Counseling College Students with Attention-Deficit/Hyperactivity Disorder (ADHD): A Consensual Qualitative Research (CQR) Study Examining the Experiences of College Counselors

A dissertation presented to
the faculty of
The Patton College of Education of Ohio University

In partial fulfillment
of the requirements for the degree
Doctor of Philosophy

Sanda Gibson
August 2017
© 2017 Sanda Gibson. All Rights Reserved.
This dissertation titled Counseling College Students with Attention-Deficit/Hyperactivity Disorder (ADHD): A Consensual Qualitative Research (CQR) Study Examining the Experiences of College Counselors

by

SANDA GIBSON

has been approved for

the Department of Counseling and Higher Education

and The Patton College of Education by

Yegan Pillay

Associate Professor of Counseling and Higher Education

Renée A. Middleton

Dean, The Patton College of Education
Abstract

GIBSON, SANDA, Ph.D., August 2017, Counselor Education

Counseling College Students with Attention-Deficit/Hyperactivity Disorder (ADHD): A Consensual Qualitative Research (CQR) Study Examining the Experiences of College Counselors

Director of Dissertation: Yegan Pillay

Despite growing recognition of Attention-Deficit/Hyperactivity Disorder (ADHD) as a common and highly impairing disorder that spans the lifespan from childhood to adulthood, there is a lack of research about the experience of adults, and even less is known about college students. Many remain unidentified and untreated. Increasing numbers of students with unnoticed disabilities such as ADHD are attending college (Weyandt, 2006). Students with disabilities are protected and entitled to educational support services because of legislation such as the Americans with Disabilities Act (ADA) and the American Rehabilitation Act. But the actual number of students with ADHD symptoms is uncertain because students are not required to report their disability at their respective colleges and others have not been diagnosed (Weyandt & DuPaul, 2013). Approximately 2 to 8% of college students report ADHD symptoms that are clinically significant (DuPaul, Weyandt, O’Dell, & Varejao, 2009). Few empirical studies have examined the outcomes of interventions on the symptoms that cause functional impairments for college students with ADHD (Weyandt & DuPaul, 2013). It is unclear to what degree ADHD college students are impaired and it is also unclear what interventions work. Students with ADHD may be underachieving or failing in college,
resulting in negative long-term consequences for several stakeholders. Many of these students, both diagnosed and undiagnosed, will access help from college counseling centers. The purpose of this qualitative study was to examine the experience of college counselors at Midwestern universities to understand their experience in working with students with ADHD. This author is unaware of any published studies on this topic. By examining the experiences of these counselors, this preliminary study investigated strengths and gaps in treatment practices so that detection, support, and treatment of college students with ADHD may be improved.

Keywords: college students with ADHD, disabilities in college, college counseling
Dedication

To Bill: Thank you for thousands of small kindnesses and boatloads of patience that
made this adventure possible for me.

Grow old with me! The best is yet to be. –Robert Browning
Acknowledgments

My mother, Joyce Dorland, taught me to cherish education and dedicated herself to making opportunities possible for me. My father, Arthur Dorland, tantalized me into reading at age eight by giving me 25 cents for every book I could read and listened patiently while I gave oral reports on each one of those books. While he never saw me make this leap into graduate school, I have always felt the spirit of his encouragement every step of the way. I am grateful for the love and support from my siblings, Euniece, who is the most thoughtful person I know, and Ron, whose spiritual strength guides us all.

My best friend, Karen Johnson Murray, constantly told me that I would love graduate school and it was never too late to start. My new friend and colleague, Sheila Williams, helped to truly empathize with what it feels like to have an ADHD brain. My advisor, Yegan Pillay, was a steady support who guided me with great intelligence, warmth, encouragement, patience, and helpful feedback. Mentors, professors, colleagues, and friends at both Ashland University and Ohio University, where I earned my graduate degrees, are remembered and appreciated.

Abundant gratitude to Bill Gibson, my husband, who never wavered in his unfailing love and belief in my ability to complete this goal. I am certain I could not have done this without him. I appreciate the support of all our children and extended family as well. Many friends were cheerleaders for me. I am indeed a blessed person.

Finally, to all the students, friends, and family I know who struggle with ADHD. My hope is that they will get the help they need, know and build upon their strengths, and live abundant, productive, and satisfying lives.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>3</td>
</tr>
<tr>
<td>Dedication</td>
<td>5</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>6</td>
</tr>
<tr>
<td>List of Tables</td>
<td>10</td>
</tr>
<tr>
<td>List of Figures</td>
<td>11</td>
</tr>
<tr>
<td>Chapter 1: ADHD in College</td>
<td>12</td>
</tr>
<tr>
<td>Introduction</td>
<td>12</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>16</td>
</tr>
<tr>
<td>Purpose Statement</td>
<td>19</td>
</tr>
<tr>
<td>Research Question</td>
<td>19</td>
</tr>
<tr>
<td>Importance of this Research</td>
<td>20</td>
</tr>
<tr>
<td>Statement of Terms</td>
<td>22</td>
</tr>
<tr>
<td>Summary</td>
<td>26</td>
</tr>
<tr>
<td>Chapter Two: Literature Review</td>
<td>27</td>
</tr>
<tr>
<td>Introduction</td>
<td>27</td>
</tr>
<tr>
<td>History of the Problem</td>
<td>27</td>
</tr>
<tr>
<td>Background on ADHD: The Hidden or Invisible Disability</td>
<td>36</td>
</tr>
<tr>
<td>Neuroscience of ADHD</td>
<td>41</td>
</tr>
<tr>
<td>Messy Models of ADHD</td>
<td>45</td>
</tr>
<tr>
<td>The Impact of Comorbidity</td>
<td>53</td>
</tr>
<tr>
<td>Adult Symptoms of ADHD</td>
<td>57</td>
</tr>
<tr>
<td>College Student Symptoms with ADHD</td>
<td>60</td>
</tr>
<tr>
<td>Developmental Complexity, Gender Differences, and Giftedness</td>
<td>67</td>
</tr>
<tr>
<td>Intervention and Treatment Strategies for Adults and College Students</td>
<td>73</td>
</tr>
<tr>
<td>Importance of the Study: Many Stakeholders</td>
<td>86</td>
</tr>
<tr>
<td>Chapter Three: Methodology</td>
<td>91</td>
</tr>
<tr>
<td>Introduction</td>
<td>91</td>
</tr>
<tr>
<td>Qualitative Methodology</td>
<td>94</td>
</tr>
<tr>
<td>Researcher as participant</td>
<td>98</td>
</tr>
<tr>
<td>Theory: Constructivism</td>
<td>98</td>
</tr>
<tr>
<td>Consensual Qualitative Research (CQR)</td>
<td>100</td>
</tr>
</tbody>
</table>
Initial steps. ......................................................................................................... 102
Researchers’ biases. ............................................................................................ 102
Participants........................................................................................................ 105
Procedures for collecting data........................................................................... 107
Piloting............................................................................................................... 108
Interviews, interview process, and transcription............................................. 108
Procedures for analyzing data.......................................................................... 111
CQR analysis..................................................................................................... 111
Trustworthiness................................................................................................. 114
Integrity of the data............................................................................................ 114
Reflexivity and subjectivity ............................................................................... 115
Clear communication of findings..................................................................... 115
Timeline ............................................................................................................ 116
Self as Researcher: Assumptions and Biases .................................................... 116
Chapter 4: Results ............................................................................................ 123
Presentation of the Data .................................................................................. 123
Domains, Core Ideas, Cross-Analysis .............................................................. 125
General Findings............................................................................................... 130
Domain One. .................................................................................................... 130
Domain Two. .................................................................................................... 132
Domain Three.................................................................................................. 133
Domain Four .................................................................................................... 134
Domain Five ..................................................................................................... 137
Domain Six ....................................................................................................... 138
Domain Seven .................................................................................................. 140
Domain Eight ................................................................................................... 144
Domain Nine .................................................................................................... 145
Domain Ten ...................................................................................................... 148
Prototypical Case ............................................................................................. 150
Chapter 5: Discussion ...................................................................................... 154
Summary ........................................................................................................... 154
Limitations and Delimitations ......................................................................... 167
Recommendations............................................................................................. 169
List of Tables

Table 1  Comparison of Clinical Presentation of ADHD Symptoms in Children and Adults ................................................................................................................................ 58
Table 2  Assigned Names and Brief Descriptions of Participants ............................................ 123
Table 3  Domains .................................................................................................................... 125
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1. Demographic Questionnaire for Participants.</td>
<td>.................................................</td>
<td>190</td>
</tr>
<tr>
<td>Figure 2. Recruitment Flyer.</td>
<td>..........................................................................................</td>
<td>191</td>
</tr>
<tr>
<td>Figure 3. Cross-Analysis of Core Ideas</td>
<td>..........................................................................................</td>
<td>192</td>
</tr>
</tbody>
</table>
Chapter 1: ADHD in College

Introduction

It is important to recognize that Attention-Deficit/Hyperactivity Disorder (ADHD) is perceived as a disorder that is both under-diagnosed and over-diagnosed (Nigg, 2006). Many adolescents who come to college are intellectually competent and have managed to compensate or mask their impairments. Others have been too readily diagnosed, by family physicians for example, and may not meet the diagnostic criteria if fully tested. There is some public perception that ADHD does not exist or is a contrived diagnosis without validity (Consensus Statement on ADHD, 2002). In addition, the alarming rise in the abuse of stimulant medications among college students creates controversy about the authenticity of the diagnosis and how medication is being prescribed (Arria & Dupont, 2010). A pure medical model of ADHD treats the disorder as pathology solved by the right prescription and this reinforces an inadequate understanding of the complexities. Research in the last 20 years indicates that ADHD is a disorder that is developmental, genetic, and neurological (Nigg, 2006). Brain imaging demonstrates functional differences in people with ADHD absolutely do exist (Beiderman, 2005; Consensus Statement on ADHD, 2002). Yet, misunderstandings and stigma persist.

For many years, ADHD has been viewed as a disorder that only affects children. Diagnostic criteria was based on children’s presentations of symptoms with a bias toward the male gender. In addition to social and academic problems in functioning that cause them to stand out from their peers, children with ADHD are appreciably more likely to develop conduct disorder in adolescence and antisocial personality disorder in adulthood.
These may lead to criminal activities and substance use disorders that may increase their risk for incarceration (DSM-5, 2013).

With the publication of the DSM-5, the clinical understanding of ADHD has been reconstructed to span into adulthood, and not just childhood. There is a new threshold for symptom impairment for children, from age 7 to age twelve. This extends the time for impairment to be noticeable for diagnosis. Symptoms now describe how ADHD may affect an adult and there is more awareness that this is a chronic condition. This change is noteworthy because it indicates that while some children may appear to “outgrow” ADHD, it may be more accurate to say they have developed life skills to compensate. For example, older adolescents and adults may struggle to maintain attention to prepare reports, complete forms, and review lengthy papers. Or, older adolescents and adults may be forgetful in daily activities such as paying bills, returning calls, or keeping appointments (DSM-5, 2013).

Adults with ADHD may function poorly and this is translated into poorer occupational performance, less job stability, more barriers to achievement and attainment of personal goals, and increased relational conflict. By early adulthood, ADHD is associated with an increased risk for suicide, most frequently when comorbid with other mental health problems. Adults with ADHD may experience pervasive lifelong difficulties in many areas, thus reducing the quality of life (Bernfort, Nordgeldt, & Persson, 2007; DSM-5, 2013).

This lifespan conceptualization beyond childhood is an important improvement in diagnosis, but it illuminates the diagnosis and treatment gap. Diagnosis and treatment
have also been biased toward boys, with little research on how ADHD is manifested and
treated in girls and women (Fedele, Lefler, Hartung, & Canu, 2012; Kelley, English,
Schwallie-Giddis, & Jones, 2007) or in persons from other cultures (DSM-5, 2013).

What is clear is that diagnosis has increased. According to the Center for Disease
Control and Prevention (2013), about 11% of children ages 4-17 or 6.4 million were
diagnosed with ADHD as of 2011. The climb in numbers has been steady with 7.8%
diagnosed in 2003, to 9.5% diagnosed in 2007, to 11% diagnosed in 2011. The
prevalence of ADHD diagnosis also changes by state, from a low of 5.6% diagnosed in
Nevada to a high of 18.7% diagnosed in Kentucky. (The Center for Disease Control and
Prevention, 2013). This suggests that differences in diagnostic thresholds exist by
geographic region, or it may be that differential diagnosis may be confounding. ADHD
may be under-diagnosed in some states or over-diagnosed in others. Environmental and
socioeconomic factors may influence who gets diagnosed (The Center for Disease
Control and Prevention, 2013).

Many children with ADHD will become college students, and several dissertations
and research articles indicate that symptoms are evident in academic functioning,
emotional regulation, and daily life (Kaminski, Turnock, Rosen, & Laster, 2006; Meaux,
Green, & Broussard, 2009; Weyandt & DuPaul, 2008; Weyandt, DuPaul, Verdi, Rossi,
Swentosky, Vilardo, O’Dell, & Carson, 2013). In addition, there may be associated
features such as low frustration tolerance, irritability, or mood lability. There may be
more problems with executive functioning and with memory. Students may battle with
mustering attention and focus for challenging tasks. Others may view these deficiencies
as a poor attitude, laziness, irresponsibility, or an unwillingness to cooperate. This may create academic, family and peer relationship problems, in addition to a poor self concept (Brown, 2006; Brown, 2013).

Finally, individuals who meet criteria for ADHD frequently suffer from other comorbid disorders simultaneously. Differential diagnosis can be challenging as a clinician strives to distinguish ADHD from an anxiety disorder, depressive disorder, substance use disorder, or personality disorder. For students from different cultural backgrounds or international students, there can be variables in attitudes/interpretations toward the child (DSM-5).

Also, the symptoms of ADHD are quite separate from other learning disabilities. Reaser, Prevatt, Petscher, and Proctor (2007) indicate that students with ADHD study differently than students with learning disabilities or for students without disabilities. As they point out, these two at-risk groups (ADHD and learning disabilities) are often banded together. Yet, the study strategies that distinguish these two groups of challenged learners have not been identified. The authors studied 150 students from a large public university, with 50 in each group—ADHD, learning disabilities, and non-disability group. They used the Learning and Study Strategies Inventory (LASSI) as a diagnostic and prescriptive tool. The ADHD group scored lower than both the learning disability and non-disability groups in four critical areas: Time Management, Concentration, Selecting Main Ideas, and Test Strategies. The ADHD group also scored lower scores than the non-disability group (but not the learning disabilities group) in these areas: Motivation, Anxiety, Information Processing, and Self-Testing. These implications
suggest different kinds of interventions are needed for ADHD students versus learning
disabled students. In addition, they recommend that the subtypes of ADHD be researched
to determine if specific interventions are more useful for certain subtypes.

This is the complex arena of problems surrounding identification, diagnosis, and
treatment of ADHD that college counselors must consider. Yet, Ramsey and Rostain
(2006) posit that staff in student health and college counseling centers may not have
sufficient training and experience in this area.

**Statement of the Problem**

Students with ADHD are attending postsecondary institutions in increasing
numbers. As many as 5% of the freshman class of 2010 have a diagnosis of ADHD (The
Chronicle of Higher Education, 2011). However, this figure does not capture the real
numbers of students with ADHD who are attending college. It is not mandated for these
students to report to disability services at their respective colleges and others have not
been diagnosed (Weyandt & DuPaul, 2008). Approximately 2 to 8% of college students
report levels of ADHD impairment that cause clinically significant difficulties in the
college environment (DuPaul, Weyandt, O’Dell, & Varejao, 2009). Many of these
students, both diagnosed and undiagnosed, will show up at college counseling centers.
There is high mental health comorbidity with ADHD and there is increased probability
for anxiety and mood disorders and substance abuse issues (Baker, Prevatt, & Proctor,
2012; Richardson, 2005; Rooney, Chronis-Tuscano, & Yoon, 2012).

The National Center for Education Statistics (2008) conducted a census of almost
all public 2-year and 4-year postsecondary schools, both medium and large institutions.
According to that census. During the 12-month 2008–09 academic years almost all these institutions (99%) reported accepting and enrolling students with disabilities. The breakdown of these reported disabilities revealed that about one-third were specific learning disabilities (31%). Eighteen percent of these disabilities were for students with ADHD. Fifteen percent were mental illness/psychological or psychiatric conditions. Eleven percent were a health impairment/condition (National Center for Education Statistics, 2008). What is apparent is that a high percentage of students with ADHD are attending college. In addition to the assessment and treatment of students with adjustment issues and mental illness, college counselors are challenged to identify and treat students with this hidden disability.

While college counselors are called to support students with disabilities such as ADHD, there is little to guide them. Most of the research for years has been focused on children and adolescents, which is a different developmental focus (Weyandt & DuPaul, 2008). The research literature began to investigate college students around the 1990s and subsequent research substantiates that college students with ADHD are particularly vulnerable to academic, social, and emotional stress (Beecher, Rabe, & Wilder, 2004; DuPaul et al., 2009; Fleming & McMahon, 2012; Heiligenstein, Guenther, Levy, Savino, & Fulwiler, 1995; Kaminski et al., 2006; Lewandowski, Lovett, Codd, and Gordon, 2008; Meaux et al., 2009; Norwalk, Norvilitis, & MacLean, 2009; Oslund, 2014; Rabiner, Anastopoulos, Costell, Hoyle, & Swartzwelder, 2008; Weyandt et al., 2013; Weyandt & DuPaul, 2008; Wolf, 2001).
College mental health issues have steadily been increasing in recent years and college counselors are treating a greater variety and severity of mental and emotional health issues (Hodges, 2001). Postsecondary institutions are challenged to work with smaller budgets and increasing needs, and it is difficult to staff the counselor centers to meet the demand in services. In the area of disabilities, few college counselors have training in this specialty (Oslund, 2014). While disability services at colleges and universities offer accommodations and support, there are few empirical studies that suggest what particular interventions may affect the impairments that students may be experiencing that are related to their ADHD symptoms. In short, it continues to be unclear as to what degree ADHD college students are impaired and it is also unclear what interventions work (Weyandt & DuPaul, 2008). In my clinical experience, it is apparent that many students with ADHD are underachieving or failing in college, resulting in serious long-term consequences for students and many other stakeholders.

The mandates of the ADA are relevant to mental health professionals at college counseling centers so this study is timely and appropriate. I reviewed educational and psychological research databases and it appears that little research has been conducted to assess the way college counseling centers accommodate and help students with disabilities (Goad & Robertson, 2000). There is not much consensus on how counselors should work with these students, what interventions are effective, what training is needed to understand how an ADHD diagnosis impacts students, and what the future initiatives should be for research and treatment.
A college education is firmly embedded in the American consciousness as a pathway to the American dream. Most citizens recognize the importance of education as foundational for lifetime employment. There is the expectation that all students leave high school with the skills to tackle college and/or career (Papay & Griffin, 2013). What was once a narrow path for those with the resources and social class to gain access has expanded to a wider highway for everyone to travel. Scholarships, loans, and improved academic support have made education accessible for lower socioeconomic classes and for minority populations. Advocacy for inclusion for students with intellectual and developmental disabilities have increased in recent years. Opportunities exist for students with disabilities to attend school with same-age peers. Yet, opportunities can be wasted if these students do not receive appropriate support to help them succeed in academia.

Purpose Statement

The purpose of this qualitative study was to intensely study the experiences of eight college counselors at postsecondary institutions to understand how they identify and treat students with ADHD, how they conceptualize ADHD in the postsecondary environment, and how they describe their challenges and successes in order to create new knowledge and suggest strategies that can enhance services to these students in college counseling centers. I am unaware of any research specifically addressing the experience of college counselors in regard to treating students with ADHD.

Research Question

Research Question: What is the experience of college counselors who provide counseling for students with Attention-Deficit/Hyperactivity Disorder (ADHD)?
I used a semi-structured interview using brief and simple questions, as suggested by Kvale and Brinkman (2009). There are eight main questions followed up by follow-up and probing questions. Prior to that this I conducted a briefing to describe the research, secured a signed consent, and ask the participant if he/she had questions. I built rapport and asked basic demographic information (See Figure 1). I began each interview with a basic introductory question to try to yield spontaneous rich descriptions based on the participant’s experience: Can you tell me about your experiences working with students with ADHD? The next two main questions concerned the participant’s conceptual understanding of ADHD and professional training about ADHD. This created a richer elaborative framework for understanding this participant. The next two questions moved away from the participant to make inquiry about other people with whom the ADHD college student would interact—family and other non-clinical staff at the institution. The next two questions explored the student and his or her understanding of ADHD; these touched on issues of self-esteem, performance, diversity, strengths, and challenges. These questions elicited the counselor’s observations, interactions, and opinions of students with ADHD and the people in their immediate circle. The final question invited the participant to be reflective about future diagnosis and treatment of students with ADHD, and how his or her work may be improved or supported.

**Importance of this Research**

While a person diagnosed with ADHD can certainly attain his or her educational, occupational, and personal goals, those with ADHD usually experience more challenges that may impede their performance. Adults with ADHD generally have lower levels of
educational achievement. In the workplace, they are more likely to be unemployed or underemployed. Persons with ADHD are also at higher risk to experience periods of incarceration (Bernfort et al., 2007). This results in production losses, health care costs, and increased criminality. These authors also suggest that individuals with ADHD have more problems in relationships and that difficulties with substance abuse are more common. They are also at risk for developing more psychiatric problems.

Bernfort et al. (2007) examine the overall socio-economic costs of ADHD. They acknowledge there is little hard data to evaluate the outcomes of undiagnosed and untreated ADHD, but they suggest the impact is considerable. They call for future research to examine the undesired life outcomes of people with ADHD, and how that affects social costs and quality of life. These questions circle back to the importance of identification, treatment, and education at younger ages. As they write,

> Further, considering the early onset and natural course, the need for further research and stronger efforts from schools and healthcare providers must be stressed. If carried out in a long-term perspective, such priorities probably have the potential to reduce both individual human suffering and major societal costs. (p. 244)

Failure in college is the type of negative experience that can drastically affect a person’s ability to move forward in life as a successful and productive person. Given the increased number of students attending college with ADHD, it is critical that colleges and universities recognize the increased risks for failure and are prepared to serve students with this problem. Consider that within a university with 20,000 students, an estimated 1,000 of these students probably have the hidden disability of ADHD (Chronicle of Higher Education, 2011) with a higher potential for comorbid mental health problems and substance abuse. Disability is a social justice issue, similar to helping underserved
populations such as minorities and the poor (Olkin, 2002). Postsecondary institutions must aspire to staff and train employees to serve the needs of all underserved students and to help them access resources. The stakes are high for the students and their families as well as the institutions and society overall. All the environmental collateral of childhood such as family support, accommodations, and extra help from educators are gone when a student enters the postsecondary arena. What may be deemed “normal adjustment” may really indicate serious functional impairments that may interrupt or stop a student’s education, and thus hold lifelong consequences.

In addition, the legal requirements surrounding ADHD and other disabilities warrant a comprehensive look at all the organizational structures of the university to determine if there are better ways to support students and enhance success. It was outside the scope of this paper to address all the institutional structures, but by focusing my research on college counseling services, I have illuminated one college support structure that can have a critical impact.

**Statement of Terms**

ADHD: Attention-Deficit/Hyperactivity Disorder: “ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development” according to the DSM-5 (2013). The terms ADHD and ADD are used interchangeably, but there are distinct differences between them. The newest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) only recognizes the term Attention-Deficit/Hyperactivity Disorder, and specifies three types of ADHD:
• Inattentive ADHD, which features forgetfulness, disorganization, and lack of focus. According to the DSM-5 (2013), “six or more symptoms of inattentiveness must have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities” (p. 59). This particular type of ADHD was called ADD in previous diagnostic manuals.

• Hyperactive-impulsive ADHD involves restlessness and impulsive decisions, but not inattention. According to the DSM-5 (2013),” six or more symptoms of hyperactivity and impulsivity must have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities” (p. 60).

• According to the DSM-5 (2013), “combined presentation ADHD is characterized by inattention, hyperactivity, and impulsivity, and these symptoms have been present for the past six months” (p. 60).

Brown (2005, 2006) elaborates further on this definition in highlighting executive functions. He describes ADHD as a complex syndrome (meaning a cluster of interactive symptoms) of developmental impairments of executive functions in the brain. This impacts cognitive functioning and the self-management system. This struggle with self-management impacts a person in daily life activities and the symptoms may vary according to the situation. The impairments also tend to be chronic throughout life. He also explains that these are largely unconscious and they can vary with developmental age.
Disability: According to the ADA (National Network Information, Guidance, and Training on Americans With Disabilities Act, 2017), disability is understood as a legal rather than a medical term. Disability refers to impairments that limit major life activities. These impairments may be both physical and mental/emotional. In addition, a record of impairment may be relevant even if the disability is not currently apparent. To discriminate against the person on the basis of that person’s disability is considered illegal.

Executive Functions: In addition to the aforementioned discussion of executive functions by Brown, Nigg (2006) writes that executive functions is a term that encompasses the regulation of particular cognitive processes. These include reasoning, working memory, task flexibility, planning, problem solving, and execution of responsibilities. Nigg also refers to executive functions as cognitive control or the supervisory attentional system.

Individuals with Disabilities Act (IDEA): IDEA is legislation that governs how states and public agencies provide early intervention, special education, and related support to children with disabilities. This includes eligible infants and toddlers, as well as children and youth. It is incumbent on institutions that work with children to identify these children with disabilities as well as provide services (U.S. Department of Education, 2011).

