EXPLORATION OF EFFECT OF DIAGNOSIS
OF HIGH SCHOOL GIRLS WITH ATTENTION DEFICIT DISORDER ON
THEIR MOTHERS AND THE MOTHER-DAUGHTER RELATIONSHIP

By

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To my precious daughter Bailey,
and the participating mothers of this study
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The purpose of this study was to explore the emotions, attitudes, and perceptions of mothers of girls who were late diagnosed with attention deficit disorder, and the ways in which these perspectives affected the mother, daughter, and the mother-daughter relationship before and after diagnosis. The goal was to identify the particular needs of mothers with daughters diagnosed at later stages of development and to determine effective coping mechanisms and parenting strategies. Methods for enhancing or rebuilding the mother-daughter relationship were also sought. The information gathered was intended to assist counseling, academic, and medical communities in improving the support and treatment of ADD girls, their mothers, and families.

Eight mothers of ADD daughters diagnosed in high school were individually interviewed. Interviews were transcribed and coded using the constructivist method of grounded theory. A distinct difference was found in both the pre and post diagnosis perceptions and attitudes of mothers who had ADD themselves and those who did not. Results indicated that early relating by the ADD mothers to their daughters increased empathy and gave them an advantage in developing a close mother-daughter relationship pre-diagnosis. Their relief in finding an answer to their daughters' struggles gave them a more positive outlook for their daughters' futures, as
well as their own. Most participants had an incomplete understanding of ADD symptoms, effects, and treatments and found themselves carrying the burden of dealing with their child's ADD before and after diagnosis. Critical factors in improving mother-daughter relationships were increasing empathy, adjusting expectations, and using effective accommodating behaviors.
CHAPTER 1
INTRODUCTION

Attention deficit disorder (ADD)\(^1\) is often difficult to recognize in girls. Many of the ADD traits seen in girls differ from those commonly perceived as ADD symptoms. Because of this misperception, ADD girls are often undiagnosed until later in their development after they have entered their middle or high school years. This "late diagnosis" presents unique problems for adolescent girls. All children are expected to meet pre-determined developmental milestones. Girls, however, are expected to meet additional socio-cultural norms, and their mothers are expected to help them do so. Girls with ADD often trail their peers developmentally and socially, leaving undiagnosed adolescents and their mothers struggling to cope with unmet expectations of themselves, each other, and their relationship.

The purpose of this study was to observe the effects of ADD on females from a unique perspective: how the mother of a late diagnosed ADD girl influences the development of her child, and how a diagnosis of ADD in the daughter influences the mother-daughter relationship. Attitudes and perceptions of the mother of herself and her daughter before and after the child's ADD diagnosis during the high school years were examined.

Statement of the Problem

Diagnosing Attention Deficit Disorder in Females

Attention Deficit Disorder (ADD) is a neurobiological disorder affecting an estimated 9.5-16% of the childhood population in the United States (Brown, 2005). Since the recognition of the syndrome by the medical profession in the early 1900's, the majority of research on the disorder has been conducted on male children, as most individuals associate ADD with the

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\(^1\) For purposes of this study, the term attention deficit disorder (ADD) will be used unless quoting a source that refers to the disorder as attention deficit hyperactivity disorder (ADHD or AD/HD).
unruly behavior often seen in young boys (Rabiner, 2006). Because of these misperceptions, current diagnostic tools for ADD concentrate primarily on the externalizing, disruptive behaviors of boys such as behavior management problems, defiance, and aggression (Nadeau, 2004b). As a consequence, males are three to five times more likely to be diagnosed with attention deficit disorder than females (Hallowell & Ratey, 2005; Strong & Flanagan, 2005). Although ADD is one of the most heavily researched psychiatric conditions of childhood, less than one percent of this research has been directed toward girls (Nadeau, 2002). Only recently have researchers turned their attention to females with the disorder, discovering that females often experience substantial differences in symptoms and consequences than their male counterparts.

As opposed to the disruptive behaviors often seen in ADD boys, many ADD girls appear lethargic, lost in their own world, quiet, shy, withdrawn, and inattentive (Solden, 1995; Taylor & Keltner, 2002). These differences often cause ADD girls to be under-diagnosed, misdiagnosed, or undiagnosed, resulting in feelings of demoralization and despair, addictive behaviors, anxiety, and depression (Biederman, Mick, & Faraone, 1998; Nadeau, Littman, and Quinn, 1999; Quinn, 2005). Lack of understanding, support and treatment can cause girls with ADD to struggle academically, socially, and emotionally (Rief, 2003; Nadeau, et al.).

Not only do children with ADD suffer, but many of their parents suffer as well, experiencing grief, guilt, anger, blame, envy of other parents, chronic tension, isolation, depression, and marital problems (Amen, 2001; Sears & Thompson, 1998). Amen has also found that ADD often causes negative bonding between ADD children and their parents. The later these children are diagnosed and treated, the greater the potential for harm to the emotional health of both parents and child. The relationship between the mother and daughter is especially crucial, not only because mothers are typically the primary caregiver, but because mothers sense
their daughters’ moods more readily, and their daughters’ emotions are more likely to affect their own (Tannen, 2006).

Unidentified ADD girls who have received no help or support, and are not diagnosed until middle school or high school can accumulate layers of self-doubt and self-recrimination, often leading to poor self-esteem, anxiety, and depression (Nadeau, et al.1999; Rucklidge & Kaplan, 2002). The later the diagnosis, the longer girls’ behaviors may be misinterpreted and criticized, particularly by their mothers, who play a crucial role in the well-being of a child, especially a female child (Caplan, 2000).

**Cultural and Societal Expectations of Females**

Attention deficit/hyperactivity disorder (ADHD) is generally described as consisting of three key problems in a person’s ability to control behavior: difficulties in impulse control or inhibition, difficulties in sustained attention, and excessive activity (Barkley, 2000). Brown went a step farther to describe "ADHD syndrome," identifying six clusters of cognitive problems seen in most individuals with the disorder: "chronic difficulties with (1) organizing, prioritizing, and getting started, (2) focusing, sustaining and shifting attention, (3) regulating alertness, sustaining effort, and determining processing speed, (4) managing frustration and modulating emotions, (5) utilizing working memory and accessing recall, and (6) monitoring and self-regulating action" (Brown, 2005, p. xiii).

Barkley (cited in Dendy, 2000) reported that ADD children also have a developmental delay of approximately 30%, causing them to trail their peers socially, academically, and emotionally. Estimates of ADD children with at least one other major disorder range from one-half to two-thirds, with the most common coexisting disorders being oppositional defiant disorder, conduct disorder, anxiety disorder, depression, and learning disabilities (Rief, 2003). The lag in development of ADD children, coupled with the characteristic symptoms of ADD and
coexisting disorders, typically prevent these children from successfully progressing through the stages of normal psychosocial development (Erikson, 1963; Kelly & Ramundo, 1993) and acquiring age-appropriate behaviors (Sears & Thompson, 1998).

Failing to meet the cultural demands of each stage of development presents unique difficulties for ADD girls. Females are raised with a different set of social and moral expectations (Choate, 2008; Littman, 2002; Tannen, 1990). These cultural role expectations demand a female be lady-like, polite, organized, neat, social, punctual and thoughtful (Solden, 1995). Great importance is placed on relationship building, with expectations for females to be highly verbal, interactive, emotionally responsive, and socially poised. In the influential book, *Reviving Ophelia* (1994), psychologist Mary Pipher claimed cultural rules for girls have not changed since the fifties. Girls are to "be attractive, be a lady, be unselfish and of service, make relationships work and be competent without complaint" (p. 28). These complex demands are particularly hard for the ADD female. Classics in mother-daughter literature such as *My Mother, My Self* (Friday, 1977) and *Of Woman Born* (Rich, 1986) described the strain on the mother-daughter relationship when a daughter fails to meet society's demands. Current writers reiterate the pressures on the relationship. Pipher explained, "Mothers are expected to protect their daughters from the culture even as they help them fit into it" (p. 112). This adverse effect on the mother-daughter relationship is particularly significant for the ADD girl. With the child’s inability to integrate with peers, reach academic requirements, and meet society’s standards, the needs of this child are numerous and can be influenced positively or negatively by her mother.

Due to mothers and daughters' expectations of each other, the mother-daughter relationship is by nature a difficult one, with mothers expecting imitation of their behaviors, and daughters expecting encouragement, nurturing, and approval (Herst, 1998). Tannen (2006)
claimed that the relationship between mothers and daughters is the literal “mother of all relationships” and is among the most passionate of women’s lives (p. 3). The mother can be her daughter’s strongest advocate or her greatest nemesis as she struggles to meet the challenges of ADD and its effect on her overall development.

This study looked specifically at mothers whose ADD daughters had received a late diagnosis when in high school, after the mother and daughter had co-existed for many years without knowledge of the disorder.

**Purpose of the Study**

The purpose of this study was to explore the emotions, attitudes, and perceptions of mothers of late diagnosed ADD girls, and the ways in which these perspectives affected the mother, daughter, and the mother-daughter relationship before and after diagnosis.

**Research Questions**

1. What are the emotions, attitudes, and perceptions of mothers of late diagnosed ADD daughters of themselves and their daughters before and after diagnosis?
2. How is the mother-daughter relationship affected by the daughter's diagnosis?

**Significance of the Study**

Research on girls with ADD is scarce, and little is known of how mothers as primary caregivers influence the development of their ADD daughters. This study will contribute to the understanding of attention deficit disorder in late diagnosed adolescent girls by looking at the perspectives of the mother as the undiagnosed child advances in age, and compare these to the mother's perspectives after learning of her daughter's disorder. How a mother perceives herself and her ADD child will help to identify the particular needs of mothers with daughters diagnosed at later stages of development, lead to the identification of coping mechanisms and parenting strategies for mothers, and result in identifying methods for enhancing or rebuilding the mother-
daughter relationship. Information gathered will assist counseling, academic, and medical communities in improving the support and treatment of ADD girls, their mothers, and families.

Research has shown that lack of timely and accurate diagnosis can cause significant difficulties for ADD females. Identifying the unique traits and special needs of ADD girls as they go untreated through advancing developmental stages will increase awareness for early detection of ADD and assist in creating more female-specific diagnostic tools and treatments.
CHAPTER 2
LITERATURE REVIEW

…although the institutions of motherhood and childhood have changed greatly through western history, some of their founding myths are still very much with us. As mothers and as daughters living in particular societies, we at once choose and are chosen by these enduring narratives of a female life" (Gelfand, 2005, p.1).

This quote from a speech by Elissa Gelfand at Mount Holyoke College embodies the weightiness of Euroamerican expectations of females, and in particular, mothers and daughters.

In *Mothering the Self*, Lawler (2000) wrote that the mother, as the individual typically responsible for family child-care, is the one held responsible for not only mothering "the self" in her children, but for making this self "good" and "healthy." Lawler insisted that the unquestionable Truth about what represents a good or healthy self is determined by "experts" in the fields of medicine, academics, psychology, and psychiatry. This knowledge of "truth" is not contained to these disciplines, but seeps out into the domains of social workers, teachers, health professionals, and counselors. This truth is announced in self-help and child-care advice literature. It pervades doctors' offices, television and radio shows, movies, magazines, and weekly news columns. Mothers are furnished child development charts in order to properly monitor their child's psychological and physical progress. Individuals who do not meet the stipulated goals and are outside the norm are considered pathological, leading mothers to constantly scrutinize their children, looking for ways they may have strayed from prescribed developmental and psychological milestones. Lawler points out that in so doing, mothers scrutinize themselves, looking for what they may have done to create anything less than a good and healthy self in their child.

Lawler (2000) maintained that not only do unchallenged experts declare the Truth about human nature, but that social and political powers join in determining what counts as a healthy individual, a "good" mother, and a "good" child. Governments want a society with citizens who
have well-adjusted selves and live in harmony with other well-adjusted selves, creating social
order. Appropriate social practices are expected of these individuals, relayed by those in power
through public policy, health provisions, education mandates, laws, and social work procedures.
Intractable Truths about human nature, created by socio-political powers, result in intense self-
scrutiny by members of the population. Concern for a well-functioning society, Lawler insisted,
keeps those in social and political power interested in what kinds of selves families (especially
mothers) are producing, setting the standards for what constitutes a good self, a good mother, and
a good child. Lawler believed that as these powers name, define, normalize, and pathologize,
they claim to speak about the Self, but are actually producing specific forms of Self. By setting
developmental and social standards and practices, socio-political influences determine what
individuals do, and are constrained from doing.

Lawler (2000) pointed out that mothers and daughters constantly scrutinize themselves,
each other, and their relationship, monitoring and regulating their actions. As childhood is
viewed as the period when the self is formed, mothers are held responsible for producing a good
child with a good self, and one who is autonomous and unique. Ironically, the mother is to
accomplish this by nurturing and regulating the child so that the child is as close as possible to
the standards of normal childhood. The mother has learned from those in power that all children
have the same needs and should meet the same developmental milestones, but that as their
mother, she should nurture her child's innate individuality while allowing the child to discover
his or her "True Self." Lawler referred to a phrase coined by psychotherapist Donald Winnicott
in the 1960's: the "good enough mother." Winnicott insisted that the natural and inherent needs
of the child could be met by its mother, who is uniquely and specially equipped to meet these
needs. Winnicott claimed that the mother must meet the child's needs, not only by mothering,
but also by *enjoying* her mothering. The mother must express love and experience pleasure while mothering in order to develop the child's "real self." Winnicott believed that mothers "naturally" desire to devote their lives to the needs of their child. Mothers who do not meet these expectations are not "normal," and cannot be good enough mothers.

**Mothering the Self in Daughters**

Mothers are typically the primary caretaker of the family and, for daughters specifically, they are the primary role model and object of identification, and the ones held responsible for their daughter's behavior (Caplan, 2000; McNab & Kavner, 2001; Shrier, Tompsett, & Shrier, 2004; Tannen, 1990). In *Mothering the Self*, Lawler (2000) maintained that mothers are responsible for creating a good and true self in their child. She identified three principle models of the self: (a) the inherited self, (b) the socially produced self, and (c) the unique, intrinsic, and autonomous self.

Lawler (2000) found that the "inherited self" suggests an unalterable tie with the past, which should relieve mothers from the responsibility of raising the "good child." If self-characteristics are in-born, one cannot choose what their self will become. How can a mother influence and nurture her child to meet the standards of human nature when character traits are in-bred? How can a daughter have freedom of choice and find her true self while recognizing parts (and often unwanted parts) of herself in her mother? Lawler has found that women acknowledge that traits are passed from both mothers and fathers, but believe that most positive ones pass from fathers to their children. Women believe that negative characteristics, however, are more often seen as passing from the mother to the self of the daughter, or in other words, from the mother's self to the daughter. If a mother sees personal traits reproduced in her daughter, especially negative ones, it is even more difficult for the mother. The mother's recognition of these unwanted traits in the daughter, suggests that she, as the mother, is to blame.
because of who she is rather than what she does. Although the model of the inherited self should let mothers "off the hook," instead, it emphasizes their genetic contribution to any deficits the child might present.

Lawler's second model of the self, the "social self," assumes the social world is responsible for the child's behavior. Societal factors outside the mother's control influence the child's self and, once again, should relax maternal responsibility. Mothers, however, do not know which societal factors will be decisive or how their children will turn out until after the fact, leaving mothers with the feeling that their mothering is crucial, as those in power have reinforced the notion that healthy children come from only healthy mother-child relationships.

The third model presented by Lawler is that of the "intrinsic self," the self that is particular and distinctive to one individual and that individual alone. This intrinsic self is made up of the child's physical, emotional, and psychological uniqueness, plus environmental/cultural factors, producing a distinctive self, influenced by both nature and culture. Lawler maintained that if a child's self can be influenced by inherited family traits and the social world outside the family, so must the intrinsic personality. If this line of reasoning is followed, then these factors should limit the mother's responsibility in mothering and in being held responsible for how her child turns out – for good or for bad. Lawler pointed out that this, however, is not the case: "..."rightness" and "wrongness" of the outcome do not function equivalently" (Lawler, 2000, p.71). Mothers tend to blame themselves when things go wrong with their children, but rarely take credit when things go right. Lawler explained this paradox:

How is it that mothers can be marked out as both responsible and not responsible? That selves can be marked as both innate and produced through mothering? This apparent contradiction is contained within the mother's constitution in terms of her responsibility to nurture the 'true', autonomous self of the child. This responsibility remains mother's primary psychological task. It is a responsibility which rests on specific constitutions of both 'nature' and 'culture', as the child's self is discursively produced as natural and
intrinsic, but also as only capable of realization through the mother's sensitive care (Lawler, 2000, p. 71-72).

Lawler's concept of mothering the self communicates the difficulties experienced by mothers of daughters with attention deficit disorder. The daughter’s continued failure to meet society’s expectations socially and academically may increase the mother’s frustration with herself as a parent and with her daughter as well. Research has demonstrated that late diagnosed ADD girls suffer from increased low self-esteem, underachievement, anxiety, and depression (Nadeau, 2004d; Quinn, 2002). These girls may experience a lack of understanding and support from their mothers who have struggled to raise their daughters to meet societal expectations, and may see themselves as culpable for any negative characteristics in their daughters. Hales (cited in Hrelic, 2003) found that a mother’s self-esteem has more influence on a girl’s self-confidence than any other factor. The later the diagnosis, the more opportunities there are for mother-daughter conflicts, and the longer the mother has to blame herself for unmet expectations and affect the emotional well-being of both mother and daughter and the relationship between the two.

This review of the literature provides an overview of studies related to the causes of under-diagnosis in ADD girls, the symptoms of female ADD, the epidemiology of the disorder, and the resultant effects on the life of the ADD individual. This review also explores the typical mother-daughter relationship and the complexities of having a female child with symptoms of attention deficit disorder.

**Difficulties in Diagnosis of Attention Deficit Disorder in Females**

Girls with attention deficit disorder are often under-diagnosed, misdiagnosed, or diagnosed after many years of struggling academically in school and in relationships with peers and family members. Nadeau et al. (1999) provided informal statistics suggesting that the percentage of
women seeking ADD treatment is significantly higher than the percentage of girls who are treated, indicating that many females are spending their formative years undiagnosed, receiving no treatment for their symptoms. Watkins (2004) emphasized that girls and women with ADD feel that “something” is wrong with them, but are unable to identify the problem. They internalize their feelings, blame themselves, and experience anxiety and depression. Feelings of guilt and shame layer over the years and exert a powerful influence on the formation of their personalities as they mature (Dendy, Durheim, & Ellison, 2006).

Although ADD symptoms often begin in pre-school, the signs are not readily recognizable in girls. One of the reasons the disorder is often overlooked is that most females present with different symptoms than those that parents and professionals characteristically identify with ADD children. Symptoms of attention deficit disorder are usually perceived as the overexcited behaviors observed in “bad” boys who display aggressive behavior, are unable to sit still, speak out of turn, and misbehave. In comparison, ADD girls rarely exhibit difficult or hyperactive behaviors. They are usually compliant and cooperative at school and at home. Instead, they exhibit forgetfulness, disorganization, anxiety, low self-esteem, and demoralization, symptoms that are less overt than usually seen in boys (Quinn, 2005). Although the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000) lists inattention and impulsivity as symptoms of ADD, many of the checklists for the disorder emphasize hyperactive and impulsive behaviors as criteria for diagnosis.

Rief (2003) has pointed out that not only do girls often go undiagnosed or misdiagnosed because of their less obvious ADD behaviors, they also work harder to hide their academic difficulties and to conform to teacher expectations. They are often misdiagnosed as anxious
and/or depressed. Girls with high IQs can compensate much longer for their ADD (Nadeau et al., 1999). Unfortunately, an ability to compensate may cause the symptoms to remain hidden until the girl is overwhelmed in high school when skills such as focusing, recalling information, organizing, and planning are necessary for academic success.

Hallowell and Ratey (1994) have noted that many girls show fewer problems in math and reading during their early school years. This proves to be problematic because the observation of learning disabilities in a child is often the precursor to an ADD diagnosis. Because most ADD girls do not fit the usual ADD profile and may not display academic problems until middle school, they often go years without diagnosis. Cognitive difficulties may be equal between ADD girls and boys, but the ADD boy's aggressive and defiant behavior will more likely lead to referral and diagnosis.

ADD symptoms are often initially identified by parents who compare their daughters to other girls in their age group and find striking differences (Nadeau et al., 1999). The authors found that these same symptoms are routinely overlooked by teachers who compare the behavior of girls to the behavior of classmates of both genders. Looking for the typical ADD found in boys, it is easy for the teacher to overlook symptoms that are not as obvious in girls and refer only the rambunctious boys or those girls with the most extreme ADD behaviors.

