about a child's academic functioning continue, the school team (of which the parent is a part) need to convene to discuss appropriate next steps. Once a child reaches a clinician, it would be helpful for the clinician to look beyond parent-reported symptoms and assess for possible co-occurring diagnoses or contributing factors. Parents reported feeling frustrated and defeated when they had to have multiple evaluations before gaining a full picture of what was affecting their child. It is possible that clinicians can prevent this by being thorough from the beginning.

In addition, a clear and succinct explanation of how their child is being affected could greatly help parents in making sense of the diagnosis. Psychoeducational

interventions are being considered a first line of intervention in ADHD treatment and should be an important part of the feedback and ongoing support offered to parents after a diagnosis (Lantz et al., 2021). For example, parents found it extremely helpful when clinicians broke down and made connections between things like anxiety, sleep, and ADHD. Parents expressed the need for continued support, information, and resources beyond the initial diagnosis. Specifically, parents found check-ins to discuss changes in behaviors and symptoms helpful. Parents wanted to continue to grow in their awareness of what is developmentally appropriate, other support options, and adjustments, both at home and school, they had not yet considered. A more comprehensive approach of providing thorough feedback, and ongoing support may better assist parents with the knowledge they need directly after the diagnosis, and as their developmental needs change (Ahmed et al., 2013).

Furthermore, working to remove the stigmas around ADHD and specific learning disorders could be hugely beneficial, both for parents and for the child (Tarver et al., 2014). If clinicians can shift the way they view and discuss ADHD, we may be able to see changes in the way ADHD is viewed in society. A consistent theme in this study highlighted that barriers are created when parents fear that their child will be discriminated against. This fear impacted parents prior to, during, and after the diagnosis. Gualtieri et al. (2005) offered that ADHD is a psychiatric disorder, but not a mental illness, viewing it as a “constellation of personality traits and cognitive styles” and that “like most mild impairments people can learn to adjust to it” (para. 11). For individuals to functionally adapt, it is necessary to improve the problematic way ADHD is

misunderstood. That understanding begins with the way clinicians teach parents about the diagnosis.

Study Strengths and Limitations

A limitation of this study was the small sample size of six participants. Although the number of participants was acceptable for this qualitative study, results from this study should not be interpreted to be a representation of the experiences of this population. Conducting a study with a larger sample size could provide more generalizable findings.

Additionally, all the participants in this study were mothers. This calls into account the absence of fathers in the study. Although the mothers represented the parents' experience, results from this study more accurately portray a mother's experience. Conducting a study that included both mothers and fathers could offer a different perspective, adding to the overall understanding of both parents' experience.

Furthermore, it is important to note that the children's coexisting conditions may have impacted the findings of this study and should be taken into consideration as to how the parent's may have perceived the child's behavior. Further research, looking at a broader scope of coexisting conditions may yield different results.

Finally, the length of time since the children had been diagnosed may have resulted in memory decay. Although, in most cases, the diagnosis had been in a couple of years of this study, even that much time elapsing could have altered the way the participants remembered their experiences. Conducting a study that followed parents through the process could provide a more detailed account of specific thoughts and feelings that were experienced in real time.

Recommendations for Future Research

These results were based on participants' perceptions of having their child diagnosed with ADHD. This specific focus was not designed to capture the complexity parents experienced in trying to make meaning of other co-occurring ailments. A significant number of participants reported having negative experiences coming to a comprehensive understanding of why and how their child was struggling, which went beyond an ADHD diagnosis alone. To understand this further, a study could focus on parents' perception and view of their level of knowledge after an ADHD diagnosis, their perceptions of the utility of different types of information and how each type was helpful in academic achievement, school functioning, and social relationships.

Furthermore, although this study did not yield significant findings regarding gender or subset type of ADHD, it would be helpful to conduct further research to understand if either of these factors altered the parent's perceptions and experience in the process.