Psychological Disorder: According to Psychology Today (2015), this term can be understood in this way,

Psychologists define a psychological disorder broadly as psychological dysfunction in an individual that is associated with distress or impairment and a reaction that is not culturally expected. When considering if something is a symptom of a disorder, consider the three Ds: Is it psychologically dysfunctional? Is it distressing or
handicapping to the individual or others? Is it associated with a response that is atypical or deviant? (para. 3)

Reasonable Accommodations: Programs and activities at postsecondary institutions are supposed to be fully accessible to students with disabilities. Schools are required to provide students with disabilities an equal opportunity to participate and engage in educational programs. To this end, they must attempt to make reasonable modifications or accommodations in policy or procedures. Academic institutions are not required to provide modifications or accommodations that present unreasonable financial cost to the school or that essentially change the program or service being provided, such as altering the integrity of a particular program or course (American Psychological Association, 2017).

The Americans with Disabilities Act (ADA): ADA is a federal statute that was designed to provide equal opportunities for people with disabilities that significantly impair and challenge them in daily life. These include physical, sensory, and mental disabilities. Title I of the ADA protects individuals from employment discrimination. Title II prevents local and state governments from discrimination on the basis of a person’s disability. Title III maintains that accommodations for the general public must also be accessible to persons with disabilities. Title IV requires that telecommunications services must be available to persons with disabilities. College and universities are required to inform students about the availability of accommodations and academic adjustments to help students with impairments, both physical and hidden (such as ADHD). However, a postsecondary institution is not required to seek out or identify students with handicaps. It is the student’s responsibility to advocate by making known the handicapping condition,
providing documentation, and requesting services (U.S. Department of Education, 2011). The Rehabilitation Act of 1973: This law was the first major legislative initiative to help individuals with disabilities. It provides many services to help with both physical and cognitive type disabilities. The purpose of this legislative was to reduce barriers that prevent persons with disabilities from enjoying full inclusion in society. The law promotes the pursuit of independent living for persons with disabilities by providing opportunities for full and continued employment and self-determination (U.S. Department of Education, 2011).

**Summary**

The introduction has illuminated a critical challenge facing postsecondary institutions. Chapter Two will explore and summarize the current literature on ADHD in this setting. This chapter will explain the diagnostic history of ADHD as well as current diagnostic criteria. Important conceptual models of adult ADHD, focusing on college students, will be explained. The particular complexities of working with various subgroups within the college setting will be explored. Finally, the most current research on treatment interventions for adults and college students will be discussed. Chapter Three will explain the methodology of Consensual Qualitative Research (CQR), step-by-step. My underlying theory of constructivism will be explained as well as the rationale for selecting a qualitative methodology. I will include personal assumptions and biases that impact the method. Chapter Four will present the data and discoveries I made in the process of research. Finally, Chapter Five will summarize the study, including limitations and delimitations, and recommendations that include directions for future research.
Chapter Two: Literature Review

Introduction

Chapter Two explores current literature relating to the research question, What is the experience of college counselors who provide counseling for students with Attention-Deficit/ Hyperactivity Disorder (ADHD)? I investigated psychological, medical, and postsecondary information databases for seminal articles and books on ADHD, disabilities, and college counseling. This chapter explains the problem broadly and then focuses on the particular issues of adults and college students with ADHD. The chapter includes the many stakeholders who are impacted by the issue, which further supports the importance of this study.

History of the Problem

IDEA governs how elementary and high schools identify and handle the needs of students with disabilities. It is the success of programs like IDEA that have increased access to higher education. Since the passing of this legislation, the number of students with disabilities identified and served by institutions has increased steadily. From 1990 to 2001, there was a 30.3 percent increase in students helped, according to the Twenty-Second Annual Report to Congress on the Implementation of Individuals with Disabilities Education Act (U.S. Department of Education, 2001). The largest minority in the U.S. is students with disabilities (Olkin, 2002).

At the postsecondary level, two laws affect legal rights and requirements. The ADA of 1990 applies to every public and private institution. This law excludes institutions affiliated with religious organizations. The Rehabilitation Act of 1973 is relevant to any
institution that accepts federal financial aid for any program or service (U.S. Department of Education, 2011). The intent of both laws was to stop discrimination against persons with disabilities. In regard to postsecondary institutions, they may be required to remove any physical barriers that may hinder students. These may include architectural, communication related, or transportation barriers. They may also be required to provide reasonable accommodations or modifications to current procedures and policies. For example, schools may provide services such as interpreters, readers, or note takers. They may be responsible to purchase and provide adaptive equipment such as audio recordings, special computer programs, or other equipment. In terms of procedures, they may provide early enrollment, special scheduling options, or substitution of certain courses within a standard program. In addition, they may allow service animals (U.S. Department of Education, 2011).

Both the academic and student development branches of colleges are affected. Teaching staff must state in syllabi that reasonable accommodations will be made for students with disabilities. Teachers are also challenged, but not required, to change instructional strategies to meet the various kinds of learning styles that students possess. On the student development side, administrative units such as student disabilities services make determinations of disability status by reviewing documentation, offer appropriate accommodations and adjustments and coordinate support with other staff. Many personnel in student development may make connections with students with disabilities. These include staff in residential life, career/workplace departments, academic advisors, extracurricular coordinators, advisors for international and diverse students,
administrative deans, and counseling staff. The mandate for professionals in the postsecondary setting is that appropriate and reasonable accommodations are made so that students are not discriminated against on the basis of disability (U.S. Department of Education, 2011).

The transition to college for students with disabilities is particularly challenging. While services and support under IDEA may have prepared them to gain entrance into college, students will not have access to the support and accommodations provided by teachers and parents. The student is encountering a unfamiliar environment with heavy academic responsibilities and expectations, and the understanding that they will be self-sufficient away from home. Because of these additional stresses, students with disabilities may find themselves in an overwhelming situation where they are just trying to get by and meet the academic requirements (Beecher et al., 2004). Mental health challenges such as anxiety and depression may emerge, and require the assistance of mental health professionals.

While ADA mandates that postsecondary institutions provide equal access to services for students with challenges related to disabilities, counseling practitioners generally receive inadequate training in their programs about disabilities. In many program, there is no training at all (Gordon, Lewandowski, Murphy, and Dempsey, 2002). These authors continue that most practicing psychologists received graduate training prior to the enactment of ADA law. Accordingly, they would be unfamiliar with the particular features of the law that apply to postsecondary institutions and how courts would interpret the law relevant to their setting. Gordon et al. (2002) surveyed 147
clinicians to explore their knowledge of ADA and its applications to practice. In this study, they found that most clinicians thought they needed more education on the topic. What they did know was fraught with misunderstandings. Beecher et al. (2004) suggest that most college counselors, which includes mental health counselors and social workers, obtain the same or similar training as clinical psychologists. Thus, college counselors overall, no matter what their training paradigm, seem to practice with incomplete or faulty knowledge about disabilities. Many are not prepared to help these students deal with their special challenges.

While disabilities such as a physical impairment are usually evident, this is not true for students with hidden disabilities. These include ADHD, learning disabilities, chronic mental health issues, and developmental issues such as Autism Spectrum Disorder (ASD) (Oslund, 2014). As stated earlier, ADHD affects a significant number of students in higher education and this does not include those who fail to register for accommodations or who are not diagnosed. Yet there is a scarceness of research on how to specifically support this population for counselors in college counseling centers.

As college counselors strive to serve more students who have disabilities, it is critical to examine the history and evolving purposes of postsecondary counseling centers. Right after World War II (WWII), the Federal Veterans Administration provided generous funding for those who served in the military. They flooded college campuses nationwide (Hodges, 2001). College was more accessible to nontraditional, often married students who had previously may not have sought access to academia. In college
counseling, the focus was on vocational preparation and job planning, as well as personal
adjustment to college for this new kind of student.

Hodges (2001) explains that the role of counseling centers changed with the Civil
Rights Movement and the Women’s Movement as social barriers to minorities were
recognized and altered in alignment with social changes. Colleges became more
pluralistic. Counselors needed more specialized training and counseling centers
developed an identity distinct from other student affairs units. This coincided with the
parallel growth in counseling and psychology and the development of more research-
based assessment instruments and treatments. Overall, the college counseling field
became more sophisticated and specialized, and counselors required a higher level of
competency.

As counseling practice has evolved, there has been a pattern of relying more on the
use of the medical model with less emphasis on the traditional development and
vocational model of college counseling. College counselors must now be clinically
licensed through their respective boards (psychology, counseling, or social work) and
may diagnosis and treat clinical issues such as depression and anxiety. Hodges (2001)
explains that more time is spent treating major mental illnesses and this has resulted in
less focus on outreach activities. More students are taking more psychotropic medicines
and suicide risk has increased. There is increased alarm about and attention to high-risk
sexual behavior and sexual assault. There is also an epidemic of problematic substance
abuse. Student problems that are addressed in counseling centers extend far beyond the
former emphases on vocation and personal development.
Hodges (2001) continues that there are significant variations in standards of care regarding diagnosis vs. non-diagnosis, number of sessions, training and credentials of practitioners, use of clinical assessments, and referral practices. Campuses are vastly different from those of the post WWII era. Diversity—multiethnic, multicultural, sexual identity, gender, religion, and disability—is the current reality. This highly pluralistic environment changes the complexity and scope of practice. In addition, the various types of postsecondary institutions and resources available are quite different. Increased specialization and skills in college counseling is needed, but services vary from school to school.

Boyd et al. (2003) address the need for standards and updated professional practice changes. They discuss this increased multiplicity of functions with students. College counselors conduct individual and group therapy, and provide crisis intervention and emergency services. In addition, despite the time constraints of clinical practice, counselors are usually expected to work with other staff in supporting the strategic plan of the college such as retention goals. This may entail consultation, program development, outreach, and research. The current spotlight on Title IX legislation and campus sexual assault is an example of the new types of problems that affect college counselors. The counseling center must align with the accomplishment of institutional goals and objectives while handling more complex workloads. Resources are stretched with new institutional priorities and the difficulty of treating a disability such as ADHD may be overlooked.
The college counseling center has the potential to have a positive constructive impact on the life trajectory of students. Hunt and Eisenberg (2010) write that the college years may be the only time in the lives of students where they exist in a single integrated-type setting. Education is certainly the most important piece of this experience. But students are also involved in social, career, service, leadership, and wellness activities. Colleges are in a unique position to address important public health and wellness challenges among young adults. The authors also indicate that there is an association between mental health and socioeconomic status during the course of students’ lives. Colleges offer a promising opportunity for treatment of problems as well as promotion of wellness, and effective interventions can impact lives after college.

Hunt and Eisenberg (2010) write that a 2008 national survey of directors of college counseling centers indicated that these directors reported that the gravity and complexity of psychological problems at their counseling centers has increased significantly. This may indicate an increase in overall illness or it may reflect increased help seeking. In looking at epidemiological data on mental disorders for adolescents and young adults, they believe that the prevalence of mental disorders has remained about the same or perhaps increased moderately. A possible factor in this data is that more youth are seeking effective help at earlier ages with fewer side effects. This may be enabling better functioning, increased access, and higher college attendance. As a social phenomenon, this is a favorable development as it broadens access. However, even with the increase in identification of illness and more treatment, untreated mental health disorders are still highly widespread in colleges. In addition, service use is especially infrequent and less
available to students with lower socioeconomic backgrounds and also for international students. The authors call for more research evidence on what programs, treatments, and policies really work for students. Research must be translated into practice to emphasize optimal use of limited resources. Prevention and positive mental health must be emphasized, and not just treatment of problems and pathologies. Innovations in practice must be rigorously studied and disseminated in a coordinated manner.

Looking specifically at disabilities, students with disabilities increased significantly under IDEA, 30.3% from 1990 to 2000 (Beecher et al., 2004). The authors explain that students who benefit from services under IDEA are not necessarily ready to engage in college life, where they must transition to managing their own education without extra support. The authors continue that many students with disabilities may find the environment intimidating and overwhelming. The Chronicle of Higher Education (2011) polled 201,818 first-time, full-time, first-year students on 2010 at 279 universities and colleges in the U.S. Of those, 5% of freshman have ADHD. This is the first time that “hidden disabilities” such as ADHD, a psychological disorder, or a learning disability have been determined in a large national poll. And, of course, this survey does not account for those who may have ADHD but have not been diagnosed.

At my current institution, Denison University, a recent survey of the incoming freshman class of 2014 revealed several types of medical and mental issues among the students with 13% reporting depression, anxiety or another psychological challenge; 12% reporting ADHD; 8% reporting a learning disability; 5% reporting a physical disability (speech, vision, hearing, etc.); and 4% reporting a chronic illness such as cancer or
diabetes (Tucker, 2015). A private university may attract more students with both obvious and hidden disabilities as consumers would most likely hold the expectation that the student will have more resources.

Goad and Robertson (2000) sent a survey on disabilities to 380 college counseling center directors and 297 responded (78%). They found that most counseling centers do receive information about disabilities but the method varies. Student disabilities may be uncovered in the formal intake process or more informally. However, about 32% of the sample (N=95) do not routinely collect information about disabilities. Of the sample that do collect information, only 45% (N=135) collect written information. The study also revealed that while half of interns may receive training for serving students with disabilities, 68% of all centers had not offered this training to senior staff. Most postsecondary institutions have a separate office from counseling to serve the accommodation needs of students with disabilities; more than half of counselor centers had a designated liaison to that office.

Goad and Robertson (2000) offer four recommendations. First, seek information directly from students about their disabilities. Second, provide senior staff with training on disabilities. Third, maintain an active liaison relationship with the office that provides accommodations. Fourth, provide senior staff with training on how to screen clients for learning disabilities. They indicate that a limitation of this study is that it is only as valid as the data reported by the university counseling center directors. But it illuminates the gap in services. In my experience at Denison University’s integrated health care center, incoming students are asked to provide information about any disabilities and/or mental
illnesses to the health center. Sometimes students and parents purposely choose to hide this information, despite assurances of confidentiality, because of perceived stigma. This can compromise student care as clinicians do not have information that could help with support and treatment. Also, general intake forms and standards vary from school to school. Disabilities may not be detected.

Furthermore, Thomas, Curtis, & Shippen (2011) explored the perceptions of 172 college graduate student counselors, rehabilitation providers, and teachers. They found that attitudes toward disability were affected by education, with rehabilitation counselors exhibiting the most positive attitudes. Mental health counselors’ preparation was more focused on mental health and they had lower receptivity toward physical disabilities. They were less aware of the obstacles and prejudices experienced by students with less obvious or undetected disabilities such as ADHD. The authors advocate for more interdisciplinary training programs to impact the perceptions and attitudes of professional providers. They call for additional qualitative studies using focus groups or structured interviews to gain more in-depth information. Improving perceptions is a critical social justice imperative to better support individuals with disabilities.

To this end, this dissertation is timely and relevant as it examines one aspect of diversity and need, college students with the hidden disability of ADHD, and the experience of college counselors who treat them.

**Background on ADHD: The Hidden or Invisible Disability**

To fully comprehend the presence of ADHD in our cultural landscape today, it is helpful to understand the history of this disorder. As early as 1798, Sir Alexander
Crichton described symptoms that we now associate with ADHD. Crichton noticed an inability to focus that is far beyond what is developmentally appropriate (Oslund, 2014).

Oslund (2014) explains the co-development of a medical understanding or biologically based explanations for this behavior. He writes that until the 1960s it was assumed that children who showed signs of what we now classify as ADHD were in some way brain damaged. They were demonstrating a disruptive behavior disorder. By the 1960s, there was a shift in thinking that the behaviors were part of the children’s make-up and not a brain damage issue. Doctors realized children could be very intelligent and hyperactive. By the 1970s hyperactivity ceased to be the core of diagnosis and more attention was given to problems with attention and focus. It wasn’t until 1980 that the attention portion was officially recognized throughout the medical community. The Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1980) was the first to include an attention disorder. However, in this version, ADHD was described in the category of behavior disorders along with Conduct Disorder.

With the publication of the DSM-5 (2013), the definition of ADHD was expanded to span the lifespan, and not just childhood. Also, for children, symptom presentation does not have to occur prior to age seven to render a diagnosis. Onset of symptoms that cause impairment may not be apparent until age 12. Subtypes are described by degree with descriptive specifiers. Most critically, the manual reflects the clinical evidence that adults can experience serious and significant impairment from ADHD symptoms. For an adult diagnosis, they need to indicate five symptoms instead of the six symptoms required for younger persons. This is for both inattention and for hyperactivity and impulsivity.
(DSM-5, 2013). As in previous manuals, a person may be diagnosed as having ADHD, Predominantly Inattentive Presentation; ADHD, Predominantly Hyperactive/Impulsive Presentation; or ADHD, Combined Presentation. Specifiers include a category that accounts for degree of remission. There is also a specifier for severity, and symptoms may designated as mild, moderate, and severe (DSM-5, 2013).

This change is noteworthy because it indicates a significant shift to conceptualizing ADHD as a chronic condition throughout life. According to the DSM-5 (2013), population surveys suggest that ADHD is a worldwide disorder and that it occurs in most cultures in about 5% of children and about 2.5% of adults. Other studies estimate that adults with ADHD may be even higher (Adler, Shaw, Stein, Mick, Newcorn, Rostain, & Ramsey, 2009; Barkley, Murphy, & Fischer, 2008; Beiderman, 2005; Brown, 2006; Faraone & Beiderman, 2005). The DSM-5 (2013) indicates that many children may not get proper treatment and that their impairments related to ADHD will continue through adulthood. Also, certain childhood patterns of behavior due to ADHD symptoms may contribute to the secondary development of social and even serious conduct problems.

In terms of culture, the DSM-5 (2013) acknowledges different diagnostic and methodological practices across cultures. There may be cultural variables in attitudes/interpretations toward the behavior of children. Indeed, this can exist within regions of the same country. The cultural group in which that the child has been enculturated may influence informant observations. In the U.S., Caucasians are identified more frequently than African Americans and Latino populations. ADHD is more frequent in males than females. Inattentive features tend to be more frequent with female
diagnoses (DSM-5, 2013).

The DSM-5 (2013) also explains that children with ADHD will probably have more challenges than their non-ADHD peers. As mentioned earlier in this document, there is increased risk for conduct problems in early adolescence and possible antisocial personality disorder in adulthood. They are also at increased risk for suicide, especially when these individuals struggle with comorbid problems such as mood disorders or substance use disorders (DSM-5, 2013). Given the fact that suicide already is a significant mental health concern on college campuses, detection of ADHD is critical.

Differential diagnosis is problematic as a clinician may need to distinguish ADHD from an anxiety disorder, a mood disorder, substance use disorder, or personality disorder. These are problems commonly presented and treated in college counseling centers. If a student is a chronic substance abuser, for example, it is impossible to gain a baseline of functioning until the substance abuse has stopped. Personality disorders may first become evident in college and these compound diagnosis and treatment of ADHD. Finally, comorbid disorders are frequent for individuals who meet criteria for ADHD and these may obscure the ADHD presentation (DSM-5, 2013).

With this changing history surrounding medical views, it is easy to see why there are public impressions that ADHD is a new disorder and that the number of children diagnosed is rapidly increasing in alarming fashion (Oslund, 2014). There is ambiguity about the threshold for diagnosis and there can be great variability in the presentation and intensity of particular symptoms. The public perception may create stigma. Popular media may challenge that ADHD really exists or highlight the abuse of stimulant
medications to create the impression that most diagnoses are bogus (Consensus Study on ADHD, 2002).

It is critical to understand that many people are suffering with untreated ADHD. This disorder is not a myth, fraud, or benign condition, according to a consensus statement by a consortium of international scientists in 2002 (Consensus Study on ADHD, 2002). This consortium of 84 experts unified to challenge the controversial opinions about the existence of ADHD. The U.S. Surgeon General, the American Medical Association (AMA), the American Psychiatric Association (APA), the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychological Association (APA), and the American Academy of Pediatrics (AAP) all recognize ADHD as a valid disorder. These experts all agreed that there are critical deficiencies in psychological abilities for individuals with ADHD. For most people who have this disorder, symptoms create hardships that might be managed with treatment. But these hardships can be devastating in many life arenas. They are more likely to underperform, not finish educational goals, experience more relationship conflict, use more illicit drugs and/or tobacco, and struggle with other mental health problems. Their lives may reflect a continual pattern of chaos, mismanagement, and risk-taking. Yet, the consortium article continues, treatment awareness and access is lacking. These experts agreed that less than half of those with the disorder are receiving treatment.

The DSM provides a foundational and diagnostic understanding of ADHD. The remainder of this literature review will focus on other aspects of ADHD to provide an in-depth understanding: the neuroscience of ADHD; messy models of ADHD; the impact of
comorbidity; adult symptoms of ADHD; college student symptoms of ADHD; developmental complexity, gender issues, and giftedness; and intervention and treatment strategies for adults and college students.

**Neuroscience of ADHD**

Because of advances in neurological screening, experts can now show that there are physical evidences for ADHD in the brain. These include Magnetic Resonance Imaging (MRI) and single-photon emission computerized tomography (SPECT) imaging (Oslund, 2014). Neuropsychological imaging also helps practitioners to understand more about symptoms in depth. Research shows that ADHD is a neuropsychological disorder where symptoms are manifested in behavior, psychosocial functions, and attention. A landmark study by Zametkin, Nordahl, Gross, King, Sample, Rumsey, Hamburger, & Cohen (1990) for the National Institute of Mental Health (NIMH) used Positive Emission Tomography (PET) scans to measure brain activity. In these scans, during an attention test with adults, they showed that brain activity for adults with ADHD was ten percent less than brain activity for adults who did not have ADHD. This difference in brain activity was more obvious in the prefrontal cortex of the brain.

While this study emphasized the prefrontal cortex, other brain regions have been identified as exhibiting deficits. These include the connections to the basal ganglia and the relationship of the prefrontal cortex and basal ganglia with the cerebellum. There is less brain electrical activity and less reactivity to stimulation in these regions. In addition, it appears that many individuals with ADHD may have smaller areas of brain matter relative to those who do not have ADHD (Consensus Statement on ADHD, 2002).
Biederman (2005) further explains that structural imaging studies with computerized tomography or MRI indicate the possibility of structural abnormalities in ADHD brains. There are smaller volumes in the frontal cortex, cerebellum, and subcortical structures. In addition, the cerebellum and corpus callosum may be indicated as different for individuals with ADHD. The cerebellum is important for cognitive functioning and the corpus callosum connects the two cerebral hemispheres. Some of the cognitive and behavioral symptoms of ADHD may be attributed to degraded communication between these two hemispheres in the brain (Biederman, 2005).

Antshel, Hargrave, Simonescu, Kaul, Hendricks and Faraone (2011) challenge the understanding of ADHD as a categorical disorder. Instead, they propose that ADHD exists on a normal continuum for functions such as attention, inhibition, and regulation of behavior. The ADHD symptoms that create deficiencies represent the extreme end of this continuum. They also write that neurotransmitters may be indicated in ADHD. They agree with other researchers who point to the role of the prefrontal cortex and its reciprocal relationship connections with other brain regions.

Cortese, Kelly, Chabernaud, Proal, Di Martino, Milham, and Castellanos (2012) conducted a meta-analysis of 55 fMRI studies of ADHD. Sixteen were studies of adults. In this population of adults, they noticed two activities in the brain related to ADHD. Hypoactivation was predominant in the frontoparietal system and hyperactivation was present in the visual, dorsal attention, and default networks. This significant ADHD-related dysfunction was apparent even when participants had a history of stimulant treatment, so medication apparently was not impactful in this area of brain function. They
believe their study adds to the body of research that provides evidence of ADHD-related differences in multiple neuronal systems connected to higher-level cognitive functions. These include the sensorimotor processes, the visual system, and the default network in the brain.

Numerous studies of twins conducted across various countries demonstrate that environmental factors make no significant contribution to these traits (Nigg, 2006; Barkley, 2008; Biederman, 2005). This supports the idea that ADHD is a neurological syndrome. Yet, environmental factors may be influential on brain development (Nigg, 2006). He writes that risk factors such as pollutants in the physical environment, chronic health problems, family dysfunction, low socioeconomic states, developmental impairment, head injury, and urban living can affect ADHD. Stress, neglect, and abuse affects the developing brain of a young child, so ADHD as a neurological phenomenon is impacted by what occurs environmentally in childhood.

On one hand, it makes sense to treat children who have a neurological problem. But Nigg (2006) writes that more children are treated with medication for ADHD than ever before, reflecting the general increasing trend to using more psychiatric medicines for both adults and children. Prescription rates tend to be higher in the U.S. than in other nations. There is also regional and county variability. This reflects widely varying diagnostic methodologies and clinical procedures nationwide and worldwide. Nigg (2006) addresses the concern about medicalization of behavior. There are legitimate concerns about whether psychopharmacology is being over-utilized as a solution to life’s problems. Public perceptions of ADHD are influenced by pharmaceutical companies that
oversimplify the diagnosis, remedied by medicine, but that fail to capture the complexity of treatment (Timimi & Leo, 2009).

Childhood has changed. There are increased demands placed on children due to the competitive demands of society, fiscal pressure on school districts to provide academic outcomes, pressure on health care systems to treat quickly, and expectations of families. Plus, due to stigma and insufficient resources and information, there is a lack of appropriate support systems beyond pharmacological treatment for families and children in need. Given the high hereditability of ADHD, impaired parents may be raising impaired children. So, this medicalization of treatment reflects multiple dynamics in our society that impact how ADHD is understood and treated by clinicians.