Another reason of under-diagnosis of young girls with ADD is the DSM-IV-TR requirement that symptoms must be evident before the age of seven. Many girls do not display ADD symptoms until middle or high school when they become overwhelmed by academics that are more difficult, or until puberty when fluctuating hormones make symptoms more apparent (Hallowell & Ratey, 1994; Quinn, 2005). Strong family support and structure can often hide the symptoms of ADD (Solden, 1995). When the girl is provided with tutors, homework guidelines,
and a structured extracurricular activity schedule, academic difficulties can be masked. The family may also encourage the child to work extremely hard to cope with her academic struggles, as well as help her discover her special talents and abilities outside the classroom.

As Lawler (2000) contends, parents (especially mothers) scrutinize their daughters for reassurance that social and developmental milestones are being met. If standards are not realized in the child, the mother may scrutinize herself as well, looking for her failures as a parent.

**Diagnosis Statistics**

Attention deficit disorder is three to five times more common in boys than girls and in clinical settings specializing in ADHD, as many as six to nine boys are seen for every girl referred (Barkley, 2000; National Resource Center on AD/HD, 2004). Between 1997 and 2006, there was observed a 4% increase in girls with ADHD, compared to a 2% increase in the percentage of boys with the disorder (Pastor & Reuben, 2008). Even with the recent increase in female diagnosis, it has been estimated that 50-75% of girls with ADHD go undiagnosed (Nadeau, 2004c).

**Causes of Attention Deficit Disorder**

Weiss (2005) described ADHD as “a particular style of brain construction…which affects the ways in which we think, feel, create, process information, learn best, manage time, organize projects and materials, respond to our environment, communicate, act physically, and relate to others” (p. 22).

Sarkis (2005) pointed out that ADD is not really a deficit in attention, but rather difficulty in keeping attention focused. ADD individuals have trouble screening out unneeded information and are unable to filter distractions. This causes them to become flooded, assaulted, bombarded, and overwhelmed by extraneous information, feeling an inner sense of chaos (Solden, 1995).
Barkley (2000) argued that ADD is mislabeled as a disorder of *attention*, insisting this term trivializes the condition and understates the vast problems caused by ADD symptoms. Barkley believes that ADD is primarily a disorder of *self-regulation*, making it difficult for ADD individuals to manage their social behavior. The child is unable to inhibit immediate reactions to the moment, making it impossible to use self-control. Because most ADD children do not learn from the past and can only focus on the present, there is no control over impulse and the need for immediate gratification. They are unable to consider consequences, plan, organize, or set goals. This inability to use future-directed thinking causes serious difficulties at home, school, and the workplace.

No one knows exactly what causes attention deficit disorder, but it is believed that most cases are inherited. Recent studies with positron emission tomography (PET scan) and magnetic resonance imaging (MRI) have shown that ADD is a neurobiological disorder (Barkley, 2000). Several factors are thought to be links with ADD symptoms: reduced volume in certain areas of the brain, under-activity in the brain, reduced cerebral blood flow, and mutations of specific genes.

**Brain Structure**

One factor believed to be a cause of ADD is an alteration in brain structures during development (Barkley, 2000). Hallowell and Ratey (2005) reported that brain scans have shown a difference in four regions of the ADD brain: the cerebellar vermis, the basal ganglia, the frontal lobes, and the corpus callosum. In particular, the frontal lobes and basal ganglia are approximately 5-10% smaller in comparison to non-ADD brains (Rief, 2003). The frontal lobes are known to control the executive functions of the brain including decision-making, time management, and organization. ADD individuals usually struggle with all of these skills. The basal ganglia regulates mood and controls impulsive outbursts, other areas of difficulty for the
ADD sufferer. The cerebellum is known to help with language, rhythm, coordinated movements, and balance, areas that ADD individuals often find difficult to master.

Kelly and Ramundo (1993) reported that some experts believe ADD is impairment in the brain stem, which is the center for arousal, regulating alertness ranging from deep sleep to full consciousness. These experts believe there is a “short” in the loop between the frontal lobes and the brain stem, causing the ADD individual to have trouble in staying awake and paying attention. Hyperactive ADD individuals may have a high activity level in an effort to stay awake. Many ADD sufferers struggle from sleep disturbances, with either sleeplessness and reawakening, or inability to be aroused from deep sleep. These severe sleep disorders may cause arousal, learning, and memory problems.

**Brain Chemistry**

Scientists have found that individuals with ADD have insufficient neurotransmitters, the chemical messengers that send information from nerve cells to other nerve cells (Brown, 2005). This chemical inefficiency results in behavior that is unpredictable and unregulated. When chemical messengers are releasing and reloading erratically in the part of the brain that controls attention, impulsivity, and activity levels, these behaviors will also be erratic. Solden (1995) claimed that the wide range of combinations possible in the transmission of information makes ADD difficult to understand. Symptoms can appear differently in each person or even within the same person.

This inefficient delivery system causes ADD individuals to have imbalanced levels of the chemicals dopamine, neuropinephrine, and serotonin. The chemical messenger dopamine is one of the main providers of pleasure (Hallowell & Ratey, 2005). A low level of dopamine causes an individual to be distracted, inattentive, impulsive, and have difficulty thinking ahead, completing a job, and delaying a response (Dendy, 2000). Dopamine also serves as a braking mechanism or
inhibitory circuit in the brain. ADD individuals often seek high risk or highly stimulating activities to increase dopamine levels in their systems. If dopamine levels are too high, an individual may get hyper-focused on an activity and repeat a behavior repetitively.

Dendy (2000) reported that low levels of the neurotransmitter norepinephrine can cause aggressive behavior, depression, or indifference. If too high, the individual may be impulsively aggressive or seek high stimulus activities. The third chemical messenger affecting ADD, serotonin, gives a sense of well being. When this chemical is too low, an individual is more aggressive and irritable.

The female’s brain is also affected by variations in estrogen levels. Nadeau and colleagues (1999) reported that lower levels of estrogen during premenstrual periods result in fewer and less sensitive brain receptors, adding to the difficulties of ADD females already affected by decreased dopamine and/or smaller functioning brain areas. With the onset of puberty and its accompanying hormonal fluctuations, ADD girls often exhibit their first symptoms of ADD. Those previously diagnosed with the disorder may experience a noticeable increase in existing symptoms. Premenstrual symptoms of anxiety, depression, and irritability are increased in girls with ADD. Amen (2001) found an overall decrease in brain activity when estrogen levels are low.

**Brain Activity**

In a 1990 PET scan study at the National Institute of Mental Health, Zametkin discovered that there was reduced blood flow and glucose uptake (the brain’s energy source) in the frontal lobes of the ADD brain. This under-activity may be caused by the problems with the brain's neurotransmitters. This reduced blood flow is linked to difficulties with attention, memory, impulsivity, emotions, and sensitivity to rewards and punishment (Dendy, 2000; National Institute of Mental Health, 2001).
Genetics

Dendy reported that scientists have found possible links to ADD and approximately thirteen genes. Especially suspect are two dopamine receptor genes and a dopamine transporter gene, believed to affect the level of dopamine in the brain and cause insufficient levels of the chemical in ADD individuals.

Types of Attention Deficit Disorder in Girls

Most researchers and specialists in ADD recognize three subtypes of the disorder: hyperactive/impulsive, inattentive, and combined. In Understanding Girls with ADHD (Nadeau et al., 1999), the authors identified these subtypes with descriptive names for the characteristics found in ADD girls: the hyperactive/impulsive "tomboy," the inattentive "daydreamer," and the combination type “Chatty Kathy.”

Hyperactive-Impulsive Type

The “tomboy” is seen as the hyperactive girl version of ADD. She is very active, and enjoys sports and risk-taking activities, as well as playing and exploring with boys and preferring their companionship. This girl may be disorganized, messy, and rush from one activity to the next, but is generally cooperative. She is seen by parents and teachers simply as an undisciplined underachiever. Nadeau et al. (1999) described most ADD females with the hyperactive personality type as being hyper-verbal and emotionally excitable.

Others with more extreme hyperactive-impulsive behaviors may exhibit loud, physically active, intrusive, and demanding conduct, as well as being defiant, aggressive, and often invading the personal space of their peers. These girls are usually very visible to their teachers and parents because they exhibit atypical female behaviors and receive unsympathetic criticism for their actions. Parents are often embarrassed by their wild activities and emotional intensity -
the same behaviors seen as normal in boys. These girls often participate aggressively on sports teams and find acceptance through their success in this arena.

The authors added that ADD "tomboys" may be extremely messy both at home and at school, have poor handwriting, run words together, forget to skip lines, or write in the margins. In a study of neuropsychological functioning, Seidman and colleagues found that these girls may also experience more learning difficulties than other types of ADD individuals (cited in Nadeau et al., 1999).

**Inattentive Type**

The second ADD personality type listed by Nadeau et al. is the "daydreamer" or ADD inattentive type. This quiet girl rarely draws attention to herself. Although she appears to be listening at school, she often daydreams in class and during homework time, moves slowly through tasks, and is overwhelmed by them. She is disorganized and forgetful about schoolwork, and anxious and worried about school in general. She is only able to complete homework assignments when a parent is sitting beside her, coaxing her to continue. She is often depressed. Because of her attempt to go unnoticed, and an inability to focus and complete tasks, she is seen as less bright than she really is.

Inattentive type of ADD was not recognized and named until 1980. It is the most predominant and least recognized type of ADD. The authors described the inattentive ADD girl as hypoactive or lethargic, even narcoleptic in extreme cases. She prefers to sit unnoticed in the back of the class, avoids challenges, and tends to give up quickly after being easily discouraged. Because of her high anxiety level and fear of humiliation, she has trouble verbalizing. This may be from central auditory processing or expressive language skill problems, or from the interference in concentration brought on by her overall anxiety. This type of ADD girl is usually bright, has a high IQ, and no learning disabilities. Her high IQ permits her to perform adequately
in school so that her ADD symptoms go unnoticed, forcing her to internalize her psychological
anguish. The inattentive, socially withdrawn girl is often misdiagnosed, and treated for
secondary conditions of anxiety and depression, rather than her ADD (Quinn, 2005).

**Combination Type**

The “Chatty Kathy” personality type is a combination of the personalities. Although she
may not be a tomboy, she is more active than the daydreamer. She is extremely talkative, rather
than hyperactive. Her love for talking may get her into trouble at school, talking at inappropriate
times. She may act silly and emotional. She is usually fun to be around because she is exciting
and active. Her friendships, however, may be volatile because of the drama and overreaction
involved in her peer relationships. Because she has trouble organizing her thoughts, she often
interrupts others and jumps around from topic to topic with disorganized accounts of movies or
stories. To hide her forgetfulness and disorganization, she may counteract poor academics by
smoking, drinking, or sexual promiscuity.

This combination type of ADD girl may be viewed as charismatic by her peers or seen
as bossy and stubborn. She may have huge mood swings with “flash-fire” type of anger. She
may have trouble getting up and out of the house and is clearly dissatisfied with life. Often, she
places blame on others for her misery. Although girls’ ADD behavior may not be as noticeable
and disruptive as boys’ behaviors, it is chronic and its seriousness cannot be under-rated.

**Effects of Attention Deficit Disorder on Girls**

In her article “Helping Your Daughter with ADD (ADHD) to Feel Good About Herself”
(2004a), Nadeau pointed out that many professionals believe girls are not as impacted by ADD
as are boys and “are unaware of the very real risks for girls with untreated ADD – including
chronic demoralization, anxiety, depression, underachievement, teen pregnancy, cigarette
addiction, and substance abuse” (p. 3). Nadeau claimed ADD is actually harder on girls, because
boys are not expected to like school and no one is surprised when boys are rebellious, noisy, or aggressive. Boys are not typically expected to be organized, tidy, and polite. Many times, the traits seen in ADD boys are even admired by their peers, but this is not the case for girls. Their disorganization, inability to focus and perform well in school, and inability to read social situations are not accepted by parents, peers, and professionals. Forgetfulness, procrastination, carelessness, impulsivity, and changeability are the traits seen in female ADD disorder. These are not the typical “acceptable” behaviors for girls, and their existence often lead to social problems and low self-esteem. Rucklidge and Kaplan (2002) also found that adolescent females with ADD have more anxiety, more distress, more depressive symptoms, and higher external locus of control than did their male counterparts.

In the introduction to *Women with Attention Deficit Disorder*, Kelly and Ramundo claimed that “girls and women with ADHD have been socialized to suffer their problems in silence. Hyperactive girls learn to either inhibit their behavior to an unnatural degree or suffer the consequences of being labeled as unfeminine. And those who have ADHD without hyperactivity fade into the background” (Solden, 1995, p. 16).

The social world of girls centers around verbal interaction (Tannen, 2001). Acceptance by peers is based on the ability to be sociable, cooperative, and sensitive (Langner, 2002; Littman, 2002). Impulsivity and lack of social skills put ADD girls at a disadvantage, as they lack the verbal control and expressive skills to form relationships. Boys, on the other hand, are often admired for their dominance, competition, aggressiveness, and participation in high-risk activities. Rather than participation in verbal interaction, boys spend most of their time in one-on-one activities such as playing video or computer games, or shared activities with other boys where active and aggressive behaviors are viewed as positive.
Because of the social realm in which girls interact, they are expected to learn age appropriate skills as they mature. Despite repeated reminders, ADD girls are often very slow to learn these skills, and behave at a social skills level well below their age. These children are often chastised for their lack of manners or social savvy by teachers, parents, and peers. They are also slower to mature in other ways. They may play with younger children, be interested in toys appropriate for younger children, or take longer to learn basic skills such as learning left from right or telling time (Nadeau et al., 1999). This lag in maturity may continue through young adulthood, making driving or leaving home more difficult than for non-ADD adolescents.

Nadeau and her colleagues noted that ADD girls have difficulty transferring a learned skill to other situations. For example, they may learn that they should mark school activities and assignments on their calendar, but may not realize that they should also keep a record of non-academic appointments and extra-curricular activities there as well.

ADD girls are unable to read social situations or know when to use appropriate behavior for certain settings or circumstances. In research studies, ADD individuals have been unable to discriminate between various facial expressions and voice intonations (Amen, 2001). This makes appropriate social responses difficult. Inappropriate social behavior is especially devastating on young ADD girls’ ability to make and retain peer friendships. They know they are different from peers, but are uncertain as to the reasons why. Their emotions are often extreme, whether it is happiness or sadness, silliness or anger. Others may see their behavior as rude, although they are oblivious that they have offended anyone. Peers may view ADD girls as “mean” due to their lack of tactfulness. Whatever they may be thinking, may come directly out of their mouths, without consideration of the ramifications of their words.
ADD girls seem to be in their own world, oblivious to the thoughts or feelings of those around them. They are overwhelmed by incoming stimuli and often aggressively overreact to seemingly insignificant events or comments. Because they can not trust their reactions or out of control feelings, they may avoid social situations by keeping to themselves or react full force on whatever feeling they are having at the time, and receive the unfavorable consequences which result. This social ineptness make the middle and high school years very difficult for the ADD adolescent.

ADD girls struggle to deal with more than one thing at a time (Nadeau et al., 1999). They are unable to discriminate between all the stimuli being received and choosing the most important one for attention. If focus does occur, it may not involve the stimuli that the teacher or parent may deem as the most important. At school, the ADD girl may be mesmerized by a bug on the windowsill and miss the entire classroom lecture. She may focus on someone tapping a pencil, unable to complete a test due to the distraction. At home, she may begin to organize every deck of cards in her room by number and suit when she is supposed to be organizing her backpack for the next day. While finally filling her backpack, she misses the assigned homework sheet that is among the crumpled papers and empty candy and chip packages on her desk. Because she has not written down her assignments, she forgets to read the chapter for first period class. Later in the day, she is unable to organize her thoughts well enough to report on a topic assigned to her in science, humiliated before the class by her poor performance.

After a difficult and traumatic day at school (both socially and academically), the ADD girl may come home exhausted and irritable from working so hard to survive the day. In *Understanding Girls with ADHD* (Nadeau, et al., 1999), this symptom is termed difficulty in “managing transitions" (p. 57). The girl may need to “crash” after being overwhelmed
emotionally and physically. Unaware of the chaos that has gone on at school, family members do not understand or appreciate the mood that the ADD child brings home with her.

**Expectations of Mothers**

Lawler (2000) found that mothers and daughters "become subjected to the rules and norms engendered by a set of knowledges about the mother, the daughter, the relationship between the two, and in particular, the role of the mother in producing the daughter's self" (p.24). Mothers can be strongly influenced by the cultural and social standards of their individual generation and pass along these expectations to their daughters (Commins, 1999). Women who grew up in the 50's may envision their daughters as perfect housekeepers, mothers, and wives. Mothers of later generations may hold high expectations for academic and career successes as well. Mothers spend a great deal of time and energy honing these skills in their daughters, teaching them how to behave, interact, study, work, and play. Daughters are viewed as the holders of "needs," and mothers are the meeters of those needs (Lawler, 2000). Herst (1998) maintains that this perception puts mothers in a double bind. Working mothers are criticized for failing to devote their entire lives to their children, and mothers who stay at home to personally raise their offspring are held responsible for any of their perceived shortcomings.

Rich (1994) wrote in *Of Woman Born*, "The institution of motherhood finds all mothers more or less guilty of having failed their children" (p. 223). Even an individual's successful psychotherapy has traditionally culminated with the tracing of his or her past problems to the mother “…just as the bacteriologists sought to trace each disease to a specific type of microbe” (cited in Debold, Wilson & Malave, 1993, p. 21). Simonds (quoted in Lawler, 2000) maintained that it is a common assumption that parents "screw us up," and because mothers do the majority of parenting, they reap the blame for any failures in their children. Simonds asserts that women are seldom considered capable of nurturing the true self in their daughters, because female selves
are deemed especially difficult, constantly in danger of being damaged or lost. In *Don’t Blame Mother* (2000), Caplan wrote of the additional challenges of raising girls:

Society has perched on our mothers’ shoulders, whispering, “If you want us to think you are a good mother, you’ll teach your daughter to be sweet and to cross her legs.” (For mothers today, the message is more likely to end with the words, “You’ll teach your daughter to get an education, develop herself, and be sweet *and* cross her legs”) (p. 71).

A mother’s success is often measured by her daughter’s behavior. Society has historically blamed the mother when children do not “turn out well,” and it has been especially accusatory with less than flawless results in a female child. Girls are raised with a different set of social and moral expectations (Caplan, 2000; Lawler, 2000; Pipher, 1994). Boys are allowed “to be boys,” to act unruly and irresponsibly; girls are permitted little variance from perfection (Dendy, 2000).

Mothers try desperately to teach their daughters society’s behavioral rules for each developmental stage. In *Mother Daughter Revolution*, Debold et al. (1993) wrote of the observations of a new mother of a baby girl:

Someday I will see her back as she walks away from me. You know, we hardly ever think of our babies’ backs. But that’s what I’ll see as she begins to explore the world. There are things that I want her to know. I know some things I can teach her that can help her make her way. (p. 6)

As daughters get older, mothers see the clock ticking, and realize little time is left to teach their children the necessary skills before they leave home. As Lawler maintains, a mother must develop her daughter's true and good self, and assist her in meeting all developmental milestones, set forth as Truth. Caplan (2000) wrote:

As daughters, we assume that the urgency in mother’s rule-making comes from her individual, critical controlling nature; we don’t often recognize that the rules come from a fundamental cultural belief, and mother is just its transmitter…What the daughter thinks she sees is a neurotic, uptight, or even heartless woman who has generated a host of prescriptions to torment her. (p. 72)

Stoddard, author of *Things I Want My Daughters to Know* (2004), lamented that although she was confident her daughters knew "the basics" she had taught them over the years, she was
constantly wondering if she couldn't tell them more in order to have a "safe and happy journey" (p. xvii).

Firman and Firman (1989) wrote that the mother-daughter relationship is one of the most powerful relationships in life. Not only are mothers given the task of raising both boys and girls and providing nurture and protection, but are also expected to raise their girls to model their behavior. A daughter sees her “impending womanness in relationship to her mother” (p. 4). The authors claimed that in effect, daughters get a “double dose of their mothers as nurturer and role model” (p. 4). Lawler (2000) contends that mothers and daughters have closer social, psychic, and emotional identification than do mothers and sons. Commins (1999) concurred, "the mother-daughter link is so basic, so primal that nothing can fully replicate it" (p. 54). Mothers are reflected in daughters and daughters are likewise reflected in their mothers.

After years of the daily tug of war regarding “shoulds and oughts” (as the Firmans describe it) between mother and daughter, a great divide can develop between the two. This tension often makes it difficult for mothers and daughters to experience the bond that both have desired and hoped for, but have found difficult to grasp and awkward to express. Caplan (2000) wrote that “mothers and daughters often find it disconcerting for the other to be warm and expressive, because [they’re] not quite sure whether that’s OK” (p. 73).