To shift the deficits perspective that often underlies ADHD research, continued effort should be made to understand ADHD through a strengths-based approach. Continuing to seek understanding from parents after they've made sense of the diagnosis could offer the field a helpful perspective. After all, the claim could be made that the family has a lot to offer outside of the clinical understanding of the effects, both positive and negative, of ADHD (Sedgwick et al., 2018). Research focusing on how parents view their child's strengths, capabilities, and adaptive functioning could contribute to this shift in perception and stigmatization of ADHD.

Conclusion

With a focus on exploring how the mental health field could better assist parents throughout their journey in raising a child with ADHD, this study comprised six study participants that had children diagnosed with ADHD. In addition, this study's objective was to gain a deeper understanding of the challenges parents face throughout the process. This included what they experienced prior to, during, and after their child was diagnosed with ADHD. This study indicates that each stage has unique challenges for parents. In addition, this study demonstrates significant importance in the parental role throughout the diagnostic process. Clinicians would benefit from designing their approach in light of how parents process, make meaning of, and assign their role in helping their child. Further research needs were identified in both the areas of academic influence in the diagnostic process and barriers to treatment that may be linked to understanding the diagnosis.

References

- Ahmed, R., Borst, J., Wei, Y., & Aslani, P. (2014). Do parents of children with attention-deficit/hyperactivity disorder (ADHD) receive adequate information about the disorder and its treatments? A qualitative investigation. *Patient Preference and Adherence*, 2014(8), 661–670. <https://doi.org/10.2147/ppa.s60164>
- Ahmed, R., McCaffery, K., & Aslani, P. (2013). Factors influencing parental decision making about stimulant treatment for attention-deficit/hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology*, 23(3), 163–178. <https://doi.org/10.1089/cap.2012.0087>
- American Psychiatric Association. (2013). Attention deficit hyperactivity disorder. In *Diagnostic and statistical manual of mental disorders* (5th ed., pp. 59–65). <https://doi.org/10.1176/appi.books.9780890425596>
- Barkley, R. A. (2015a). *Treating children and adolescents with ADHD: Empirically based treatments*. Continuingcourses.net. <http://www.continuingcourses.net/active/courses/course082.php>
- Barkley, R. A. (2015b). *History of ADHD*. In R. A. Barkley (Ed.), *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (pp. 3–50). The Guilford Press.
- Bell, Z. E., Shader, T. M., Webster-Stratton, C. H., Reid, M., & Beauchaine, T. P. (2018). Improvements in negative parenting mediate changes in children's autonomic responding following a preschool intervention for ADHD. *Clinical Psychological Science: A Journal of the Association for Psychological Science*, 6(1), 134–144. <https://doi.org/10.1177/2167702617727559>

- Blaney, P. H., & Millon, T. (2009). *Oxford textbook of psychopathology*. University Press.
- Brinkman, W. B., & Epstein, J. N. (2011). Promoting productive interactions between parents and physicians in the treatment of children with attention-deficit/hyperactivity disorder. *Expert Review of Neurotherapeutics*, *11*(4), 579–588. <https://doi.org/10.1586/ern.10.151>
- Bussing, R., & Gary, F. (2001). Practice guidelines and parental ADHD treatment evaluations: Friends or foes?. *Harvard Review of Psychiatry*, *9*(5), 223–233. <https://doi.org/10.1080/10673220127905>
- Center for Disease Control and Prevention. (2020, April). *FastStats*. National Center for Health Statistics. <https://www.cdc.gov/nchs/fastats/adhd.htm>
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE Publications.
- Coghill, D., Soutullo, C., d'Aubuisson, C., Preuss, U., Lindback, T., Silverberg, M., & Buitelaar, J. (2008). Impact of attention-deficit/hyperactivity disorder on the patient and family: results from a European survey. *Child and Adolescent Psychiatry and Mental Health*, *2*(1), Article 31. <https://doi.org/10.1186/1753-2000-2-31>
- Cunningham, C. E. (2007). A family-centered approach to planning and measuring the outcome of interventions for children with attention-deficit/hyperactivity disorder. *Ambulatory Pediatrics: The Official Journal of the Ambulatory Pediatric Association*, *7*(1 Suppl), 60–72. <https://doi.org/10.1016/j.ambp.2006.05.003>