Nigg (2006) writes that ADHD has historically been treated as a static disorder rather than an unfolding developmental pathway. The diagnostic nosology did not capture the appropriate and most relevant symptoms to address in adolescents and adults, and this only changed with the publication of the DSM-5, which recognized the longitudinal trajectory of the disorder. What is most essential to understand, despite disagreements in diagnostic thresholds and medical treatments, is that ADHD is essentially developmental, neurological and genetic. People who suffer with these symptoms do so through no fault of their own or their families. Emotional, developmental, and personality factors interact with the developing brain. While some scientists are refining theories of neurobiology, other professionals are arguing that ADHD is too frequently diagnosed and that medication treatment is excessive. Some hold a reductionism view that it is mostly a matter of biology while others claim there are etiological mechanisms at work. More
specifically, Nigg (2006) argues that there are within-person differences with ADHD that reflect causal mechanisms or breakdowns in functioning of key abilities. He emphasizes that ADHD reflects multiple conditions, arising from multiple pathways of causal actions. This diversity of presentation, combined with the strong possibility of comorbid conditions, should inform clinical practice.

Biederman (2005) explains that symptoms of hyperactivity/impulsivity are more evident early in life and may decrease, whereas the symptoms of inattention tend to persist into adulthood. Individuals respond to their symptoms in many ways and their social, emotional, and educational adjustment varies according to these different responses. While Biederman emphasizes the importance of psychopharmacological interventions to affect the brain, it is also interesting to consider how brain based behavioral and psychosocial interventions may impact the brain. Given the evidence that the brain is capable of neuroplasticity, it is thought provoking to speculate how these types of interventions impact brain functioning for those with ADHD. Even with the core neurological differences, environmental, developmental, and therapeutic influences may significantly impact outcomes for adults. These considerations pose new challenges to college counselors. In addition to psychotropic remedies, are counselors aware and trained to supplement these with other interventions? To imagine how these kinds of interventions may be conceptualized, this paper will consider more specifically how the region of the brain, the prefrontal cortex, is affected by ADHD.

**Messy Models of ADHD**

ADHD researcher Thomas Brown (Brown, 2006) posits that a true understanding of
ADHD is complex and messy. This section will discuss two conceptualizations of ADHD by experts, Thomas Brown and Charles Barkley, related to the concept of executive function. Both describe ADHD as a disorder that affects the individual’s ability to regulate executive function. ADHD symptoms delay the development of capacities needed for managing for this part of the brain.

Barkley describes ADHD as a developmental disorder of self-regulation or the ability to inhibit. He believes that behavioral inhibition is the dominant and core executive function among all the other executive functions. The other functions do not work well unless behavioral inhibition is managed. Brown, by contrast, challenges the view that behavioral inhibition is central. He writes that it is interactive and synergistic with other executive functions, and it is not a core or controlling function (Brown, 2006).

Barkley describes his model as, first, problem with persistence toward a goal. A person cannot sustain persistence toward a goal. A person with ADHD reacts to events differently. First, there is an inability to sustain the response until the goal is achieved (and this is different from the impairments that come with anxiety, depression, and learning disabilities). Second, the person lacks resistance to a distraction. People who don’t have ADHD challenges possess the ability to resist interference and this holds them to the goal. People with ADHD are provoked to respond to whatever distracts them while others without ADHD can suppress the response to irrelevant events and distractions. Third, an ADHD individual cannot hold in mind information that guides behavior toward a goal. When distracted, the person does not return to the task. The distracting event has destroyed the capacity to hold information (working memory). This has nothing to do
with attention but rather the capacity to hold information. This special kind of working memory is different from usual memory. It may be described as “remembering to do what you are doing” (Barkley, 2008).

Also, there is an inhibition problem, according to Barkley (2008). Feeling the need to be busy and doing multiple things creates the tendency to make impulsive decisions. A person fails to think before acting. Hyperactivity may decline but the inhibition is manifested differently. Barkley adds that these features are chronic and unremitting since childhood, and that ADHD is a unique disorder from other disorders. He also does not agree with the subtyping of ADHD in the diagnostic manual but views ADHD as one essential diagnosis with different dimensions that vary in severity.

Barkley (2008) also writes about many qualitative differences that are important to understand. For example, a mentally foggy spacey child may not attend well to reality. This is the opposite of the distracted, active child. This difference in presentation is quite striking. This foggy child has information processing issues that other ADHD students do not have. These children may have social impairments and they are shy. They may have less of an inhibition deficit but they are more anxious. They tend to have more problems with math disorders. He writes that stimulant medications don’t help this type and they may respond to social skills training.

Returning to Brown, behavioral inhibition is just one of multiple impaired executive functions. Brown (2006) writes that a neurological test is an inferior marker when examining how ADHD impacts an individual. He thinks that observing a person’s ability to self-manage in everyday life with all its complexity is a better measure of how
symptoms are causing impairment. He further explains that diagnosis is further confounded by the extraordinary overlap and comorbidity between ADHD and other disorders, many of which involve deficits in executive functioning.

I subscribe to Brown’s model as a dynamic model that best explains what is occurring for college students with ADHD. Brown (2006) conceptualizes the prefrontal cortex as having six clusters of cognitive functions that interact dynamically: Activation, Focus, Effort, Emotion, Memory, and Action. Accordingly, the following by Brown describes each function. I briefly describe each function, according to Brown, and suggest examples of how each function may impact adults in general and college students in particular.

- **Activation** refers to arranging and organizing materials and tasks, estimating time, setting priorities for accomplishment of work and tasks, and getting started on those priorities. Students with ADHD frequently describe constant difficulty with organization of projects and papers as well as excessive procrastination.

- **Focus** refers to focusing, maintaining focus, and also the ability to shift focus when needed. Students may constantly be distracted by stimuli such as constant social media alerts or chatter at a nearly desk.

- **Effort** refers to regulating alertness, sustaining effort, and working with adequate processing speed. Students may have trouble with completing long-term projects. They may also struggle with regulating sleep and alertness, so they lack energy to work.
• Emotion refers to managing frustration and modulating emotions. Emotions can take over behavior the way a computer virus takes over a computer. Students may struggle with self-regulation of emotions in relationships or in their reactions to the failure to complete tasks or meet deadlines. Repeated failures add to emotional distress and poor self-esteem.

• Memory refers to accessing recall, usually short-term, when doing a particular task. This is referred to as working memory. Students may have difficulty holding one or several things in their heads while attending to other tasks. Tasks such as reading may require more time and repeated effort as the student may need to make several attempts to retain the information.

• Action refers to monitoring and regulating self-action. Students may be too impulsive or jump to conclusions too quickly. They may not monitor the context of situations, failing to recognize when other people are hurt or annoyed. They may experience constant difficulty pacing tasks.

Brown (2006) writes that ADHD is essentially a developmental lag or ongoing impairment of these six clusters. They vary in quality and degree for each person and they react synergistically. In subsequent research Brown focuses on the role of emotion in ADHD. He also cites developmental psychologist Jerome Kagan (Kagan, as cited by Brown, 2013) who asserts that each child is born with a temperamental bias. Children range in temperament naturally and that creates propensities to be quiet or noisy, relaxed or anxious, smiling or irritable, or laidback or energetic. Parents’ behaviors, sibling rivalries, teacher attitudes, peer social interactions, ethnic class, socioeconomic status,
religious experience, and a host of other contextual experiences can sustain or alter how these early temperamental biases develop in strength and form (Brown, 2013). These factors all impact the emotional life of the student with ADHD.

He writes that memories vary in intensity in terms of their emotional impact, and these emotions may be single or multiple. The emotional charge associated with a memory provides the energy that drives, amplifies and attenuates cognitive activity (Brown, 2013). There are conscious feelings and also unconscious emotional processing that goes on outside of conscious awareness. Brown posits that people with ADHD are powerfully influenced by these unconscious emotions. Hence, people get stuck emotionally because they can’t manage the complex emotions and tasks and relationships that are intertwined. A person may become overwhelmed with one emotion and unable to deal with other emotions, or cannot attend to relevant facts and memories about a presenting situation. Or, conversely, the person may have deficient emotional sensitivity to the task at hand and fail to accurately assess the situation.

Brown (2013) adds to the neuroscience discussion and explains that people with ADHD may have four aspects of brain development and functioning that may be different. He explains that these are compromised brain connectivity, impaired coordination of brain rhythms, and delays in brain maturation and problems with brain chemistry dynamics. And, he stresses, many suffering from ADHD also struggle with comorbid learning and psychiatric impairments.

Conscious and unconscious emotions influence perspectives, choices, and behaviors for the person with ADHD. A person flooded with emotion may become rageful. The
opposite extreme may occur and a person with ADHD may have working memory issues that fail to keep the person aware of the emotional priorities that are important in daily decisions. Important time management tasks such as getting up in time for class or hygiene tasks such as doing laundry regularly can be daunting. In college, a student cannot prioritize the relative importance of various tasks, actions, and opportunities that require regular attention (Brown, 2013).

Family stress is another important factor in emotional development. Each parent reacts to the constant stresses of living with a child with ADHD differently; parents may become polarized against each other. A parent with ADHD may struggle with parenting. The complexity of these interactions affects the child. Also, these students labor under what Brown calls the “willpower assumption.” Well-intentioned adults assume achievement is simple an issue of stronger willpower, and getting willpower will close the gap between ability and achievement. Criticism is internalized, often resulting in shame and frustration which constantly remain in the emotional memory of the person with ADHD (Brown, 2013). This pattern can easily continue into college where parents become frustrated with lackluster performance. Also, in my clinical experience, parents frequently are exhausted from parenting a high needs child and hope that college will somehow solve the issues that were so frustrating in childhood.

With college students, it is particularly important to know how ADHD impacts that student emotionally. Each student has an ADHD story charged with social and emotional experiences. As that student transitions to college and faces all the challenges therein, those emotional experiences may affect coping, persistence, and resiliency. Brown (2013)
claims that research is lacking in the role of emotions, and emotional regulation is an underestimated and little understood function of the prefrontal cortex. He writes that studies have focused primarily on irritability or anger. Both positive and negative emotions are highly influential in starting and prioritizing tasks, sustaining or changing interest, managing working memory, and in the choices a person makes about what to do or what to avoid. Students with ADHD have “attentional bias,” meaning they pay attention to things that preoccupy them and hyperfocus on that activity. An example would be excessive time spent on social media. Students experience enthusiasm, stimulation, and pleasure, which enhances motivation. Or they may be excessively aware of signs of things to worry about or any signs of potential frustration. This can result in anxiety, discouragement, stress, and hopelessness, which compromise a person’s motivation.

Brown (2013) also writes about “ignition and motivation,” citing that research has focused too much on putting the brakes on expressions of emotion. Insufficient attention is given to the constant difficulties associated with simply getting started on necessary tasks. There is the problem of immediate gratification versus delayed payoffs, which means that students with ADHD struggle with staying committed to tasks for which the pleasure or satisfaction are not immediate. It is hard to motivate for a task when the payoff is delayed. This feeds the truly debilitating aspects of ADHD as untreated symptoms and behaviors continue into adulthood, bringing more suffering, internal turmoil and frustration in achieving goals.

This consideration of the role of emotions in students with ADHD is particularly important for counselors. Others in academia who interact with students may focus on
skills and techniques, and they may fail to comprehend how emotions impact motivation and performance. Counselors can be attuned to the nuances of emotions and address them in treatment planning.

**The Impact of Comorbidity**

In addition to the DSM-5, numerous studies indicate it is common for people with ADHD to experience other disorders (Beiderman, 2005). He reports a 60% comorbidity of Oppositional Defiant Disorder with ADHD, 55% coexistence of anxiety disorders, and a high rate of learning disorders and mood disorders. Adult males with ADHD have addiction rates in approximately 35% of cases. Barkley (2008) writes that ADHD rarely presents as an isolated diagnosis and that comorbidity rates are 50% or greater with learning and disruptive behavior disorders.

Nelson and Gregg (2012) examined students with ADHD and/or LD and compared them to a control group without these disorders. They found that college students with ADHD and/or LD reported higher levels of anxiety and depression when compared with high school students who were transitioning but were not yet in college. This study suggested that the increased expectations and stresses of college, along with reduced support from home and high school, may lead to more frequent or problematic internalizing symptoms. So mental health wellness may decrease over time during college.

Addiction is a serious possible comorbidity. Given the abuse of alcohol on college campuses, it can be riskier for students with ADHD transitioning into adulthood to use drugs and/or alcohol to self-medicate and develop an addictive disorder (Richardson,
2005). Weynandt and DuPaul (2008) write that numerous studies substantiate that drug and alcohol problems are a common problem on campuses, with approximately 90% of college students reporting regular consumption of alcohol. This is a dangerous intersection of high developmental risk with problematic substance use and abuse. Rooney et al. (2012) examined substance use in college students with ADHD as this is a largely unstudied area. They compared 53 students with ADHD to 39 without the disorder. The results of this study indicated students with ADHD used alcohol more frequently and they were 3.3 times more likely to have used marijuana and 4.5 times more likely to have used illicit drugs. They were more likely to have tried tobacco at an earlier age and continue to use tobacco. On one of their measures, the Alcohol Use Disorders Identification Test (AUDIT), scores for students with ADHD were higher on the hazardous use subscale and showed an increased likelihood of emerging dependence. Likewise, they found that ADHD was associated with greater impairment related to illicit drug use.

They suggest that therapists working with the ADHD population consider the role of substance abuse in assessment as they evaluate symptom presentation. Rooney et al. (2012) also suggest that students and parents of students should be aware of the elevated risk for problematic substance use. It may be prudent to consider the living environments on campuses and make choices based on less exposure to excessive substance use. Also, medical doctors need to be vigilant about prescribing stimulant medication and should assess current substance use. Education about the hazards of combining stimulant medications with alcohol or illicit drugs, as well as the health and legal consequences of
medication diversion should be offered. Finally, they call for the development of prevention and wellness programs specifically addressing the issue of substance use and students with ADHD.

Baker et al. (2012) examined reported levels of drug and alcohol use between college students with and without ADHD. They used the Michigan Alcohol Screening Test (MAST) and several self-report and interview questions. They were also interested in knowing if demographics (ethnicity, gender, and the particular year in college) were relevant. They also explored if subtype, symptom severity, and stimulant medication treatment accounted for differences within the group with ADHD. Participants were 148 undergraduate students. Of these 44 had a diagnosis of ADHD, inattentive type; 49 were combined subtype; and two were primarily hyperactive/impulsive type. Their results indicated that participants with ADHD struggled to stop drinking once they started. They related this to core deficits of self-restraint, problems with inhibiting actions, and lack of foresight to consider consequences. Compared to their peers the ADHD group reported less marijuana use, but researchers thought this may have been influenced by assessment conditions.

In terms of subtypes, Baker et al. (2012) found that those with the combined type of ADHD endorsed that they tried to limit their drinking, while this was not so highly endorsed by the inattentive subtype. However, the combined subtype indicated more arrests for drunk driving, which the inattentive type did not. This may speak to the problem of impulsivity.
In terms of ethnicity factors in the ADHD group, results showed that 81.8% of Hispanic participants, 61.4% of White participants, and 31.3% of African American participants indicated that they were “normal drinkers.” In terms of gender, 71% of female participants and 51% of males participants reported thinking they were “normal drinkers.” (Baker et al., 2012). In examining those who used stimulant medication, researchers found that 78% of participants taking stimulant medication reported blacking out. By contrast, only 32% of participants not taking stimulant medicine blacked out. Also, those taking stimulant medicine indicated more problems with relationships due to drinking. It appears in this study that medication treatment did not reduce symptoms related to drinking and relationships. It is not clear why this occurred. This study, as the authors point out, is tentative in nature (Baker et al., 2012).

Richardson (2005) writes about the pain and humiliation of ADHD. Individuals may feel frustrated, depressed, hopeless, chronically overwhelmed, isolated, ashamed, and rageful. She also suggests that alcohol or drugs may calm the physical, emotional, and intellectual restlessness of ADHD. Other process-like addictions such as gambling, online gaming, excessive Internet and social media use, and pornography viewing may be more tempting and problematic for individuals with ADHD (Brown, 2013). He refers to addiction as a habitual compulsion to engage in a certain activity or to use a substance, despite significant negative consequences. Individuals may be motivated to pursue the achievement dimension, the social interaction, or the emotional intensity.

This all illuminates the complex nature of ADHD for college students, with more future research and statistical tests needed to understand comorbid related problems and
how to help. As stated in my reflective statement in Chapter Three, students mandated for alcohol and drug counseling at Ohio University frequently appeared with symptoms of ADHD. Most campuses have remedial and judicial programs to help students who abuse alcohol and drugs, but is ADHD on the radar as a possible compounding factor? Also, are there other mental health issues that have not been addressed? As is the case for Ohio University, it might be a best practice to direct mandated students to mental health professionals in order to screen for these comorbid conditions and other addictive behaviors.

**Adult Symptoms of ADHD**

As stated earlier, the DSM-5 does mention how symptoms may be manifested in adults with ADHD. While research has increased, there is still a gap in the knowledge about how to best treat adults with this disorder (Knouse, Cooper-Vince, Sprich, & Safren, 2008; Barkley & Safren, 2008; Matte, Rohde, & Grevet, 2012). Capturing the clinical presentation for adults is challenging as well as determining the best threshold of symptoms to determine diagnosis for adults.

Knouse et al. (2008) illustrate how childhood symptoms may be considered in their adult presentation. They compare the DSM-IV childhood symptoms and write about how these may present in an adult with ADHD. The following table is adapted from the more detailed table by Knouse et al. (2008):
Table 1. Comparison of Clinical Presentation of ADHD Symptoms in Children and Adults

<table>
<thead>
<tr>
<th>Inattention Clinical Presentation in Children:</th>
<th>Examples of Adult Symptom Presentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently fails to give attention to details or makes careless mistakes in schoolwork or other activities. Often has difficulty staying attentive in work or play activities.</td>
<td>Omits important details in work projects or important steps in completing tasks. Submits incomplete work. Shifts to another task without completing the first job. Is bored easily by the task at hand. Struggles with a short attention span.</td>
</tr>
<tr>
<td>Often does not follow through on instructions and fails to complete schoolwork, chores or duties.</td>
<td>Constantly struggles to finish a project. Has multiple uncompleted tasks and projects around in personal life. Workplace productivity is compromised.</td>
</tr>
<tr>
<td>Often loses items necessary for tasks or activities.</td>
<td>Constantly misplaces daily tools such as keys, wallet, or cell phone. Often loses important papers or electronic files necessary to do or complete work.</td>
</tr>
<tr>
<td>Regularly forgets things needed to do daily activities.</td>
<td>Chronically late to appointments. Misses time-sensitive obligations. Procrastinates important tasks until later in the day. Often has poor prospective memory.</td>
</tr>
<tr>
<td>Is frequently and easily distracted by extraneous stimuli.</td>
<td>Often gets off-task due to distractions from people, the Internet, or anything else that grabs interest. Unrelated thoughts during tasks or conversations may interfere with focus.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hyperactivity–Impulsivity Clinical Presentation in Children:</th>
<th>Examples of Adult Symptom Presentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently fidgets with hands or feet or moves restlessly in seat.</td>
<td>Appears more restless than the average adult. May constantly fidget, tap things, move around across several kinds of situations in work and personal life.</td>
</tr>
<tr>
<td>May get up from seat in classroom even when remaining seated is expected. Often runs/climbs excessively and inappropriately in various situations.</td>
<td>Finds it difficult to sit for long periods of time such as a long social event, business meeting, college lecture or religious service. Seeks reason to get up.</td>
</tr>
</tbody>
</table>
Table 1: continued

| Engaging in quiet play or activities is difficult. Child may be perceived as constantly driven or on the go. Talks excessively. | Feels uncomfortable when physical movement is restricted and complains of almost constant urge to get up and move around. Experiences mental restlessness. May be noisy. Struggles to engage in quiet, solitary activities for extended periods of time. Can’t seem to stop and just relax. May talk inappropriately or excessively in relation to the social context. |

In addition to the ways that symptoms may present differently for children and adults, the threshold for diagnosis may differ. Faraone and Beiderman (2005) conducted a study of 996 adults via a telephone survey of randomly selected adults, and computed two diagnoses from the survey results. Symptoms were interpreted narrowly and broadly, with the results of 2.9% prevalence for a Narrow ADHD diagnosis and 16.4% for a Broad ADHD diagnosis. Patterns of diagnosis differ among clinicians. For example, a clinician who rarely diagnoses will be more skeptical about presenting symptoms. In this study, a narrow diagnosis included adults who showed continued evidence for ADHD in both childhood and adulthood. Symptoms had to occur often. By contrast, the broad diagnosis screening counted symptoms as positive if they occurred sometimes or often. The authors suggest that a broader criteria would result in more positive diagnoses and that many true adult presentations of ADHD fail to be detected. The study implies that ADHD should be considered more frequently as a possible adult diagnosis for patients. This would be especially critical if the adult is not getting relief from treatment of another primary disorder such as a mood disorder. A broad threshold diagnosis for adults may be warranted and clinicians may expand their consideration of clients to include impaired
executive functioning and emotional impulsivity. This is important for college mental health counselors, as undiagnosed students may warrant a broad ADHD diagnostic lens, so that proper identification may be investigated.

**College Student Symptoms with ADHD**

Heiligenstein et al. (1995) published one of the earliest studies on the psychological functioning and academic performance of students with ADHD. The investigators looked at the charts of 69 students who had a documented diagnosis of ADHD, with 26 students meeting the criteria for ADHD and 28 consisting of a control group. All students completed the Inventory of Common Problems (ICP) and researchers looked at Grade Point Average (GPA). The students with ADHD had lower GPAs and were more likely to be on academic probation. They reported poorer functioning on several academic variables. They did not find that students with ADHD were significantly different from the control group on other non-academic measures. These included mental health problems such as depression and anxiety, relationships issues, physical health, substance use, and lethality. But ADHD students with comorbid issues were screened out, and they acknowledge that this may have minimized impairment issues from comorbid conditions.

What is interesting about this pattern of academic impairment is that the students in the study did not have apparent academic problems in childhood or prior to college (Heiligenstein et al., 1995) They suggest that external factors such as academic difficulty, the loss of family routine and structure, or absence of institutionalized education services may be salient factors. They also speculate that college health professionals may struggle with identification of ADHD because of limitations in the definition of impairment, then
indicated by the DSM-IV. Clinicians may perceive academic struggles related to the suspicion of ADHD as an alibi for marginal effort or poor academic skills on the part of the student. What is important about this study is that the students in this study were generally well adapted and high functioning but still suffered impairments in academics. They were also almost entirely Caucasian. Twenty years later, more research indicates that there are cultural and gender factors relevant to college students with ADHD (DSM-5, 2013), and it is more likely that students will suffer comorbidities such as substance abuse and internal emotional impairments relative to ADHD that affect functioning (Beiderman, 2005; Brown, 2013; Richardson, 2005).

Weyandt and DuPaul (2008) conducted an analysis reviewing the recent literature on critical developmental issues for college students with ADHD. What they indicate is that these students experience a sort of conundrum. The educational and parental support they receive prior to college enables them to qualify for college. Yet, college students with ADHD are at risk for academic underachievement once they arrive in academia. They have impaired organizational skills, and deficits in study skills and executive functioning. Some studies also look at social functioning and these indicate that students struggle with social relationships. And, of course, all this may lead students with ADHD to experience psychological distress. These researchers acknowledge that accommodations and adaptations are offered students, such as audio resources, note-taking services, and extended time for exams. However, they found only two studies that examine the effectiveness of these interventions. What they concluded is that most studies of ADHD in the college age group are preliminary in nature or methodologically
weak. And, there is not a robust quantity of research.

Meaux et al. (2009) write about the health risks for students with ADHD. They conducted semi-structured interviews with 15 students with ADHD. They identified three global themes in this study. These themes were students gaining insight about ADHD, managing life, and utilizing sources of support. This article, written for nursing professionals, indicates that students with ADHD generally have insufficient understanding of their disorder and they fail to realize the whole impact of ADHD in their lives. Patterns of bad decision making and falling into a chaotic lifestyle can lead to negative academic and health consequences.

Meaux et al. (2009) also reveal that students frequently felt confused and frustrated about their diagnosis. They wanted to keep ADHD secret for fear of stigma and being labeled as different from their peers. Others, who had a better understanding of ADHD, had learned from experience about what works and what does not. They accepted their diagnosis and opened up to others. They accessed support and became more accountable for learning how to cope by developing life skills. Those who did not focus on managing behaviors frequently engaged in addictive type behaviors that interfered with time management, organization, staying focused, completing work, getting up in the morning, and going to class. These addictive behaviors were not just alcohol and illicit drugs, but process type behaviors such as video gaming. They also failed to remove distractions and they engaged in negative self-talk.

In reviewing support systems, relationships with parents, friends, teachers/tutors, academic support, and disability services were all critical. Positive connection and
accountability was helpful. The authors conclude that early education about ADHD and how untreated symptoms may impact self-management is sorely needed. They found that students infrequently used disability and healthcare sources of support, so providers must find ways to reach out to help these students improve self-management and coping skills. In this case, nurses can be important front line providers as they meet students who refill prescriptions and who access health services (Meaux et al., 2009).