**Effect of Attention Deficit Disorder on the Mother-Daughter Relationship**

Mother-daughter relationships are complex, and a diagnosis of ADD in the daughter makes the relationship even more complicated and confusing. Dendy (2000) wrote that mothers are more critical of their daughters with ADD and treat their daughters and sons with ADD differently, providing more praise and direction to their sons, even though there is less compliance in boys' behavior. While mothers adopt a "boys will be boys" attitude, girls are held to a much higher standard (Langner, 2002). In addition, boys predominantly socialize in more
high energy group activities where aggressive behavior and less verbal interaction are acceptable. Girls interact on a more personal and verbal level. Mothers can become frustrated by the lack of sensitivity and cooperation their ADD daughters show toward others due to their lack of verbal control.

Girls with hyperactive ADD may be more interested in tomboy type activities and socializing with boys, concerning the mother that the girl is not more “ladylike.” Other hyperactive girls may instead be hyper-verbal and overly emotional. They may act wild, childish or “show-off” in order to be socially accepted. These girls may participate in risky activities during their teen years such as taking drugs, drinking or sexual promiscuity, causing the mother great cause for alarm (Nadeau et al., 1999).

While these hyperactive girls are often criticized and rejected by their peers, inattentive type ADD girls may be ignored. Their verbal ineptness and timidity cause them to be neglected and left out. Mothers suffer from seeing their daughters with few friends, finding little success in teaching their daughters the art of socializing.

While mothers may already be struggling with their daughters’ messy rooms, careless appearance, poor academics, lack of social skills, explosive behavior, and unorthodox sleep patterns, puberty may bring about a whole new wave of new symptoms. Depression and anxiety that may be seen in adolescent pre-menstrual syndrome (PMS) is exacerbated with ADD (Solden, 1995). With increased independence and freedom of the teen years, the daughter may also exhibit more signs of impulsive behavior such as impulse buying, body piercing, tattooing, substance abuse, or sexual promiscuity.

Many ADD girls experience a hypersensitive central nervous system that causes them to be extremely aware of uncomfortable as well as comfortable sensations (Nadeau et al., 1999). They
may recoil from a hug and reject scratchy or confining clothing, or spend hours in a bathtub of warm water. They usually prefer only bland foods and are particular about texture, odor, and adequate space between food items on the plate, making meal time a trying event. ADD girls have a heightened sensitivity to physical discomfort, sounds, and light. They may urinate frequently, focusing on the slightest feeling of fullness or wait too long and have an accident, focusing on an activity which captures their attention. They may be skilled athletes or terribly clumsy, bumping into things and falling over objects.

To gain some control in their chaotic thoughts and lives, ADD girls often find comfort by obsessing over something external. They may compulsively organize to overcome their out-of-control feelings (Dendy, et al. 2006). They may organize tables or racks of clothing in a department store as their mother shops, obsessively count items, or keep a compulsively neat room. As anxiety increases, obsessive behavior will do the same.

ADD girls (and their mothers) are all too aware that they are different from most girls their age, but uncertain as to why. Most are embarrassed and self-conscious and lose more self-confidence as time goes by. Girls are "socialized to look to the outside world for rewards and praise" (Langner, 2002, p. 72). With the constant criticism girls receive from peers and teachers and the frustrations and disappointments that the mother expresses regarding their behaviors, the girls internalize the criticism, feeling shame and blaming themselves for their inadequacies. These girls develop anxiety, depression, and a negative self-image that usually persist into adulthood (Rucklidge & Kaplan, 2002).

**Role of the Informed Mother**

Considering Lawler's (2000) three principles of the Self, questions arise regarding mothers of ADD daughters: (a) does the mother continue to feel responsible for her ADD daughter's Self after knowing that much of *who the daughter is* may be due to an inherited condition producing
an inherited self? (b) does the mother continue to struggle to shape her ADD daughter to fit societal norms, knowing the daughter's social self is being influenced and judged by social factors and expectations outside her daughter's control and possibly outside her reach? (c) how does the mother determine what part of the daughter is her intrinsic self, the self she was born with and belongs to her and her alone?, and (d) how do mothers find a balance in letting their ADD daughters find their true and good selves, while nurturing them through and around the pitfalls of ADD?

A mother who recognizes ADD symptoms and understands her daughter's behaviors can play an integral role in helping her accept and cope with her disorder. Commins (1999) claimed that a daughter continues throughout her lifetime to seek the praise of her mother, to find her favor and work to please her. Herst (1998) maintained that "craving a mother's approval is almost a primal urge. Her opinion carries more weight than anyone else's…" (p. 27). Mother-daughter relationships that are filled with reciprocal communications and are considered supportive and harmonious by the daughter are significantly related to the daughter's self-esteem and academic achievement, as well as her ability to successfully meet the challenges of adolescence (Gross & McCallum, 2000).

Being a more perceptive and supportive parent is a significant part of raising a confident and healthy ADD daughter. More importantly, a mother can help her daughter appreciate the many gifts and special talents that she does have, of which many ADD proponents claim are a direct result of her ADD condition: versatility, a good sense of humor, an ability to multitask effectively, creativity, the ability to let go of grudges, the drive to focus on something of interest, and a talent for thinking “outside the box” (Sarkis, 2005).
Weiss (2005), an advocate for ADD individuals, listed other positive attributes of the ADD child of which they should be aware. These children tend to be sensitive, empathetic, inventive, great at finding lost items, spontaneous, fun, energetic, open and un-secretive, eager for acceptance and willing to work for it, quick to do what one likes to do, difficult to fool, responsive to positive reinforcement, and rarely harbor resentment. They are also perceptually acute and down to Earth, good networkers, and can see unique relationships between people and things. ADD individuals are less likely to get in a rut or go stale, and are original, observant, and loyal. In addition, they are intense when interested in something and more likely to do things because they want to than because they should, thus they are often wholehearted in their efforts. Cimera (2002) reminded parents that they are the most important teachers their children will ever have, and to help make ADD a gift rather than an impairment, it is crucial that parents recognize the positive attributes of their child and point out these special qualities daily.

The mother is often the catalyst for action in the household. She is the "power center" of the family (Commins, 1999) and in a position to help her daughter receive assistance at school, simplify home life, and help her obtain medication and interventions to relieve her ADD symptoms. Teachers and school administrators often question a late diagnosis of ADD (Nadeau et al., 1999). The difference that an understanding and supportive mother can make in the well-being of an ADD daughter’s life is immeasurable. For girls who are not diagnosed until middle school or high school, a close relationship with their mothers can help them survive the peer pressures of adolescence and realize that these years are difficult for everyone. Mothers can help repair self-esteem that has been bruised and battered throughout the years. Mothers who can observe their daughter’s ADD behaviors without criticism and teach them to value their strengths
and uniqueness have given their child an exceptional gift. These mothers can find satisfaction in the fact that they have been good mothers, and raised a daughter with a good and true self.

Summary

The mother-daughter connection is a unique and complex one even under the best of circumstances. Many moms and daughters may find this special relationship difficult and strained, simply from dealing with the normal stages of growing up. In For Mothers of Difficult Daughters, Herst (1998) provides further explanation for stressful mother-daughter relationships:

For all the complexity of mother-daughter relationships, a single theme runs through every situation: unmet expectations. Mom expects her daughter to be a reincarnation of herself, a younger version who should behave exactly as Mom behaved. Daughter expects Mother to encourage her individuality, but at the same time to approve of all her decisions and be there to nurture her throughout her life. Mother and Daughter each expects the other to understand her as if, because they share the same genes, they also share an invisible mind link. Mother and Daughter both are deeply disappointed in the other's failure to meet her expectations (p. 39-40).

When undiagnosed and misunderstood, the child’s ADD symptoms can multiply the stresses of the relationship to the breaking point. When the daughter needs her mother’s understanding the most, the mother may be unable to extend it.

Understanding can go a long way in helping the girl with ADD to fend off anxiety disorder and clinical depression, but parents can not help their daughters if they can not identify the problem. Our educational system must teach medical, educational, and counseling students about the symptoms and needs of ADD children. Informed physicians, therapists, and school personnel must then educate parents regarding the signs and symptoms of ADD. Once diagnosed, parents need to know all the options for helping their daughter, not only that medication is available. Of special importance is educating parents who have daughters diagnosed late in their development. Repairing the girl’s confidence and self-esteem, and
building a strong mother-daughter relationship, will have positive consequences that will affect the ADD child and her mother for the remainder of their lives.
CHAPTER 3
METHODS

The purpose of this study was to explore the emotions, attitudes and perceptions of mothers of girls who were late diagnosed with attention deficit disorder, and the ways in which these perspectives affect the mother, daughter, and the mother-daughter relationship before and after diagnosis. The objective of the study was to promote understanding of ADD among professionals in the medical, academic, and therapeutic communities, as well as the individuals and families affected by the syndrome.

The research questions were:

1. What are the emotions, attitudes, and perceptions of mothers with ADD daughters of themselves and their daughters before and after the daughter's diagnosis during the high school years?
2. How is the mother-daughter relationship affected by the daughter's diagnosis?

Participants were recruited from a family psychiatric clinic specializing in the treatment of ADD. Participant comments made during the interviewing process do not pertain to the clinic from which participants were recruited or interviews conducted. Mothers were individually interviewed, and interviews were recorded and analyzed thematically with a focus on generating a theory grounded in the collected data. These processes are discussed in detail below according to the following subjects: theoretical perspective, data collection, data analysis, subjectivity statement, validity in qualitative research, reliability in qualitative research, limitations, and definition of terms.

Theoretical Perspective

The Researcher's View

The researcher believes that an individual's attitudes and perceptions are formed by cultural, social, and political influences in the individual's environment. Each individual's belief
system or "reality" is unique and constantly changing according to ongoing life experiences. Individuals construct their own reality; therefore, there is no one truth or one reality, but rather multiple realities. The effects of one's race, culture, sex, religion, education, intrinsic self, and family combine with societal and governmental influences to create the individual's system of knowledge and values. What one considers as Truth may change as one is influenced by interactions with the world. Because of these constant influences and the resultant created beliefs, it is impossible for an individual to be completely objective and neutral. This individual subjectivity means that both study participants and the researcher enter the project with unique beliefs that will influence their thoughts, responses, and behaviors. These beliefs may continue to change and reformulate even as the research progresses, as participants and researcher interact with each other and participate in the world. In order to understand human nature and the unique view each individual has of the world, the researcher believes that individuals must be studied face to face, in an interactive manner, and in a natural or field environment, rather than an experimental setting.

**Constructivism-Interpretivism**

This study was conducted from a constructivist-interpretive theoretical perspective, in which individuals and groups construct their own reality, giving meaning to events, processes, people, and objects in order to make sense of the world around them (McMillan & Schumacher, 2006). These constructions are then organized and grouped together to form perceptions and belief systems, guiding the individual's or groups' emotions, deeds, and ideas.

Grbich (2007) describes constructivism as an epistemology that views reality as societally and socially embedded and existing within the mind. In constructivism, it is assumed that there is no objective knowledge independent of thinking. It is therefore also assumed that reality and knowledge are changing and being constructed by the researcher and participant through
consensus as the two interact. Glesne (2006) sees the constructivist paradigm as a combination of social constructivism and interpretivism where "human beings construct their perceptions of the world, that no one perception is "right" or more "real" than another, and that these realities must be seen as wholes rather than divided into discrete variables that are analyzed separately" (p.7).

True to the constructivist-interpretivist paradigm, the understanding and interpretation of the interaction with participants will be limited by the structures drawn from the researcher's own life experiences. "Subjectivity (the researcher's own views and how they have been constructed) and intersubjectivity (reconstruction of views through interaction with others…") (Grbich, 2007, p. 8) play a crucial role in the constructivist framework.

**Grounded Theory**

Grounded theory methodology was used in this study in an attempt to find a central phenomenon between mothers and their ADD daughters who have co-existed for many years without knowledge of the daughter's disorder. Qualitative research provides a detailed description and analysis of a phenomenon from the participants' perspectives. Grounded theory, a subtype of qualitative research, goes a step further, developing intense, comprehensive concepts that relate to a particular phenomenon (McMillan & Schumacher, 2006). It uses systematic procedures of collecting data, identifying themes, connecting the themes, and formulating a theory about an experience. Grbich (2007) states the strength of grounded theory is its ability to "tease out the elements of the operation of a setting or the depths of an experience" (p.70), making it an appropriate methodology to explore this unique mother-daughter relationship.

Developed in the 1960s by sociologists Anselm Strauss and Barney Glaser, grounded theory is used by social scientists in many disciplines and by researchers in nursing, public
health, social work, and education. It is a valuable method of analysis because it does not depend on specific disciplinary perspectives (Strauss, 1987). Grounded theory uses methodically collected social research data to systematically test and generate a theory (Glaser, 1978). Glaser emphasized that generating theory and doing social research are two parts of the same process:

How the analyst enters the field to collect the data, his method of collection and codification of the data, his integrating of the categories, generating memos, and constructing theory – the full continuum of both the processes of generating theory and of social research – are all guided and integrated by the emerging theory (p.2).

In grounded theory, the researcher creates a story line from the research data, and then "suggests a conditional matrix that specifies the social and historical conditions and consequences influencing the phenomenon" (McMillan & Schumacher, 2006, p. 27). Social phenomena are complex, and in conducting research, the researcher develops many concepts and links, searching for variations that characterize the central phenomena of the study (Strauss, 1987). Creswell (2005) described grounded theory design as a procedure that explains at a broad conceptual level, an interaction, a process, or an action about a substantive topic that develops over time.

While Glaser and Strauss originally built grounded theory around the idea of constructing middle range theories from collected data simultaneously coded and analyzed, their model also involved touches of empiricism, positivistic assumptions, and specialized quantitative terms left over from methodological practices of earlier times (Charmaz, 2006). Later work by Strauss and Corbin modified the original model by developing preconceived categories, stressing prescriptive aspects of grounded theory research. More recent researchers have chosen to return to the basic tenets of grounded theory (looking at processes, reviewing actions, and forming interpretive understandings of the data), and viewing the theory as a collection of practices and principles rather than as a prescriptive model (Charmaz, 2006).
Charmaz (cited in Creswell, 2005) promoted a constructivist approach to grounded theory in which the researcher is more interested in the ideologies, assumptions, beliefs, values, views, and feelings of participants in a study, rather than describing acts or gathering facts. This design emphasizes imaginative understanding of the studied phenomenon, looking for patterns and connections rather than explanations and linear reasoning (Charmaz, 2006). Charmaz's constructivist paradigm of grounded theory was used throughout this study.

**Qualitative Research**

Berrios and Lucca (2006) wrote that the qualitative approach “allows us to explore the richness of the personal experience of our profession for both the counselors and the participants who are looking for help” (p. 181). The purpose of this study was not to recognize one truth or determine causality, but rather to study mothers of ADD daughters in holistic fashion, looking at the physical, psychological, social, economic, and cultural factors that affect mothering an ADD daughter. Although qualitative research is limited in its generalizability, Glesne (2006) pointed out that generalizability in the constructivist paradigm does not apply in the same way, or at all, as it does for other paradigms. The value of qualitative research lies in its potential for application (McAuliffe & Lovell, 2006).

Qualitative research methods allow a social phenomenon to be examined on a multi-faceted level and to be understood from the perspective of all participants involved, considering the context of the participants' social, cultural, and political environments (Glesne, 2006). With qualitative research, the “centrality of interpersonal relations defines its domains” (Berrios & Lucca, 2006, p. 175). This approach allows the extraction of rich information from the personal experience of the participants who are considered the experts on the topic being investigated. Although there are many qualitative research strategies and techniques, Mason (1996) listed three common elements across qualitative studies. They are: (a) interpretivist in nature,
concerned with how the social world is interpreted, understood, experienced or produced; (b) based on methods of data generation which are flexible and sensitive to the real-life social context in which data are produced; and (c) aims to produce well-rounded understandings of rich, contextual, and detailed data while placing more emphasis on holistic forms of analysis and explanation, rather than charting patterns, trends and correlations.

The use of qualitative research is more beneficial than a quantitative design when the intent is to describe subtleties of process (McLeod, 2001). The purpose of qualitative research is broader in scope and supports a complex understanding of a specific phenomenon such as a process, environment, or belief (Gay, Mills, & Airasian, 2006). The "thickly detailed descriptions" of qualitative methods allow readers to understand the nature of the context and the participants in the study (Stringer & Dwyer, 2005, p. 50). It provides information that is more easily integrated into practice in counseling and educational settings than are the results of a quantitative study (McAuliffe & Lovell, 2006).

Although there has been limited research in the past on females with ADD, more findings are becoming available in the literature, most appearing as quantitative studies. Valuable insights gained from qualitative studies can be used alongside quantitative research to build knowledge and enhance interventions with this population and those with whom they live, socialize, and interact, especially the mothers who are their primary caregivers.

Data Collection

Prior to actual research, a pilot study was conducted to test the suitability of procedures such as usefulness of the demographic data, the effectiveness of the interview questions, and appropriateness of length of interview. For purposes of the pilot study, two mothers were interviewed.
Data collection for all of the eight participating mothers occurred in a three step process: (a) a collection of demographic and background information through the use of demographics forms and a questionnaire; (b) an initial interview with each individual participant; and (c) a second interview with each individual participant. Because of time constraints, some participants were contacted a third time by email to clarify interview statements.

**Demographics and Questionnaires**

Mothers received two demographics forms, one regarding herself, and another regarding her daughter's ADD history. Mothers also received a questionnaire to complete before arrival or after the first interview, as well as a copy of the informed consent to examine before the study began (see Appendix A for demographics forms and questionnaire; see Appendix B for informed consent).

**Interviews**

Mason (1996) characterized the qualitative interview as: (a) having a relatively informal style with the appearance of a conversation or discussion; (b) generating data via the interaction; and (c) having a range of topics, themes, or issues that the researcher wishes to cover. Kvale (1996) described interviews as “conversations where the outcome is a co-production of the interviewer and the subject” (p. xvii). With these principles in mind, mothers were interviewed to examine their perceptions of themselves, their daughters, and their relationship before and after the daughter's ADD diagnosis. Constructivist interviews allow exploration of the mother-daughter relationship, and permit the gathering of views, values, assumptions, feelings, and perceived needs of the participants. To gain knowledge and evidence that are interactional, situational, and contextual, Mason (1996) stressed the importance of a distinctive approach that is flexible and sensitive to the specific dynamics of each interaction, tailor making each interview as it is conducted. This design allows participants to become co-researchers and play
an active role as collaborators with the investigator. This constructivist approach lends itself to an interpretive method of analysis. Blumer (1969), who coined the term *symbolic interactionism*, claimed that in interpretivism, the researcher’s role is to understand lay interpretations in conjunction with social science interpretations, and move from these towards an explanation.

Kvale (1996) suggested the basic subject matter in qualitative research is “meaningful relations to be interpreted” (p. 11). Analyzing the interview from a constructivist-interpretivist epistemological framework coincides closely with the process of counseling, as counselors are trained to pay attention to the content and process in counseling, including what the clients’ feelings are, how they present themselves, underlying issues, their tone of voice, hidden agendas, and the nature of the counselor-client interaction (Merchant & Dupuy, 1996). Merchant (1997) also pointed out that counselors’ tolerance of ambiguity is one of their most valuable qualities. In the process of counseling, therapists must be attuned to the ambiguity and unpredictable accounts relayed by their clients. Because of the skills acquired in counselor education, a design utilizing qualitative interviews and constructivism (in which meaning is constructed from the realities of the participants) fits well with the purpose of the study. Semi-structured interviews, an in-depth form of interviewing, were used in order to elicit participants' feelings, ideas, beliefs, thoughts, and actions concerning the relevant issues of the study (see Appendix C for interview questions). Open-ended interviewing and a constructivist-interpretive epistemological framework allowed the flexibility to tailor-make each communication, realizing that, as Mason (1996) suggests, the interview would not be separated from the social interaction in which it is created.
At the initial meeting, participants completed the informed consent, and the interview process began. Each semi-structured interview lasted approximately one hour. Interview questions consisted of open-ended questions and scaling questions, integrating aspects of deShazer’s (1985) solution-focused model. This popular form of brief therapy concentrates on solution building rather than problem solving, which coincides with the direction of this study: finding solutions to improving the well-being of those affected by ADD. deShazer (1991) insisted that the only important and possible way to interpret a word is according to how the participants use it in a conversation.

A scaling question asks the participant to rate something on a verbal or written scale (e.g., rating on a scale of 1 to 5 the relationship with another individual, with one being "conflicted" and 5 being "excellent"). In this study, a visual scale using a semantic differential was given to each participant in order to elicit descriptive reactions (see Appendix D for visual analogue scales). A goal of scaling questions is to help define a problem in terms of a gradient and measure it in degrees rather than merely stating that the individual does or does not have a problem (Becvar & Becvar, 2006). If clients state, for example, that their depression is at a four, they are then asked questions such as “What might you do to move to a five?” focusing on the solution rather than the problem. This method of questioning helps clients to shift their level of consciousness, focusing their awareness on actions and behaviors. In so doing, it helps to tease out the "differences that make a difference" (Bateson, 1979, p. 99). Combining the qualitative interview with a constructivist epistemology and solution-focused concepts helps in exploring how participants view the present and the possibilities of the future.