- Curatolo, P., D'Agati, E., & Moavero, R. (2010). The neurobiological basis of ADHD. *Italian Journal of Pediatrics, 36*(1), 79. <https://doi.org/10.1186/1824-7288-36-79>
- Dahl, V., Ramakrishnan, A., Spears, A. P., Jorge, A., Lu, J., Abraham Bigio, N., & Chacko, A. (2020). Psychoeducation interventions for parents and teachers of children and adolescents with ADHD: A systematic review of the literature. *Journal of Developmental and Physical Disabilities, 32*(2), 257–292. <https://doi.org/10.1007/s10882-019-09691-3>
- DeNisco, S., Tiago, C., & Kravitz, C. (2005). Evaluation and treatment of pediatric ADHD. *The Nurse Practitioner, 30*(8), 14–23. <https://doi.org/10.1097/00006205-200508000-00004>
- Dopheide, J. A., & Pliszka, S. R. (2009). Attention-deficit-hyperactivity disorder: An update. *Pharmacotherapy, 29*(6), 656–679. <https://doi.org/10.1592/phco.29.6.656>
- Evans, S. W., Timmins, B., Sibley, M., White, L. C., Serpell, Z. N., & Schultz, B. (2006). Developing coordinated, multimodal, school- based treatment for young adolescents with ADHD. *Education & Treatment of Children, 29*(2), 359–378.
- Foley-Nicpon, M., Allmon, A., Sieck, B., & Stinson, R. D. (2011). Empirical investigation of twice-exceptionality: Where have we been and where are we going?. *Gifted Child Quarterly, 55*(1), 3–17. <https://doi.org/10.1177/0016986210382575>
- Garland-Thomson, R. (2012). The case for conserving disability. *Journal of Bioethical Inquiry, 9*(3), 339–355. <https://doi.org/10.1007/s11673-012-9380-0>

- Glatz, T., Stattin, H., & Kerr, M. (2011). Parents' reactions to youths' hyperactivity, impulsivity, and attention problems. *Journal of Abnormal Child Psychology*, 2011(39), 1125–1135. <https://doi.org/10.1007/s10802-011-9541-3>
- Grusec, J., & Danyliuk, T. (2014). *Parenting skills: Parents' attitudes and beliefs: their impact on children's development*. Encyclopedia on Early Childhood Development. <http://www.child-encyclopedia.com/parenting-skills/according-experts/parents-attitudes-and-beliefs-their-impact-childrens-development>
- Gualtieri, C. T., & Johnson, L. G. (2005). ADHD: Is objective diagnosis possible?. *Psychiatry*, 2(11), 44–53.
- Halperin, J., & Healey, D. (2011). The influences of environmental enrichment, cognitive enhancement, and physical exercise on brain development: Can we alter the developmental trajectory of ADHD?. *Neuroscience & Biobehavioral Reviews*, 35(3), 621–634. <https://doi.org/10.1016/j.neubiorev.2010.07.006>
- Hamed, A. M., Kauer, A. J., & Stevens, H. E. (2015). Why the diagnosis of attention deficit hyperactivity disorder matters. *Frontiers in Psychiatry*, 6, 168. <https://doi.org/10.3389/fpsy.2015.00168>
- Harpin V. A. (2005). The effect of ADHD on the life of an individual, their family, and community from preschool to adult life. *Archives of Disease in Childhood*, 90 Suppl 1(Suppl 1), i2–i7. <https://doi.org/10.1136/adc.2004.059006>