Another study by Kaminsky et al. (2006) examines academically high-achieving ADHD college students by comparing them with less academically successful ADHD peers. They used 84 participants and compared GPAs, using academic reports; stress coping, using The Coping Resources Inventory for Stress; and intelligence, using The Wonderlic Personnel Test. They found that the amount of time spent on studying was the strongest determinant in their academic success. They also suggested that good time management and reduced financial stress are key factors. The successful students reported working harder and longer than their peers. They suggest that school programs aimed at supporting success for ADHD students should focus on how to create a sense of perseverance toward long-term goals, and teach the importance of managing procrastination and improving motivation. They warn that those students who rely on stress as a motivator to do work should be educated about the potential negative consequences of a chronically stressful lifestyle.

Rabiner et al. (2008) speculated that students with ADHD in college would have enjoyed academic success prior to college and may therefore not exhibit the same difficulties experienced by general populations of adults with ADHD. They were also
interested in how medicine impacted their adjustment to college. They gathered 1,648 freshman participants from two universities and administered a survey to them that focused on these items: ADHD status, ADHD symptoms, personality factors, academic concerns, social dissatisfaction, depressive symptoms, and alcohol, tobacco, and drug use (Rabiner et al., 2008). Sixty-eight students who participated indicated they were currently diagnosed with ADHD. Nineteen indicated they had been previously diagnosed with ADHD. Both of these groups reported high levels of inattentive and hyperactive-impulsive symptoms. Those who were currently diagnosed reported more concerns about academics and they experienced more mood-related symptoms. Student with current or past diagnoses did not report that they consumed more alcohol or used illicit drugs; however, they did report more tobacco use. Of the 68 students reporting a current diagnosis, 21 reported no medication treatment at all. They did not find large differences between these groups, but students who reported using medication were more likely to have used marijuana in the prior six months.

In terms of mood, females reported higher rates of depression than males and inattentive symptoms were relevant to the presentation of depressive symptoms. They also found that students at the public university were more likely to be depressed than students at a private university. In conclusion, the study suggests that the kind of adjustment depends on the particular domain being examined. Among the more interesting findings was that medication treatment seemed to provide little benefit. However, they indicate the need for more controlled studies with a more longitudinal emphasis. In the first semester, at least, it was also interesting to note that students with
ADHD did not seem to experience greater social difficulties or to use more alcohol. However, they were more likely to use tobacco and to experience higher incidents of mood problems (Rabiner et al., 2008).

Another study by Weyandt et al. (2013), which compares students with ADHD from their non-ADHD peers, examined differences in neuropsychological, academic, psychological, and social functioning. They wanted to monitor weekly academic performance in a systematic fashion. They pointed out that previous studies had methodological problems. They are based solely on self-report or they may identify the impact of ADHD symptoms on students. They theorized that the ADHD students would score lower on neuropsychological, academic, social, and psychological functioning measures than their peers. The researchers recruited 50 students, 24 with ADHD and 26 without ADHD. They were recruited from two universities, one public and one private. After the initial diagnostic interview, students with ADHD also completed several measures: Conners’ ADHD Rating Scales short form; BRIEF-A; Expression and Emotion Scale adapted from EESC; Conners’ Continuous Performance Test; California Verbal Learning Test-Second Edition; Symptom Checklist 90-R; Social Adjustment Scale Self-Report; and self-report questionnaires regarding study and organizational habits as well as use of alcohol and illegal substances. These additional screenings weeded out participants who self-reported but did not meet the full criteria for ADHD.

The students with ADHD were between 18 and 23 years of age and they were primarily male (62.5%). Of this group, 91% were White non-Hispanic. In addition, 44% were in their senior year of college and had fathers (65%) and mothers (62.5%) with
bachelors’ or higher degrees. Control participants were between 18 and 22 years of age and they were also primarily male (54%). In this control group, 81% were White non-Hispanic. In addition, 31% of these control group participants were in their senior year of college and had fathers (62%) and mothers (65%) with bachelors’ or higher degrees (Weyandt et al., 2013).

The students with ADHD revealed higher levels of psychopathology in numerous areas. They endorsed higher levels of Obsessive-Compulsive Behavior, Depression, Anxiety, and Hostility. They also endorsed higher levels of Flat Affect and Emotional Lability. In terms of academics, this ADHD group reported lower grades on course assignments. This could be attributed to deficiencies in organizational skills and overall executive dysfunction and greater difficulties related to their work role as students. In measures of social adjustment and leisure activities at college, there was not any significant difference between the groups (Weyandt et al., 2013).

One result was particularly interesting. While the ADHD participants appeared to experience greater impaired executive functioning than control participants, they demonstrated fewer differences in executive functioning on laboratory performance measures. They suggest that students with ADHD may hold negative perceptions about their functioning. It is possible that they expect themselves more impaired in relation to executive functioning than they actually are. There may be differences in intrapersonal insight. They have specific impairment but not global neuropsychological impairments (Weyandt et al., 2013). This has implications for mental health practitioners as it may be helpful to address perceptions of impairment with student clients. This relates to Brown’s
Weyandt et al. (2013) write that what is particularly compelling is that these differences are associated with moderate to large effects sizes. They also write that the presenting elevated symptoms are both internalizing and externalizing. They advocate for treatment that reduces these internalizing and externalizing symptoms. They also call for research to design, implement, and evaluate which interventions effectively supplement medication treatment.

Developmental Complexity, Gender Differences, and Giftedness

As the aforementioned research indicates, neither child or adult models of ADHD adequately capture the wide breadth, complexity, and persistence of this syndrome as it is found on college campuses among young adults. College is a pivotal developmental period and success or failure can launch a trajectory that lasts a lifetime. Chickering and Reisser (1993) write about The Seven-Vector Theory of Development, a comprehensive theory of psychosocial adjustment for college students. They write that each vector may be considered a path toward individuation, but the path may not be linear. These vectors are: Developing Competence, Managing Emotions, Developing Autonomy, Developing Mature Interpersonal Relationships, Establishing Identity, Developing Purpose, and Developing Integrity (Chickering & Reisser, 1993). For the student with unmanaged ADHD, achieving maturity and competence in these vectors can be stalled as neurological differences impede their progress toward individuation.

Ratey and Hagerman (2008) write that students with ADHD live in a state of chaos,
high drama, and deadline pressure. They describe ADHD as a malfunction of the brain’s attention system, a diffuse linkage of neurons that sometimes do not hitch together properly. These glitches in connectivity alter arousal, motivation, reward, executive function, and movement. Parents and teachers may say that people with ADHD just need to get motivated, yet is not that simple. For the student with ADHD, the reward center in the brain, a cluster of dopamine neurons called the nucleus accumbens, varies. What provides pleasure or satisfaction to the prefrontal cortex is a factor in motivation, and this fires differently for students with ADHD.

Paradoxically, as indicated by other studies in this paper, students with ADHD also have the ability to hyperfocus. Others do not understand why they can get completely absorbed in what they are doing yet fail to give attention to more important tasks such as a final exam or a research paper. Ratey and Hagerman (2008) explain ADHD as an attention variability disorder; the deficit is one of consistency from task to task. The attention system is patchy—discontinuous, fragmented, and uncoordinated. For an uninteresting task such as a required general education course, the ADHD brain faces a monumental challenge and becomes a master procrastinator. Students cannot control or manage their focus for a long-term goal, and it seems that they lack motivation or are lazy. Until they are up against a final deadline, they cannot arouse and motivate themselves to do the critical task. Abnormal sleep patterns are also common as circadian rhythms are also affected. The authors write that one of the best treatment strategies for ADHD involves establishing an extremely rigid structure which prioritizes self-care such as regular sleep and daily exercise. Yet, this structure is what often collapses in college.
Academics compete with social opportunities, extra-curricular activities, college sports, risky drinking culture, new financial responsibilities, romantic relationships, and roommate adjustments. The developmental path of adulthood collides with the chaotic brain of the ADHD college student.

Fleming and McMahon (2012) also write about the developmental context of college for students with ADHD. They write that the executive function impairment of ADHD will generally not change over time and it should be viewed as a fundamental deficit. They also assert that ADHD should be understood in all its complexity and that there are multiple pathways to symptomology and impairment. Accordingly, ADHD must not be viewed as a one-size-fits-all disorder where the same treatments will be effective with each individual. Rather, assessment and treatment for ADHD must be specific for each individual—identifying the core deficits and tailoring interventions accordingly.

Furthermore, they assert that these interventions should target inattentive-disorganized symptoms as the most significant functional impairment among college students with ADHD, and they cite studies that lend strength to this focus on inattention (Norwalk et al., 2009; Rabiner, et al., 2008). In addition, Erk (2000) writes the symptoms of individuals with ADHD, Inattentive Type, are more invisible. They are less likely to be diagnosed. He writes that children with inattentive type may experience greater levels of internal stress and a deep-seated dissatisfaction with how their lives are going. They may experience ongoing impaired personal-social functioning. He writes that counselor must address this internalizing dimension and consider how the personality has been shaped by the multiple effects of the disorder. Treatment will need to be long-term.
Another observation is that more research suggests that the socio-emotional context is highly relevant in managing the functioning and decision-making among emerging adults. With this age group, the reward-seeking motivation may trump the executive function system under contexts of high arousal, such as transitioning to independent living during freshman year. This is described as the “double deficit” in self-regulation as college students with ADHD can become besieged and exhausted when faced with increased executive demands along with the transitional stresses of college. They may develop adaptive impairment such as avoidance behaviors toward long-term goals (Fleming & McMahon, 2012). Skipping classes, failing to seek help from professors, immersing oneself in video games, socializing too much, engaging in substance abuse, and sleeping excessively may be indications of avoidance behaviors related to ADHD.

Gender bias may impact ADHD diagnosis and treatment among college students. Kelley et al. (2007) write that for females intentional impairments are often missed or remain undiagnosed longer because girls tend to exhibit different kinds of symptoms. They tend to be more compliant and less disruptive. Like males, ADHD can have an impact on their self-esteem, executive functioning skills, relationship dynamics, and ability to plan and execute tasks effectively. All these factors influence academic success, work competence, and career goals. In this study, they point out that little is known about the particular needs, educational patterns, symptom impairments, and career obstacles facing young women with ADHD.

In this article, Kelley et al. (2007) state that girls and women tend to show more inattentive type symptoms. Their symptoms tend to be more of an internalizing nature,
including withdrawal, somatic complaints, anxiety, depression, and social problems. They discuss that women may develop maladaptive coping styles as a result of experiencing negative feedback as children. Repeated failure and internalizing symptoms may generate a feeling of learned helplessness.

Fedele et al. (2012) suggest that gender affects symptom manifestation and impairment. They recruited participants from three universities with ADHD (N=164) and without ADHD (N=170). These students completed online measures of symptoms and impairments. They determined that college women with ADHD experience more symptoms of inattention, hyperactivity, and impairment than college women without ADHD. They also suggest that women have higher impairment than men with ADHD. The levels of impairment extend beyond academic life and reach into domains of social life, self care, relationships, financial management, and daily life tasks. The results “within gender” comparing women with and without ADHD would be expected. But, why might women report more impairment than men with ADHD? As the authors suggest, they may hold themselves to higher standards of over-activity and performance. Men may have a more positive bias and underrate their impairment. A limitation of this study is that participants were not asked about previous or current treatment. Plus, the sample was primarily European American (85%). However, the novel findings of this study point to the need for more research to determine how females may differ in symptom presentation and to train professionals accordingly. It would be interesting to consider if pathologies where there is more female presentation, such as eating disorders, are related to ADHD symptoms.
Kelley et al. (2007) advocate for more approaches to offer women good choices in how they may manage their ADHD. They view treatment as holistic and call for an array of medical, psychological, educational, counseling, and rehabilitation approaches to support women with ADHD achieve satisfying lives. In particular, recognizing the complexity of developmental problems for women pursuing postsecondary education, it is critical to recognize and treat this disability. They are typically receiving less support and understanding than their young male peers with ADHD.

Another emerging area of interest is how ADHD may impact high-IQ or gifted college students. Frequently, it is assumed that their superior intelligence excludes them from having ADHD. They may excel on certain tasks in which they have a personal interest, yet still suffer from the typical chronic ADHD problems with organization, time management, excessive procrastination, inconsistent effort, and inadequate focus. These translate into poor academic performance and chaotic personal living. Brown, Reichel, and Quinlan (2008) stress that it is critical to distinguish general cognitive ability from impairments from ADHD. They assessed 157 ADHD adults with IQ > 120 with eight normed measures of Executive Function (EF). Three of these measures were index scores from standardized tests of memory and cognitive abilities. Five measures were subscales of a normed self-report measure of EF impairments in daily life. The study showed that 73% of these high IQ participants were significantly impaired on five of eight measures of EF markers. Compared to the general population on all eight measures, the incidence of impairment was significantly greater.

Furthermore, clinical interviews with patients in this study indicated that
individuals with high IQs and an ADHD disorder may be delayed in getting assessed and treated. In my own practice, I do preliminary diagnoses every semester if I suspect ADHD, even when the students come from caring, educated families and have performed well in high school. Parents and teachers may blame their disappointing academic performance on laziness or boredom, especially when they notice the situational variability of their ADHD symptoms. They assume these talented individuals can focus on all tasks and do well; their lackluster performance is a matter of willpower (Brown, 2013). This late diagnosis may increase negative self-talk and poor self-esteem as they fail to live up to their high potential. They may be at risk for educational disruption, such as dropping out of college. Besides the personal costs, the social costs are immense. These gifted individuals may never recognize their inherent potential to achieve personal fulfilment and to contribute to society and culture.

**Intervention and Treatment Strategies for Adults and College Students**

The challenge for clinicians is to determine who has ADHD—are identified students connecting to resources and are unidentified students getting proper diagnosis? Multiple viewpoints or lenses are needed. So, in treating college students, a comprehensive psychological diagnosis is required to determine if the disorder exists and to offer a *DSM-5 medical view*. Subtypes of ADHD can be identified as well as any other learning disabilities or comorbid disorders. A clinician can understand broadly how this student’s ADHD symptoms in particular may affect his or her performance. Accommodations may be suggested to address the deficit, such as extra time to accommodate slow processing speed. A *developmental lens* is necessary for the clinician
to understand how ADHD symptoms may be impacting this student’s complex developmental journey. Delayed maturity or competence may be an issue for a student lacking in self-efficacy for tasks such as getting up for class. How are emotions affecting this student? Can this student regulate emotions and impulses? Does this student constantly feel a sense of overwhelming anxiety and failure? A student must be considered in his or her social context to determine if self-regulation is suffering because of social and environmental conflicts. Is the student falling into negative social behaviors such as regular alcohol abuse? Is the student experiencing positive friendship and romantic relationships? Are deficits in executive functioning negatively impacting social interactions? A systems lens brings attention to the family system that influenced this student. Did the parents understand the diagnosis? Do the parents have ADHD? Was the student constantly criticized for failing to achieve up to potential, resulting in lower self-esteem? Is this student in frequent avoidance mode due to poor self-efficacy and learned helplessness?

Medications are helpful for approximately 70% of those treated. As Wadsworth and Harper (2007) indicate, counselors need to be aware that the effectiveness of ADHD medication for adults is not well established, and that about 30% of those diagnosed will not respond adequately to stimulant medication or cannot tolerate side effects. Even for those who do respond, students may still have residual symptoms that may necessitate psychosocial interventions. The types of medication that are typically prescribed include short-acting stimulants, intermediate and long-acting stimulants, non-stimulants, and antidepressants (WebMD, 2016). There are many options, requiring a knowledgeable
medical provider and patience and persistence on the part of the patient. Much like antidepressants, it takes time to determine the right medication and dosage for the individual patient. This can be a problem for students who want a quick fix. Plus, side effects may occur and these must be considered in weighing the value and benefits of medication.

Unfortunately, there has been an increasing trend in diversion and nonmedical use of prescription medications among college students across campuses (McCabe, West, Teter & Boyd, 2014). They conducted a cross-sectional Web survey in 2003, 2007, 2009, 2011, and 2013 at a large public four-year university in the Midwest United States. From data from these surveys, they determined that one in five individuals reports nonmedical use of one prescription medication in their lifetime. Between 2003 and 2013, the diversion of prescription stimulants specifically increased significantly (McCabe et al., 2014). Prescriptions stimulants have high abuse potential. Nonmedical use of stimulant medications can cause depressive symptoms, sleep difficulties, irritability, headaches, and increased risk for abuse and dependence (Zullig & Divin, 2012).

Students with ADHD frequently feel pressured to share their medication. Advokat, Guidry, and Martina (2008) indicated that 84% of students diagnosed with ADHD were asked to give their medication to non-diagnosed students. Additionally, 54% had received requests to sell their medication, and 195 were consulted about how to fake symptoms to obtain a prescriptions.

There are many variables to consider. Non-prescribed stimulant users may use stimulants to get high, lost weight, or experiment recreationally. Those prescribed the
stimulants may also misuse them for recreational purposes. Others may be struggling with the rigors of academics, using stimulants as a “study drug,” or desiring to improve their grades. There are also those students who may have ADHD but who are not diagnosed who may be self-medicating and finding that stimulants help them legitimately to study. Students who misuse are generally misinformed about the risks and minimize any potential harm, thinking that medication is safe (Arria & Dupont, 2010; DeSantis & Hane, 2008). DeSantis and Hane (2008) conducted in-depth interviews with 175 undergraduate students at a large Southeastern university. They determined that there is cultural acceptance of stimulant medication as safer than street drugs, little social stigma to using, and the belief that these medications are no more dangerous than coffee. Students typically rationalize their use. This growing problem of prescription drug abuse must be considered as clinicians carefully assess, treat, and monitor students with ADHD.

Typically, the first line of support in a counseling center is individual therapy. There are a handful of studies that support counseling interventions for adults. These are individual and group Cognitive Behavioral Therapy (CBT), individual and group Mindfulness Training, and individual and group Psychosocial Interventions (Knouse et. al., 2008; Fleming & McMahon, 2012). The premise behind CBT is that cognitive perceptions affect behavior, and that such behaviors can be monitored and modified. Included in these may be training in behavioral management, social skills, anger management, and help with self-identity and self-esteem. Most recently, Fleming, McMahon, Moran, Peterson, and Dreesen (2014) piloted a group study using Dialectical Behavior Therapy (DBT) for college students with ADHD. This intervention adds
mindfulness and skills training to cognitive work.

Knouse, Sprich, Cooper-Vince, and Safren (2009) conducted a study to determine which symptoms are more frequent and severe for adults receiving medication treatment. By self-report and clinician-rating of 105 adults with ADHD receiving medication, they determined that disorganization and distractibility were the most frequent and significant residual symptoms. These overwhelming belong to the inattentive symptom list. They suggest that adjunctive psychosocial treatments should target the inattentive symptoms. This finding agrees with Erk (2000), who also writes that the inattentive cluster of symptoms are most impairing, particularly in a setting such as college that demands great focus and attention.

CBT interventions, individually or by group, include the identification of thinking errors, cognitive restructuring of maladaptive thoughts, psychoeducation, training and practice of skills/coping strategies, and accessing/utilizing support. With groups, the individuals experience less personally targeted interventions but gain peer normalization, support and modeling. Knouse et al. (2009) posit that CBT helps individuals cope with core symptoms, as supported by studies by Safren, Sprich, Perlman, and Otto (2005), and Solanto, Marks, Wasserstein, Mitchell, Abikoff, Alvir, and Koffman (2010). Safren et al. (2009) examined 31 adults with ADHD who were stable on medications but still showing clinically significant symptoms. They divided the participants between two groups, those who received medication alone and those who received both medication and CBT. Licensed psychologists delivered the CBT training in three core modules designed to target ADHD symptoms. They determined that CBT was an effective next-step
intervention for those receiving medication. The group received CBT experienced clinically significant improvements.

Solanto et al. (2010) used metacognitive therapy with a group of 88 adults with ADHD but no comorbid conditions. The study lasted over 12 weekly sessions. Half of the participants were randomly assigned to a metacognitive therapy group and half received supportive group therapy. With the metacognitive group, instead of focusing on what individuals think as in traditional CBT, they focused on how they think. Facilitators helped participants to focus on their thinking styles to improve time management, setting priorities, organization, and planning. The group learned broader thinking skills. Nineteen of 41 (42%) participants who completed the metacognitive therapy improved, compared with five of 40 (12%) participants who completed supportive therapy. This study shows that metacognitive therapy can be effective in helping adults with ADHD to improve practical skills and life management overall.

Both studies demonstrate that CBT and metacognitive therapy reduces functional impairments in adults. Among the skills learned in these groups were organization/planning, task lists, problem solving, generating and rating solutions to problems, learning to cope with distractibility, changing the environment, doing cognitive restructuring, and protecting against relapse prevention. However, Ramsey and Rostain (2006) caution that while cognitive type interventions are the emerging intervention of choice for adults, there are periodic mishaps in working with students with ADHD. College students may experience “coping fatigue” and fall into patterns of excessive negative thought when they fail to accomplish a task. They write that providers must
learn to help students handle these missteps and maintain encourage students to maintain a resilient, problem-solving attitude. Failures such as a bad grade, taking an incomplete in a class, or being placed on academic probation or suspension may ultimately lead to self-defeating behaviors. The student with ADHD may think that efforts are fruitless which leads to more procrastination and avoidance. The student may come to believe that he or she does not belong in college. Anticipating these potential roadblocks is critical when using CBT with college students and they stress that postsecondary institutions must strive for early intervention before the problems are overwhelming.

Mindfulness training looks promising and is an emerging area of research. Purposeful nonjudgmental attention to the present moment may be helpful to students. Mindfulness practice is a kind of mental training that can regulate attention and brain function, thus improving self-management skills and reducing mental health symptoms. A seminal study by Zylowska, Ackerman, Yang, Futrell, Horton, Hale, Pataki, and Smalley (2008) examined 24 adults and eight adolescents with ADHD who participated in an eight-week 2 ½ hour group intervention. Participants did weekly mindfulness training and also conducted an at-home mindfulness practice using guided meditations on compact disks. Seventy-eight percent of participants reported reduction in their total ADHD symptoms and 30% of those 78% participants reported that they experienced at least a 30% symptom reduction. The authors propose that mindfulness can significantly impact symptoms of attention problems, emotional regulation, and cognitive inhibition. Mindfulness can also facilitate improvements in anxiety and depression. The authors propose that mindfulness is a feasible intervention but more controlled clinical studies are
Fleming et al. (2014) applied mindfulness practice to a group of 33 ADHD college students recruited from three universities. Participants were between ages 18-24, were stable on medications for one month, and were screened out for substance abuse or comorbid conditions. The study was conducted over eight weeks, comparing a mindfulness skills-based intervention, DBT, with a skills handouts training. The theorized that while DBT targets individuals with borderline personality disorder, many of the symptoms of this disorder are similar to those experienced by students with ADHD such as emotional regulation and problems structuring the environment. The mindfulness intervention consisted of eight weekly 90-minutes sessions on skills acquisition and training. This face-to-face contact was supplemented by weekly 10- to 15-minute individual coaching phone calls. The participants in the skills handouts treatment intervention received 34 pages of self-help skills work pages, with no group work or additional phone coaching. The individuals in the first group receiving the DBT treatment showed improvement in executive functioning, quality of life, and improvement in inattentive and total symptoms of ADHD. They did not outperform the skills handouts group in improving mental health symptoms of anxiety and depressive symptoms, or in improving GPA. The DBT group rated mindfulness training as the most important skill learned, followed by learning to structure the environment and learning to plan. It appears that both mindfulness training and skills training can facilitate improvements, but in different ways. Also, it is interesting to consider if the phone coaching was a significant factor in treatment. This is the first randomized controlled trial of any intervention for
ADHD among college students, according to the researchers (Fleming et al, 2014).

ADHD coaching is an emerging intervention that has gained in popularity, following models of executive or wellness coaching (Quinn, Ratey, & Maitland, 2000). There are numerous ADHD “certification” programs but no professional licensure; it is unregulated. Plus, there is little research on the efficacy of coaching. However, the evidence that does exist is promising. An early study by Zwart and Kallemeyn (2001) studied a peer-based coaching program for students with ADHD and other learning disabilities. Results were promising as students developed better academic and coping skills. Allsopp, Minskoff, and Bolt (2005) examined the efficacy of coaching in an open trial with 46 college students with ADHD. Over the course of the semester, they received two to six hours of individualized coaching in academic skills by graduate students with training in special education. There were moderate effect size changes in GPAs. This study was evaluated both quantitatively and qualitatively. Quantitative analysis indicated that the group as a whole, and also the subset of students on probation and suspension, significantly improved their grades. Notably, they sustained this improvement over time. In the qualitative analysis, two factors were identified as important for improvement: independent use of strategies by the students and the supportive nature of the instructor–student coaching rapport. The support aspect speaks to the efficacy of a coaching relationship. Students who did not improve much had significant skill deficits and problems with emotional regulation as well as medication-related issues.

Swart, Prevatt, and Proctor (2005) similarly posit that peer coaching is helpful. They recruited graduate students to coach undergraduates with ADHD for eight weeks. A
focused case study about one of the participants, a female Caucasian nursing student, illustrated gains made in time-management, setting priorities, and other areas requiring good executive functioning and self-regulation.