As each interview was tailor-made for participants, an analysis of the data from each interaction was initiated prior to conducting the next. This allowed the data from the first set of
interviews to modify the second set. This fine-tuning continued throughout the interviewing process.

The second interview was used for theoretical sampling to further explore any areas identified in the demographics form, questionnaire, and initial interview as needing further clarification. Theoretical sampling in grounded theory is the intentional selection of data collection that will yield content and descriptions useful in creating a theory (Creswell, 2005). More simply, it is used "to refine and develop categories by going back to fill in conceptual gaps as a theory is developed" (Sprenkle & Piercy, 2005, p. 47). Initial data is collected and analyzed for preliminary categories. It is then determined what categories are underdeveloped and what information is still needed. The information is then solicited from participants during the second interview using an interview guide constructed to complete any perceived conceptual gaps in previously gathered data. This recursive process was used in this study in order to reach saturation, the point when new data will provide no further information on the category in question (Grbich, 2007). The second interview also served as a form of member checking to validate information and contribute to trustworthiness. Some participants were contacted a third time by email to clarify answers given during the interviewing process.

All but one of the interviews were conducted by the researcher at the clinic site. One was conducted at the home of the interviewee. Interviews were both audio and video taped, and transcribed by a typist hired by the researcher. There were 375 pages of transcribed information.

Memoing

Memoing was used throughout the research process to elaborate on ideas about the data and coded categories, and to describe the thoughts of the researcher while exploration was in progress. Glesne (2006) encourages the writing of memos during participant observation, as well as at the end of each day of research, to "write down feelings, work out problems, jot down
ideas and impressions, clarify earlier interpretations, speculate about what is going on, and make flexible short- and long-term plans for the days to come" (p. 59). Morse and Richards (2002) refer to memo writing as the storage of ideas, used by researchers to think aloud and record hunches. Memos in grounded theory are also "the theorizing write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collection, and analyzing data..." (Glaser, 1998, p. 177). Using multiple methods of data-collection elicits information that will enhance understanding of participant perspectives and further contribute to the trustworthiness of the study (Glesne, 2006).

**Population and Setting**

Purposive, or purposeful, sampling was used for this study. In this type of sampling, participants are intentionally selected in order to understand a central phenomenon (Creswell, 2005). Criteria-based selective sampling, based on a predetermined set of criteria that originates from the researcher's assumptions and research questions, was utilized (Rafuls & Moon, 1996). Purposeful sampling produces information-rich participants, chosen specifically because of their knowledge and information about the topic investigated.

The participants selected for this study were solicited from a local psychiatric clinic specializing in attention deficit disorder. Their daughters must have been diagnosed with ADD (any type) while in high school, and within the last ten years, by clinicians at a local diagnostic and counseling center. Diagnosis criteria was based on the DSM-IV-TR. Diagnosing clinicians consisted of licensed psychiatric nurses, psychologists, or psychiatrists using the same diagnostic criteria. Eight mothers were interviewed. Participants were recruited through flyers posted at the clinic, or by phone or face-to-face contact from their daughter's attending clinician (see Appendix E for recruitment flyer). Compensation was offered to each participant after the first interview and upon completion of the second interview.
Data Analysis

Qualitative coding is the first analytic step in qualitative research. By coding, the researcher names parts of data with a label "that simultaneously categorizes, summarizes, and accounts for each piece of data" (Charmaz, 2006, p. 43). Grounded theory analyzes and codes the collected data of a study into units such as events, sentences, or paragraphs and then links the units that are similar, developing categories for the data. By looking for relationships between these units, a more general explanation can be made from the categories, and a theory grounded in the data, may be formulated. In this study, four types of coding were used: descriptive, initial, focused, and selective.

Demographics

Demographic information was collected prior to the interviewing process or in the early stages of interviewing, through the use of questionnaires. Descriptive coding was then used to store demographics such as the daughter's type of ADD, her current age, her grade level and age at time of diagnosis, as well as any co-existing disorders, medications, and previous or current counseling experiences. Additional demographics were collected including the mother's age, marital status, possible ADD diagnosis, and ADD medications. (See Appendix F for participant and daughter demographics.) This demographic information was used in seeking patterns, explanations, and theories (Morse & Richards, 2002).

Interviews

Many grounded theorists follow constructivist principles, using interviewing in order to best capture the experiences of participants in their own words (Charmaz, 2000). Following interview transcription, qualitative coding of the data began. Charmaz (2006) described qualitative coding as the first analytic step in defining what is happening in the data and what these happenings might mean. Coding allows the researcher to simplify and focus on particular
characteristics of the information gathered (Morse & Richards, 2002). Segments of data are labeled with a simple name that groups, encapsulates, and accounts for each piece of data.

Schwandt (1997) described this inductive, context-sensitive method as one in which the researcher (a) examines the actual language of respondents to generate the categories or codes and (b) works back and forth between the data segments and the codes or categories to refine the meaning of categories as they proceed through the data. This "constant comparative method" is used to systematically and recursively analyze collected data. Sprenkle and Piercy (2005) explained that a researcher using this process inductively collects data, analyzes this data, and then collects additional data in a more focused manner. The researcher proceeds, looking for interrelationships and meaning, refining the initial analysis, and interpreting the data. Charmaz described the constant comparative method in grounded theory as a means of:

"(a) comparing different people (such as their views, situations, actions, accounts, and experiences), (b) comparing data from the same individuals with themselves at different points in time, (c) comparing incident with incident, (d) comparing data with category, and (e) comparing a category with the other category …" (cited in Sprenkle & Piercy, 2005, p. 50).

Coding takes data from tangible spoken words to analytic interpretation. This interpretation is then used to develop an emerging theory that explains the collected data. In grounded theory, each phase of analysis raises the level of abstraction and the conceptual level of gathered data, allowing a theoretical framework to be built at the mid-range level of theory. This grounded theory emerges when there is a theoretical saturation of patterns, meanings, and categories.

In this study, each interview was first coded using initial coding. Charmaz (2006) suggested looking for actions rather than topics in each segment of data, preventing the urge to take conceptual leaps and adopt existing theories before analysis is complete. Many grounded theorists refer to this process as open coding because it is aimed at opening up the data, allowing
new ideas to surface and emerge, and looking for gaps and holes in the data by using the constant comparative method. Charmaz pointed out that during initial coding, the researcher may need to reword codes to condense actions and meanings, and improve the fit between the label and the phenomenon seen in the data.

The second stage of coding interview data was *focused coding*, and was used to group larger segments of data into categories (Charmaz, 2006). Charmaz described this stage as using the most frequent and/or significant earlier codes for more directed, selective, and conceptual coding. This process results in integrating and describing larger segments of data, and verifies presumptions about the topic.

Resulting categories from focused coding were then analyzed and coded into larger and more inclusive over-arching themes, using *selective coding*. This phase of analysis entails coming up with a "story line" to incorporate categories that have emerged in the focused coding stage (Sprenkle & Piercy, 2005). The themes selected served to clarify and sharpen analysis. They were used in combination with theoretical memos to formulate provisional proposals or hypotheses about the phenomenon.

Theorizing in grounded theory begins early, examining the details of the data in order to understand social structures, patterns, processes, and behavior through the constant comparative method. Data segments were compared across databases and with existing literature, and used in conjunction with concepts that helped explain what was emerging in the data and data groupings. In this study, this process was intended to generate a general or middle-range theory in order to explain a phenomenon. A description of the data analysis process for this study follows:

1. Queries were addressed to each participant, following a pre-planned list of interview questions. During each interview, possible follow-up questions were noted, as well as potential changes for increased efficiency and clarity. Quick memos were made in the
margins regarding the researcher's thoughts and reactions, as well as possible ideas to
develop.

2. A transcription was made of each interview. The transcription was then coded line by line,
using gerunds to show action. This initial round of coding was an open one, labeling every
event with little concern for brevity, e.g. "Mom taking forgotten assignments to school."

3. The second interview was conducted, addressing questions arising from the first interview
and reviewing demographic forms and any personal records and information brought to the
second meeting. The transcription process was repeated after each interview.

4. Prior to interviewing the next participant, data analysis was conducted on the transcribed data
in order to inform the next round of questioning. Items were added, eliminated, reworded, or
rearranged to improve the interview process and begin the search for themes.

5. During the interviewing process, more detailed memoing was kept in a separate notebook.
The researchers thoughts, feelings, ideas, and questions were noted in the book, as were
quotes from each interview that were of potential importance in the forming of themes.

6. A second round of data analysis was conducted on the interviews, looking for the most
frequent and significant information within and across data. At this stage, the initial codes
were reduced to more specific or focused codes. "Mom taking forgotten assignments to
school" became "shielding."

7. A concept map was made from colored index cards and placed on a large bulletin board in
order to sort out relationships and processes found in the data. Charmaz (2006) suggests
using Adele Clarke's idea of conceptual mapping, as it allows researchers to take details of
their research and place them at organizational levels in their analysis.

8. Using selective coding, focused codes were then combined to produce conceptual categories
and create a storyline. This stage concentrated on clarifying categories and the relationship
between the components that were a part of these categories. For instance, "shielding"
became a property of "accommodating," a sub-category of the overarching category or theme
"coping."

9. The properties, subcategories, and categories were then arranged and placed in a hierarchy to
create the final story line and mid-range theory.

10. The concluding report was written following the recurrence of themes among and across
participants.

Researcher Subjectivity

Qualitative research often requires the researcher to personally collect the data for analysis.

Denzin and Lincoln (2000) claimed that the qualitative interview is not a neutral tool because the
two people in an interview situation create the reality. For this reason, it is crucial for the researcher to critically reflect on actions and predispositions that might influence objectivity. Attention deficit disorder came to my attention after my youngest daughter was diagnosed with ADD as a junior in high school. The effects of the disorder have been obvious in her academic pursuits and social relationships. There are deep personal regrets over the late diagnosis that she received, knowing that earlier discovery could have made life events more understandable for her and life in general, easier. There is also frustration that after diagnosis, the only recommendations for improvement were medication and special school accommodations. As an individual diagnosed with ADD at the age of 55, and the mother of a late-diagnosed ADD daughter, I have personal beliefs about how the timeliness of ADD diagnosis might affect mothers, daughters, and their relationship with one another. I am also a certified CHADD Parent to Parent teacher, an instructor for college students with ADD, a mentor for women with ADD, and a mental health counselor. I completed my doctoral internship in counseling at the family psychiatric clinic from which I recruited research participants. These experiences have given me the skills necessary to conduct this study, but have also increased my sensitivity to the symptoms and difficulties associated with attention deficit disorder. I was keenly aware of these potential areas of bias and the need to closely monitor the interview and data analysis process.

Mason (1996) claimed it is inappropriate to see social interaction as “bias” which can potentially be eradicated, as one “cannot separate the interview from the social interaction in which it produced and should not try” (p. 40). Hatch (2002) wrote that qualitative research "is as interested in inner states as outer expressions of human activity. Because these inner states are not directly observable, qualitative researchers must rely on subjective judgments to bring them
to light" (p. 9). Fontana and Frey (2005) describe the importance of reflexivity during the interviewing process:

Gubrium and Holstein (2002) actually considered the interview as a contextually based, mutually accomplished story that is reached through collaboration between the researcher and the respondent. Thus, just to tell what happened (the what) is not enough because the what depends greatly on the ways, negotiations, and other interactive elements that take place between the researcher and the respondent (the how) (Denzin & Lincoln, 2005, p. 714).

With this caveat in mind, personal reactions to the participants and their responses, as well as the analyzing of these responses, were closely monitored. Several safeguards were used to protect against bias: (a) monitoring by my doctoral committee, (b) self-monitoring, and (c) member checks. An audit trail was also used by practicing memoing, maintaining a record of coding, interpretation decisions, initial drafts and diagrams, and retaining all records of participant transcripts and instruments completed. Video and audio tapes were made of each session to insure accuracy of transcription.

Validity in Qualitative Studies

Validity in qualitative research addresses whether researchers (a) actually observe what they think they see, and (b) hear the meaning they think they hear (McMillan & Schumacher, 2006). Validity measures the level of agreement on the descriptions of events and, in particular, the meaning of those events between participant and researcher. In qualitative studies, validity equates with the dependability, credibility, objectivity, and transferability of results in quantitative research (Sprenkle & Piercy, 2005).

In order to enhance validity, strategies recommended by McMillan and Schumacher (2006) were utilized: (a) multiple in-depth interviews with each participant; (b) on-going data analysis and corroboration with research participants to verify conclusions made by the researcher; (c) triangulation in data collecting and data analysis by incorporating questionnaires, memoing, and
visual analogue scales; (d) precise record keeping of participant interviews using audio and visual recordings; (e) memoing to record detailed descriptions of participants and events that occurred during the study; (f) actual participant quotes in the reporting of results; (g) use of participant records of their own perceptions during research for purposes of corroboration; (h) participant checks of data collected and researcher conclusions; and (i) the recording, analyzing and reporting of any data which is an exception to patterns found in the data.

Reliability in Qualitative Studies

Reliability in qualitative research refers to the consistency of the data collected, and is often termed "trustworthiness" in qualitative work (Sprenkle & Piercy, 2005). It is the consideration of the reliability of the techniques used during research, and the degree to which the data would be consistently collected if these same techniques were used over time (Gay, Mills, & Airasian, 2006). To enhance reliability or trustworthiness, the researcher must "explain the context of the research, cycling between the interpretation and data, and grounding interpretations with examples" (Sprenkle & Piercy, 2005, p. 27). In order to enhance reliability, many of the strategies recommended by Gay et al. were used: (a) fully describing the researcher's relationship with the participants and setting; (b) providing detailed documentation of observations and interviews using written notes and recordings; (c) describing the interviewer's expertise and training; (d) describing all instruments used; and (e) fully documenting sampling techniques and the sufficiency of those techniques.

Limitations

This study may be limited by the small number of participants, and their lack of cultural and geographic diversity. Research was conducted with eight Caucasian mothers, all living in the same southern geographic region. The study is also limited in generalizability due to its directedness to mothers of late-diagnosed ADD daughters.
Definitions

**CONSTRUCTIVISM – INTERPRETIVISIM.** Also called “naturalistic inquiry” (Creswell, 2005, p. 42). Refers to a theory of knowledge that assumes objective truths do not exist and that meaning is derived from our engagement with realities in the world (Behar-Horenstein, 2006).

**CONSTANT COMPARATIVE METHOD.** "An inductive (from specific to broad) data analysis procedure in grounded theory research of generating and connecting categories by comparing incidents in the data to other incidents, incidents to categories, and categories to other categories…with the intent to "ground" the categories in the data" (Creswell, 2005, p. 406).

**EPISTEMOLOGY.** The study of the nature of knowledge (The American Heritage Dictionary, 2000).

**EUROAMERICAN.** A United States citizen (The American Heritage Dictionary, 2000).

**GROUNDED THEORY.** Qualitative research procedures using detailed description and analysis of social phenomena to develop substantive theory (McMillan & Schumacher, 2006).

**EXTERNAL LOCUS OF CONTROL.** The belief that the outcomes of events in life are the result of forces outside of oneself (Rucklidge & Kaplan, 2002).

**INTRINSIC SELF.** The self that "is bounded, unique and idiosyncratic; it belongs to the person and to no-one else" (Lawler, 2000, p. 60).

**MEDIUM RANGE THEORY.** Useful theories built on abstract interpretations of social phenomena grounded in data (Charmaz, 2006).

**REFLEXIVITY.** The critical reflection of how the researcher, research participants, setting, and phenomenon of interest interact and influence each other, as well as how they affect the generation of data, behaviors, and the development of interpretations (Glesne, 2006).

**THEORETICAL SAMPLING.** A means of seeking pertinent data in order to elaborate and refine coded categories in the process of developing an emerging theory (Charmaz, 2006).
CHAPTER 4
RESULTS

The purpose of this study was to explore the emotions, attitudes, and perceptions of mothers of girls who were late diagnosed with attention deficit disorder, and the ways in which these perspectives affected the mother, daughter, and the mother-daughter relationship before and after diagnosis. Eight mothers of ADD girls diagnosed in high school were interviewed and the data was thematically coded and analyzed. The findings of this study are presented below in narrative form, and participants' stories are presented to illustrate the themes that emerged from the research data. A counter narrative is presented at the end of the chapter, highlighting a common scenario often found when addressing issues of ADD.

Influencing Factors

Lawler (2000) observed that mothers and daughters constantly scrutinize themselves and each other, as well as the quality of their on-going relationship. This study seems to confirm this observation. All of the participating mothers were concerned with nurturing their daughters to have a "good self," a "healthy self," and to meet the lofty standards for females in our society. The difference in these mothers of late diagnosed ADD girls is the intensification of their concern and their feeling of fighting an overwhelming and continuous battle. Not only do these mothers worry about the normal everyday aspects of raising an adolescent daughter, but they often also find themselves in a wearing, agonizing, and time consuming struggle to support their daughters academically, socially, and emotionally as the girls battle the effects of ADD at home, at school, with their peers, and within themselves. Several mothers had dealt with the effects of their daughter's ADD since elementary school. Others had experienced a dramatic behavior change in middle school or during the transition to high school. Regardless of the timeframe, all of these mothers were aware of the profound consequences of their own past, present, and future
thoughts and actions upon their daughter's well-being and the quality of their relationship
together. One participant came to realize the emotional influence she had on her daughter:

…I'm not constantly on her back about it, um, I'm not chastising her, I'm not, um, making
her feel badly because she did forget to do something or didn't make as well on a test as I
thought she was capable of making. I stopped that. She is who she is and we want to help
her to be the best that she can be and that has to be. I always said when my kids were
little, the biggest thing I wanted for them is just to be a happy person and here I was taking
two people, or one person that I love most in the world and turning her into one of the most
unhappy people that I had ever seen.

Three aspects were found to have a significant influence on the relationship between
mother and daughter. First, mothers diagnosed with ADD seemed to have more of an
understanding of their daughter's behavior. They did not initially recognize the symptoms as
ADD symptoms, but could empathize with the struggles of the daughter because of their own
childhood experiences. Mothers who had not felt the effects of ADD in their own lives, often
assumed their daughters were irresponsible, thoughtless, or impulsive. One non-ADD mother
described the frustration she felt with her ADD daughter:

I will make comments to her, you know [name], you're just being a butt head, you know,
and you know it and be nice, play nice, you know, things like that. But not just, you know,
you're driving me crazy, you know, which I used to just, you know, throw up my hands
and say. I even can remember this vividly saying, "What is wrong with you? You are a
smart kid, you know, you should be able to put this all together, you know? What is the
matter with you?" And I don't even go there anymore. I think it, but I don't say it.

The ADD moms were able to relate to the difficulties resulting from their daughters' behaviors,
and recognize the fact that their daughters could not always prevent their actions.

The second influencing factor was the mother's ability to cope with the difficult situations
in which she often found herself and her daughter. Having the capacity to adjust to fluctuating
circumstances as they arose was a contributor to the mother's self-preservation, the daughter's
overall well-being, and the maintenance of the mother-daughter relationship.
The third factor that influenced the mother's perspective and her relationship with her daughter was the mom's outlook for the future. Some mothers viewed the diagnosis as encouraging, finding relief in the explanation of the diagnosis, and in the prospect of positive change through medication. Others felt that the diagnosis was a severe limitation to their daughter's opportunities for future accomplishment. The mother's outlook for the daughter's future directly affected the mother's outlook for her own.

Regardless of whether or not the mother had ADD herself, had learned effective coping skills, or saw the future as promising or discouraging, all struggled with guilt and anxiety about their role as mother, and the part they played in their daughter's success. They questioned not only whether they had been a constantly nurturing mother, but also if they had enjoyed mothering in unwavering fashion as Winnicott (Lawler, 2000) and society demanded. One participant explained the pressure she experienced attempting to be both a successful and joyful parent:

…you know if you're not happy, then it's a tough front to keep up to make everybody else think everything's just great. Because you're the mother, you're the woman, you're the wife, you are expected to do that. If something's wrong, you're going to be the one to be looked at. Um, you know, "Oh, she couldn't hold it together, um, what did she do to make her kid act that way?" That's the way people are.

All were concerned with whether they were the "good enough mother" in their daughter's formative years, whether they were presently doing the right thing to help her meet societal expectations, and whether they would be able to help their child in the future as she entered adulthood. One mother described her far-reaching concern:

…all this time we've been trying to, you know, fit her into what everybody else is doing and suddenly I'm like oh well, you know, I just, you know, she just is not going to be there as much as I'd want her to be and, you know, I worry about her whole life - how she's going to do a job and all that stuff. But I think that's the biggest thing. I just want her to not be penalized, you know, and I want her to be able to learn however she can do that without feeling punished all the time….Well, now I guess suddenly it makes me wonder…is this something that she will ever outgrow? Is it going to be a constant life
challenge? And that sort of hit me, you know, like oh, how can we…how can she have a fulfilling life and how is she going to handle college and a job and relationships? ...So thinking about her future is scary to me.