- Hart, S. A., Petrill, S. A., Willcutt, E., Thompson, L. A., Schatschneider, C., Deater-Deckard, K., & Cutting, L. E. (2010). Exploring how symptoms of attention-deficit/hyperactivity disorder are related to reading and mathematics performance: General genes, general environments. *Psychological Science, 21*(11), 1708–1715. <https://doi.org/10.1177/0956797610386617>
- Healey, D., & Rucklidge, J. (2006). An investigation into the relationship among ADHD symptomatology, creativity, and neuropsychological functioning in children. *Child Neuropsychology, 12*(6), 421–438. <https://doi.org/10.1080/09297040600806086>
- Hinshaw, S., & Arnold, L. (2014). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: evidence, paradox, and challenge. *Wiley Interdisciplinary Reviews: Cognitive Science, 6*(1), 39–52. <https://doi.org/10.1002/wcs.1324>
- Hinshaw, Stephen P. (2015). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: Evidence, paradox, and challenge. *Wiley Interdisciplinary Reviews, 6*(1), 39–52. <https://doi.org/10.1002/wcs.1324>
- Johnston, C., & Mash, E. J. (2001). Families of children with attention-deficit/hyperactivity disorder: review and recommendations for future research. *Clinical Child and Family Psychology Review, 4*(3), 183–207. <https://doi.org/10.1023/a:1017592030434>
- Kanarek, R. B. (2011). Artificial food dyes and attention deficit hyperactivity disorder. *Nutrition Reviews, 69*(7), 385–391. <https://doi.org/10.1111/j.1753-4887.2011.00385.x>

- Koelsch, L. E. (2013). Reconceptualizing the member check interview. *International Journal of Qualitative Methods*, 12(1), 168–179.
<https://doi.org/10.1177/160940691301200105>
- Lantz, S., Fornwall, C., Lööf, M. & Isaksson, J. (2021). SKILLS – A psychoeducational group programme for children with ADHD. *Scandinavian Journal of Psychology*, 62(4), 460–467. <https://doi.org/10.1111/sjop.12727>
- Lange, K. W., Reichl, S., Lange, K. M., Tucha, L., & Tucha, O. (2010). The history of attention deficit hyperactivity disorder. *Attention Deficit and Hyperactivity Disorders*, 2(4), 241–255. <https://doi.org/10.1007/s12402-010-0045-8>
- Lebowitz, M. S. (2016). Stigmatization of ADHD: A developmental review. *Journal of Attention Disorders*, 20(3), 199–205. <https://doi.org/10.1177/1087054712475211>
- Loe, I. M., & Feldman, H. M. (2007). Academic and educational outcomes of children with ADHD. *Journal of Pediatric Psychology*, 32(6), 643–654.
<https://doi.org/10.1093/jpepsy/jsl054>
- Merriam, S. B., & Tisdell, E.J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). Jossey-Bass.
- Muñoz-Silva, A., Lago-Urbano, R., Sanchez-Garcia, M., & Carmona-Márquez, J. (2017). Child/adolescent's ADHD and parenting stress: The mediating role of family impact and conduct problems. *Frontiers in Psychology*, 8, Article 2252.
<https://doi.org/10.3389/fpsyg.2017.02252>
- Nandini, M. (2016) Using field notes to facilitate critical reflection. *Reflective Practice*, 17(2), 114–124. <https://doi.org/10.1080/14623943.2015.1134472>