Prevatt, Lampropoulos, Bowles, and Garrett (2011) suggest that “between sessions homework” within a coaching format is efficacious. They evaluated 13 coaching clients engaged in an eight-week structured program. Student clients who had a positive attitude, who wanted to please parents, and thought the quality of the between sessions work was practical, experienced overall treatment gains. In traditional therapy sessions, clients may be given homework assignments to be completed for the next session. A more formal coaching type agreement with specific homework related to ADHD may require more contact between counselor and student.

Perhaps the most relevant coaching study was a longitudinal study by Field, Parker, Sawilowsky, and Rolands (2010). It was conducted over two years in ten universities and community colleges throughout the country. A total of 110 students were tracked. Both quantitative and qualitative measures were used by the research team to measure and evaluate results. The study determined that the coaching model was highly effective in supporting students improve executive functioning and related skills. These were measured by the LASSI. In the qualitative analysis, researchers determined that the personal input and encouragement from a coach was highly impactful, especially in areas of positive self-talk and improved self-efficacy. Coaching helped students clarify and achieve personally meaningful goals. In a subsequent scholarly publication of this study by Parker, Hoffman, Sawilowsky, and Rolands (2011), they summarized the effect of
coaching on students’ goal attainment based on qualitative data. Students managed time more effectively, learned personal learning strategies, improved personal organization, persisted at goals longer, overcame ADHD obstacles, reflected upon goals more often, maintained motivation to attain goals, and improved well-being. In addition, the students benefitted from a unique professional caring relationship that was different from friends and family.

A clinician must also consider readiness to change. Murphy, Ratey, Maynard, Sussman and Wright (2010) identified factors that indicate a student is “coachable.” They consider the Transtheoretical Model of Change (Prochaska, Norcross, & DiClemente, 1994). Active learning cannot occur if a student is in a precontemplative mode of thinking, which is a state where the person is not aware or does not acknowledge a problem. Untreated mental health comorbid conditions may also interfere. They write that some students with ADHD are not candidates for coaching and these must be screened out. These are students who are also currently struggling with an active mood disorder, an anxiety disorder, substance abuse or dependence, or a major mental illness.

This may also apply to interventions such a CBT or mindfulness practice. Stable functioning and motivation must be established for psychosocial interventions to be efficacious. This illuminates the problem of coaches treating ADHD who may not have awareness of or licensure to treat mental and emotional problems. Again, the complexity of diagnosis and treatment is apparent.

A less considered but highly significant matter for students with ADHD is career development. Parents and students are more demanding of career outcomes, given the
high cost of a degree, especially at private colleges. There are few studies to help counselors who work on vocational and career issues with college students with ADHD. Dipeolu (2011) writes ADHD is the second most commonly endorsed disability by college students, following learning disabilities. This author adds that counselors need to develop a repertoire of effective strategies to help in the career planning process. Reilley (2005) writes that ADHD may have negative effects on post-college work performance. Interventions typically focus on what happens in the classroom in terms of attention difficulties. Yet, schools may neglect career planning and vocational decision-making difficulties for students with disabilities. Difficulties associated with ADHD may impede career development and complicate the student’s overall success. Significant mistakes such as showing up late, missing deadlines, or not showing up for appointments can ruin a student’s reputation in the workplace or make that student appear incompetent.

Reilley suggests (2005) that counseling professionals lack appropriate training to understand how ADHD may impact college and post-college work functioning. They are not prepared to offer interventions tailored to the ADHD student. He encourages counselors to pay attention to clues that a student may be impaired by ADHD symptoms such as family history of ADHD. Other observational clues may be excessive talking in session, lack of focus, low frustration tolerance, excessive and continued procrastination, time management problems, constant lateness, difficulty with planning, and jumping into impulsive vocational and career decisions.

Dipeolu (2011) also illuminates the fact that many students with ADHD have already experienced many failures. Multiple failures may translate into discouragement,
avoidance, and negative self-evaluation, which slowly forms the student’s self-image and ability to function in important domains. Similar to academic frustrations mentioned earlier, failures may translate into avoidance behaviors in pursuing career exploration and internships. The author recommends that counselors develop effective practices, starting with a referral for proper diagnosis if this has not occurred yet. Following that, it is important to promote the student’s acceptance of ADHD and to provide structure for the career planning process. A counselor can work with the student to instill hope to overcome the lack of motivation that may accompany multiple failures and to provide opportunities to learn about the disorder. A counselor can dispel common myths about ADHD and help students realize it is not a character defect, but also inform students of the chronicity and persistent nature of the disorder. Once this occurs, the typical career planning process of identifying work-related values, skills, strengths, interests/preferences, and such can begin with more success. Ultimately, with support, students can increase determination and self-advocacy. They must buy into a process that does not promise immediate gratification but requires a perspective on the long-term future.

Appropriate career choice is vital. A poor choice, such as sitting at a boring traditional job that requires constant sitting and attention to detail, may set a person up for failure. Also, students need to set realistic goals. They can become informed on how to address future workplace accommodation issues and ways to find environmental modifications and tools (Dipeolu, 2011). Counselors must understand the complexity that ADHD brings to the lives of students and have the knowledge and training to implement
strategies to execute successful career planning. Career planning is ultimately a lifelong process, not just a senior year worry, and counselors can be instrumental in guiding students and/or in educating career staff in student development about ADHD.

Finally, wellness is a priority for all college students. The type of daily dysregulation that occurs commonly in student with ADHD makes wellness problematic. Healthy sleep routines, balanced and nutritional eating, regular exercise, positive social relationships, harm reduction in drinking and other substance use, and medication adherence are all important facets of managing ADHD symptoms. Yet, the very nature of the disorder can make these types of wellness decisions difficult to achieve and maintain. Some researchers have suggested that ADHD is a problem with performance, not knowledge. So, despite their best efforts and extensive knowledge of their symptoms, students may continue to suffer functional impairments. Without the routine and stability of adequate self-care, the lives of students with ADHD may continue to be chaotic.

In conclusion, emerging research is promising but in its infancy. It appears that combinations of interventions using evidenced-based treatments such as CBT and DBT as well as less-proven interventions such as mindfulness and coaching can improve symptoms for students and increase chances of success in academia. However, researchers do not know whether interventions are generalizable or sustainable over time. As research is occurring, college counselors are challenged to consider what can be helpful in the here-and-now and what is possible in their unique institutional settings.

**Importance of the Study: Many Stakeholders**

The intersection of three trends—increased numbers of students with disabilities
coming to college, the increased complexity and comorbidity of mental and emotional disorders occurring on college campuses, and the increased specialized role of college counseling centers in student development—challenges postsecondary schools. Serving students with disabilities is a legal requirement and a social justice issue. While schools strive to meet the responsibility and do offer accommodations, there is little research on how to best serve students with ADHD. Women, minorities, international students, and the gifted may be particularly underserved. The ability of college counselors to detect and treat students with ADHD, to do outreach activities on campuses, and to educate other staff members is critical for many stakeholders. These are the stakeholders:

Postsecondary Institutions: The revolution in online learning, different financial models that include for-profit schools, and the increased presence of non-traditional students such as veterans challenge both public and private schools. With the heavy burden of student loans, consumers are questioning the value and cost of a college education. Retention is a critical issue for all schools. In a recent study of full-time, first-time students who began seeking a bachelor’s degree at a 4-year institution in fall 2005, only about 59% completed that degree within six years (National Center for Education Statistics, 2013). Helping students succeed to complete their degrees in timely fashion, and to have an education that increases their worth in the marketplace and ability to repay student loans is critical. Postsecondary institutions are also interested in reputation. A school that retains and graduates students, delivers high quality and a good collegiate experience to all students including those with disabilities, is highly desirable.

Parents: If parents are informed about the transitional challenges, they can select schools
more carefully. They can determine what kind of campus environment might better serve their child and also consider the extent of disability resources available. Are advisors and counselors trained to support students with disabilities? Parents may consider the role they will play in the transition. Will their child need more contact with parents? Will the child benefit from a personal ADHD coach? Is a child better served by staying closer to home or commuting to college for the first couple years? Would a gap year provide time for the student to mature? Parents need to carefully assess their child’s strengths and weaknesses and how ADHD impacts their child to determine a best fit. Anticipatory guidance can be strategic in helping students avoid some of the pitfalls. A good fit with a “high touch” campus with many resources may be a better choice than a school with a more prestigious reputation.

Faculty/Instructors/Tutors: Faculty and tutors may or may not have knowledge of the learning challenges of students with disabilities. They can seek more education in serving student with disabilities. Instructors may adapt their teaching strategies to address more learning styles and provide varied forms of assessment. With all the varied instructional strategies available because of technology, instructors can consider how to move beyond the basic lecture format to address the learning styles and needs of all students. They can develop alliances with resources on campus to proactively support their students with disabilities.

Disability Office Directors and Staff/ Academic Skills Center Personnel: In addition to coordinating individual accommodations, staff can coordinate services and link students with counselors and tutors who are effective in working with students with disabilities.
Staff can provide psychoeducation to students and proactively develop strategies to help. They can also learn what supports and assistive technologies might be helpful for particular symptoms. They may make referrals to ADHD coaches who can provide daily support and accountability.

Academic Advisors: Academic advisors can better advise and support students with ADHD by helping students develop reasonable schedules, balance academic and social activities, etc. They can make earlier referrals to other resources on campus if students continue to flounder because of ADHD symptoms.

Career Consultants/Workforce Training Coordinators: Career consultants can become informed about the chronicity of ADHD symptoms and how ADHD symptoms may impair a student in the workplace. Consultants can help the student assess strengths and steer them toward careers that play to strengths and avoid careers that may be difficult, such as one that requires high attention to detail or little variability in the job. If they understand the impairments related to ADHD, they can be more helpful in the process of seeking internships and jobs, especially the details of resume writing, interviewing, and other skills related to career planning.

Wellness and Alcohol/Drug Coordinators: These coordinators can become knowledgeable about possible vulnerabilities of students with ADHD, such as increased abuse of alcohol and drugs, increased comorbidity for other mental health disorders, and problems with personal wellness and skills of daily living. Understanding vulnerabilities of decreased self-efficacy, impulse control, and immature judgment can be valuable in developing early support and treatment interventions and making referrals to other
resources on campus.

Students: The stakes are high, given the high cost and social desirability of a college education. Given the paucity of awareness and research on how ADHD may impact the experience of college students, most students with ADHD have little understanding of symptoms may impact them in this new and challenging transitional experience. Students who struggle with symptoms and who do not access support may be at risk for lower achievement and failure. Stigma, avoidance, substance abuse, and low self-esteem may be barriers. Early identification and treatment can change a negative trajectory of self-blame and frustration, and enhance chances for success not only in college but life.

Society: Bernfort et al. (2007) and write about the long-term consequences for individuals who have untreated ADHD. The financial costs include production losses, health care costs, increased criminality resulting in incarceration, underemployment, and increased risk of psychiatrist problems. Fighting stigma and helping young adults access treatment increases their chances for living productive lives and contributing to their communities.

To conclude the literature review, functional impairments clearly exist for college students with ADHD. There is variability and complexity in both the nature and degree of the impairments for each student, as well as an enormous range of coping and compensatory strategies. Stigma and misunderstanding continue to exist. Treatment and intervention research is sorely needed. By closely examining the multiple complex experiences of counselors in postsecondary institutions, this study elucidates directions for future research, provider training, and student treatment paths.
Chapter Three: Methodology

Introduction

This chapter describes the research approach used in this exploratory and descriptive study. The research question, What is the experience of college counselors who provide counseling for students with Attention-Deficit/Hyperactivity Disorder (ADHD)? guided my research decisions. Psychological research has historically been dominated by the scientific method and positivism. In recent years, however, counseling psychologists have been promoting the merits of qualitative research. Psychology researcher Goldman (1976) writes,

Published research in counseling has, on the whole, been of little value as a base or guide for professional practice. Tied to largely inappropriate models derived from the physical sciences, much of the research has been trivial, atomistic, and obsessed with statistics and technical matters of research design. (p. 543)

He calls for a revolution in research that would include not only the kinds of research conducted, but that would also suggest ways researchers could collaborate throughout the process.

My therapy paradigm and training, professional clinical counseling, is closely aligned with counseling psychology. Counseling emphasizes wellness, holism, and empowerment of the client. In addition, as a counselor educator I am invested in pursuing research that best informs therapy practice. While this study is descriptive and exploratory, the desired end result is that it will contribute to research in a manner that will influence practical therapeutic interventions.
Counselors Berrios and Lucca (2006) noted the shift from positivism in the 1980s to increased qualitative research in the 1990s. While counselors are trained in evidence-based practices and rely on empirical research similar to other clinicians who work in mental health, they posit that counseling is unique. The philosophical premises of counseling make it suitable for narratives, life stories, and in-depth case studies. Counseling also focuses on process and the richness and depth of human experience, and thus aligns with qualitative research. Yet, they explain that little attention has really been given to qualitative research in counseling. Among the reasons they cite are little emphasis on qualitative research in training programs and the continuing strong influence of quantitative methods. They call for counselors to add a qualitative research component to improve their practice. They also call for new assumptions in research as advanced by Hill and Gronsky (1984): (1) the recognition of multiple realities and not just one truth; (2) the studies of human beings in a holistic rather than fragmented way, and (3) the awareness that linear models of causality are limited and that there is more usefulness in considering systemic or circular models.

Patton (2002) writes that Thomas Kuhn’s classic book, *The Structure of Scientific Revolutions* Kuhn (1970) has been highly influential in bringing the idea of socially constructed knowledge to science. Kuhn argues that tightly organized communities of specialists were the central forces in scientific development. Psychology and psychiatry have historically been organized as communities of specialists; these specialists hold power to determine diagnosis and treatment. I believe that the ADHD experience for young adults in college is not understood, and the experience of counselors who support
them in postsecondary institutions must be constructed by listening to the voices of the counselors themselves. The scientific, medical model of psychology is thus deconstructed and reconstructed, using a postmodern qualitative approach, to capture the multiple realities for the individuals studied.

Qualitative method in psychology and counseling also offers a vivid, dense, and full description of the phenomenon under study and the description is in the natural language of the object (Polkinghorne, 1994). The researcher is not obligated to pursue a particular investigative course and can thus remain open to discovering hypotheses, theories, and ideas about the topic that may not have been considered prior to collecting data (Heppner, Kivlighan & Wampold, 1992).

I selected a particular qualitative research method, Consensual Qualitative Research (CQR), which has been used and validated in recent psychological research (Hill, 2012). Hill added the element of consensus to the method that meets the expectations of psychologists for rigor of scientific inquiry (Hill, Thompson, & Williams, 1997). She has created a resource for this approach because of its increasing usage in the field (Hill, 2012). The American Psychological Association recently published this resource, with Hill as editor: *Consensual Qualitative Research: A Practical Resource for Investigating Social Science Phenomena*. In addition, counselors Hays and Wood (2011) write that within counseling research the strength of the CQR approach is that it combines post-positivistic and constructivist paradigmatic assumptions. The mutual influence of researcher-participant is valued.
The next portion of this chapter will offer an overview of Qualitative Methodology. Next, this chapter will discuss Constructivism as a theoretical lens for the research. The middle section of this chapter will discuss the particular features of Consensual Qualitative Research (CQR), and how they integrate with the design and theoretical choices of the researcher. The latter sections of this chapter will include the Timeline and Self as Researcher: Assumptions and Biases.

**Qualitative Methodology**

Qualitative methodology is needed to explore little-known topics and to explore under researched groups (Patton, 2002). Marshall and Rossman (2011) write that qualitative research is particularly well suited to research questions that delve in depth into complexities and processes, and that explore novel or ignored issues of marginalized populations. As discussed in the literature review, there is a lack of research about the adult experience of ADHD and even less is known the specific and complex experiences (academic, emotional, social) of young adults who come to college. As more students with this disability attend college, the gap in knowledge is troublesome. Little is known about how to assist these students in the academic environment. A quantitative methodology may measure particular features of ADHD symptomology or student functioning, but cannot capture the lived experience of the students or the counselors who support them. I maintain that academicians and student development personnel who attempt to assist these students are operating without a firm basis from which to design supports and interventions. Students and their families rely on the expertise of those in academia to support and guide students toward success. Students who are in distress will
frequently seek help in college counseling centers. There does not appear to be research
to help understand what counselors currently know and what they are doing, their
strengths and challenges, and how they feel about counseling students with ADHD.

I favor Creswell’s (2013) working definition of qualitative research:

Qualitative research begins with assumptions and the use of interpretive/theoretical
frameworks that inform the study of research problems addressing the meaning
individuals or groups ascribe to a social or human problem. To study this problem,
qualitative researchers use an emerging qualitative approach to inquiry, the
collection of data in a natural setting sensitive to the people and places under study,
and data analysis that is both inductive and deductive and establishes patterns or
themes. The final written report or presentation includes the voices of participants,
the reflexivity of the researcher, a complex description and interpretation of the
problem, and its contribution to the literature or a call for change. (p. 44)

Qualitative data captured through interviews, observations, and documents can
provide depth and breadth of research (Patton, 2002) that answers the central research
question. This methodology facilitates an understanding of the individual experiences of
college counselors, which are varied and complex, and also facilitates the creation of
themes from the individual experiences to inform best practices for supporting students
with ADHD overall. In this sense, this research is applied. This project seeks to explore
the nature and sources of human and societal problems, with the desired results of
contributing to theory that can be used to create problem-solving interventions (Patton,
2002). It has limited application context. A core assumption of this methodology is that
problems can be solved with knowledge (Patton, 2002). In addition, qualitative methods
allow the researcher to understand how the college counselor makes meaning of the
therapy experience and to study the counselor in the environment (Patton, 2002).
The literature review discusses the woundedness that accompanies a disability and how that feeling affects self-worth and self-efficacy, functioning in the current environment, and future success and happiness. The little research that has emerged about how to support college students with ADHD has focused on the experiences of the students themselves. Little is known about the counselors who do therapy with them. Yet, these key providers are in a unique position to make a difference in the lives of these young adults. Talking directly to the counselors in their natural setting of academia and encouraging them to share their experiences from many angles—their internal processing, their experience in therapy, their successes and challenges—provides data that has breadth and depth. This rich data enabled me to develop themes and theories about their experience that informs other counselors, educators, student affairs and offices of disabilities personnel, families, and most importantly—the students themselves. In this sense, the qualitative method opens up an understanding of how these counselors feel as they support and treat ADHD students who may feel marginalized, confused, or misunderstood. These counselors’ experiences, said in their own language in their own voices, may challenge prevailing attitudes and assumptions.

Experience is continuous and life is a storied experience (Clandinin & Connelly, 2000). As I pondered the participants to be studied, it was apparent that their experience in college counseling was nestled in a textured space of stories, perceptions, relationships, contexts, and puzzles. There were several layers and strands to understanding their experience: how the counselor understood and conceptualized the diagnosis; how the counselor determined the particular symptoms that were impairing;
how the counselor understood the family system and peer environment of the student; how the counselor understood treatment by counselors and educators in the present and past; how the counselor understood the psychosocial development of self in the ADHD student (identity, self-efficacy); how the counselor detected and treated the presence of comorbid psychiatric conditions; and how the counselor understood the impact of ADHD on career exploration.

In addition, there is a unique historical context. As indicated in the literature review, the ADA requires accommodations for learning disabled students and offers opportunities for students who most likely would not have pursued postsecondary education in previous generations. Beecher et al. (2004) write about factors that often affect students with disabilities such as lack of responsibility and accountability, little consistency, the absence of validation, an unawareness of resources, unrealistic goals, and the inability to compensate the same as before college. How prepared and confident do college counselors feel in meeting these needs? It was apparent that their experience as counselors needed to be framed in a “Three Dimensional Inquiry Space” (Clandinin & Connelly, 2000). This entailed personal, social, place, past, present, and future considerations as well as historical context. Creswell writes (2013) that understanding emerges through the interaction of researcher and participant; the individual experiences may shed light on the identities of individuals and how they see themselves. Face-to-face interviews are appropriate for a narrative design and this is the primary method of data collection. Also, I desired to gather information about the educational and clinical
background of the college counselors, length of service, type of institution, and how they perceive their jobs may have evolved and changed over the years.

**Researcher as participant.** Creswell (2011) also writes about the place of the researcher in qualitative inquiry. He writes that both the researcher and the researched party will change in the research encounter. Creswell also asserts that the participant’s story may reveal interwoven and interconnected story lines with the researcher as the researcher gains insights in her or his own life (Huber & Whelan, 1999). The collaborative interactive nature of the relationship, where the researcher also contributes to the topic through the process, makes qualitative research a logical choice. Huber and Whelan (1999) write that, “A sense of fluidity shapes our story to live by as it is composed over time, recognizing the multiplicity of situations and experiences we embody.” (p. 382).

In the latter part of this chapter my personal biases and experiences are revealed. I have already been affected by working with college students with ADHD and this study will undoubtedly affect researcher as self, especially as a clinician and educator. In this study, I interwove personal experience with the participants, and this interaction enriched the results and the experiences of both participants and researcher.

**Theory: Constructivism**

Guba and Lincoln (1990) assert that the human world is different than the natural, physical world and, accordingly, must be studied differently (Patton, 2002). With the population being studied, each student constructs a reality about having the diagnosis of ADHD. Neimeyer (1993) writes that these realities are interpersonally forged and
contextually embedded. These individual experiences result in multiple realities. Although the diagnosis is the same, the personal reality is different. Yet, by forming some consensus about these multiple realities, a researcher can construct a “truth” about their experiences that will facilitate understanding and emancipation. The latter concept, emancipation, is important because the stigma and confusion that accompanies an ADHD diagnosis may stifle the student in a higher education setting. Understanding by both the student internally and by others in the social environment can emancipate the student to achieve satisfaction and success in college. It can also lead to better diagnosis and treatment modalities. Emancipation is not a central focus of this study, but emancipatory data may emerge under this constructivist lens.

More specifically, Patten (2002) outlines Guba and Lincoln’s (1989) primary assumptions about constructivism research. Accordingly, Patton explains that truth is a consensus or agreement among informed constructors and not a matter of trying to correspond with objective reality. It follows that facts only hold genuine meaning within a value framework. Therefore, phenomenon can only be understood within the actual context where they are studied. These contexts are particular and cannot be generalized or transferred to another context or setting. So data derived from constructivist inquiry simply represents another construction to be taken into account in the goal toward consensus among constructors of knowledge (Patton, 2002).

My exploration to understand the central research question can only be constructed from listening to the voices of the persons who are being studied in their unique frameworks and contexts. Their worldview is socially constructed, as is the worldview of
those who interact with them. Psychiatry has created the categories and language for understanding ADHD. There is the flavor of “deficit” in the language. What if “deficit” is simply difference? And why are the natural strengths of ADHD not included in the psychiatric language? This research may be an impetus for creating new language and theory for understanding ADHD, and that challenges the deficit model of psychology.

**Consensual Qualitative Research (CQR)**

Psychologist Clara Hill was trained in quantitative methodology but descended into what she termed an “existential crisis” (Hill, 1984) when she realized this research paradigm did not work after a decade of researching verbal therapist responses in therapy session. Hill investigated qualitative methods and was particularly attracted to Grounded Theory, Comprehensive Process Analysis, and Phenomenology. As she tinkered with the methodology, she asserted that many of the methods seemed to lack rigor that those in mental health have come to expect (Hill et al., 1997). She proposed a new methodology, Consensual Qualitative Research (CQR) in 1997 as a method that she believed would be replicable and meet standards for scientific inquiry in psychology. She cited this blending of the three methods as an initiative to integrate the best features of each for psychological research.

In 2005, she summarized the progress of CQR as a recognized methodology as 27 studies had been conducted by that date (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). In her recently published book (Hill, 2012) Hill provides an annotated bibliography of studies that have used CQR. She identifies 120 studies that have been published in peer-reviewed journals prior to 2010. These studies cover a variety of topics
including psychotherapy, multiculturalism, trauma, and same-sex relationships. CQR is thus emerging as a useful research tool in the social sciences, particularly therapy-related fields. In addition, the flagship publication of counseling, *The Journal of Counseling & Development*, has identified CQR as an important emerging research method (Hays & Wood, 2011). The hallmark of CQR is that consensus is developed among researcher and participants regarding the experience of a phenomenon and its general applicability. CQR values collaboration and data consistency. It provides a researcher a thorough description of the phenomenon and allows for theory development.

Hill (2012) outlines the key components of CQR: (1) data analysis is gathered inductively, (2) researchers use open-ended questions to stimulate thinking and elicit rich responses, (3) words, narratives, and stories are primary rather than numbers, (4) each element is understood within the context of the entire case, (5) a small number of cases are studied in depth and with great focus, (6) researchers rely on multiple perspectives by working with primary team members to conduct data analysis and with one or two auditors to check the work of the team, (7) researchers seek and rely upon consensus among the team members, (8) there a emphasis on ethics, trustworthiness, and the role of culture, (9) researchers must continually return to raw data to verify their emerging theories and conclusions.

CQR is aligned with my constructivism approach. There are multiple constructed realities to be described and explored in gathering data, and these must be included in the research process. Researcher biases are taken into account when presenting results. The
deep interactions between researcher and participant are embedded in the process (Hill, 2012).

**Initial steps.** It is important to determine that the research question is suited to CQR. As a topic that has received little attention that I am aware of and that lends itself to in-depth discovery, the question is suited to this method. Open-ended questions provide an excellent means of gathering data. In addition, the inductive analysis, use of words and stories over numbers, intense focus on a small number of cases, and the emphasis on each case in context make this method suited to the central research question and the narrative design.