All of the mothers were surprisingly open in relaying the challenges and triumphs they had experienced with their daughters. The emotions expressed by these women were startlingly and unexpectedly candid. For many of the mothers, the interviews seemed to be a cathartic experience.

The interviews were designed to explore the differences in the thoughts, emotions, and actions of mothers before and after the ADD diagnosis of their daughters. The findings are outlined in the remainder of this chapter through the presentation of grounded theory categories and subcategories, and excerpts taken from the mothers' interviews.

Category Identification

Three major categories emerged from the interview data. The first was Understanding the ADD Struggle. Three subcategories were identified within this major category: Seeing Herself in Daughter, Reaching Empathy, and Knowing the Facts. The ADD mother's ability to see herself in her daughter was a major factor in the mother's perception of her daughter and their relationship together. The ability of the non-ADD mothers to reach empathy for the struggles and behavior they saw in their daughters was of important consequence in the mother-daughter relationship. Also significant was the amount of knowledge the mothers possessed regarding the causes, symptoms, and treatment of ADD. This subcategory, Knowing the Facts, includes the following properties: (a) being uninformed and (b) feeling powerless.

The second prominent category identified was Coping. Within this category were two subcategories: Dealing with Personal Issues and Accommodating. The first subcategory includes the following properties: (a) dealing with own chaos, (b) carrying the burden, and (c)
blaming self. The Accommodating subcategory includes three properties: (a) changing parenting style, (b) shielding, and (c) finding balance.

The third major category was Envisioning the Future. Mothers saw their daughter's ADD diagnosis as either positive or negative in regards to their daughter's success in the future. Subcategories within this core category are Expecting More or Expecting Less and Providing Reassurance.

Understanding the Struggle

Seeing Herself in Daughter

Almost half of the mothers had been diagnosed with ADD and had experienced many of the same symptoms in childhood as their daughters. Seeing themselves in their daughters seemed to give them a level of insight and empathy that was difficult for the mothers that had not experienced ADD as a child. One ADD mother expressed this level of understanding of her daughter's impulsiveness:

I have to remember there's several times I've been in situations and they are kind of embedded in my mind that, saying something and not thinking about what, you know, what I'm going to say first and like, oh gosh, why did I say that, you know? And that's the kind of thing [she] does too.

Relating to the inappropriate ADD behaviors did not prevent these mothers from disciplining their daughters before or after diagnosis and attempting to correct their behavior. This same mother, for example, acknowledged that even though she understood the impulsiveness, she held the child responsible for her actions and wanted her to understand that the behavior was inappropriate. She also realized that she dealt with the issue differently pre and post diagnosis:

Yeah, yeah, I would get a little, you know, upset with her, make her go to her room or something like that, you know...Now, um I think I'm more - I talk to her more about why she said what she said and try to figure out what, you know, why - why, you know,
because she has some control now. It's not as bad as it was because I think she's on the medication…

Not only did ADD mothers recognize and relate to their daughters' inappropriate behaviors, but also to the academic struggles of the daughters. Many had difficulties in the same academic realms as their daughters, such as math and reading comprehension, and remembering, completing, and turning in assignments on time. This ADD mom tells of a conversation she had with her daughter regarding her college studies:

…[my daughter] says, "I see other friends in college, mom, and they can sit there and they can read and know it and not have any problems, but me, I have to read it. I mean sometimes I have to read it again and sometimes even again I have to read it, you know?" …I know what she's talking about because I'm the same way.

The ADD mothers did not want their daughters experiencing the difficulties and lack of support they had experienced as a child. One ADD mom, for instance, reported that although she often felt guilty for helping her daughter academically and not having her "pay the consequences," she also felt a strong sense of pride that she had stood up for her daughter, no matter what the difficulty. Asked why she had not let the daughter pay the price, the mom responded, "Um, I can only think now that I must have seen some of what was in me at her age, and my mother didn't go to bat for me, and so I know what that felt like."

ADD mothers and daughters often shared difficulties in the social realm as well, finding it difficult to make and maintain friendships. This common trait seemed to help in forming a closeness between these mothers and daughters. One mother described her own difficulties with friendships and expressed her concern that her daughter may be following in her mother's footsteps:

I really don't have anybody other than a counselor to share [ADD] with - some of those thoughts like you can have like with a girl friend or a close friend. I mean I have one close friend, but you know, she's got a lot of her own stuff, but um, you know someone you could – that could be happy for your diagnosis or, you know, and so I don't have
that…[my daughter] has some friends, but no like close, close friends, but I hope she will before she turns into an adult, you know, before she goes too far down the road.

The ADD moms reported very close relationships with their daughters, ones that were less strained than those of the non-ADD moms and their daughters. Not only could the ADD mothers relate to their daughter's ADD, but the daughters often found more of an understanding of their mother's behavior. The ADD created a unique bond between them. The mothers also reported more mother-daughter activities and a strong sense of friendship with their daughters.

One ADD mom expressed her closeness with her daughter:

I think she looks at, too, before diagnosis that she knows that I would talk to her about how hard it was for me and that I struggled and I think that she knew….I think she kind of, you know, there's an understanding between us about, you know, she knows what I went through when I was younger and we've both been diagnosed so we kind of both know what it's like, you know? So I think we have a good relationship still.

I wanted to be a friend, but I also knew I needed to be her mother, too, so I tried to find a balance between the two…She's becoming a young woman now, you know, and that's – I see us having, you know, still a good relationship even after that, you know, wanting me to do things, you know, and go shopping…

Non–ADD mothers often reported difficulty in creating a consistent bond with their daughters. The two non-ADD mothers quoted below discussed the difficulty in finding special mother-daughter moments and activities:

…I'll pick her up and we'll be chatting about her day and then we'll get home and I'm like, "Can you feed the cat?" And then five minutes later, you know, I don't even know where she is, you know? "Have you fed the cat?" So, you know. So it's like, it was nice there for a minute, but…

…you would start out with these, you know, um, grand visions of having a wonderful mother-daughter time when in reality, she's …but just me trying to give direction, she doesn't, you know, because she sees a recipe or sees something and she starts processing it her way and then she just tunes me out, so it's like, hey, okay. We can cook together, but we're going to cook separate things and we're going to do it our separate ways, so actually, we're just sharing the kitchen. Yeah, it's really not a mother-daughter activity.

ADD moms consistently rated their mother-daughter relationships higher than the non-ADD moms, both before and after diagnosis. On the mother-daughter relationship rating scale,
all three of the ADD mothers rated their relationships as a 4 or "good" before diagnosis. After diagnosis, one rated the relationship as good, while the other two gave their relationships the highest rating of 5 or "excellent."

**Reaching Empathy**

The love that all eight of the mothers felt for their daughters was evident. The non-ADD mothers shared a level of concern and caring for their daughters equal to that of the ADD mothers. They had searched for answers to their daughters' problems, worried about their emotional and physical well-being, and stressed over their welfare at school, at home, and with peers. However, the absence of the ADD experience in their own lives put these mothers at a disadvantage in relating to their daughters before and often after diagnosis. They had a longer and more difficult learning curve in reaching an understanding of their daughters and the behaviors witnessed on a daily basis. One non-ADD mother described the on-going frustration she experienced with her daughter:

…if she was cleaning out her room, she would start doing something and then start scrapbooking or, you know, pull stuff out so what started out as her room as a wreck, it would be a tornado because she was left to her own devices in there and she just, you know, got into everything. There was no focus…Yeah, I thought she was being disobedient…[I would tell her] you're not leaving the house until, you know, you're not going to do anything the whole weekend until your room's picked up. And just - it was an inability to just follow through, to finish it, to stay focused, to stay on task.

Having no personal experience with the symptoms of ADD created an added barrier for the non-ADD moms. Although the diagnosed mothers' understanding and empathy were incomplete before their daughters' diagnoses, they benefitted by an earlier and increased level of understanding and empathy that the non-ADD mothers lacked. All the mothers knew that their daughters were struggling with academic, social, and personal issues, but the non-ADD mothers were at a disadvantage, seeing their daughters as purposefully belligerent, unmotivated, or bad mannered. This disadvantage may have contributed to the significant disparity in mother-
daughter relationship scores between the ADD and non-ADD mothers. One non-ADD mother rated her pre-diagnosis relationship with her daughter as a 1 or "conflicted," described on the scale as "fighting most of the time." Another gave a score of 2 or "poor" for a relationship that was "strained most of the time." The other two non-ADD moms gave their pre-diagnosis relationships a 3 or "average" score, described on the scale as "good and bad days." After diagnosis, the relationship that had been rated as 1 or "conflicted," increased to a 3 or "average" relationship. The relationship given a "poor" rating of 2 increased to a 4 or "good." One of the relationships rated 3 or "average" stayed the same, while the other increased to a 4.

It was more difficult for the non-ADD moms to increase understanding and empathy until they came to the realization that the inappropriate behaviors were often beyond the daughter's control. A mother who rated both her mother-daughter relationship and her parenting as poor before diagnosis, felt that she had improved her post parenting to the highest rating of "supportive" because she had removed blame from the daughter:

Interviewer: Why do you think that it's so different, going from a 2 to a 5?

Mom: It was not her fault. I mean, if anything, what she's dealing with would be my fault and her dad's fault either because of the genetic makeup we happened to give her, not that we did on purpose, I mean we didn't have a choice, but um, genetic makeup. I don't know. Maybe it has something to do with environment. I - one thing I still don't understand is why in some people that apparently there's a part of the brain that just doesn't develop and have the activity that it should. Maybe it had something to do with um, her being a second child and I worked full time and um, had a year and a half old at home. Maybe I didn't get her the time that she needed either when I was pregnant with her or after I had her. Maybe that had something to do with that not developing, so it's not her fault. She's just dealing with what she was given.

With gradual understanding and empathy came increased patience, which all of the mothers expressed as an important aspect in supporting their daughters.
Knowing the Facts

Another factor in understanding their daughter's struggle with ADD was the mother's extent of knowledge regarding the disorder. None of the participants had been offered detailed information on ADD from school, medical, or counseling professionals. One ADD mother expressed her frustration with obtaining information and assistance:

…you know, you go to a psychiatrist and they prescribe you medicine, but that's not the person that teaches you how to deal with your illness….I sought counseling, sought out help, um, because all during the times I was taking medicine or whatever, you know, counseling assistance, but I just find it interesting that psychiatrists really just say, "Well, are you feeling better with this pill or not?", but they really don't want to hear your story, you know. So I just find that interesting, that's all.

Although a few of the mothers had sought information on their own, their knowledge of ADD remained incomplete. For example, one of the mothers who had obtained information about the symptoms of ADD, lacked an understanding of the importance of continual and regular ADD medication. Her daughter received medication only during class time, missing the benefits of medication after school hours for issues such as enhanced driving ability, improved social skills, or increased focus for homework assignments. Others knew that ADD was hereditary, but were unaware of the behaviors associated with ADD or the importance of combining medication and counseling. It seemed that all but one of the mothers (who was trained in the field of medicine and psychology) lacked a thorough understanding of ADD, and had more of a piecemeal image of the disorder. Their knowledge of the causes, symptoms, treatment, and repercussions of ADD were incomplete, placing them at a disadvantage in understanding the behavior of their daughters and the unique role of mothering an ADD child.

Being uninformed

Not having all the facts about ADD left many of the mothers feeling uninformed and powerless. Improving a situation requires that the circumstances surrounding it be understood.
The feeling of "being in the dark" left many of the mothers feeling incapable of correcting or improving their daughter's situation. Lacking the facts contributed to the mothers' level of anxiety, worrying if they had caused the problems they observed in their daughters and wondering how to deal with the issues their daughters experienced:

Q: You said you did not feel very knowledgeable about her ADD. What would you like to know more about regarding ADD itself?

A: Um, maybe what causes it, um, how you, um, how the best way to deal with it, with your kids. What's, you know, the – like the techniques to make it better for them. Because that's where I feel that I lack. I feel like I hindered her more than helped her by always staying on her....I feel like I really made her life more stressful by not knowing and not knowing what to do for her, and I feel like I really made it just very stressful, you know, looking back on it, and just really put a lot more stress. And I just wonder that, you know, maybe that could have caused some more of these medical issues that she's having because they're brought on by stress.

Mothers of an only child had the additional drawback of having no older sibling with which to compare behavior:

Mom: You know, I think, you know, just every little thing – everything that she does takes a lot longer. Everything, whatever it is, than a normal person....

Interviewer: And it's always been that way?

Mom: I don't know that I noticed it. Having just had one child, I, you know, I just, you know, I figured this is what an eight year old does. You know, maybe I just didn't have a good perspective. It didn't seem extreme to me until maybe middle school...

The mother quoted below relayed her daughter's description of ADD. This small, but critical account emphasizes the importance of understanding the ADD struggle in order to effectively support ADD children:

[my daughter described ADD as]...it's like someone constantly changing the radio station and just hearing every little noise come out and not being able to focus or having to keep going back to something five or six times before she could get it completed.
Feeling powerless

Having little information about ADD often left the mothers feeling powerless in how to appropriately deal with issues surrounding the disorder: how to communicate and discipline appropriately; how to respond to others regarding their daughters (including fathers, stepfathers, family members, friends, and professionals); how to strengthen the mother-daughter relationship; and how to support their daughters socially and academically.

Many also felt powerless regarding input on the treatment of their daughters. They were uneducated on the treatments available and the effects of the treatments prescribed, leaving all medical decisions to the discretion of the prescribing physicians or nurses. Frequent and regular individual counseling for the daughter was rarely recommended, whether alone or in conjunction with medication. Recommendations for mother, mother-daughter, or family counseling were also rare, leaving mothers often feeling powerless to find answers for positive change.

Coping

Dealing with Personal Issues

The mothers in this study were under continual pressure to find ways to manage their own personal and professional lives, their home life, and their daughter's ADD. None of the eight had received training in how to deal with such a mix of events and emotions. The subcategory of Dealing with Personal Issues includes three properties: (a) dealing with own chaos, (b) carrying the burden, and (c) blaming self.

Dealing with own chaos

The first factor found to affect the mother's ability to cope, was her capability to deal with her own personal turmoil. Several of the mothers struggled with their own ADD in addition to that of their daughter. The disorder often found them continually overwhelmed, attempting to overcome their symptoms in order to focus at work, organize home life, support their daughters,
and deal with their own emotional issues. In addition, they dealt with sadness and frustration about their own missed diagnosis, and speculated how things could have been different for them.

One of the mothers offered handwritten notes regarding random thoughts of her individual experience with ADD:

Increased responsibilities can bring out ADD; make it more apparent.
Undiagnosed ADD causes chaos; failure after failure.
Capable of more; could have been more
On a professional level, praised for my work. Good at work, then feel like failure at home.
Overwhelmed
The noises, sights, own thoughts made me lose focus; made me move from one thing to another.
Compulsive shopping
Forget things – where are my keys?
Avoid people, friends – need time to keep my basic life together.
Women are expected to organize for others – men, children.
Wanted to focus on one thing for more than a few minutes, to not worry, and focus on one particular thing all the time.
I was depressed from dealing with ADD.

Another ADD mom admitted she could not always give her daughter the support or attention she needed because she had "nine or ten things rushing through her own head." She would often "gloss over" or reroute conversations with her daughter because it was too much for her to deal with at the time.

Other moms who did not have ADD, dealt with their own life issues while trying to manage their daughters' problems as well. One mother described her attempts to help her daughter while dealing with the tumult of a divorce:

Well, I, I asked her, I said, "Does it have anything to do with your dad and I getting a divorce, you know, if we've done something then we need to try to fix this," and she told me, she said, "No," she said, "You just don't get it. It doesn't have anything to do with you and dad. You think it's all about you. This is not about you and dad. This is about me. This is about something else..." She came to me one night and she had scratch marks on her arms and I looked at that and I said, "What is that?" She said, "I cut myself." So I freaked out. She did not cut herself to the point that it was like a suicidal attempt, she cut herself to get somebody to "pay attention to me." Well, she got my attention, yeah. I mean I had seen, you know, read a couple things about this and it's like, "Why did you do that?!" [She said] Because it made – it feels better than the way I feel inside."
Managing a complicated personal and professional life, while trying to piece together the puzzle of dealing with ADD, creates a difficult task for mothers of ADD children. Many of the moms had made countless visits to professionals trying to find the cause of their daughter's struggle. Several mothers told of searching for answers since their daughters were in kindergarten. One of these mothers brought stacks of records, tests, reports, and multiple diagnoses that she had collected over the years from schools, clinics, and hospitals regarding her daughter's condition. The time and emotional commitment of such a search was evident, especially when the mothers had additional personal responsibilities such as large families, additional children with ADD, single parenthood, and relationship issues with husbands and/or ex-husbands.

Carrying the burden

Seven of the eight participating mothers felt that they carried the majority of the responsibility of dealing with their daughter's ADD. These mothers felt alone not only in carrying the burden of parenting and disciplining, but also in single-handedly dealing with their daughter's academic, emotional, and social issues. Six of the eight mothers were no longer married to their daughter's father, and although three had remarried, assistance often remained limited or non-existent. Several of the fathers refused to accept their daughter's ADD diagnosis, which added to the weight of the mother's burden. One mother described her husband's resistance:

…something bothers him about it, and I don't know if it's the imperfection that people perceive…and I'm like, well, you know something's wrong with your mind, but, you know, you wouldn't think bad if something was wrong with my heart or my liver or my kidneys. Then I'd be an okay person, but because I have mental issues or – you're just thought of differently and I think he has that stereotype as much as I try to tell him, you know, about medicine and try to tell him – I don't put my daughter on any medicine that he doesn't know about or anything like that, but as she becomes older she's not going to need to discuss that with him or – and he's not going to understand that, but I want them to have that relationship, but my husband is just not real open to that. I'm taking care of myself
and I'm taking care of my daughter, our daughter, and um, you know, you can take it or leave it….Most of the responsibility for her is on me and it always has been. I used to joke privately…I was a single parent in a marriage.

Another father accepted the diagnosis but was unable to assist his wife in tackling the daughter's issues. The mother expressed her frustration with the lack of emotional and physical help she received from him:

…it was almost like [he said], "I've washed my hands of it, there's nothing I can do, I just – you know, what I do aggravates me or aggravates her; it's obviously not helping, so you know, I'm just going to turn her over to you." I mean, that's the level of frustration that it was, you know? "Only involve me if, you know, it's non-controversial," you know?

This same mother relayed her resentment of carrying the burden alone:

…I think moms are the one that, you know, kids come to for the nurturing, for the – we're the first line, front line of defense for them so I think it's just the natural – I mean, it seems natural that they go to mom and um, you know, sometimes I think that's a blessing and other times I go, "Dad, it's your turn. Yeah, come on, pick it up. There's more here to share."

Not only did most of the mothers lack shared responsibility from spouses or partners, but found little assistance from academic, medical, and psychological personnel. Many mothers were frustrated by the inability to adequately tell their problems to a professional, feeling dismissed due to the professional's lack of expertise or knowledge regarding ADD, the limitation of the professional's time, or the professional's disinterest in the counseling, advice giving, or educational process.

Others felt alone in carrying their burden because of their unwillingness to share their daughter's diagnosis with others. Some felt it was important to protect their daughter's privacy because it was not their place to disclose their daughter's personal information. Others felt that there was stigma involved in the diagnosis, choosing to keep the diagnosis private or within the immediate family, and encouraging their daughters to do the same. Some mothers reported receiving "a hard time" at the pharmacy from technicians and pharmacists when they or their
daughters submitted their prescriptions. Most mothers felt that ADD was misunderstood and believed that they would have to defend the disorder to anyone told of the ADD diagnosis. Several mothers feared that their daughter's diagnosis would be scorned by others because their daughters were well behaved and caused little or no trouble at school and did not fit the stereotypical pattern of hyperactive ADD. Others had daughters that were overly organized and perfectionists regarding schoolwork, and although their obsessive behaviors resulted in extreme anxiety and exhaustion, they performed well academically. These mothers worried that, if revealed, the daughter's ADD diagnosis would be misunderstood and rejected. Outsiders could not see the wide array of symptoms that made the daughter's life (and that of her family) a day-to-day struggle. For instance, one mother who had two other children with ADD and a good understanding of the disorder, had an academically successful ADD daughter. She avoided telling others, concerned that they would not believe the daughter's diagnosis:

Sometimes I just think they see [her] and they go, "No way. Everybody's ADD [sarcastically], no way she's ADD because she gets good grades," and they don't understand. I think it's really lack of understanding and then I just don't really want to hear it because I know they don't – they are not educated, you know? They are not educated in that way.