- Nigg, J. T. (2012). Future directions in ADHD etiology research. *Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, 41(4), 524–533. <https://doi.org/10.1080/15374416.2012.686870>
- O'Connor, C., & Joffe, H. (2020). Intercoder reliability in qualitative research: Debates and practical guidelines. *International Journal of Qualitative Methods*, 19. <https://doi.org/10.1177/1609406919899220>
- Peasgood, T., Bhardwaj, A., Biggs, K., Brazier, J. E., Coghill, D., Cooper, C. L., Daley, D., De Silva, C., Harpin, V., Hodgkins, P., Nadkarni, A., Setyawan, J., & Sonuga-Barke, E. J. (2016). The impact of ADHD on the health and well-being of ADHD children and their siblings. *European Child & Adolescent Psychiatry*, 25(11), 1217–1231. <https://doi.org/10.1007/s00787-016-0841-6>
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7–14. <https://doi.org/10.14691/cppj.20.1.7>
- Pollock, B. E., Khaddouma, A., Huet-Cox, K., Fillauer, J. P., & Bolden, J. (2017). Emotional intelligence, relationship satisfaction, and the moderating effect of ADHD symptomatology. *Journal of Adult Development*, 24(1), 15–21. <https://doi.org/10.1007/s10804-016-9242-9>
- Rojas, N., & Chan, E. (2005). Old and new controversies in the alternative treatment of attention-deficit hyperactivity disorder. *Mental Retardation and Developmental Disabilities Research Reviews*, 11(2), 116–130. <https://doi.org/10.1002/mrdd.20064>

- Runco, M. A. (2004). Creativity. *Annual Review of Psychology*, *55*, 657–687.
<https://doi.org/10.1146/annurev.psych.55.090902.141502>
- Saldaña, J. M. (2015). *The coding manual for qualitative researchers* (3rd ed.). SAGE Publications.
- Sedgwick, J., Merwood, A., & Asherson, P. (2018). The positive aspects of attention deficit hyperactivity disorder: a qualitative investigation of successful adults with ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, *11*(3), 241–253.
<https://doi.org/10.1007/s12402-018-0277-6>
- Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.
- Spencer, T. J., Biederman, J., & Mick, E. (2007). Attention-deficit/hyperactivity disorder: diagnosis, lifespan, comorbidities, and neurobiology. *Journal of Pediatric Psychology*, *32*(6), 631–642. <https://doi.org/10.1093/jpepsy/jsm005>
- Tarver, J., Daley, D., & Sayal, K. (2014). Attention-deficit hyperactivity disorder (ADHD): An updated review of the essential facts. *Child: Care, Health and Development*, *40*(6), 762–774. <https://doi.org/10.1111/cch.12139>
- Visser, S. N., Zablotsky, B., Holbrook, J. R., Danielson, M. L., & Bitsko, R.H. (2015). Diagnostic experiences of children with attention-deficit/hyperactivity disorder. *National Health Statistics Report*, *81*, 1–7.
<https://www.cdc.gov/nchs/data/nhsr/nhsr081.pdf>

Wehmeier, P. M., Schacht, A., & Barkley, R. A. (2010). Social and emotional impairment in children and adolescents with ADHD and the impact on quality of

life. *Journal of Adolescent Health, 46*(3), 209–217.

<https://doi.org/10.1016/j.jadohealth.2009.09.009>

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167–177.

<https://doi.org/10.1037/0022-0167.52.2.167>

Appendix A

Informed Consent

Counseling Psychology Doctoral Dissertation, Northwest University
Moriah Boggs, MA

You are invited to participate in a research study conducted by Moriah Boggs, graduate student in the doctoral program in Counseling Psychology at Northwest University. The study is being conducted as her doctoral dissertation. The purpose of this study is to understand parents' experience after their child is diagnosed with Attention Deficit Hyperactivity Disorder.

If you agree to participate in the study, you will engage in a 45 to 90-minute interview. I would like to audio-tape the interviews. However, your name would not be mentioned during the interview and the information you provide would be kept confidential. During the interview, I will ask you some questions about your views regarding your experience and access to support for your child. I would also like to take notes about your answers to the questions and my observations during the interview.

There are minimal risks associated with participation. Some individuals may be uncomfortable or embarrassed answering personal questions. Some questions asked may also raise uncomfortable feelings regarding your experience after diagnosis of raising a child with ADHD. The benefit of taking part in this study is the opportunity to participate in the research process as a research subject. You will also have an opportunity to share some of your thoughts and feelings freely in a safe environment. If you need additional support following the interview, psychologytoday.com is recommended as an online resource to find a therapist in your area, and access to the Care Crisis Line is available by calling 1-800-584-3578.