The next critical step was the selection of the research team and auditor(s). I recruited team members who have an interest in college counseling. In addition, I sought age and experience diversity: two clinically experienced counselors, doctoral candidates, to be team members; and another college counselor, doctoral level, with experience in qualitative methodology to function as auditor.

**Researchers’ biases.** I discussed biases and assumptions with members of the research team and the auditor on June 2 and also on June 10, 2015. Doctoral student #1 was a Caucasian female, age range 35-45. She commented that her general view of ADHD was that it was a disorder that applied mostly to male boys and adolescents. She thought it was “genderized.” Also, she did not think she had much education in her graduate training on ADHD. She thinks ADHD can be an umbrella for many issues and that it can be misused; in other words, “it is the go to diagnosis when a blank needs to be filled in when making diagnosis.” She thinks ADHD can become an “excuse” to not
perform. With adults, she suspects that some people engage in scapegoating and that ADHD offers “permission to fail.” She also has personal experience in that her 15-year-old niece has ADHD as well as other learning issues. She thinks ADHD is not just a behavioral issue as she has seen how her niece has struggled. She also had an adult friend in graduate school who struggled with chronic disorganization and who received an ADHD diagnosis as an adult. She noted that the friend felt a huge relief when the diagnosis was made but this research team member was privately skeptical. She said she has mixed feelings. She believes it is a valid diagnosis but she is not sure how symptoms are measured and what assessments are most valid. She also does not know much about medications to treat ADHD. She thinks ADHD poses differential diagnosis problems, i.e. how does one distinguish between ADHD and anxiety? In terms of the college population, she thinks students may not feel comfortable coming in to a college counseling center. She thinks college coaches will do anything to keep their students playing and may be more aggressive than the students in help-seeking. She also feels the transition from high school to college would exacerbate symptoms for students with ADHD.

Doctoral student #2 is a Caucasian male, age range 35-45. He shared that he has worked with clients who have ADHD and has diagnosed them. However, he feels it has been historically over-diagnosed and medicine has been too freely prescribed. He thinks this has been partly driven by med-seekers. He thinks this has calmed down a bit and that physicians are more careful about prescribing stimulant medicines. In terms of his own experience with diagnosis, he said he looks carefully at what a client reports versus what
behaviors that he observes. He is suspicious of people who self-diagnose ADHD and he is aware of the complexity of diagnosis, i.e. ADHD symptoms may really represent another disorders such as anxiety or substance abuse. Plus, there is the added clinical issue of comorbidity which makes diagnosis difficult. When he does think he is seeing ADHD, he focuses on behaviors that indicate attentional issues, the inability to start and execute important tasks, the inability to complete tasks, and the sense of being bored (lacking stimulation) that are pervasive since childhood. Depending on the age of the client, he thinks symptoms that look like ADHD are actually behavioral issues. In this sense, he thinks symptoms may reflect a developmental issue. With adult and college-aged presentation of ADHD, he thinks the abuse of stimulant drugs is a significant problem and that students are self-medicating. He said stimulant medicines can be like speed when improperly used. He is somewhat skeptical of adult ADHD. He thinks they may malinger to get a prescription. He has worked in crisis and residential treatment facilities and acknowledged that his views have been influenced by this clinical experience. Doctoral student # 2 is also concerned about who is diagnosing and who is prescribing. He think family physicians diagnose too rapidly and that it takes an expert to evaluate and diagnose, such as a psychiatrist or psychologist who are trained and qualified to administer a battery of tests. He also thinks ADHD is a “white” diagnosis and that minority populations such as African-Americans don’t get diagnosed. He also thinks there are gender differences in presentation and he reflected that women may be diagnosed as having borderline personality disorder rather than ADHD because of gender bias in the conceptualization of symptoms.
The auditor is an African American female, age range 55-65, with 30 years of experience in college counseling and who has a her doctorate in Counselor Education and Supervision. Her biases include the belief that ADHD goes unrecognized and that it is inappropriately treated. She believes professors offer the best help they know how to offer, but that it is unrealistic to think that strategies that work for non-ADHD students will work for those with ADHD. She also thinks that medication is not the “be all and end all” of treatment, and that it will not work for all people. With her years of experience, she believes not all college counselors are capable of working with students with ADHD. She has extensive clinical experience working treating both individuals and groups in the college setting and in private practice.

In summary, the research team members brought an understanding of ADHD but held some reservations and suspicions about diagnosis, especially adults. They both understood the complexity of the disorder and the inherent cultural and gender bias that has developed around understanding ADHD. They were aware of the challenges of differential diagnosis and comorbidity. They were both aware of the problem of med-seekers and the abuse of stimulant medication. The auditor, with broad and lengthy experience in college counseling thought ADHD was under-diagnosed. She believed not all college counselors can work effectively with students with ADHD.

**Participants.** Next, the sample was chosen. Participants must be able to communicate in a coherent and cooperative manner. Hill et al. (1997) recommend criterion-based sampling that are clearly defined. This is sound research practice and also allows results to be transferable. The recommended number of participants to be recruited
is eight to fifteen participants. This is a small sample to be studied intensely. The interview protocol needs to be developed based on the literature. In CQR, open-ended semi-structured interviews are recommended, starting with “warm up questions” to build rapport. In addition, pilot interviews are recommended to fine-tune the protocol. Rubin and Rubin (2012) explain that semi-structured interviews are developed when the researcher has a specific topic to learn about, has prepared a limited number of questions in advance, and plans to ask follow-up questions.

Accordingly in this study, eight participants were recruited from counseling sites with the following criterion: (1) currently working at a college or university counseling center or has worked at a college or university counseling center within the last three years, (2) at least two years of experience working in college counseling, and (3) an advanced degree in counseling, social work, or psychology. Gender, ethnicity, and experience were acknowledged in the demographics section of the study. I sought to capture multiple experiences of counselors in their naturalistic setting at Midwestern institutions.

I recruited interviewees through counseling listservs and the snowball method of recruitment and an online recruitment flyer (see Figure 2). A $50 Amazon gift certificate was offered as an incentive to participate. Over a nine month period, I recruited and interviewed eight college counselors who met the criteria of the study. The setting was naturalistic with six interviews conducted at the university sites and two in other private locations. Each interview lasted 60-90 minutes.
Procedures for collecting data. The data collection process consisted of conducting face-to-face interviews, keeping memos about impressions, and transcribing the interviews (Hill, et al., 1997). Accordingly, I conducted all the interviews face-to-face in a responsive interviewing style and recorded the interviews on a password-protected device. I also kept notes about impressions during the interviews. After transcribing all the interviews, I studied all the data extensively. True to the methodology, I stayed close to the data by performing the transcription as well as continually reviewing the transcripts. As a Professional Clinical Counselor, I possess interview skills and understanding of boundaries and ethics in interviews. I used a responsive interviewing style (Rubin, & Rubin, 2012) that fits the topical nature of the study. Rubin and Rubin (2012) write that the topical interviewing process is a research quest to seek different information from various participants. These participants also hold varying perspectives about the information they tell the researcher. The researcher’s task is to thoughtfully assemble this information and these perspectives to create a coherent answer to a research question. They describe the topical interviewer as a portrait painter rather than a photographer, as details are selected and interpreted to create an image of the subject. In addition, a topical style is appropriate because the research questions addresses a specific problem. My version of interviewer as portrait painter is indicated in my prototype later in this chapter.

Confidentiality was maintained at all times. Identifying names were replaced by pseudonyms. Identifying information was deleted prior to submitting data for review by team members and the auditor. All interviews were transcribed verbatim (except for
sighs, fillers and non-language such as “um”). In addition to the password protection on my recording device, transcriptions on my computer were also password protected.

**Piloting.** Marshall and Rossman (2012) write that pilots can be used to refine research instruments such as questionnaires and research schedules. In addition, pilots help the researcher to better understand self as researcher. Technical problems such a recording devices can be tested. Marshall and Rossman (2012) encourage piloting as a way to strengthen a proposal. Hill (2012) also encourages pilot interviews to ensure that the interview is capturing the relevant data. Hill suggests that the piloting be conducted with two people who fit the sampling criteria but are not part of the final sample. I did not conduct a pilot as insufficient participants were recruited and it was important to interview at least eight counselors. However, I did practice interviewing prior to the interviews to test the recording device.

**Interviews, interview process, and transcription.** Interview questions were formulated based on the central research question and the literature review. Rubin and Rubin (2012) write that the interviewee’s experience with the research concern is a broad entry to a topic. After writing the questions, I consulted with members of the research team as well as the dissertation committee (at the time of dissertation proposal) to fine-tune the questions, rearrange the order, and develop new probes. The content of the questions was essentially the same but the consensual input improved the quality of questions. The following questions were asked to explore in more detail to explore the central research question.
Research Question: What is the experience of college counselors who provide counseling for students with Attention Deficit Hyperactivity Disorder (ADHD)?

Can you tell me about your experiences working with students with ADHD?

What have been your successes?

What have been your challenges?

Of these challenges you have identified, what have been the most frequent and frustrating?

How do you conceptualize ADHD clinically?

Do you use a particular model of ADHD or psychological theory and how do you apply it?

How do you explain a potential diagnosis of ADHD to a student?

Have you become aware of any particular comorbidities with ADHD?

Please discuss your thought on how comorbidity relates to and impacts treatment.

Please explain the training you received in assessment and treatment of adult ADHD in your graduate training and subsequent continuing education, reading, and training?

How does a student’s diagnosis (or potential diagnosis) come to your awareness?

What are your thoughts about why more males are identified than females?

What are your thoughts about academic and career planning for students with ADHD?

Has your understanding of ADHD changed over time? If so, how?

How do you think families understand the diagnosis?

What is your perception of how schools and families prepare ADHD students for
college, i.e. how are high school and college different?

How do you think other non-clinical staff in postsecondary institutions understand the diagnosis?

What has been your experience in connecting students to other resources in the college or making outside referrals?

How do you think students understand their diagnosis and the kinds of supports they need to succeed in academia?

How does their understanding impact your work with them?

What has been your experience with students who use medication to aid symptoms?

How do you think the time of diagnosis, early or late in development, impacts the college experience for these students?

How do you think culture, ethnicity, and socioeconomic status impact the students who have ADHD?

What do you perceive are the most significant obstacles these students face in college?

Along with this, what do you perceive to be some general strengths for these students?

How do you think ADHD impacts identity and self-esteem?

What do students do to cope and adapt to ADHD?

Please explain how your institution provides resources for you to get the help you need to serve these students.

What do you think would help you work most effectively with student with ADHD?
What are your ideas on how to better serve the ADHD population in colleges?

Prior to the interview, I cited a self-written introduction that was prepared in advance. It read,

Thank you for agreeing to participate in this study. I became interested in studying the experiences of college counselors who treat with ADHD because of my counseling experience at Ohio University and Denison University, and also because of personal experience in my own family. While all college counselors know about the diagnosis of ADHD, the training and experience to work with students with this kind of hidden disability is varied. By intensely studying the experiences of college counselors who do therapy with students who have ADHD, I hope this research will contribute to a richer understanding of the students and the kinds of treatments and interventions that are occurring in postsecondary institutions. I also hope this research will contribute to novel treatments and interventions in the future.

**Procedures for analyzing data.** The process of moving from field texts to research texts is complex (Clanidin & Connelly, 2000). The researcher must spend many hours reading and rereading the field text. There may be continuities and discontinuities, gaps or silences, and emerging tensions. This is a fluid process and the researcher must stay close to the data while contextualizing the work socially and theoretically. Ultimately, I hoped to create new theoretical propositions from the central research question that will improve support for students. By conducting all interviews personally, and continually reviewing the transcripts, I stayed closely connected to research data from field texts.

**CQR analysis.** CQR Analysis provides the steps to analyze the data. Data analysis begins by developing domains, or topic areas (Hill et al., 1997). I created a list of domains stemming from the interview data. While domain development has historically been created by the literature review, researchers may also work directly from the data (Hill et al., 2005). My domain list evolved as the interviews were analyzed. This list was deleted, added to, or combined until I was satisfied that an appropriate list had been
developed. After the initial domain development, I read and reread through each transcript and assigned data to a domain. A phrase to several sentences of data were assigned to a domain, and every word was be placed somewhere. Data that did appear to fit into a domain were moved into an “other” domain to be examined later. If data fit into more than one domain, they were be “double-coded” (Hill et al., 1997) into multiple domains. After I inserted data into domains, the research team reviewed the work to verify or challenge the most suitable domain for the data. Once team agreement was reached, a consensus version for each case was created, which includes the domain titles followed by all of the raw data (transcribed interview excerpts) for each domain.

The second major step in CQR data analysis was the construction of core ideas, which summarized the content of each domain for each case (Hill et al., 1997). Similar to the Grounded Theory process of “boiling down” the data, the goal of developing core ideas is to describe the interviewee’s response in a more succinct fashion. During this abstraction process, I strived to stay true to the explicit meaning of the interviewee’s words and not search for implicit meanings. I also stayed focused on the domain I was working in with the data. The research teams also reviewed the core ideas. After consensus was reached for the core ideas for each domain of a case, the cases were sent to the auditor for review. Hill et al. (1997) suggested that the auditor review and provide feedback about (1) whether the data has been inserted in the correct domain, (2) whether all important data have been formulated into core ideas, and (3) whether the core ideas are succinct and correct with respect to the raw data. Once the auditor’s comments were returned, I addressed the feedback and sought consensus with the team about whether to
accept or reject each comment.

In CQR data analysis, cross analysis is the final step. This process involves the researcher searching for patterns to determine how core ideas cluster into categories. In this project, core ideas were coded into narrative categories. As part of the cross analysis, I examined the representativeness of the sample by determining the frequency of categories within the whole sample. According to Hill (2012), this is influenced by Comprehensive Comparison Analysis: (1) a category that applies to all or all but one of the cases is labeled general, (2) a category that applies to more than half of the cases is labeled typical, (3) a category that applies to either two or three and up to half of the cases is labeled variant, (4) any categories that apply to only one case are omitted or dropped.

Once I completed the cross analysis, a final review by the auditor determined whether the core ideas fit well in the specified categories, whether the category labels were appropriate, and whether categories should be further divided or collapsed. Again, I digested the auditor’s comments and came to a consensus on whether to accept or reject the comments.

Through every stage of the process I kept personal memo notes and also tried to highlight memorable quotes. Rubin and Rubin (2012) write that these memos and quotes suggest themes that may warrant more systematic analysis as the process continues. I copied these significant quotes into the data findings section, Chapter Four, for interest and clarity.

Once the analysis had been reviewed by the research team and auditor, I examined
patterns or pathways that emerged in the data. Results included the presentation of domains and core ideas, and the merging of data in the cross-analysis of interviews. A summary of a prototypical case is included in the results as well. Further discussion in Chapter Five focuses on the meaning of the results and ideas for future research. The data depicts a collected and reconstructed view of the experience of college counselors who do therapy with students with ADHD. I hope I constructed the data provided by the interviewees to provide new information that will be relevant to the audience.

Trustworthiness. Hill and Williams (2012) cite three criteria that consensual qualitative researchers can use to establish trustworthiness. She cites Morrow (2005) and Williams and Morrow (2009) as researchers who refined these criteria: (1) establishing the integrity of the data, (2) balancing the tension between subjectivity and reflexivity, and (3) clearly communicating the findings and their applicability to research and practice. In this study, I strived to honor these criteria and to stay true to the methodology.

Integrity of the data. In this CQR study, per the methodology requirements, I described the team members and auditor in detail as well as their biases and expectations. I included a description of team members and the auditor in the analysis. The sample of eight was adequate and a copy of the interview protocol was included in the appendix. A table was included to briefly describe each participant as well in the body of the study. Because of the small sample and the qualitative nature of the study, generalizability would not be an appropriate concept. Rather, this study attempted to provide sufficient
detail about methods and about the participants so that the findings may carry weight to hold transferability to other settings.

**Reflexivity and subjectivity.** CQR researchers must be mindful of balancing the tension between what the participants say and how the researcher interprets their responses. The inherent subjectivity of the researcher is acknowledged. To that end, my assumptions and biases are offered at the end of this chapter so that personal issues can be bracketed (Hill et al., 2005). In addition, the presence of team members and an auditor increases consensus. Multiple perspectives increase a truer approximation of participant’s meanings (Hill et al., 1997). As the primary research tool, I made the final decisions on the data. However, by utilizing this consensual process, the integrity of the project was enhanced.

**Clear communication of findings.** Results and their meanings should be communicated clearly and with purpose. Hill (2012) encourages CQR researchers to tie findings to theory and to the previous literature. The context of the findings (strengths and limitations of the sample, the setting, the researchers, the procedures) are described in Chapters Four and Five. With this study, it is my intent to demonstrate how the findings increase description and understanding of the experience college counselors who provide therapy for students with ADHD. This deeper understanding can be used to provide more individualized and targeted interventions and supports for these students in the academic setting. They can also be used to better inform student and their families of the transitional challenges of college. Given the stigma and lack of understanding about ADHD, this study may also serve an emancipatory purpose and engage more social
action, i.e. colleges and universities may more intentionally develop multimodal programs to help students with disabilities.

I have strived to analyze and reconstruct the experiences of participants with clarity and creativity to inform the audiences of a new empowering story that can be created for counselors and the students with ADHD that they serve.

**Timeline**

After acceptance of the research proposal, the IRB was submitted to Ohio University Research Office immediately after. After some revisions and final approval of the IRB, I sought participants, screened and selected participants, and arranged interview times. The interviews were conducted from 2015-2016. Transcription and memo writing was ongoing as the interviews were conducted. Data analysis continued through fall of 2016. I solicited input by the review team and auditor as each stage of analysis occurs. There were some delays because of team availability and time constraints. This delayed the final analysis. The latter chapters of the dissertation were written in fall of 2016, after all the analysis and review had been completed by me, the team, and the auditor.

**Self as Researcher: Assumptions and Biases**

To conclude this chapter, it is incumbent on me as primary researcher to expose my assumptions and biases. As a clinician, I was trained to diagnose and treat according to the DSM-5, the “Bible” for mental health professionals. While it is an extremely impressive body of work, it has been drive by quantitative evidence based practices of what clinicians observe and categorize (DSM-5, 2013). First, I am mindful that it is always a work in progress and clinical work should not be limited simply because we
have not described what is occurring with the clients we serve. Second, quantitative methodology and categorical descriptions do not illuminate the inner or environmental experience of the client.

While the DSM-5 expands the understanding of ADHD and illuminates that adult symptoms of ADHD may persist, the actual experience for adults, particularly the adult college student, is simply not understood. The literature review discusses that leading researchers have called for studies to find best practices for diagnosis and treatment for adults. I value the DSM-5 but look at it with a critical eye. The gap in both diagnosis and treatment for adults with ADHD is a significant problem. Also, the DSM-5 does not capture the various dimensions of individual neurological difference and complexity.

Creswell (2013) writes that the qualitative researcher must address assumptions about ontology, epistemology, axiology and methodology in designing a study. Ontologically speaking, I think that reality is seen through multiple views. Every person who experiences a particular mental health issue experiences symptoms in a unique way. While some generalizations can be made broadly about clusters of symptoms, the degree and intensity of symptoms is different for each person. In addition, the person experiences symptoms within a context—family, school, community, culture—and the social factors influence the how the person experiences reality. Epistemologically speaking, I assume that the clinician cannot know the person who is being served without learning about that person’s subjective experience. As a mental health professional, there is a distance between therapist and client that is often perceived as a power differential. The clinician cannot treat based on what the clinician knows or sees without
understanding the person’s experience in a very deep way. In terms of axiology, I acknowledge the presence of social bias. With ADHD, there is often a bias that a learning disability makes a person “less than.” This is often the perception of educators and it is a perspective often adopted by the client. Because of diagnosis and experience in the family, educational system, school, and community, narratives have been shaped that may be harmful to treatment. Certain value judgments have been formed about ADHD. Finally, in terms of methodological assumptions, I believe that an inductive logic that is flexible and that looks at the persons in their immediate and narrative context, can illuminate the true experience. Induction provides a basis for deductive analysis that can be used to develop themes and insights; these may be translated into practical strategies.

Because ADHD is classified as a disability, I also believe that there is an advocacy aspect to this research design. Frequently in our social contexts, individuals have constructed a certain worldview of what is normal and not normal. Persons who are disabled are frequently marginalized and underrepresented. Those with ADHD have a hidden disability; they may experience disadvantage and lack of advocacy and support in academia because well-meaning educators and clinicians simply do not understand the complexity of their experience of disability.

In qualitative research the researcher is the instrument, bringing one’s unique personality, curiosity, experience, and speculations to the study. I started the doctoral program with an entirely different topic in mind for research. ADHD was not on my radar, especially because I did think that I could contribute to the immense research discussion, with many experts weighing in on the subject. However, the topic choose me
and I could only nod my head and proceed in the path that was marked for me. Even with thousands of articles and books on the subject, I felt compelled to tackle new questions that were not examined in current research.

In my first professional job as a counselor I worked in community mental health. Some clients simply could not organize themselves to work on any treatment plan or to improve their lives. They had poor educational experiences. I began to wonder if I was looking at undiagnosed ADHD. I discussed this with a psychiatrist I worked with who basically disregarded my concerns; this psychiatrist maintained that ADHD should be diagnosed by age seven or it doesn’t exist. However, I made more queries and learned that ADHD does indeed present in adulthood. Later, in my doctoral internship work at Ohio University, I worked with students mandated to attend two sessions of counseling for alcohol and/or drug offenses. In counseling these students I noticed that I frequently came across the diagnosis of ADHD and it was often not treated. Students presented various manifestations of core symptoms. Treatment was irregular. Some were diagnosed and never treated; some had high support and treatment as children but lost that structure when they went to college; some appeared to have symptoms but had never been assessed. I realized that certain social behaviors, abuse of alcohol and drugs, sometimes morphed into a form of self-medication to deal with feelings of low self-esteem, a sense of constant chaos, a failure to master the organization and focus necessary to succeed in academia, and helplessness over how to access help.

At this point in my career, my research was influenced by the impression that ADHD was under-diagnosed and also undertreated. I thought comorbidity with substance
abuse was high. I also thought that people suffering from ADHD did not understand how it impacted them, and frequently experienced low self-esteem because of their inability to understand and manage core symptoms. I began to feel a great empathy for these students who struggled so hard to manage their lives.

In my desire to improve my ability to work with these students, I joined a senior colleague in facilitating a weekly psychoeducation/support group for students with ADHD. I believe I started to understand these students, who were bright, creative, and talented, but lived in daily frustration and frequently underachieved. While postsecondary institutions realize they may experience more challenges academically, socially, and relationally because of their symptoms, I developed the opinion that most institutions simply don’t know how to best serve them.

Working in college counseling centers at both Ohio University and Denison University, public and private institutions respectively, I noticed that many students with ADHD showed up for counseling. Typically, ten percent or more of my caseload would include students with ADHD and related comorbid mental health issues. While these students shared core diagnostic markers, their experience with ADHD in academia was different. I also realized that my colleagues, while understanding ADHD diagnostically, were wide-ranging in their training and understanding of how to help these students. I wondered about their successes, frustrations, and concerns. In addition to the actual syndrome, other issues such a comorbidity, gender, ethnicity and culture, and socioeconomic background factored into how these students fared. With demanding workloads and increased severity of mental health cases coming to college counseling
centers, I wondered about the experience of these counselors serving students with ADHD. Having spent much of my clinical time on the front line with these students, I have pondered if I have sufficient skills and tools to help. Personally, I had little training about ADHD and what I learned was a single in a class that focused on diagnosis and treatment of children. I learned that there is little research on best practices to help students with ADHD succeed in postsecondary institutions. So I bring the assumption that most college counseling centers are not equipped to effectively meet the needs of students with disabilities, specifically ADHD. Most treatment focus has been on children.

Finally, after a considerable amount of personal study and clinical experience, I experienced a minor epiphany in my personal life. A couple years ago I was sitting at a long table with ten family members, eating barbequed chicken wings and burgers after a Saturday morning of junior league football games. Watching all the distracted interactions, impulsive moves, and emotional outbursts across the table, I realized that the baby and I were the only ones without a diagnosis of ADHD. I was acutely aware of how this neurological difference has affected all of them in their decisions, career paths, relationships, self-evaluation, and life management in general. I came to understand that ADHD is a condition that affects an entire lifespan. Untreated ADHD can result in significant impairment and personal suffering. I developed the conviction that helping adolescents and young adults early in their adult development could impact their entire life. So, what began as academic interest expanded to become a more intense personal interest. In terms of research, I believe it is imperative for postsecondary institutions to
develop good practices and programs to intentionally support students to manage their symptoms and reach their full potential.