Another mom returned to the second interview and admitted an additional motive for her silence regarding ADD:

Um, okay. I gave some more thought to um, why I don't share the diagnosis, because I don't know. That question just really stuck with me. Um, and I think I kind of eluded to this in another question you asked, and perhaps this is selfish, but honestly when I thought about this, I don't think I tell because I'm the mom, and I will be suspect, you know, if anything's wrong. That's for the question [to myself] like, did I give it to her through my genes or whatever. And maybe I wasn't a good mother or wife or woman, or you know, implicated when home stuff is wrong, you know, goes wrong. It's like, what did she do wrong? I mean that's just how I felt, okay?...Like I'm liable for any failing.

Feeling alone and solely responsible for dealing with their daughter's ADD was a burden to many of the mothers and added to the complexity of coping.
Blaming self

An additional factor that affects the mother's ability to cope is her feeling of guilt and self-recrimination. All of the participating mothers questioned their part in negatively affecting their daughter's well-being. They wondered if they had caused their daughter's disorder through genetics, inadequate prenatal care, inadequate attention, childhood falls, poor parenting, or other personal mistakes. They regretted procrastinating in seeking help, and missing what, in hindsight, seemed like an obvious diagnosis from the symptoms they observed in their daughters. One mother expressed the frustration she felt with her lack of awareness:

You know, I feel bad because we're pretty, two pretty intelligent, you know, educated adult parents and didn't catch it, didn't realize it….if I could have figured out a way to make her life better. If I had known, then I might have been just a little more helpful. I mean not – I was frequently at a loss, what do I do here, you know, and part of it being – having her as an only child, I guess, you know, I frequently just thought, well, this is something she'll go through, pass through and then six months later, a year later, it's like, you know – it hasn’t gotten better.

Many regretted they had not been more insistent with school and medical personnel to have their daughters tested or reevaluated when initial discussions, diagnoses, or medications were unproductive. Several felt a strong sense of regret that diagnosis and treatment had not come earlier, believing that their daughter's social, academic, and emotional issues could have been diminished if addressed in a more timely fashion. One mother expressed her frustration with what she perceived as a lack of professional awareness:

…you know, it didn't make any sense and no one else had ever mentioned it except that one person, and people that had really close contact with [her], her teachers and the counselor at school that had talked to her and, you know, her physician, her pediatrician, nobody else had even mentioned that knew her a lot better. And would we expect those people to know that though? Like are they really – elementary school teachers – are they trained to try to diagnose?
Because of the delay in the identification of their daughter's ADD, most mothers felt they had contributed to their daughter's struggle by years of inappropriate and inadequate responses and parenting methods. One mother relayed her feelings of remorse:

Mom: [I felt] guilty. I wasn't listening. I wasn't hearing what she wanted me to hear. I was hearing what I wanted to hear.

Interviewer: Which was?

Mom: That I have um - that she's a very bright child and if that – if she would work harder - and maybe she is a little bit lazy and where did you get this lazy streak from? Certainly not from me. It must be your dad, yeah, that's probably it. I mean, those are the kind of thoughts.

Another mom agonized over her previous lack of understanding and the pressure she had placed on her daughter:

Interviewer: …Do you remember that when you said, "We would argue a lot, I realize I was doing the wrong thing." Do you know…what did you mean by that?

Mother: With the way that I would argue with her and what my expectations were of her, she wasn't going to be able to – she wasn't going to be able to do what I was demanding that she do. Um, like with school, to get more organized, you know?

Interviewer: Try harder?

Mother: Yeah. Try harder, listen in class, write down the homework, bring it home, um, she's, she wasn't able to do that. When she told people she couldn't hear in elementary school, I mean there's nothing wrong with her hearing, but apparently there's just so much going on in her head that she doesn't hear and, you know, I kind of knew that at home because I just always thought she's ignoring me or she doesn't want to listen to me because I would repeat something over and over to her again. You know, you need to do this, you need to do that, and then she wouldn't do it and then I'd get irritated with her. Why didn't you do that, I've asked you five times, that's your responsibility to do that, and I would think she's just, you know, being lazy, ignoring me, and now in hind sight, I know, and I don't chastise her if I ask her to do something…

Some of the mothers expressed regret that they had tried to find their daughter's interest or talent and had failed in doing so, overlooking the fact that they had tried their best to provide an outlet for their child:
…you know, like she's always on me, "You put me in dance. Why didn't you ever put me in sports? I'm never good at sports," and even to this day that kind of stuff still bothers her and upsets her…"Why didn't you put me in softball with my other friends?...I'm a nerd. I can't play any sports, and you know everybody plays sports and I can't do it" …You want your kid to be happy, but you know then again the attention span, you know, [she] wanted to do cheerleading, wanted to do Girl Scouts, wanted to do art, wanted to do piano. She did them all, but she didn't want to practice at them, but she wanted to do them all, and I let her do them all.

Blaming herself for her genetics, thoughts, or behaviors often affected the mother's perception of herself as a mother and friend to her daughter before and after diagnosis. All of the mothers felt that they had improved in their parenting after diagnosis, but continued to hold themselves responsible for past issues and for future successes. When asked what would improve the mother-daughter relationship from "good" to "mostly good," one mother had no answer, expressing her frustration about past events with her daughter while simultaneously worrying about her daughter's future without the mother by her side:

I don't know and that's because I've tried different approaches when you just kind of bang your head against the wall and you say, okay, you know, all these years I've been saying she's a smart girl, she should realize, she should adapt, she should adjust, she should realize this isn't working. And then you go, okay, let me change me, let me change my approach, let me change my expectations, so you do. And I tried different approaches from being very strict, very hard on her, to being very relaxed, very tolerant, but very accommodating, trying to go middle of the road where, you know, hey, I can't do everything for you so you've go to learn to do some of these things on your own, or let's try to figure out together how we can make this work and just talking to her more openly about when you go to college, how is this going to work? What are you going to need? What do you think you're going to need? What can you do on your own? What will you need help with? So we've kind of been through the whole spectrum, but each time, you know, I try to take a different approach. It's – there's nothing really consistent from her except surprises.

Accommodating

The mother's ability to adapt to the situations in which she found herself contributed to her ability to cope with her daughter's ADD. Rather than adapting, the term accommodating, seemed to be more inclusive and appropriate in describing the ways in which these mothers adjusted their behaviors and obliged their daughters in trying to assist them, avoid tension, and
increase harmony in the family and in the mother-daughter relationship. The subcategory of Accommodating includes three properties: (a) changing parenting style, (b) shielding, and (c) finding balance.

**Changing parenting style**

One of the most significant and consistent themes across all eight of the interviews was the mother's need to change her mode of parenting for her ADD child. Most of the mothers had discovered creative ways to help their daughter deal with ADD symptoms, such as keeping a special calendar for her, writing a "to do" list, having the child look them in the eye as they spoke, going over a checklist before leaving for school, or breaking down large tasks into small parts. They were continually utilizing trial and error to find what worked in particular situations.

Most of the mothers found themselves "choosing their battles," bending the rules, and adjusting responses in ways that they would never have imagined and in ways they would never have considered with a non-ADD child. ADD and non-ADD moms alike had come to the realization that in order to adequately cope with their daughter's ADD, they would often have to be the one to change behavior, not their daughter. Changing their own way of doing things seemed to be the key to containing their frustration, as well as that of their daughter's. As one mother stated, "We now accommodate her if for no other reason than it makes our lives simpler."

She described how she avoided conflict during shopping trips to the mall or family movie outings:

Mom: We do fine if we just go and it's all about her. Then it's fine. It's more I adapt to her because I know what works and I know what will make her have a better time, so then in turn, just knowing that she's having a good time, makes me have a better time, you know, to see her…

Interviewer: Less conflict.

Mom: Yeah, less conflict to see her enjoy herself and there are times, you know, we just say, like picking a family movie, the family just surrenders it to [her] because by the time
you convince her of the movie that you want to see, you've missed all of the movies that day….Now it's unspoken. "[Daughter's name], what do you want to see?" and she, you know, again, she doesn't even think twice about saying, "What would you guys like to see?"

Often, mothers changed their parenting approach in order to support their daughters academically or in day-to-day living, as shown in the quote below from a mother who made the decision to go against what she would normally do as a parent, and make a special request at her daughter's school:

…she thrives being put in a role where she can lead, but it frustrates her in team things if she's not the leader of the pack, I mean, you know, it just …group projects are a nightmare. Group projects are just, you know, to the point that I went to ask teachers if she could just do projects by herself. That's kind of defeating the purpose of the group project.

Another tells of letting go of the idea that her daughter would take all advanced courses in high school as she and the dad had always expected, allowing her daughter to take less challenging ones to alleviate the stress they both were experiencing:

I felt that intellectually she was capable of [succeeding in advanced classes] and that the only reason she wasn't doing as well as I thought that she should is because she just didn't work hard enough at it and didn't put enough effort into it, and didn't study hard enough. Um, I don't think that now….I don't understand the way her mind works, and the type of brightness that she has because it's probably – my brain probably works a little differently. I'm trying to learn to respect that and um, let her kind of find her way that's comfortable for her rather than me trying to push her in a direction that I think that she should be in; try to kind of lead her and hopefully she's going to find that place that she's comfortable in and that she's happy with….I did pull her out of some of the uh – most of her gifted classes this year because she told me, she said ,"I'm tired of struggling."

Two other moms explained why they excused their daughters from completing household chores, the first to try to help the daughter socially, and the second to keep harmony between mother and daughter:

Um, I guess, you know, we used to like say, "Oh you can't" - like if somebody would ask her to do something, we'd say, "No, you can't do this if you haven't done this," but now it's like we're just so glad that she gets an invitation that we just, you know, whatever. We just let her do it. That sounds pathetic doesn’t it? It's so sad.
...I mean I think we've worked on certain things, too, because we've identified the thing like I said, having her pick up stuff when she does come to visit – I just let it go. Like I didn't feel well yesterday. She was there; she had my living room a disaster in 20 minutes. I didn't even say anything, not because I didn't feel good, but you know, what it's – why worry about it. I'd rather have a good time with her being there. You know, I know that's her personality. I know what causes it, so let it go.

This mother recognized the fact that she had adapted her parenting in order to cope with the situation at hand, letting go of the methods with which she had been raised:

...there comes a point when you should recognize that what you're doing, or your parenting style or whatever, is not really effective or not working very well...you set the rules, the kids go by them, that's the rules that I was brought up with which didn't, you know, [she] would not have survived in that same kind of atmosphere. So, I mean, the parenting was – it was good, it just wasn't effective...

Another accommodating behavior often described by the mothers was "giving in." Mothers were often so frustrated by circumstances with their daughters, they would figuratively throw up their hands and give up. Mothers would walk away from discussions and particular situations with their daughters to avoid confrontation. One mother gave an example of such an instance when her daughter was younger:

...I just felt frustrated by her inability or her own – I don't know if it was inability or unwillingness to do things, um, or to focus on things...I mean, sometimes she just wouldn't cooperate and, you know, as a little – being so little, it's like what do you do, you know? You can only do so many time outs and, you know, then I would just give up, you know, expecting her to do something and then – so then, too, I'd just get lazy...

Some of the mothers had discovered that incorporating humor into their parenting had helped them and their daughters cope with ADD after diagnosis. The advantage of using levity was evident in the following account of interactions between this mother-daughter pair:

...she would kind of laugh about some things and say, "You know, I guess I'm having an ADD moment," or whatever, and she still will say that, you know, she'll say, "I'm having a blonde ADD moment," so she's blonde now, so that means it's a double whammy... [laughing].

The mothers were asked to rate themselves on their level of parenting before and after their daughter's ADD diagnosis. Significant differences were seen on the parenting scores of ADD
and non-ADD mothers on the 1-5 Parenting Rating Scale. One of the ADD mothers gave herself a 4 or "good" rating on the scale before diagnosis, while the other two ADD mothers gave themselves a 5 or "supportive" rating. After diagnosis, all of the ADD mothers rated their parenting as a 5, one giving herself between 4 and 5 because of her struggle to give her daughter more independence as she left for college.

The non-ADD mothers rated themselves much lower in parenting before diagnosis, with three of the four giving themselves a 2 or "poor" rating and one a rating between 2.5 and 3 or "average." Post diagnosis, these mothers reported varying degrees of perceived improvement in their parenting. One increased from a 2 to a 3, and another from a 2.5-3 range to a 4-5 range. The remaining two improved from a 2 to a 4 (good) and from a 2 to a 5.

**Shielding**

Another property termed *shielding*, was also found to be a significant part of the coping process. All of the mothers reported covering for their daughters in various areas, especially at school. This process might also be seen as defending or bailing out their daughters, or as one mother described it, being a "buffer" between her daughter and teachers at school. The mothers were adamant about defending their daughters at school and at home. They saw this as an important and necessary part of being a good mother to their ADD child and providing necessary support. Many would meet with teachers at the beginning of the year to notify them of the daughter's problems, and request their understanding and assistance. The moms often found themselves "doing what needed to be done" no matter how uncomfortable for them personally, and knowing their actions may not be in the best interest of their daughter long term. One mother noticed her daughter using the excuse that she was sick on days she had tests for which she was unprepared, or on days that assignments were due that she had not completed:
Um, well, the school stuff, even though I have always been supportive of her and would go to bat for her no matter what, and no one was going to tell me that anything was wrong with her, and you know, "She was just sick that day, by gosh, and you know, you're going to let her make it up," but it did become frustrating and made me weary, you know?...The school thing kind of drug me down.

The moms often carried forgotten assignments to school, helped with assignments that were still incomplete at the witching hour, and asked for leniency with school personnel. The mothers were frustrated and often angry for having to cover for their daughters, but did so on an ongoing basis because they could see the pressures of school "taking its toll." They helped their daughters in order to keep their heads above water and to help them survive academic pressures for which the daughters found overwhelming. The cause of the daughters' stress came from a multitude of sources. Some were unable to keep up or comprehend the material at school, and felt overwhelmed and embarrassed by their inability to perform as they saw others doing. Other daughters were perfectionists. Their stress was self-imposed by the strict organization and flawlessness they required in their work. Because of the daughter's high level of stress, mothers were often worried about the daughter's physical and emotional well-being, compelling the mothers to help their daughters with their academic struggles.

**Finding balance**

Finding balance is the final property of the subcategory Accommodating. Mothers found themselves walking a tightrope trying to give their daughters independence while simultaneously providing support. Several felt that their daughters should be autonomous in accepting or denying treatment, but privately hoped their daughters would seek treatment, knowing the difficulties the daughter experienced on a daily basis. Others tried to prepare their daughters for the independence of young adulthood, but found themselves unable to relinquish total support due to the special needs of their child.
Others were concerned with the balancing of attention between their children, knowing that siblings were cognizant of the additional time, effort, and consideration paid to the ADD daughter. Several mothers worried over finding a balance between "backing off" at one end of the spectrum and pushing (even gently) at the other, to encourage their daughters to act appropriately, fulfill family responsibilities, or meet academic expectations. There was an underlying fear of creating too much stress, and affecting their daughter's self-esteem or literally taking her over the edge. One mother worried that with too much pressure, her daughter would "really fall into depression." Another was continually concerned over "how much [her daughter] did not like herself." She feared her daughter's depressed mood and self-perception:

Q: What about the behaviors that worried you the most before diagnosis?

A: I worried about the signs of depression…That concerned me a lot because…I do have a history of mental illness, um, do have a history of suicide in my family and um, also actually, on her dad's side, he had a half sister that committed suicide when she was like 20 or 21. Um, I was really, really worried about that. The other things that I worried about because [her] aunt…is an alcoholic; she has been since she was a young person. She had two sons that she just almost totally destroyed because of self-destructive behavior so that's the other thing that I worried about with [my daughter], um, because some of her personality traits seem to be so much like her aunt's…[my daughter] would bring that up and she was concerned about that because she would - and this was before she went into treatment, she would say, "You know, sometimes I remind myself of [my aunt]."

Another mother questioned her motives for backing off:

…you know, I think sometimes I take her um, her, her need to not be harassed, I take it almost as an excuse for me not to have to do, you know, it's like, okay, she doesn't want to be harassed, then, you know, then I sort of – that lets me off the hook, and so sometimes I think I've been not the most helpful with her…

**Envisioning the Future**

The third core category found was Envisioning the Future. The two subcategories identified within Envisioning the Future were (a) expecting more or expecting less and (b) providing reassurance. The mother's outlook for her own future and that of her daughter's was affected by the mother's reaction to her daughter's ADD diagnosis and whether she saw the
diagnosis as positive or negative. Another factor that affected the mother's self-concept and her relationship with her daughter, was her ability to recognize her daughter's need for reassurance.

**Expecting More or Expecting Less**

Some of the mothers felt relief when they received their daughter's ADD diagnosis. There was finally a name attached to the symptoms and a reason for all the struggles they had witnessed in their daughters. One described this as an "ah ha!" moment. Another commented that her daughter had found relief in the diagnosis as well, discovering "it's not me…you, know. It's just how I do things, you know, it's different…"

For the ADD mothers, there was liberation in the diagnosis, giving them hope for their daughter's improvement and encouragement that their daughters would fare better than they themselves had as undiagnosed and misunderstood teens and adults. The prospect of medication that would alleviate their daughter's symptoms and provide her with positive opportunities for the future, left these moms expecting more for their daughters than they had prior to diagnosis. The ADD mothers had seen positive results after treatment, expected their daughters to make better grades than they themselves had made in school, and surpass them in level of education. An example of the difference in before and after diagnosis perceptions was seen in the account of one of the ADD moms as she told of how she related to her daughter's struggles, and described the hurt she felt for her daughter pre-diagnosis:

Well, I would be frustrated like whenever she brought home a report card, those type of things, when she would come home and she wouldn't get what she, you know, she felt like – she would try and try and try and I wasn't frustrated at [her] specifically. I was just frustrated with the whole thing….I felt that she just couldn't help it. That, that because of my experience and I knew what it was like. I mean, what do you do? You just do the best that you can, you know, but it was frustrating.

After diagnosis and treatment, this mother could see a brighter future for her daughter, expressing her pride over her daughter's graduation from community college:
So she had a two year scholarship. She even worked. She was able to get a scholarship with the grades that she made after diagnosis. Yeah. I didn't even see that for her, you know, I never saw that for her. I'm so thankful, you know, I'm so thankful.

As another ADD mother described the benefits of diagnosis, "It's not the end of the world; it's the beginning for them."

The non-ADD mothers tended to have a heightened sense of concern after diagnosis. Some of their daughters were not being treated with ADD medication, and had not experienced any of the possible positive results of ADD treatment. A mother whose daughter was not receiving ADD treatment commented on the difficulty of the mother-daughter relationship:

I think if we could manage – if I felt like she was improving, if I saw improvement over the course of, you know, a few weeks, I would feel a lot happier knowing that, you know, her attempts were actually paying off. You know, because right now, it is hard, you know, and I know what her teachers are thinking because it is hard for me to think that she is trying. I mean, I know she's trying, but it's hard to remind myself of that sometimes.

Others had seen improvement in their daughters' symptoms after receiving medication, but continued to worry about troubling behaviors that remained. Most of the non-ADD moms doubted that their daughters would reach the level of education or professional success that they had initially expected of them and that the mothers themselves had achieved. All of the non-ADD mothers were concerned with their daughters' ability to enjoy a completely fulfilling personal, academic, and professional life.

Several mothers feared that they would be taking care of and worrying about their daughters even into adulthood, seeing no light at the end of the tunnel. One mother expressed the strained relationship she had had with her daughter and her concern about her daughter's future, even after diagnosis and treatment:

…you know, the feelings we've had throughout makes you feel bad and inadequate and that you're not saying or doing the things that your kid needs to, to excel or feel better about themselves or feel like they think that you're, you know, um, but at the same time, it was a continuous, you know frustration, because she wasn't meeting the expectations and um so that, I think that pretty much sums it up, the – it's a bad feeling for me and a bad
feeling for her and just very hard even after the diagnosis, it's not like once you get a diagnosis, it's great; everything's fine. She's on medication and maybe you're a little bit, you know, I'm a little bit more tolerant of things, but it's still frustrating that, you know, for how she will cope as an adult when I'm not in her life and not there as either a crutch or someone to, you know, poke and you know, drive, and do whatever I need to do to make sure, you know, she follows through on things.

A critical turning point for many of the mothers occurred as they changed their expectations, and accepted the fact that their daughters may not meet the social, academic, and professional standards they had originally anticipated. After the initial stun of this realization, as seen in the quote below, mothers were able to begin accepting their daughters as they were and supporting them in being the best that they could be:

… I was constantly riding her. I was, you know, the bitchy mom, you know, constantly. I always felt like I was on her all the time, you know, about something and she even said that, you know, "Do I do anything that makes you happy?" you know, and that's a terrible feeling when your, you know, kid says that to you. But if you weren't so frustrated all the time…she even told me at one point, um, I was so frustrated with her and she said, "Mom, let me help you out with your problem." [I'm thinking] with YOUR problem [pointing to herself and laughing] MY problem?!…"Why don't you just lower your expectations," and um, that was kind of a wake up call.