Participation in this study is voluntary. You may choose not to participate in this study at any time and for any reason. There will not be any negative consequences for you if you refuse to participate. You may refuse to answer any questions asked. All responses are confidential and will not be linked to any of your identifying information. You will be given two consent forms to sign. One will be for me and you may keep the other for your records. By turning in this questionnaire, you are giving permission for your responses to be included in this research study.

Following completion of the study, I anticipate the results to be presented in a published dissertation document during the summer or Fall of 2021. Results may also be published in a psychological journal or presented at a professional conference or meeting. All data forms will be destroyed by June 1, 2023.

If you have any questions about this study, please contact Moriah Boggs at [REDACTED]. If you have further questions, please contact the faculty advisor Dr. Leihua Edstrom at [REDACTED].

You may also contact the Chair of the Northwest University IRB, Dr. Cherri Seese at

[REDACTED]

.

Thank you for your consideration of participating in this study.

Moriah Boggs, MA
Doctoral Student in Counseling Psychology
College of Social and Behavioral Sciences
[REDACTED]

Leihua Edstrom, PhD, ABSNP
Professor of Psychology
College of Social and Behavioral Sciences
[REDACTED]

Principal Investigator	Date	Participant	Date
------------------------	------	-------------	------

Appendix B

Interview Questions

Participant ID# _____

Demographics

1. What is your child's gender?
2. How old is your child?
3. What grade are they currently in?
4. What age was their when diagnosed with ADHD?
5. What is your marital status?
6. How many children currently live in your home?
7. What are the ages of your children?
8. Do all of your children have the same parents?
9. Where do you currently live?
10. What is your occupation?
11. What is your highest level of education?
12. Has anyone else in your immediate family been diagnosed with ADHD?

Prior to Diagnosis

- 1) Would you describe your experience with (*child*) and parenting (*child*) prior to the diagnosis? (home, school, social settings)
 - a. Were there any behaviors that your child exhibited that were difficult or noticeably different than other children?
 - b. Did you suspect your child had ADHD prior being diagnosed? If so, why?

- 2) What challenges, if any, did you face in finding a clinician to evaluate your child?
 - a. How did you determine who to use for your child's evaluation?
- 3) What were your feelings about having your child evaluated?

Experience with the diagnosis process

1. Tell me what your experience was like having your child diagnosed?
 - a. How far did you have to travel?
 - b. How long did it take to schedule with the clinician?
 - c. In what ways did you feel supported or unsupported by the clinician?
2. What do you remember about the assessment process?
3. What rating scales or tests were used by the clinician?
4. Were your child's teacher (s) included in the assessment?
5. What was it like to be told that your child has ADHD?
 - a. What emotions did you experience during this time?
 - b. Did the assessment uncover any additional diagnoses?

Psychoeducation and Treatment Options

1. Following the diagnosis. . .
 - a. Where and by whom did you learn about ADHD and treatment options?
 - b. What sources did you find the most helpful?
 - c. Were there individuals that you reached out to for support? If so, whom?
 - d. Did you feel properly supported during this time?
2. Would you describe any challenges you encountered when deciding on treatment options?

Treatment options utilized and perception of usefulness

- 1) What treatment options have you tried to help manage your child's ADHD symptoms? (school, home, social settings)
- 2) How did you decide on these treatment options?
- 3) What has worked well?
- 4) What has not worked well?
- 5) How do you view your role in the treatment process?

Hurdles and Strides

- 1) What would you consider to be the greatest challenges you and your child have experienced with regard to ADHD?
- 2) What would you consider to be the greatest strides you and your child have made?
- 3) Has your parenting role changed with (*child*) as you have progressed on your journey of raising a child with ADHD?
- 4) Is there anything else you would like to share about your journey of raising a child with ADHD?