So professionally and personally, I bring experience, respect, empathy, and inquisitiveness to this project. I have a love of college counseling with all the messy developmental and transitional events that are occurring for students. I believe skilled college counselors may greatly impact the trajectory of a student’s life. We are the behind-the-scenes providers, quietly providing scaffolding for our students. I also have a love for education. As a first generation college student myself, I am grateful for parents who encouraged me to learn and modeled a robust work ethic. Education has formed me as a person and empowered me to live a rich personal and professional life. I believe we, as a society, need to value and provide opportunity for all people, including those with differences and disabilities. Those who flounder and are burdened with self-doubt because of these differences will often find their way to the counseling centers. Parents are exhausted. Students are frustrated. Counseling centers often operate in silo fashion. By intensely studying the experience of eight to twelve college counselors, I hope I have created knowledge that assists educators and counselors to help their students persevere and shape their distracted stories and experiences into positive futures.
Chapter 4: Results

Presentation of the Data

This chapter will present the data findings from the research. I interviewed counselors from various postsecondary institutions, including three state universities, two private universities, and one community college. There was diversity amongst the interviewees with six Euromerican or Caucasians, one Asian, and one African American; and gender diversity with six women and two men. Three were licensed in psychology, three in counseling, and two in social work. Even with a methodology requiring only a small sample, I made the effort to achieve as much diversity as possible in the recruitment and selection of interviewees. The interviewees had varying years of experience in college counseling and in counseling overall. I de-identified all the interviewees and assigned them names based on impressions of the interviewer. Henceforth, the interviewees will be identified by these assigned names, alphabetically arranged:

<table>
<thead>
<tr>
<th>Counselor Pseudonym:</th>
<th>Brief Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assert</td>
<td>Assert identifies as a male Euromerican, age range 35-45, who is director of counseling and disability services at a small private liberal arts college. He stressed that students must learn to understand their symptoms and advocate, and be assertive for themselves, thus taking responsibility for their learning.</td>
</tr>
<tr>
<td>Table 2: continued</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Analogies</strong></td>
<td>Analogies is a female Caucasian, age range 35-45, who is the training director at a large public university counseling center. She used creative comparisons to help educate and motivate students to manage their symptoms.</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td>Barriers is a female African-American, age range 25-35, who is a training fellow at a very large public university counseling center. She believed students with ADHD have much to overcome and need to overcome obstacles on many levels.</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td>Lifestyle is a female Asian, age range 35-45, who is assistant director for clinical services at a very large public university counseling center. She emphasized that lifestyle and behavioral changes are a necessary component to managing ADHD.</td>
</tr>
<tr>
<td><strong>Ninja</strong></td>
<td>Ninja is a female Caucasian, age range 25-35, who serves as a counselor (works alone) at the satellite campus of a large public university. She favored a creative approach to working with students and liked to use toys such as Ninja figures in her practice to help students.</td>
</tr>
<tr>
<td><strong>Perseverance</strong></td>
<td>Perseverance is a female Caucasian, age range 45-55, who works as a counselor as a small private liberal arts university. She emphasized patience and understanding because of diverse presentation of symptoms and reactions to treatment. She stressed that perseverance is needed by both students and the providers.</td>
</tr>
</tbody>
</table>
Table 2: continued

<table>
<thead>
<tr>
<th>Radar</th>
<th>Radar is a male Caucasian, age range 25-35, who works at a medical facility but has five years of college counseling experience. He was highly conscious of comorbidities and differential diagnosis and thought it was critical to pay attention to substance abuse vulnerability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggle</td>
<td>Struggle is a female Caucasian, age range 35-45, who works at a community college. She believed that identifying, treating, managing ADHD is a challenge and resources differ for each individual. Many students struggle more because of limited resources.</td>
</tr>
</tbody>
</table>

Domains, Core Ideas, Cross-Analysis

The following are the ten domain categories with my accompanying researcher notes as to why the category was formulated. The underlined portions of the domain description were used in the transcription notes to designate the domain in the grouping of interview data for ease in working with the grouped entries.

Table 3. Domains

<table>
<thead>
<tr>
<th>One: Time of Diagnosis and Treatment Impacts Functioning In College</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually early is better</td>
</tr>
<tr>
<td>Over-diagnosis and under-diagnosis occurs</td>
</tr>
<tr>
<td>Prepared versus not prepared for college transition</td>
</tr>
<tr>
<td>Families differ in their response to diagnosis</td>
</tr>
<tr>
<td>Variability in symptom presentation and in treatment</td>
</tr>
</tbody>
</table>
Table 3: continued

Two: Comorbidity is a Significant Issue

Self-medication with substances and other addictive behavior
Anxiety, depression and other diagnoses
Primary or secondary—determining which diagnosis is most impactful
Differential diagnosis problem
Can be other learning disability issues
Can be other physical health issues

Three: School Functioning Issues Bring Students to Counseling

Desire to be “just normal”
Underestimating difficult of transition
Differing degrees of readiness before college
Social skills also impact school functioning
Underlying issues with self-esteem and self-efficacy; internal dialogue
“Other” diagnosis may also bring students to counseling

Four: Training/Education Concerns

Most interviewees have evolved understandings
Desire more training specific for college students
Other staff need training (psychoeducation, learning styles of students, flexibility versus rigor)
Different types of students at various institutions

Five: Stigma

Validation through diagnosis and psychoeducation
Ignorant discrimination
Professors
Table 3: continued

Family
General mental illness/Counseling stigma

Six: Advocacy

Students need to understand in order to articulate; students need confidence/skills to advocate
Stigma
Maturity
Parents can help advocate/Parents may not be helpful
Counselors can be campus advocates
Counselor can be advocates before parents
Table 3: continued

<table>
<thead>
<tr>
<th>Seven: Treatment Issues – Specific Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity—on micro level</td>
</tr>
<tr>
<td>Accommodations</td>
</tr>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Self-medication</td>
</tr>
<tr>
<td>Psychoeducation—how ADHD is described</td>
</tr>
<tr>
<td>Skill and strategies are essential to change/Whole person and wellness perspective</td>
</tr>
<tr>
<td>Motivational Interviewing approach (small changes, prioritizing concerns, readiness to change, working with resistance); Issues with implementation</td>
</tr>
<tr>
<td>Cognitive work</td>
</tr>
<tr>
<td>Manuals</td>
</tr>
<tr>
<td>Coaching</td>
</tr>
<tr>
<td>Groups</td>
</tr>
<tr>
<td>Follow-up provided (retesting)</td>
</tr>
<tr>
<td>Technology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eight: Treatment Issues – Global Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity—on macro level</td>
</tr>
<tr>
<td>Help that handicaps/Crutch of too much help</td>
</tr>
<tr>
<td>Variability in who gets treatment</td>
</tr>
<tr>
<td>Takes time—as no quick fix</td>
</tr>
<tr>
<td>Developmental concerns</td>
</tr>
<tr>
<td>Structure that is external (i.e. athletes may have advantage)</td>
</tr>
<tr>
<td>Compliance/Motivation is a struggle despite the best specific treatments</td>
</tr>
<tr>
<td>Self-esteem and Self-efficacy (beat down, overwhelmed); may influence self-medication and also motivation</td>
</tr>
<tr>
<td>Future goals and planning/Careers</td>
</tr>
<tr>
<td>Untreated adults continue to have problems</td>
</tr>
<tr>
<td>Learning styles</td>
</tr>
<tr>
<td>Institutional resources differ</td>
</tr>
<tr>
<td>Different types of institutions have students with differing needs</td>
</tr>
<tr>
<td>Have institutions kept pace with the influx of students who have disability issues?</td>
</tr>
</tbody>
</table>
Table 3: continued

<table>
<thead>
<tr>
<th>Nine: Multicultural/ Gender/Social Justice Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underserved students</td>
</tr>
<tr>
<td>Access to treatment</td>
</tr>
<tr>
<td>Women get later diagnosis</td>
</tr>
<tr>
<td>Cultural barriers</td>
</tr>
<tr>
<td>Financial barriers</td>
</tr>
<tr>
<td>Outreach</td>
</tr>
<tr>
<td>Institutional resources differ</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ten: Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multitasking</td>
</tr>
<tr>
<td>Creative, intelligent</td>
</tr>
<tr>
<td>Hyperfocus (mixed bag)</td>
</tr>
<tr>
<td>Energetic</td>
</tr>
</tbody>
</table>

I completed changes suggested by the team members and the auditor, which were essentially minor. The first team member agreed with the domains and the domain categorizations for each interview. The team member pointed out the universities had not been de-identified and this was confusing. This team member also wondered if there were more gender-related issues besides inattentiveness. She noted that most practitioners seemed to be self-taught overall. She noted that socioeconomic factors, diversity, stigma, comorbidity, environmental stress, and lack of preparedness for college are impactful and these were captured in the data.

The second team member suggested more multimodal domains needed to be created and pointed these out. He said information seemed to bleed together in domains. Also, this team member noted that the diversity of the participants was a strength; he thought more male voices would be helpful. He noted that no one had treated an international student and this was an interesting fact. He observed that there seems to be a pervasive lack of understanding about ADHD, and that denial, stigma, and lack of education about
adult ADHD was really evident. He also noted that while every counselor was treating ADHD, each counselor was, more or less, trying to practice according to experience and self-education. There is no real consensus on best practices. He said his own biases changed after reading the interviews. He also was reflective that the world has changed and that students have enormous external pressures, perhaps more than previous generations. He thought the domain category that focused on global concerns identified important issues. He wondered if ADHD would manifest and be treated differently according to a related comorbidity that the student was also experiencing. He thought this spoke to the complexity of the diagnosis, which he said was captured in the data.

The auditor thought there were more multimodal domains than initially identified and suggested the writer include some information in more domains. The auditor suggested that the schools be described more specifically without giving the names of the schools. The auditor also pointed out that there needed to be more distinction between Specific and Global Treatment Domains. The auditor also thought items in the Other Domain could be moved to another domain as the information was relevant to other domains. The auditor also noted that the counselor from the community college had the most insight about stressors that students face and that interfere with academics, and this was probably due to the kind of school it was; this school is a kind of outlier. The auditor suggested that the nickname Advocacy was slightly confusing since it is also a domain; this was changed to Assert. I agreed and executed these changes.

The auditor noted that the importance of treatment issues—distinguishing specific treatments from global concerns. With specific treatments, I captured the particular
interventions that counselors used. This would include a theory or perspective, such as CBT, or a particular behavioral skill, such as helping student to learn to keep a calendar. These would be treatments that the counselors are already using. Global concerns, as noted by the name “concerns,” reflects the counselors’ broader perspectives on treating students with ADHD. For example, there are no specific interventions for career planning for students with ADHD, yet the counselors expressed concern that this needs to be addressed in college as students are making career decisions that can impact them for a lifetime.

The auditor’s most helpful insight was in adding data to the multimodal domains. I especially failed to capture all the data that related to training and education. This domain was a recurring theme that needed to be approached from more than one angle. The auditor’s perspective was helpful. The data in this dissertation, the domain formation, the domain assignments for all interview data and my summary of core ideas for each participant, reflects team and auditor editing, input, changes, and suggestions. Once I created the cross-analysis of data, I submitted it to the auditor for review and consensus. The auditor asked for some language clarifications as language was ambiguous and also made some grammatical corrections.

**General Findings**

**Domain One.** This domain refers to the time of diagnosis and treatment and how that impacts functioning in college. All participants, with one exception, agreed that early diagnosis of ADHD is a benefit to college students. This gives students the opportunity to get assistance with academics, develop skills and strategies, strengthen coping skills, and
hopewfully learn more about the diagnosis. Early diagnosis may give them more confidence to advocate for themselves. Early diagnosis allows access to special resources which can continue through college in the way of accommodations. One participant, Lifestyle, who challenged this finding, thought that an early diagnosis may give internal negative messages and even stall skill development. She did have the experience of seeing underrepresented students over-diagnosed because of behavioral problems, so this may have influenced this perception.

Two counselors, Barriers and Perseverance, also remarked that too much help can be handicapping to a student if self-efficacy is not developed. However, if a student is diagnosed late or not at all, this can be ruinous to self-esteem when a student struggles and can’t seem to manage academics. It may lead to substance abuse or other destructive coping behaviors as an available escape. The student will not understand the symptoms of the diagnosis nor know how to access resources and support.

There were no typical findings in this domain. Variant responses included the assertion that early diagnosis can be a problem, students are frequently ignorant about their diagnoses, and families respond differently. As Analogies point out, students and families are ambivalent about how they tackle (or do not tackle) treatment. Some families are in denial. Other students who are well-managed in high school may lose this structure and make a poor transition to college. So while early diagnosis is a benefit, it does not guarantee that the student will get treatment or that readiness for college will occur.

But even a later diagnosis can be helpful because it is validating. As Assert said about a student’s reaction to a new diagnosis, “Well I always knew something was going
on and now I have a name for it…finally they get an accurate description of what’s been going on.” Struggle was empathetic to the pain of not being diagnosed. As she said, “It breaks my heart to see students who have struggled, struggled, struggled multiple times, right, only to find out, Oh I have ADHD and if this had been addressed a whole long time ago I could have been successful.”

**Domain Two.** This domain refers to comorbidity as a significant issue. A second general finding is that comorbidities commonly exist with ADHD, more often than not. These may be mental health diagnoses such as depression and anxiety. Or they may be other learning disabilities or a physical health condition. Comorbid conditions make both diagnosis and treatment complex. As Radar stated, “The most challenging situations are when it’s not diagnosed, and it never has been, and it is masked by something else. Such as an anxiety disorder or even a substance use disorder.” Because ADHD can resemble other symptoms, a counselor can do an initial assessment but a referral must be made to a qualified psychologist who complete a comprehensive assessment. When ADHD is present with another condition, a coordinated approach is important. As Struggle pointed out, medication treatment for ADHD must be done so that a comorbid condition such as substance abuse is not triggered. All counselors addressed the comorbid issue and agreed that this makes diagnosis and treatment even more complex overall and that it demands a high level of skill. This complexity of diagnosis is a third general finding.

There were two typical responses in this domain. Counselors stated that environment, emotional challenges, learning disabilities, and physical health issues are other important comorbid factors. Lifestyle mentioned that environmental factors such as
bereavement or relationship issues, while not pathologies, can be impactful. Perseverance thought behavioral patterns, such as chronic avoidance, was a comorbid factor because the behavioral pattern impacted functioning and treatment.

Most mentioned that alcohol and drug use, or even excessively caffeine use, may be present as confounding comorbid issues. Variant responses included that self-medication of symptoms can impact functioning. A final variant response was that wellness and self-care are critical in dealing with ADHD and comorbidities, especially if medication is not being used.

Domain Three. This domain refers to the assertion that school functioning issues bring students to counseling. A fourth general finding is that the first clue that signals a possible ADHD issue is academic functioning. So when a student comes to counseling and is experiencing academic stress that cannot be alleviated by the usual means, or if the impairment seems to be more profound, a counselor should explore ADHD symptoms. Ninja was insightful in identifying the kinds of academic tasks a student may struggle with and identified these types of issues: in-class engagement, homework, and execution of particular tasks related to academics. Lifestyle and Struggle specifically mentioned procrastination, time management, goal setting, and disorganization as skill deficits that point to academic stress. Analogies mentioned specific factors related to untreated ADHD symptoms, such as high emotionality (frequent rage) or self-medication (frequent cannabis use) that are problematic and that impact academics. She noticed the lack of structure. As she said,

Whereas a freshman coming to college, they’re losing that structure which is where we see this sort of . . . it goes from a kid who is really well-managed to completely
out of control. Or a student, maybe who wasn’t diagnosed, their symptoms become incredibly clear because they don’t have adequate coping without the imposed structure.

Ninja echoes this observation and stated that there are social aspects of functioning that are deficits for students with ADHD and that are linked to academics. Perseverance mentioned that in sessions a student may get easily distracted or jump from topic to topic, and she linked this observed behavior to academic stress presenting issues.

Typical findings included that schools differ in their readiness to help change behaviors of students with ADHD and that development factors can be impactful. As Assert observed, despite the desire for improved academic performance, students differ in their readiness to seek help or to initiate behavioral changes to impact academics. This may be a developmental issue. A variant finding is that ADHD is more than a college or academic issue; students’ problems in functioning can be lifelong.

**Domain Four.** This domain refers to training and education concerns. General findings five through nine are related to the training and education domain. This domain captured the largest number of responses. Training needs are multiple. Two of the participants, as psychologists, were trained to diagnose ADHD. However, they and the other six clinicians were not formally trained on how to treat college students and adults. (Several did receive training on how to work with children with ADHD.) But self-education was the predominant mode of education for the professionals (fifth general finding). Outside reading and experience formed them, but they all noted the absence of training opportunities for college counselors. Also, there is no
blueprint for best practices or outcomes for working with the college population. Analogies, for example, has gleaned much of her knowledge from the work on Daniel Amen, M.D. and focused on learning styles. But Lifestyle favors a manualized approach. Assert and Barriers have more training in assessment but not necessarily in treatment; their treatment is based on self-instruction and trial and error about what works. Lifestyle said the training of professional counselors is “hit or miss” overall, depending on the type of program. Ninja thought there is more training about the autism spectrum in college versus people with ADHD, and there are just as many students. In most cases, their knowledge about ADHD has evolved and matured to include adults. They were motivated to educate themselves.

In addition to the training needs of counselors, the participants also noted other categories of individuals who need more training/education about ADHD. The counselors were all engaged in psychoeducation to some degree and they observed that the students themselves, the parents and families, and other staff outside counseling at postsecondary institutions need more education. These were the sixth, seventh, and eighth general findings in this domain related to education and training.

In regard to student education, the counselors indicated that understanding the neurobiological and developmental elements of diagnosis can be validating and very helpful. Radar and Analogies noted that educating with a positive spin is important. Struggle suggested that all colleges offer some sort of training seminar for students with ADHD. Working at a community college with non-traditional students, she thought this may improve their ability to perform academically. Ninja stated,
One thing I know is that my SAS person and I have talked about seeing a trend of students who were diagnosed at some point with something and no one told them what that was. And they come to college and they have to get the documentation and suddenly they are hit with this conversation from a totally new person, Oh, OK I see you were diagnosed with ADHD at age 13. And the student will say, What?!! Well, I knew I had to take medicine and I knew I had an IEP but. . . .

Parental education can be challenging as there is still denial and stigma about mental conditions. As Analogies stated about one family,

But her mother finally sort of came to an understanding that the kid needed, it wasn’t just her being stubborn, it wasn’t just her being bitchy or difficult as a kid, that her impulsivity, that some of the ruptures in relationships…some of the ruptures, some of the impulsivity, this was directly a result of the ADHD and not just because the kid was an asshole. But the dad would not agree to treatment. So the mom was paying for ADHD medication out of pocket so it wouldn’t go through insurance and the dad wouldn’t know.

And even when parents have provided support and structure in high school, the self-efficacy is not there. As she explained,

Well, I DON’T (emphasis) think they prepare them for college very well. And that is why we see kids who have been well-managed tank their first semester. Because no one has taught them is that the reason you are doing well is because there is this structure and when you get to college that will go away.

Sometimes this information for students and families is corrective as many think that ADHD symptoms will disappear in college. Ninja lamented about what parents may tell their children,

Again, going back to people telling them that ADHD is not a thing when you are an adult. You will just grow out of this. It’s not that hard to pay attention to a 50 minute class, and all of that. Parental misinformation can lead to unrealistic expectations and increased stress for the student.

Assert spoke about parental indifference as a problem in addition to misinformation. He explained that parents simply don’t care or they are parenting first generation students
and they think the students just need to figure it out themselves. There may blame the students for lackluster performance.

All the counselors thought that their peers in academia had limited understanding of the diagnosis. Colleagues in disability services would be the exception. But other colleagues in student development or faculty were simply not informed unless they had personal experience with ADHD, such as having a child with ADHD. Analogies thought faculty should go beyond mere understanding and also be intentional about teaching to divergent learning styles. Assert thought it was important for counselors to be advocates and educators in their student development communities—to help colleagues understand the diagnosis. All spoke about building more collaborative relationships around helping students with ADHD.

A ninth general finding under training was that they all desired more education and resources to better serve the students. They were not aware of any specific resources to improve their practice in this area. There were no typical findings. Variant findings include the assertion by three counselors that prior experience in college residential life was helpful for them as counselors in working with students with ADHD.

**Domain Five.** This domain is about stigma. A tenth general finding is that students with ADHD struggle with personal stigma regarding how they think about themselves. This includes internal narratives from underachieving or failing to execute tasks well or as efficiently as others. Frequently, the stigma is fertilized by the messages they receive from others, which may include parents, professors, and other students. Wounded self-esteem is impactful whether is an accumulated self-narrative from childhood or a sense of
inferiority that comes with a difficult transition to college. It can lead to self-harming behaviors. As Struggle noted,

> They usually scramble to make any sort of effort to get organized. But it’s a constant failure, which you know, kind of weighs on their self-esteem and makes it more difficult to continue trying. Just trying their own methods of staying organized and trying to apply themselves. It’s sad to watch it and hear about it. And obviously you get the people who self-medicate. They use drugs or alcohol because it helps the brain calm down and it seems they focus more, you know.

Two typical findings in this domain are that parents/families and others in academia hold stigma about ADHD. A variant finding is that more psychoeducation is needed to validate and normalize an ADHD diagnosis. This finding intersects with the finding that more training is needed to educate others who interact with students. Many persist in thinking ADHD only happens to kids. As Ninja noted,

> I think for the students, and I’ve heard it multiple times. It’s that they have been told ADHD is a kid issue. Kids have ADHD. Many of them have talked about feeling like when they turned 18 and came to college like magically you were supposed to be different. Magically you were supposed to be better. That seems to be a frustration. And it’s not so frustrating that it is still happening but they are most frustrated that there is this stigma that once you are an adult you don’t get to have ADHD because that is a kid thing. Counselors cue in to the emotional pain and discomfort that students may feel.

Analogies explained that students just want to fit in. They want to be accepted by their peers and have a good college experience. As she stated,

> But I do think again in college that a lot of students just want to be normal. They don’t want to be the kid who has to go to the distraction-reducing setting to take tests. They don’t want to ask for accommodations.

**Domain Six.** This domain refers to advocacy. There were no general findings in this domain. Two typical findings in the Advocacy domain were that students needs to
learn to advocate for themselves in academia and that academia needs to be a safe place for them to speak for themselves. Assert stated,

Advocacy again. It’s the biggest thing… With family members who are enthusiastic about helping their kids out, they seek those services or consult with me. But unfortunately, some don’t. Some don’t seek them out as they transition from high school to college. So they sort of fall through the wasteland a bit. Which is unfortunate because I think… one of the toughest things from switching from high school to a college setting, especially in regards to ADHD or any type of disability per se is the combination process: They become 18 and they are classified as adult so a lot stuff the school did for them, and was required by federal law. They come here and they need to learn to advocate for themselves. Sometimes you see the helicopter parents doing a lot for them, and then they leave the student here and go back somewhere across the country, and they’re here left alone because mom and dad did that for them. So it’s kind of hard for them to do that kind of stuff.

Lifestyle also suggested that students seek accommodations even if they don’t feel they will need them as an “insurance policy.” Perseverance stated that advocacy is important because there is a pattern of avoidance that goes with ADHD. As she stated,

It’s important to have more self-efficacy. And I see that it kind of goes hand-in-hand with students with anxiety and ADHD, the avoidance things. So, I don’t have self-efficacy so I can’t do this. So I’m stuck. And I don’t want to call academic services but I need help but I’m not going to ask for help. And now I’m mad and I can’t do this.

Variant findings included more about the particulars of advocacy—that students need to advocate with medical providers, their parents, and their professors. There is a power differential with professors. As Radar stated about his own personal teaching experience,

And, too, some other experience I’ve had outside of college counseling when I have taught briefly at the undergraduate university level. Some of the students who have had ADHD or needed another accommodation, it’s almost like they felt, it’s like the tone in their voice when they come to me specifically asking for accommodations, almost expecting me to give them a hard time.
Analogies added to this understanding of student relationships with their professors.

As she stated,

I think that is a really good question because I think it is uneven. I think that there are some instructors who understand and can be really accommodating and then there are some people who think it’s just an excuse. So it’s pretty uneven. I think there are some instructors who get that reputation that they are willing to work with students, and some of them don’t.

Some students may be loath to advocate for themselves, and parents may not desire to advocate either. Counselor can be important advocates for students. Finally, too much advocacy may be a crutch, perhaps a reason to not meet requirements instead of learning the skills to get the work done. As Struggle stated,

Honestly, it depends on the student. I’ve had students try to use it as a crutch to excuse just poor investment in school and as an excuse, to you know, get out of academic probation. And I’ve also had some with a pretty decent understanding of it and took responsibility for treating it. With our students there tend to be a whole lot of other factors going on. A lot of the students that we see also work, also have families, so there’s all these different factors involved that tend to get very complicated.

**Domain Seven.** This domain refers to treatment issues that are specific. The next five general findings, eleven through fifteen, related to specific treatments. The counselors connected students to medical treatment and also to other resources in the academic community such as academic support. They used some form of CBT in their treatments and they also valued psychoeducation and skill building/strategies in their treatment plans. The degree to which they used these strategies varied counselor to counselor. They all thought medical treatment was usually beneficial and typically the first line of treatment. But this can be challenging. As Assert explained,

So, it’s like a Catch 22 right? The symptoms that, so medication manages the symptoms, so it’s really helpful. But at the same time, navigating the side effects so
that the clients will actually take the medications as prescribed, or being really open
and honest with the psychiatrist or nurse practitioner or whoever is prescribing,
about what the side effects are, so they can collaboratively problem solve about
what dosage, what time would be best. Like that can get tricky. I have students who
will take vacations and they won’t take their medications all weekend. Or I’ll have
clients who just don’t take their medications after 2 pm because the side effects
really impact sleep. So they’re trying to on their own figure out what works.