Providing Reassurance

A recurring theme throughout the interviews was the need for the daughters to find reassurance from their moms. Not only did they want their mothers to "watch their back" but also to offer signs that everything would be okay for them. The daughters sought out success stories from their mothers about their own achievements and happiness, as well as affirmation that the daughters had done some things well and could do well in the future. Consciously or subconsciously, they needed their mothers to build their confidence and boost their self-esteem through praise of their own achievements, or through perceiving or observing optimistic experiences in their mother's life.

Supporting or "being there" was also important in providing the daughters reassurance. This included attending their activities, offering reassuring words, helping them complete
assignments, shielding them at school, and accepting and allowing them to be themselves without criticism. As one daughter wrote in a note to her mother, "I treasure the comfort of having you there for me, which you have always been. I don't know how I could have overcome so much this year without you having my back every time." Another mother commented that even after her daughter was receiving ADD treatment and doing well, she still seemed "needy," wanting continual affirmation:

Oh, I guess [she was] wanting that reassurance that everything was going to be okay…she's still insecure in a sense because she's been so – she's had to worry all of her life and so she's still worrying even though she knows she can do it.

**Attention Deficit Disorder or Depression?**

One of the eight participating mothers (referred to below as "Mother #07") did not agree with the ADD diagnosis her daughter had received, believing that her daughter suffered from depression as the mother and other female relatives in her family had experienced. The girl's father had also been diagnosed with a mood disorder, as well as ADHD. It is unknown whether this mother, her child, or the relatives actually had depression or attention deficit disorder. Although her interview was separated from the others in compiling results, her experience was included in the study because her situation is a common one. Females experiencing attention deficit disorder symptoms are often misdiagnosed with depression, or are found to have depression as a co-existing disorder with ADD (Biederman, Mick, & Faraone, 1998; Nadeau, Littman, and Quinn, 1999; Quinn, 2005). Several of the mothers in the study reported that their own daughters had initially been diagnosed with depression. One mother was concerned that medical personnel fail to "look outside the box" and assume everyone has depression and treat them accordingly. The symptoms Mother #07 saw in her daughter mirrored many of those recognized by the other seven mothers in their children: lack of focus, forgetfulness, procrastination, declining school performance, low self-image, depression – all starting at the
end of middle school. The frustrations she and her daughter experienced were similar to many of the other mother-daughter scenarios including personal conflicts, unfinished chores, and delayed school work. She expected her daughter to do her best, but found that her daughter was unable to do so:

[I expected her to] do the best you can at what you're doing and um, treat people the way you would want to be treated and, you know, your general, you know, be a decent person and find what you're good at and find what you love and do that and find what makes you happy….she was not trying, she was not trying because she just didn't care….I mean like I said, I have a long history of clinical depression and a family history of it and I know that it's not – you want to care about things, you want to do things, but you just don't have the – and I don't even know what word to give it, it's not motivation, it's - and it's not willingness, it's, it's just ability, the mental ability to do these things, so as far as intentional, like she's acting out or something, no.

As with the other moms in the study, this mother knew her daughter was very bright and capable intellectually, and was frustrated with the lack of academic performance. She saw her daughter's disappointment in herself and realized that her daughter also saw disappointment from both parents and her teachers as well. She saw "how much [her daughter] did not like herself," and worried about stressors that would "put her over the edge." As with many of the mothers, this mom also worried about the friends her daughter had chosen:

Mother: I don't like being judgmental or – but her group of peers for the most part are not at the same level that she's at, you know, so it's easy for her…

Interviewer: Do you mean intellectually?

Mother: Yeah, intellectually and uh, the social consciousness and the sense of place in the world and it's, you know, they are very self-centered and you know, typical teenagers and um, so it's very easy – it was very easy for her not to perform because she didn't have that competition from her peers.

This was a common thread between all the mothers – concern that their daughters had few friends, and the friends they did have were underachievers, dominating, or unkind. Many ADD girls have difficulties forming healthy friendships because of their lack of social skills or as this mother observed, because of their lack of self-confidence, believing they are not as pretty, as
smart, or as likable as others around them. As another mom described it, "I think she's afraid she's not going to be accepted. She avoids." Another believed her daughter had few friends because of the "different thought processes" she saw in her daughter. Another said that her daughter felt a kind of "loss of place," failing to fit in with any group at school. One mom described new friends that her daughter brought home as "future former friends," describing her daughter's repeated short-lived friendships.

Mother #07 also felt she was solely responsible for dealing with her daughter's well-being. She felt like she was "drowning" at times and found herself "winging it" in trying to parent her daughter through difficult times. Like the other mothers, she came to realize the importance of her own patience and flexibility in successfully dealing with her daughter, backing off when necessary and accommodating to diffuse difficult situations.

This mother had rejected her daughter's ADD diagnosis and refused ADD medication, choosing to "deal with the devil I know" (depression). Although she had received little counseling and information regarding ADD, she had seen good results in her daughter after receiving medication for depression, and had a positive vision for the future. Whether or not the daughter suffered from ADD, depression, or a combination of the two, the similarities between this mother-daughter pair and the other seven were significant.
CHAPTER 5
CONCLUSION

This chapter will review the findings of the study and discuss the general observations made during and as a result of the research process. Theoretical implications of the study will be discussed, as well as the potential applications, and implications for prospective research.

Summary of Findings

The purpose of this study was to explore how a late diagnosis of attention deficit disorder in girls affects their mothers, themselves, and the mother-daughter relationship before and after diagnosis. The data obtained in the study was expected to provide practical information for professionals in the counseling, academic, and medical communities in improving the support and treatment of ADD girls, their mothers, and their families. The data was also intended to increase understanding at a theoretical level of how mothering contributes to the welfare of ADD girls.

An unexpected occurrence was observed during the two pilot study cases of the research. By coincidence, one of the pilot study mothers had been diagnosed with attention deficit disorder, while the other had not. The differences in their stories were remarkable. The third participant had also been diagnosed with ADD, her interview having many of the same traits as the previous ADD mother. When the study began, such an obvious divide was unexpected. There had been no intention to separate the participants by ADD mothers and non-ADD mothers; however, as the data accumulated, a striking difference continued to be found in their stories. Like patterns emerged in the thoughts and feelings of the three ADD mothers. Different but consistent patterns emerged with the four non-ADD moms as well.

Having daughters who were diagnosed with ADD while in high school, meant that all of these mothers interacted with their daughters for a long period of time without knowledge of the
cause of the behavioral differences observed in their child. Just as Lawler (2000) predicted, these women often doubted their ability as a mother, questioning their genetics, their parenting, and their overall capabilities. They felt personally responsible for raising a daughter who might not be capable of meeting society's expectations socially, academically, and professionally. In turn, their daughters were aware that they were not meeting parental or societal (including academic and peer) expectations. These girls were often overwhelmed from the effort to perform and demoralized by the inability to do so. Although the ADD moms related early on to their daughters and the difficulties they encountered, the turning point for all the mothers, especially the non-ADD mothers, was receiving the daughter's diagnosis of attention deficit disorder. Finding an answer for the daughter's symptoms and a reason for the struggles experienced by the mother and daughter helped the mothers to gain understanding. Understanding then led to the mother's increased empathy, which was key in finding alternatives to coping with the daughter's ADD.

The mother's perception or understanding of the disorder also had an impact on the mother's view of the future for herself and her daughter, and affected her ability to reassure and provide hope to her daughter. ADD mothers seemed to find the diagnosis as hopeful, providing their daughters more opportunities for the future. The non-ADD moms were relieved to have an explanation for their daughters' symptoms, but were concerned with what the diagnosis would mean for their daughters' success academically, professionally, and personally. Both groups of moms continued to experience feelings of guilt over showing their frustration and responding negatively to their daughters, especially before diagnosis.

Although diagnosis was instrumental in increasing the empathy of all the mothers toward their daughters, these parents still struggled with dealing with their daughter's ADD. Both before
and after diagnosis, most had little or no help from the girl's father or stepfather, few friends, or family members with whom they could share their concerns, and an incomplete knowledge of ADD and how to cope with it. Methods of coping were often by trial and error or by simply avoiding difficult situations.

ADD moms reported closer relationships with their daughters that involved more intimate mother-daughter talks and more frequent mother-daughter activities. The closeness was more ongoing, comfortable, or "natural," whereas the non-ADD mothers seemed to have a more difficult time finding a way to bond with their daughters. It seemed to take more of a conscious effort. Some of the non-ADD mothers reported difficulty in finding opportunities for mother-daughter activities because of the additional time it took their daughters to get ready, prepare for school, or perform chores. There was little time left for fun whether at home or elsewhere. There were also difficulties finding activities that appealed to the daughter or to both mother and daughter. If one liked the indoors, the other preferred nature. If one liked to shop, the other detested the mall. It seemed difficult for the two to find a middle ground.

The mother-daughter relationships varied in intimacy: some mothers had a close friendship with their daughters, while others seemed to have a more awkward or strained relationship. Regardless of the level of closeness, both groups of mothers were incredibly supportive of their daughters when it came to defending them to others, including family members, peers, and school personnel. The role of protective mother and caretaker was obvious in all. They found themselves changing their own behaviors in order to increase stability and harmony to the mother-daughter relationship. They covered for their daughters in an effort to alleviate their daughters' stress and keep their heads above water. The time, effort, and diligence these mothers took to help their daughters were significant. Most of the mothers had personal
issues of their own involving relationships, work, or attention deficit disorder in themselves or in their other children which exacerbated their situation. Dealing with their daughter's ADD was often a huge part of their life. Because of the all-consuming nature of ADD, mothers often found it difficult to establish equilibrium in life's activities. It was also often hard to find a balance in mother-daughter relationships. Moms struggled with being a mother vs. being a friend, giving independence while still providing support, disciplining vs. understanding or backing off.

All admired the intelligence of their daughters and their struggles to succeed. Most had questioned (especially before diagnosis) how a child could be so intelligent and have such noticeable academic and social issues at home and at school. This conundrum was a confounding factor in understanding their daughter's symptoms. Despite some intense mother-daughter conflicts throughout the years, all talked of the positive aspects of their daughters’ character such as a caring nature, sweet personality, perceptiveness, helpfulness, wisdom, sense of humor, and maturity beyond their years.

In analyzing the data, a concept map was made to clarify the differences between the ADD mothers and non-ADD moms before and after diagnosis. Diagrams can provide a visual of emerging categories and how they are related, giving a concrete image of ideas (Charmaz, 2006). This visualization is presented in Figure 5-1.

**Theoretical Implications**

Charmaz (2006) reminds us that analysis of data from a constructivist standpoint is contextually situated in culture, time, place, and situation. Constructivist researchers acknowledge that their personal values mix with the facts and result in what they see and don't see in the data. This study has been conducted following a constructivist approach to grounded theory and has searched for how and why the participants think and act as they do in specific situations. The results were interpreted, taking into account the culture, time, place, and
situations of both the participants and the researcher. These factors were considered in accounting for the pattern seen in the analysis of data and the categories that emerged.

The participants in the study were bound by expectations of what they should be as mothers. Their identity and the value they placed on themselves were closely tied to their mothering. Their expectations of who their daughters should be, affected their value as mothers and individuals. The key to self-acceptance, as well as daughter acceptance, seems to lie in the ability to override long-standing expectations and adjust to a new view of what is good enough. Although all of the mothers had consciously or subconsciously adjusted some of their expectations, guilt, disappointment, and a sense of sadness often remained.

Lawler (2000) claimed that a child is influenced by inherited family traits, the social world in which she lives, and the innate personality, influenced by nature and environment. As the birth mother, the mom feels responsible for her child's genetics although the mother's genes are not the only ones contributing to the child's makeup. As the primary caretaker, she feels that she must control how her child is socially produced, even though she cannot monitor human society, everything the child does, or everyone the child meets. As the mother, she feels that she is held responsible for her child's intrinsic character although she does not have full control over nature and the surroundings of the child. Lawler pointed out that society's version of the "Truth" insists that all individuals live up to the same high principles. Girls especially must be attractive, stylish, socially adept, outgoing, and popular. They must be organized, focused, talented, healthy, well educated, over-achieving, and successful. They are expected to meet developmental milestones within a prescribed period of time. As Lawler pointed out, society also holds mothers responsible for getting their children to conform to these expectations. How
can mothers be certain their child will achieve these lofty standards? How can mothers maintain self-confidence if their child is unable to be a stamped out version of the perfect citizen?

As mentioned in the literature review, a mother's self-esteem affects her daughter's self-confidence more than any other factor. Many women see themselves as having failed in achieving society's version of the Truth. They may not feel smart enough, pretty enough, or successful enough. They often start out "behind the eight ball" before motherhood is even in the picture. If a woman becomes a mother, she must not only reach society's standards herself, but raise her daughter to reach the goals as well. If a mother believes her value as a person depends on both her and her child mirroring society's version of the Truth, then the mother faces a difficult task in achieving and maintaining a positive self-concept and a positive attitude toward her daughter. Pursuing the Truth confines mother and daughter to a pre-packaged relationship that can only be a happy one if both live up to the ideals of others.

Mothers are known for taking care of everyone else before themselves, and ignoring their own well-being. As Lawler (2000) stated, mothers and daughters constantly scrutinize themselves and each other. When mothers are not taking care of themselves physically and emotionally, they may see themselves as failures. As the daughters observe their mothers, they will see their moms as unable to control their own lives and have little faith that their mothers can support them in managing theirs. Being confident and in control of their own lives, gives mothers a stable starting point from which to parent their daughters.

As a mother becomes more self-assured and is able to find personal happiness, she will be more willing and capable of rejecting society's definition of Truth. The mother will be able to set her own definition of what constitutes a "good enough mother" and a "healthy self" in her child. Readjusting expectations for herself and her daughter releases them from the pre-
packaged notion of the perfect mother-daughter relationship. According to the mothers in this study, understanding, availability, empathy, patience, and healthy accommodating are what can build a loving mother-daughter relationship. Readjusting expectations for any daughter, especially an ADD child, can be a great gift to the child. It can also be a great relief to the mother and a source of personal satisfaction to reach this level of empathy and understanding. A great deal of stress is removed from everyday life when a mother comes to the realization that it is okay if her child makes average grades, has unique quirks, procrastinates, forgets, misses social cues, and never cleans her room. Less stress from the mother means less stress on the daughter, and less stress on the mother-daughter relationship. When a mother can acknowledge that she has a "healthy self" and appreciate that she is a "good enough mother" (both defined by her own standards), she can develop a positive image of herself, knowing she is capable as a woman, wife, mother, friend, and professional. Self-satisfaction, or more descriptively, personal peace can play a critical role in envisioning a positive future. Mothers in this study reported that their daughters enjoyed listening to positive stories about the mother's work, studies, and interests. It seemed that the daughters had a need to see that their mothers were happy, successful, talented, or involved in special personal activities. It appeared that these stories gave the daughters a sense of reassurance, offering them hope for themselves and allowing them to envision a positive future for their own lives. The stories may also have provided unique mother-daughter moments that were otherwise difficult to find.

How do counselors and medical personnel help mothers of ADD daughters? An axiom in the counseling profession is that the mother is also the patient. This is never more true than when dealing with the mother of an ADD daughter. Counseling the mother of an ADD daughter
is equally as important as treating her child, because the mother's well-being can be the foundation for a strong mother-daughter relationship.

Formulation of Theory

The questions in this study were designed to examine the emotions, attitudes, and perceptions of mothers before and after their daughter's ADD diagnosis and the effect each had on the mother-daughter relationship. From the data received, it was theorized that mothers' expectations of themselves and their daughters play a major role in the well-being of both mother and daughter, and their relationship together. The objective then, in formulating a constructivist theory, was to consider how mothers could achieve an independence capable of overriding society's expectations of them as females and mothers. This is an issue for all mothers, but an especially critical one for mothers of ADD daughters. The goal in creating a theory was to (a) examine the perceptual and reactional processes of mothers dealing with late diagnosed ADD daughters, (b) assist these mothers in readjusting their expectations for themselves and their daughters, and (c) facilitate perceptual and lifestyle changes in order to effectively cope with daily parenting and trying life events, resulting in a healthier mother-daughter relationship.

From the data collected, a sequence of events was seen among the mothers of the study as shown by the concept map in Figure 5-1. This concept map was then formulated into a theoretical model, depicted in Figure 5-2, showing both the disparate and congruent factors between the ADD and non-ADD mothers. This model shows the evolution of the mothers' thoughts and observations as they detect problem cues, seek an explanation, react to the clinical findings, and adapt to their new situation as mothers with ADD daughters.

From this model, an additional theory was formulated for counseling both ADD and non-ADD mothers to a healthy mother-daughter relationship. This model is shown in Figure 5-3.
Both models in Figure 5-2 and 5-3 utilize the memos, concept map, properties, subcategories, and categories from the data in the study, as well as information from the review of the literature. The counseling theory in Figure 5-3 is based upon Lawler's (2000) position regarding society's version of the unquestionable Truth of what constitutes a good and healthy self and a good enough mother. In studying the phenomenon of the mother-ADD daughter relationship, a sequential progression of events was found necessary for improving the well-being of the mother, the daughter, and their relationship together. Although grounded theory models are rarely one-dimensional and linear in nature, the data revealed a chronological process when counseling for positive change in the well-being of mothers with daughters of ADD. Mothers stressed from raising an ADD daughter may find it difficult to find satisfaction in who they are. Improving the relationship and self-concept of mothers and their ADD daughters is a progression, and can rarely be improved with a quick fix mentality. The model in Figure 5-3 shows the process of building a healthy mother-daughter relationship using sequential events. It attempts to address Choate's (2008) finding that many female clients cannot answer the question, "Who am I really, apart from what others want from me?" The process begins with the well-being of the mother: understanding society's version of the Truth, formulating her own version, and finding balance in life activities. The process continues with the mother obtaining a complete knowledge of ADD and finding empathy through increased understanding. The mother can then reformulate expectations of the daughter and their relationship, appreciating the daughter for who she is and recognizing her positive attributes. Next, the mother learns daily coping skills, including gaining the support and involvement of the father (or father figure) when possible and other family members who can provide both emotional and physical support. Lastly, the mother creates a positive view of her own future and that of her daughter's, and
communicates this to her daughter through personal stories and encouragement for the daughter's upcoming opportunities.

Although the theory depicted in Figure 5-3 is intended to show the steps necessary in building a healthy mother-ADD daughter relationship, the same sequence, with the exception of becoming knowledgeable in the issues of ADD in Step 3, can apply to all mother-daughter relationships. It emphasizes a strong self-concept in the mother and reciprocal communication between mother and daughter, both known to have a significant impact on mother-daughter relationships.

**Potential Applications**

Data from this study confirms the difficulties mothers experience in raising an ADD daughter. It highlights the importance of early detection of attention deficit disorder, as mothers and ADD daughters often build a negative history of conflict. The earlier a child can be diagnosed, the earlier she can be understood and supported by her mother, family, teachers, and counselors. Mothers can learn of the symptoms and effective methods of coping before her own self-esteem is battered, as well as that of her daughter. As a result, a healthy and more intimate mother-daughter relationship can begin.

In order for this to occur, there must be a significant change in the current approach to dealing with ADD. College and graduate school programs must modify curriculum so that their graduates can better meet the needs of today's students. Beginning administrators, teachers, social workers, and counselors must be educated in the symptoms of developmental disorders such as ADD. Developmental disorders affect all ethnic, racial, and social groups, and are increasing in incidence. Many of the mothers in the study were surprised and disappointed that their daughters' teachers and counselors had never mentioned the possibility of attention deficit disorder. With a basic knowledge of the symptoms of developmental deficiencies, educators can
refer parents to professionals who can test struggling children early in their academic careers, preventing years of frustration and disappointment for parents and children alike. Middle and high school instructors and counselors must be aware of the potential of late developing ADD in females, often presenting at the start of puberty or during adolescence. All educators must be trained to recognize not only the stereotypical hyperactive behavior associated with ADD, but also the inattentive behavior that is equally as critical.

Educational Leadership, Social Work, Counselor Education, Teacher Education, and Special Education departments should all be held responsible for training their graduates to recognize the symptoms of this disorder. School districts need to provide continuing ADD education, keeping their personnel informed of medical updates and improved educational and counseling practices regarding the disorder. With increased recognition and understanding of ADD, patience and empathy for these students and their families will follow. Learning simple coping skills for helping ADD students academically and socially could make a huge difference in the emotional well-being and academic success rate of these children.

Medical personnel must also be better informed of the symptoms of ADD and of female ADD specifically. Some of the mothers in the study were dismayed by the rude treatment they had received from pharmacists when filling a prescription. Others reported physicians who insisted that ADD did not exist. Misdiagnosis and lack of diagnosis are far too common, and cause irreparable damage to females of all ages. Medical personnel must take the time to listen to patients and their parents. They must take the time to talk with them as well, explaining the causes and symptoms of the disorder. It is important for both mother and daughter to understand why the daughter acts as she does, why she is chronically late, acts impulsively, lacks focus, procrastinates, forgets, has mood swings, can't sleep, or can't wake up. Having an explanation
for these idiosyncrasies will decrease parental criticism of the daughter, as well as self-criticism by both the mother and daughter. Understanding the effects that ADD behaviors can have on the daughter's emotional and physical health, her academics, peer relationships, home life, and future can help the family in finding effective methods of supporting her. Several mothers, for example, mentioned the importance of having a sense of humor about ADD. Getting to a point where both mother and daughter (and other family members) can see the humor in ADD life, helps to remove the stigma, lighten the mood, and remove the embarrassment and stress of ADD occurrences.

Many of the participating mothers lacked information about the treatments available. Some were unaware that their child was not on an ADD medication, but rather a medication aimed at other symptoms or disorders. Others were unaware that it was often necessary to try different dosages and different medications before finding the one that worked best. Some expected a cure from the treatment their daughter was receiving. Many did not know the importance of using ADD medication in conjunction with behavioral counseling (MTA Cooperative Group, 1999), and the implications of untreated ADD. Those providing counseling, whether psychiatric, family, or mental health counselors need to provide their clients with the knowledge and skills to deal effectively with ADD. This includes dealing with parenting and disciplining issues, organizational and academic problems, and social skills awareness and training. The counseling provided must be ongoing and consistent, and address the needs of parents, families, and the ADD client. Psycho-educational groups, conducted by counselors or medical staff would be of great help to those dealing with the disorder. Unfortunately, the cost of counseling and medication is prohibitive for many families. In order to provide an alternative source of assistance, more on and off-campus support groups for ADD children are needed, as
well as support groups for ADD adults (especially ADD parents), and parents of ADD children. Providing the names of support groups, websites, journals, and books should be an essential part of the counseling process. With an earlier and more complete understanding of ADD, mothers will feel more informed, more empowered, and more positive about the role they can play in their daughters' lives. Learning positive ways of adjusting responses and parenting styles, effectively assisting with academics, balancing support and discipline, as well as mothering and friendship, will create a healthier relationship for mother and daughter.

As the facts about ADD become more widespread, there will be fewer stigmas associated with the disorder, and allow mothers and ADD daughters to share their experiences with others. Doing so will increase the support the two receive from friends, family, and professionals, and decrease the need for mothers to carry the burden alone. Fathers and/or stepfathers, especially, can play an important role in lessening this burden. Dads or stepdads who are available to discuss personal and parenting issues serve as a tremendous comfort and resource for mothers who typically serve as the main caretaker of the home and children. Dads or stepdads who share the responsibilities of schoolwork, teacher conferences, doctor appointments, and day-to-day activities send an unspoken message to their ADD daughters or stepdaughters that they matter. Knowing also that the father acknowledges and understands the ADD diagnosis, supports the daughter in seeking effective treatment, and appreciates her for who she is, are all crucial in the daughter's self acceptance. A father's interaction can have a significant impact on the self-concept and success of an ADD daughter. Research has shown the importance of a positive father figure in a girl's success (Burns, 2008; Kieffer, 2008; Lichtenberg, 2008).

A factor that contributed to many of the mothers feeling overwhelmed was that in addition to dealing with their daughter's ADD, they were also dealing with their own personal issues,
whether emotional, professional, or relational. Mothers should be encouraged to receive help in dealing with their own issues so that they are not overwhelmed by dealing with the issues of others. Reaching personal wellness can contribute to a positive outlook for the future for themselves and their daughters.

**Implications for Future Research**

1. The results of this study came from the perspective of mothers of ADD daughters. It would be interesting and beneficial (not to mention ideal) to interview the daughters to compare their perspectives on themselves, their mothers, attention deficit disorder, and the mother-daughter relationship. If the daughters of the participants in the study could not be interviewed, interviewing other ADD girls diagnosed in high school would be a helpful alternative.

2. The disparity in answers between ADD mothers and non-ADD mothers was unexpected, and warrants further research into the special needs of mothers with and without attention deficit disorder. Both appear to have different but significant needs. These factors could be studied through individual interviews or focus group discussions.

3. According to the results of the study, most of the fathers played a minimal support role in helping the mothers and daughters deal with the effects of ADD. Research into the thoughts and attitudes of fathers and father figures could determine methods of increasing their understanding and involvement.

4. All of the participants in this study were Caucasian women from one southern community. Interviewing mothers and daughters from multi-cultural backgrounds and from different areas of the country would be helpful in gaining a more complete perspective.

5. The model in Figure 5-3 was created from the information gathered in this study. The efficacy of this model should be examined to determine if adjustments are needed in order to make the counseling process more beneficial for mothers of ADD daughters.
Figure 5-1. Concept map of participating mothers' perceptions.
Figure 5-2. Perceptual/reactional process of mothers of late diagnosed daughters with attention deficit disorder.
1. Understanding society's expectations of females, mothers, and daughters.

2. Finding own wellness/happiness; balancing work, love, play (self care). Formulating own expectations for self.

3. Understanding ADD symptoms, effects, treatments.

4. Increasing empathy, patience, communication with daughter.

5. Formulating own expectations of daughter & relationship. Valuing uniqueness vs. standardization, appreciating daughter's positives.


7. Creating positive vision of daughter's future – readjusting expectations, finding creative possibilities & alternatives, sharing own experiences, hope, personal happiness.

Figure 5-3. Building blocks for developing healthy relationship between mother and daughter with attention deficit disorder.
APPENDIX A

DEMOGRAPHICS FORMS AND QUESTIONNAIRE

Questionnaire for Mother
Participant #: ___________

1. Who asked for your daughter to be evaluated initially?
   You     Her Dad  Teacher  School Counselor  Family Physician  Other: ______________________

2. What led to your daughter's ADD diagnosis? (Why was she evaluated initially?)
   __________________________________________________________________________
   __________________________________________________________________________

3. If someone other than yourself requested your daughter's evaluation, please answer a-e:
   If someone other than yourself requested your daughter's evaluation:
   a) Had you noticed anything about your daughter that concerned you prior to that request?
      Yes    No

   b) If yes, what was your concern? ____________________________________________
      _______________________________________________________________________
      _______________________________________________________________________

   c) When did you first notice a problem? _______________________________________
      _______________________________________________________________________

   d) If you had not noticed any problems, what did you think about the request to have her
      evaluated? __________________________________________________________________
      _______________________________________________________________________

   e) How did you feel about the request for evaluation? ______________________________________________________________________
      _______________________________________________________________________

4. Looking back on her younger years, what behaviors do you now recognize that may have
   been related to ADD (if different than #2 answer)? ________________________________
   __________________________________________________________________________
   __________________________________________________________________________

5. What was your reaction when you received the ADD diagnosis on your daughter and how did
   it make you feel? ____________________________________________________________________
   __________________________________________________________________________
6. How was your daughter told about her diagnosis?

____________________________________________________________________________

b) What was her reaction to the diagnosis?

____________________________________________________________________________

7. Outside of your immediate family, with whom do you talk about your daughter's diagnosis?
   ___ No one
   ___ Other family members
   ___ Close friends
   ___ Others with the ADD
   ___ Anyone

8. Do you feel that you are knowledgeable about your daughter's ADD?  Yes    No

9. Do you feel that you have adequate input into your daughter's ADD treatment?  Yes    No

10. Do you feel that you are "in control" of your daughter's ADD treatment:

    a) in regard to medication?  Yes    No

    b) in regard to counseling?  Yes    No
Demographics Form for Mother
Participant #: __________

1) Name ___________________________ Home Phone __________________________

2) Street Address __________________________________________________________
   City ___________________________ State _____ Zip _________________________

3) Cell ___________________________ E-mail Address __________________________

4) Race: African American/Asian/Caucasian/Hispanic/Other (Please specify) ________

5) Single _____ Married _____ Divorced_____ 

6) Age __________________________

ADD History

7) Have you been diagnosed with ADD?  Yes     No
   b) At what age were you diagnosed? ______
   c) Who diagnosed your ADD? __________________________
   d) Please list any medications you take to manage your ADD:
      ___________________________________________________________________
   e) Have you received counseling for your ADD?  Yes     No

8) Are there any other family members diagnosed with ADD? If so, please list their relationship
to you and their age: (Example: son, 9 yrs; brother, 45)
   __________________________________________________________________________

Counseling History

9) Have you received counseling to help with your concerns with your daughter's ADD?
   Yes     No

_________________________________________________________________________
Demographics Form Regarding Daughter
(To be completed by mother)

Participant #: ___________    Mother: ________________________

1) Daughter’s Age _________   Current Grade___________

2) Please list your children in birth order by age: (Ex: boy, 15; girl, 13; girl, 8) ____________
_____________________________________________________________________________
_____________________________________________________________________________

ADD History
3) At what age was your daughter diagnosed with ADD? _______________

4) In what grade was she when she received her ADD diagnosis? 9 10 11 12

5) With what type of ADD was your daughter diagnosed?
   _____ Inattentive _____ Hyperactive _____ Combined _____ Don't Know

6) Please list any medications she takes to manage ADD__________________________

7) Has your daughter ever received counseling for ADD? Yes No

8) Outside of your immediate family, with whom does your daughter talk about her diagnosis?
   ___ No one
   ___ Anyone
   ___ Other family members
   ___ Close friends
   ___ Others with the ADD
   ___ Don't know

Co-existing Disorders
9) Has your daughter been diagnosed with any other (co-existing) disorders? Yes No

b) If yes, please specify_________________________________________________________

c) Please list medication taken for management of the above disorder(s):____________________
_____________________________________________________________________________
Informed Consent

Protocol Title: Exploration of Effect of Diagnosis of High School Girls with Attention Deficit Disorder on Their Mothers and the Mother-Daughter Relationship

Please read this entire document carefully before you decide to participate in this study.

PURPOSE of the research study: The purpose of this study is to examine how a diagnosis of ADD in high school affects mothers of girls with attention deficit disorder and the mother-daughter relationship. Results will be used for educational purposes.

WHAT YOU WILL BE ASKED TO DO: You will be asked to complete brief demographic sheets and a questionnaire, which should take approximately 15 to 20 minutes total, and bring them to the first interview. You will be asked to participate in an initial interview, which will last about 1 hour. You will then be asked to participate in a second interview, again about 1 hour in length, to further discuss questions or reactions to the initial interview. Both interviews will be conducted by the principal investigator listed below, and audio and videotaped to insure accuracy in transferring interview information to text.

TIME REQUIRED: The demographic forms and questionnaire will take approximately 15 to 20 minutes to complete. The two interviews will be approximately 1 hour each. First and second interviews will be conducted within approximately 1 month of each other.

LOCATION: Interviews will take place at Sarkis Family Psychiatry, 529 NW 60th Street, Gainesville, FL, or a location convenient to the participant.

RISKS AND BENEFITS: There are no risks anticipated from participating in this study. As a possible benefit, you may develop insights into emotions and reactions related to attention deficit disorder that might help further strengthen the mother-daughter relationship. If you feel that you would like to work with a counselor or other professional as a result of the study, the researcher will assist in finding an appropriate referral.

COMPENSATION: Each participant will receive $10 in cash following completion of the first interview and $20 in cash following the second interview.

CONFIDENTIALITY: Your identity will be kept confidential to the extent provided by law. Your interviews and questionnaire will be identified by number only. Videos will be seen only by the researcher. Audio tapes may be transcribed (recorded) by a hired typist, but will be identified by number only. Audio and video tapes will be kept in a locked compartment and destroyed after transcription is complete and the report is finalized.

VOLUNTARY PARTICIPATION: Your participation in this study is completely voluntary. You do not have to answer any question you do not wish to answer. There is no penalty for not participating.
RIGHT TO WITHDRAW: You have the right to withdraw from the study at any time without consequence.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY:
Principal Investigator: Mary Ann Williams, Ed.S.
Doctoral Candidate in Counselor Education, University of Florida
(352) 317-4350
mawcw@hotmail.com

Supervisor: Peter Sherrard, Ed.D.
Associate Professor and Doctoral Committee Chairman
1215 Norman Hall
University of Florida
Gainesville, FL 32611
(352) 392-0731
psherrard@coe.ufl.edu

Agreement:
I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.
Participant: ___________________________ Date: ________________
Principal Investigator: ___________________________ Date: ________________

Notification:
I would like to receive notification of the location (electronic computer address) of the final manuscript of this study.
Participant: ___________________________ Date ________________

For questions about your rights as a research participant, contact the Institutional Review Board at 352-392-0433.
APPENDIX C
INTERVIEW QUESTIONS

Date ___________  Participant # __________
Begin Time_______ End Time_______ Folder____  File # _____

Interview Questions for Mother

Today we are going to be looking at how ADD impacts you and your daughter. We will also be exploring how things with your daughter may or may not have changed since her ADD diagnosis.

**Expectations**
1. I would like for you to think about things that you expected of your daughter at home and as part of the family and tell me if any of those expectations have changed since the diagnosis of ADD. (Behavior with siblings, expressing affection, eating and sleeping habits, chores, activity level, etc.)

2. What about school or academic expectations? (Social behaviors, study habits, grades, etc.)

3. And what about socially? (Relationships with peers, teachers, other adults)

4. Before diagnosis, can you think of ways you "went to bat" for your daughter? (At school, with a physician, peers, other adults, or family) If so, how did you feel about doing this?)

What about after the diagnosis? Were your feelings different at that point?

5. Since the diagnosis, how have your expectations changed with other family members like your spouse or your other children in regard to their behavior with your daughter?

**Conflict**
6. Tell me about your daughter's behaviors that caused you the most frustration before diagnosis. And now?

7. What about the behaviors that worried you? Has this changed since the diagnosis?

8. What were the behaviors that caused the most conflict between the two of you? And now?

9. Think about your relationship with your daughter before you knew she had ADD. How would you rate the quality of that relationship before diagnosis? Let's use a scale of 1-5, with 1 being conflicted and 5 being excellent. (See visual analogue scale.)

And what about now - how would you rate the quality of your relationship on a scale of 1 to 5?

*If ratings are different:

10. Why do you think the relationship has changed since diagnosis?
11. What would improve the relationship and raise that number from a ____ to a _____?

12. Besides your daughter, whom do you think is most affected by your daughter's ADD? Why? (Was it the same before meds?)

13. What do you like most about your daughter? Why?

14. What do you like least? Why?

15. What do you think your daughter likes most about you? Why?

16. What do you think she likes least? Why?

**Conflict Resolution**

17. How did you and your daughter deal with conflict before diagnosis? (Avoidance, arguing, yelling, punishment, etc.)

18. What about after diagnosis?

19. Were there activities that you avoided doing together before diagnosis? If so, what and why? What about now?

20. What mother/daughter activities do you enjoy doing together the most? How has this changed since diagnosis?

**Aspirations**

21. How have your ambitions or goals for your daughter changed since her diagnosis?

22. On a scale of 1-5, with 1 being unsympathetic and 5 being supportive, how would you rate your parenting with your daughter before her diagnosis? (See visual analogue scale.) And now?

*If number is different:*

23. Why do you think that number has changed? (Diagnosis alone, education about ADD, daughter's medication, counseling, etc.)

24. You rated your current parenting skills with your daughter as a _____. What would raise that to a ____?

25. How do you think things would have been different with you and your daughter if she would have been diagnosed earlier? What about with family, academics, and peers?
Follow up Questions from Pre-Interview Questionnaires & Demographics

Mother's counseling:
_____ You indicated on your Demographics Form that you had received counseling about your daughter's ADD.

1. Did you begin counseling before or after your daughter's diagnosis?
2. How long before or after the diagnosis did your counseling begin?
3. Was counseling offered by your daughter's diagnosing physician?
4. Who provided the counseling you received?
5. How often did you attend counseling?
6. How long did you attend counseling?
7. Did you go alone, with your daughter or other family members?
8. What types of things did you cover in counseling?
9. Did you find counseling helpful?
   • If yes, how?  If no, why not?
10. How did counseling improve your relationship with your daughter?

_____ You indicated on your Demographics Form that you had not received counseling about your daughter's ADD symptoms.

11. Have you been offered counseling regarding your daughter's ADD or has it been recommended?
   a) If yes, by whom?
   b) What was your reason for not participating?

12. Do you wish now that you had received counseling?  Why?

13. If you were to receive counseling about your daughter's ADD, what types of issues would you want to cover?

14. With whom (if anyone) would you want to attend counseling?
Daughter's Counseling

____ You indicated on the demographics form for your daughter that she had received counseling about her ADD.

15. Who provided her counseling?

16. How often does/did she go?

17. How long has she gone/did she go to counseling?

18. Has the counseling been helpful?
   If yes, how?  If no, why not?

Disclosure about Diagnosis

____ You mentioned on your questionnaire that you were not very open about your daughter's ADD diagnosis.

19. Why are you hesitant to share this information?

____ You mentioned on your questionnaire that you feel comfortable discussing your daughter's ADD diagnosis with _________________?

20. Why do you think you are comfortable discussing her ADD?

Knowledge of ADD

____ You indicated on the questionnaire that you feel knowledgeable about your daughter's ADD.

21. How did you become knowledgeable about ADD?

____ You indicated on the questionnaire that you do not feel knowledgeable about your daughter's ADD.

22. What would you like to know more about, regarding her ADD?
23. Do you think you have been a help or a hindrance to your daughter?
24. Do you think your own ADD has had an effect on your daughter?
25. What have you given up because of your daughter's ADD?
26. What have you learned about yourself because of your daughter's ADD?
APPENDIX D
VISUAL ANALOGUE SCALES

Participant # ______

MOTHER-DAUGHTER RELATIONSHIP RATING (Scale #1)

How would you rate your relationship with your daughter **before** her ADD diagnosis?

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<th>4</th>
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<td>Poor</td>
<td>Average</td>
<td>Good</td>
<td>Excellent</td>
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<tr>
<td>2</td>
<td>Fighting</td>
<td>Strained</td>
<td>Good &amp; bad</td>
<td>Mostly good</td>
<td>Happy</td>
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<td>3</td>
<td>most of the time</td>
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How would you rate your relationship with your daughter **after** her ADD diagnosis?

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PARENTING RATING SCALE (Scale #2)

How would you rate your parenting of your daughter before her ADD diagnosis?

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<td>Helpful</td>
<td></td>
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<tr>
<td>Insensitive</td>
<td>Encouraging</td>
<td></td>
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<tr>
<td>Unkind</td>
<td>Accommodating</td>
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How would you rate your parenting of your daughter after her ADD diagnosis?

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Volunteer Moms Needed for
ADD STUDY

Must be the mother of an ADD daughter diagnosed during high school and within the last eight years

Daughter must have been diagnosed at Sarkis Family Psychiatry

Each participant will be interviewed separately in 2 one hour interviews about ADD

Participants receive $10 in cash following the first interview, & $20 in cash following the second interview

All information completely confidential

To participate, call Mary Ann Williams at 352-317-4350 or mawcw@hotmail.com
### APPENDIX F

#### PARTICIPANT DEMOGRAPHICS

<table>
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<tbody>
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<td>North Central Florida</td>
</tr>
</tbody>
</table>

**Marital Status:**
- Married to daughter's father: 3
- Married, but not to daughter's father: 2
- Divorced: 3

**ADD History:**
- Diagnosed with ADD: 3
- On medication for ADD: 3
- Ages at time of diagnosis: 35, 50, 51

**Level of Education:**
- High School diploma: 1
- Community college degree: 2
- Four-year degree: 1
- Advanced degree: 4

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### DAUGHTERS' DEMOGRAPHICS

**Birth Order:**
- Only child: 4
- Oldest: 2
- Middle: 0
- Youngest: 2

**ADD History:**
- Age of diagnosis:
  - 14: 2
  - 15: 3
  - 17: 2
  - 18: 1

- Type of ADD:
  - Inattentive: 3
  - Hyperactive: 1
  - Combined: 1
  - Don't know: 4

- On ADD medication: 4
- Diagnosed with co-existing disorder: 1
LIST OF REFERENCES


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BIOGRAPHICAL SKETCH

Mary Ann Williams was born in Shreveport, Louisiana and attended her first two years of college in San Bernardino, California. She graduated with a degree in elementary education in 1973 from Centenary College in Louisiana, and taught as a second grade teacher. She then moved to Miami, Florida where she worked in the Veterans Administration Hospital as a neuropsychology technician. Her interest in testing led her to graduate school at the University of Florida where she eventually changed direction from school psychology to student personnel in higher education. She received her Master of Education and Specialist in Education degrees from the Department of Counselor Education in 1978. After working in a local hospital, where a graduate internship turned into a permanent position, she became a full-time mother to her two young daughters. She worked as a civic, church, and school volunteer until she returned to graduate school in 2005. She received her Doctor of Philosophy in mental health counseling from the University of Florida's Department of Counselor Education in December of 2009.