But they also stressed that behavioral skills and strategies are equally valuable as
medication for helping the student. Lifestyle thought that any treatment will fail unless
the students commit to learning and practicing skills, starting with time management. She
thought process-type therapy has limited value. She said,

Honestly, we spent a lot of time talking about the difference between ‘us’ and
‘them.’ Normal people. No. Those normal people don’t have any difference. They
do assess a situation quicker but you can learn to do that. And they use all those
tools. They are all accessible to you. Why wouldn’t you use online banking or
reminders or different tools? So I keep a running list from students of different
things that work for them. Things like Trello, Wunderlist. I had an engineering
student develop his own system, which was fabulous, and this was a kid who didn’t
feel successful. He has been on medication since he was three and graduated very
successfully and kept that system and did it in two years. Basically, he got the
behavioral treatment he needed in his last two years of academic work.

Counselors tended to have unique approaches. Ninja, for example, enjoyed using
fun, tactile interventions. Her office contains toys and gadgets. As she stated,

Reminding clinicians that working with students who have ADHD, that the
techniques or tactics that were used in high school or middle school, even in grade
school, are worth continuing to explore as an adult. Things like tangles, worry
stones. I have someone who went out and bought a. . . I literally sent them to like a
Bed, Bath, and Beyond. I told them to just go around and touch something. I have a
mental picture and they touched different silverware and they touched different
mechanical things and they touched different towels until they found . . . it was
literally a specific loofah, like, OK, I like this, and it was one of those natural
loofahs. So they took it home and cut it up so they could have different pieces in
their pocket and their book bag so when they were taking a test or listening to a
lecture, they could have this tactile things that helped them to pay attention. And
that’s very much something we give to littler kids.
Analogies liked to use metaphors to help students understand the process of change. She tried to understand the world of the student and select metaphors accordingly that would be personally relevant. As she stated,

And for him he had a standard car. So I would say like when you started driving a standard it was very conscious. He had to think about pushing a clutch in and moving the gearshift. And like learning the timing. But eventually it becomes second nature. So for him it was like, right now this feels awkward and clunky like when you first learn but if you keep doing these things it will become second nature. You will not always be going to have to remind yourself to walk through the steps. Eventually the steps will just become part of your routine.

Ninja also liked to use metaphors to explain ADHD to students and used this one to provide a comprehensive view of ADHD. As she explained about a particular metaphor she borrowed from another professional,

It’s from a behavior modification class from a couple years ago. She described ADHD as: Image a cable box and it is connected to the table box where you have your TV and you also have your remote control. In the cable box there’s one cord that brings all that information in and the cable box organizes it into different channels and then you get to choose which channel you want to go to, how long you stay on it, how fast, and if there are some channels you never look at, some channels you look at all the time, that kind of thing. With ADHD it’s like the cable box is broken. You can’t make any choices about the information that is coming out the front, which information to the back, how fast you stay with it, how much attention you give it, you kind of lose that ability—of choice.

There were no typical findings. Variant findings included access to affordable testing, use of the Stages of Change (Transtheoretical Model), strengths-based emphasis, using metaphors and analogies, individualized treatment, solution-focused treatment, and using technological tools. There were all specific treatments used in a variant fashion among the eight counselors. This sense of acknowledging individual presentations was interesting. As Analogies described it, “Thinking of it manifesting differently in different
people. Being able to look at the idiosyncratic ways it might manifest and affect people, and then being able to talk to people about different ways to manage.”

It is noteworthy that access to testing for ADHD evaluation is uneven. One institution currently offers it free through their psychology department, and two other schools have access through academia at a cost lower than the private sector. Two other schools have limited resources for testing because of the rural location, and these assessments must be paid privately through insurance of the family. The community college is unique in that students access services outside the university because student are non-traditional commuter students. However, these students frequently do not have insurance so there is no path to getting evaluated. And, they must have access to medical providers to get scripts for medication.

Schools also vary in terms of the collaborative support throughout their student services. Barriers shared that she was intentional in building relationships with staff from other offices to build credibility and collegial support. As she stated, “They are most likely to squeeze my client in if they need something. I think if different offices across campus have really good protocols or interact really well, I think that facilitates patient care.”

When students committed themselves to learning skills and strategies, the consensus among the study participants was that they could be successful. As Assert said, I think maybe one big thing is like there’s more recognition that students who have been most successful are the ones who are able to essentially incorporate the things we talk about in session and tie it into things they are already doing. So it’s like an extra step. It’s not completely foreign. It’s not completely outside their norm or routine. It’s more about meeting the students where they are, really thinking about their specific environment, their specific challenges or perceived barriers. Their
perceived barriers are important to address. And so the clients who I’ve had the most success with are like using the things they have in their environment that they can access. I think there’s building some sense of hope and self-efficacy that works with ADHD students.

**Domain Eight.** There were no general findings in this particular domain of treatment issues that are concerned with global concerns. Two typical findings included the assertion that more training and preparation is needed for overall skills on the high school level, and that more help and coaching is needed for career choices. Barriers said there is too much “teaching to the grade” and that parents and educators fail to teach the importance of daily study habits.

So, when things come too easily in high school, poor habits can hinder the student in college. In reference to pre-college preparation, Assert said,

There is not one ADHD student who I have had in the last three years who said, Oh, I used to set aside time in high school studying or doing my assignments. No, because I did really great on tests. I didn’t actually have to study. They don’t understand the supports they need but they understand like what’s lacking. They will come to me and say, I never did this. I never had to do this. I never had to sit and read three chapters in a week. I didn’t have to do that. So they recognize like the gap or lack of skills and why it is they’re struggling. But they’re not sure how someone else can help me to sit down and read the three chapters I need to read. So I think there’s some awareness about building between the things that they feel they lack and the different offices on campus or my role as a counselor. So there needs to be some providing of education that these are skills that developed over time and it has to be built.

Variant findings included concerns about over-and under-diagnosis, the need for more role models who have been successful, and the need for stigma-reduction and more flexibility in the institutional structures of postsecondary schools. Ninja spoke about college serving as a “safety net” where students can fail as they learn to manage themselves and develop the maturity needed to function in the workplace.
There was concern about a holistic life perspective approach for the student after school, especially as the student starts a career. Analogies, in particular, noted the relational piece as impacting how a student functions. As Analogies stated,

I think that one of the things that I’m more aware of now is that interpersonal costs of relational... when I first started it was purely in the academic realm. I was a mentor. I was an instructor focused on how is this going to affect you in the classroom, how is this going to affect you in a career, blah, blah, blah. But I think now I am thinking about it more holistically. Like how does this affect your relationships? How does this affect your friendships? The way that you present in public, in a classroom, in a job interview. So, I have, and I think it’s been a good progression for me as a clinician to move away from just those encapsulated views. Like students aren’t going to be in college forever. College is more than just being in the classroom. So being able to think about, like how does this affect how we integrate hobbies or maybe exercise. Your schedule. How does this affect your primary romantic relationship? How does this affect your communication and relationship with your parents? So I think that’s the direction—being more holistic with how this is affecting the individual.

Domain Nine. This domain is about multicultural, gender, and social justice concerns. The final, and sixteenth general finding, concerns multiculturalism and gender concerns. Most expressed that they had not seen international students presenting with ADHD. Lifestyle, who works at the largest public university in the state and can provide services in different languages, said she personally has only seen Caucasian or African Americans for ADHD. Barriers, who also works as a large public university, observed,

Well, so I guess one thing, and this is an ongoing discussion that I’ve had with my colleagues, is around like the disruptive behavior piece and how it is normalized in certain cultures and certain economic status, um, and so I think the cultural piece can lead to some of the students going undiagnosed for a longer period of time. Whether the behavior is normalized or there is just not the attention to that particular kid, so culture broadly is ethnicity, socioeconomic status, like on the individual levels, that makes the difference to whether students are diagnosed and treated.
Other clinicians shared this concern and acknowledged that attitudes are deeply rooted in family biases as well as culture. Perseverance explained,

Obviously, some cultures do not support treating things that are mental health issues medically or even treating them from a psychological perspective. So, especially here at this school, you know, the Asian culture clearly does not have support from their families to be treated medically for ADHD when they’re not at college. So I think that does impact the student’s self-esteem, it impacts feelings. Do I have a right to take this medicine? Am I violating my family’s code if I’m taking this medication?

Radar thought that students may be taught to suffer and cope. Asking for help may be perceived as a sign of character weakness. As he said,

Maybe in certain cultures and in certain ethnicities they could be resistant to treatment of any kind. Whether it’s ADHD or anxiety or depression, they need to keep a stiff upper lip and it’s not OK to ask for help. So I see that impacting it, maybe not specifically with ADHD but with any mental health treatment or accommodations. They’ve been trained that it’s not OK to advocate for yourself or to ask for help. You have to know how to handle things on your own.

Two typical findings in this domain are that more males are diagnosed with ADHD and that access to treatment and medication is uneven. Variant findings include that African-American males are both over- and under-diagnosed and that those from privilege are advantaged. Barriers thinks males are socialized differently and this may account for more diagnosis. Barriers is also concerned about the social justice issue as she said cultural norms determines who gets diagnosed in childhood and economic barriers may keep students from getting diagnosed properly. For her, culture broadly is ethnicity and socioeconomic status, and on the individual levels, that makes the difference to whether students are diagnosed and treated. Perseverance also thought that differences in school districts determines who gets identified. Lifestyle commented,
Uh, that goes back to early childhood and I think cultural differences between who’s actually teaching the course, which tends to be white, younger, females. I’ve watched teacher after teacher. . . minority males are over-identified. I have a lot of experience with and advocating in educational systems as young as preschool. I think that has a lot to do with that over-identification, especially in educational systems where compliance is a norm in a particular manner. Raising your hand, sitting still, waiting your turn, and anyone not raised in those cultural norms will stand out. I’ve watched teacher after teacher tell parents to medicate children when they really don’t need it. They could use some behavioral techniques and really come up with a way to help manage things.

Analogies was also sensitive to the issue of who gets diagnosed in childhood and saw it as an issue of institutional racism. As she added,

So I think often that in students of color, behavior gets identified as something other like conduct disorder, oppositional defiance disorder when they’re younger. And then that’s going to affect if they even make it to college, frankly, if they don’t get the appropriate treatment. But I do think that often times, it’s been pretty rare that I’ve worked with students of color who come in with a diagnosis of ADHD. So I do think there’s differential, I mean socioeconomically, if you have more access to resources, if your parents are able to advocate for you because you’re educated about this, you’re going to be at an advantage. If you’re in a better school system, there are going to be advantages. And I think that is a part of that institutional racism and part of the racism in our profession. That we don’t, the research shows that for people of color, are more highly pathologized or their concerns are invalidated in many ways. I think there are differences in terms of who is getting diagnosed, who is getting treatment, and accessing resources for sure.

With Struggle, the economic barriers are frequent in her practice and many students do not have health insurance who attend a community college. The cultural piece is important as well. She explained that her school includes students from the Middle East, Asia, and Africa and they typically have taboos about any sort of mental health diagnosis. She said she has been given little training on cultural competency to help her improve her practice with these students. Other counselors echoed this desire for more training on cultural competency as related to disabilities. She sees two problems in relation to socioeconomic status. First, some students don’t get treated or helped as children. They
are never diagnosed or, if they are diagnosed, the families do not pursue the treatment they need. Second, even if they make it to the postsecondary level, she thinks that if problems arise in college they do not have the financial resources to get evaluated.

As she further explained,

People believe that they might have ADHD or some sort or learning disability or whatnot, and unfortunately once they’re in college it’s more expensive for them to get testing. When they’re in school and younger, often school systems will cover that sort of thing. When they’re adults, we have the lists for them to instruct them if they want to get formal psychological testing and blah blah blah, these are the people you can go see. But they’re looking at about a thousand dollar cost out of pocket... and most of them don’t have that kind of money so they can get disability accommodations through disability services.

Ninja sees more Caucasian males with ADHD. As she explained about other ethnicities, “I have not seen them walking in with the diagnosis as much. It doesn’t mean they don’t have it. I’ve just not seen them walk through the door with pre-existing.”

Perseverance thinks girls tend to present more as inattentive and it’s not so easy to observe. Radar saw more males with ADHD and he attributed it to roles and expectations, and possibly brain differences.

**Domain Ten.** This domain is about strengths. There were no general findings in this category. Typical findings in the strengths domain are that students with ADHD have courage, willpower, motivation, and energy. Variant findings related to a positive outlook, creativity, passion, and a need for stimulation. If they have healthy self-esteem, this is a strength. There was a sense that a particular symptom, such a hyperfocus, could be both a strength and a liability depending on the situation—a double-edged sword.
Perseverance noted that in her practice her approach has changed to be more strengths-based and to teach students that they need to find alternative creative paths. As she stated,

I used to think about ADHD in terms of hyperactivity and impulsivity. And I think it’s changed, too, in that I really try hard to de-stigmatize having ADHD. To present and help people to know there are strengths. And having this diagnosis doesn’t mean you can’t get this job, or get a degree, or finish this course. You just have to find creative ways to do the things that other people look like they’re doing easily but not might be.

Both Analogies and Ninja expressed that strengths may be more apparent once the student leaves school and gets into an appropriate career. And this is relevant to a previous domain category of helping others in student development who do career planning to understand ADHD. Ninja explained,

Not to steer towards or against certain careers but more of this helping them to conceptualize, OK if I know I have this struggle and how am I going to manage that. Like if I want to go and be a doctor, for example, how are these symptomologies going to play into some of those decisions? One of the best emergency department doctors I ever met told me he had ADHD. He said it’s the greatest thing ever. It’s a huge advantage.

Analogy stated about focusing on strengths rather than mistakes is critical. This is also applicable to the previous domain category of stigma and how it impacts self-esteem. As she stated,

So ADHD and learning disabilities is the same thing. I love telling people that Einstein didn’t talk until he was five years old. You know Walt Disney was fired from his first job because he wasn’t creative enough. So like normalizing, also the idea that we see other people’s highlight reels and we’re always looking at our blooper reels. And I think that often times therapy can add to that because we are focused on how do we fix this? Instead of how do we enhance what you’re already doing?
Prototypical Case

The typical college student with ADHD is not typical. While a diagnosed student must meet diagnostic criteria for the Inattentive/Impulsive, Inattentive, or Combined Type, every student has a unique experience in college. The experience and history of each student creates the foundation for the college experience, and the particular symptoms play out differently for each person. Comorbidity and environmental stressors both within and outside the institution can be confounding. If a student seeks counseling support, the training and knowledge base of the counselor about ADHD and the resources of the institution may determine the quality of treatment.

John Doe is attending a large state institution for college. He plans to study economics and go to law school. He just joined a fraternity. He plays intramural basketball twice a week and really looks forward to some action on the ball court. He did well in high school although he did not have to study hard to succeed. He was popular at school as he was quick-witted, fun-loving, and creative. Typically, he procrastinated homework but he always managed to get work done and earn good grades. John was diagnosed with ADHD at age 7 when his hyperactivity and distracted behaviors prevented him from learning. He was prescribed Ritalin through elementary school and middle school. He was given an IEP and tutoring to assist his learning. His parents stopped the medication his freshman year of high school as he appeared to doing well and his grades were good; he played three sports year-round. His mother was organized and insisted on a structured family lifestyle. Because he was so busy, she kept his room clean, did his laundry, and managed his schedule. John typically went to school, ball practice,
and then came home for dinner and then did homework each night. John was happy to go to college where he could be in charge of his own life.

By the middle of second semester, John is feeling increasingly anxious. His cumulative GPA is disappointing, 2.6. He worries that he will not get in to law school. He is doubting his own abilities as friends who study less seem to getting better grades. He tries to study in his room but gets easily distracted by friends. In boring classes, he finds it difficult to stay focused and misses some of the lecture material. Sometimes he procrastinates by playing video games and gets hyperfocused on gaming, wasting an entire evening. He usually gets the small homework assignments done but can’t get organized to do the large projects and papers. He has developed the habit of pulling all-nighters to work, but still has missed some deadlines. His work is mediocre and he always feels bad because he knows he has the ability to do better. Plus, he usually panics when he has to task a test because he rarely has time to finish it, even when he is prepared. He has started hanging out regularly with some guys from his fraternity who smoke weed together each evening. This helps him to relax and he likes hanging out with fraternity brothers who are more “chill” about everything. They also go drinking together, typically 2-3 nights a week.

John’s older brother, who took six years to complete his undergraduate degree, tells him to see a counselor because John does not seem like himself. His brother noticed that John is less social and more irritable. His brother said he had some problems in school and needed to get help. His brother was also diagnosed with ADHD. John doesn’t know much about ADHD but thinks it is mostly something fidgety kids experience and they
grow out of it. John sees a counselor twice who diagnoses him with an adjustment disorder with some anxiety. He needs to get organized and develop routines to successfully transition into college. The counselor gives him a list of study and time management skills to execute. John never discloses that he has been diagnosed with ADHD. When he loses the skills sheets the counselor gave him, he feels embarrassed and wants to skip his next appointment. Plus, he has continued to skip his Calculus class and he avoids responding to his professor’s emails.

This prototypical case indicates the situation for a student with an excellent support system, solid college preparatory courses, and resources to get help. Although he had support prior to college he did not develop the skills to self-manage. And, with the freedom of the college lifestyle outside the watchful eye of his mother, he developed poor habits. While John appears to be a freshman student with ordinary transitional and maturity issues, it is not a simple solution. When he cannot do the homework of therapy, the counselor may consider if there is a possible ADHD issues. Or, John may disclose his diagnosis and share that his brother also has ADHD. The counselor may refer to get an updated diagnosis, do psychoeducation on ADHD and help John understand it is a lifelong condition, encourage him to seek accommodations that would be relevant for his symptoms, and do skill-building in sessions in a slow, intentional manner that targets his unique executive functioning deficits. If the family is willing, John could seek an outside ADHD coach. He could revisit medication to see if he needs medication while he is in college, and work with a provider to find the right type and dosage. The counselor could also explore cannabis use and attempt to help John commit to his own wellness and self-
care. With the ADHD properly treated, the temptation to abuse cannabis to relieve anxiety could be challenged. The counselor could also explore if there are other comorbidities impacting John. Behavioral coping behaviors such as spending too much time on video games should a topic of therapy as well. The counselor can also use a strengths-based approach and help John to understand and work from his natural strengths. If the ADHD issue is not illuminated in therapy, the underlying neurological and developmental problem may go untreated and John may continue to spiral down.

John Doe’s case illustrates many findings of the research and depicts the difficulties that can quickly put a student in a negative trajectory. There are many variations on this story. In this case, John Doe was fortunate in that he was identified early and has a strong support system. This story would play out quite differently for an international student with ADHD who was never diagnosed and may be reluctant to go to a counseling center. It would be yet another kind of story for an African-American female student who was academically competent in an urban high school, but whose symptoms of inattention are overwhelming her when faced with the rigor of college work. In every case, postsecondary institutions need to provide equal access for all students with disabilities, diagnosed or undiagnosed, to get assessment, treatment, and support. Chapter Five will provide recommendations that address this need.
Chapter 5: Discussion

Summary

In summary, this study is innovative in nature in that it examines the experiences of college counselors who provide therapy for students with ADHD. Some previous studies have illuminated the problem through quantitative and qualitative research on the students themselves. But little is known about the counselors who serve these students. By studying a small number of therapist participants in depth, this study elicited rich responses and new knowledge. The use of inductive data analysis, multiple perspectives (research team and auditor), words instead of numbers, consensus among team members, acknowledgement of research bias, and cross-analysis of data, improved the trustworthiness of the study (Hill et al., 1997). As I expressed in Chapter Three, the experiences of these college counselors were nestled in a textured space of stories, perceptions, relationships, contexts, and puzzles. There were several layers and strands to understanding their experience, and this methodology answered the research question in a meaningful way. I encouraged them to share their experiences from many angles—their internal processing, their experience in therapy, their successes and challenges—and thus provided data that has breadth and depth.

The findings of the first three domains align strongly with the literature review. Research indicates that adult ADHD is not commonly understood and that it is not a static condition but an unfolding developmental pathway that must be considered through multiple lenses (Nigg, 2006; Fleming & McMahon, 2012). Brown (2006) writes specifically about deficits in executive functioning that are complex, synergistic, and
different for each student. Barkley (2008) focuses more on behavioral inhibition. But all clearly indicate that this is a brain-based disorder and that diagnosis and treatment is complex. Domain one results support the research that early diagnosis and early intervention is generally better (Weyandt & DuPaul, 2008) as students receive support to manage the symptoms, to learn, and to help them qualify for college. Federal laws exist that require public and private schools to provide free, appropriate education. School districts are responsible for identifying, evaluating, and planning educational services for students with disabilities at no extra expense to the parents or individual. Early identified students will usually get the help they need.

But the conundrum of this is that college is not the finish line but the start of a new race. Even with early diagnosis, students coming to college have differing degrees of self-efficacy and self-management. The students lose the support of family and school at a time when they are making a critical change into independent living fraught with many developmental challenges (Chickering & Reisser, 1993). The findings of this research indicate that there are varying degrees of understanding about ADHD for the college student, and early diagnosis, while preferable, does not guarantee a successful transition. Whether that unfolding developmental pathway is a positive experience depends on the buy-in of students and their families about adult ADHD, available resources at the college, treatment experience in childhood, and the sufficiency of the student in academic and life skills upon entering college. It is now the responsibility of the students to seek support. Family denial or support is formational for the student. Students may understand their diagnosis and know how to advocate, or they may think they have outgrown
symptoms and want to appear “normal.” Students may come to college as confident learners or may suffer from low self-esteem because of struggles with ADHD. This study shows that low self-esteem is the rule, even for very bright students, as depicted in the research (Brown et al., 2008; Brown, 2013).

In addition, as indicated in domain eight, high schools vary in their resources and students from more affluent communities will generally be better prepared. Students from poorer communities may not be identified or they may be identified but not receive the necessary support. Another finding of this study is that some counselors observe that students overall do not come to college with basic study skills and that they never had to work hard in high school for good grades. This is interesting in that it may reflect a decline in standards, grade inflation, or a general lack of persistence in some millennial students to tackle intellectual rigor. What this points to is the readiness gap between high school and college for students with ADHD. Preparation is uneven.

Domain two illuminates yet another lens—the comorbidities. This domain supports the research that other factors, notably other mental health problems (Beiderman, 2005; Barkley, 2008; Brown, 2006), but also medical issues, other learning disabilities, and environmental issues interact with ADHD symptoms. Nelson and Gregg (2012) suggested that wellness overall may decrease for students with ADHD because of higher levels of anxiety and depression. Weyandt et al. (2013) indicated that students with ADHD endorsed higher levels of pathology. While all students in college will suffer environmental stresses, particular symptoms of ADHD such as impulsivity or social skills deficits may make coping more difficult. A comorbidity may mask ADHD and it will
usually make differential diagnosis and treatment more complex. The counselors all support the research in that they universally agreed that they saw significant comorbidities in their practice, that comorbidities usually exist, and must be factored into helping students. Treatment is more complicated and requires more time.

The research (Baker et al., 2012; Richardson, 2005; Rooney et al., 2012; Weynandt & DuPaul, 2008) indicated that students with ADHD may be a higher risk for substance abuse. Meaux et al. (2009) and Ratey and Hagerman (2008) indicated that students with ADHD frequently live chaotic lifestyles with high drama and deadline pressure, and this can lead to health risk behaviors such as smoking, drinking, illicit drug use, and other addictive type behavior. Most of the counselors in this study agreed that substance abuse was a critical comorbidity. Two that did not perceive this as a problem worked in particular types of situations—one was a branch campus of a large university that was largely commuter-based and the other was a very small private liberal arts college in a small town setting. This is an area that warrants more attention: considering differential diagnosis between ADHD symptoms and substance abuse; assessing if a student is using substances to self-medicate ADHD symptoms and/or to cope with low self-esteem and failure; and determining how to treat if the student is using medication for ADHD and substance abuse is also occurring. I did not address the problem of abuse of stimulant medication on campuses in my questions, although two counselors made mention of this. However, research does indicate this is a significant problem (Arria & DuPont, 2010) and abuse of medication and diversion of prescribed medication is a serious issue that warrants more research. This is an added layer of the psychoeducation that professionals
need to have in their toolbox when educating students and families about managing medication in college, especially one that is a controlled substance.

Domain three regarding the red flag of academic functioning is aligned with the pioneering work of Heiligenstein (1995) in college students. Important skills needed to function in academia are typical deficits for the young adult with ADHD. Students experience varying degrees of impairment when transitioning to college. The academic skills problem is related to life skills. Students lose the structure and routines of high school and flounder in self-management. It is not surprising that academic stress is the first red flag. This study supports that students with ADHD are vulnerable most noticeably to academic stress but social and emotional vulnerability accompany this academic deficit (Beecher et al., 2004; DuPaul et al., 2009; Fleming & McMahon, 2012; Heiligenstein et al., 1995; Kaminski et al., 2006; Lewandowski et al., 2008; Meaux et al., 2009; Norwalk et al., 2009; Oslund, 2014; Rabiner et al., 2008; Weyandt et al., 2013; Weyandt & DuPaul, 2008; Wolf, 2001).

Also, as pointed out by Weyandt and DuPaul (2008), students with academic stress who have undiagnosed ADHD may be slipping through the cracks. If these students do not access counseling services or see a counselor who is knowledgeable about assessing and treating college students with ADHD, an opportunity to help may be missed. The counselors in this study acknowledged that students with undiagnosed ADHD are coming to college, and there does not seem to be a uniform way of screening for this. The priority to assess will vary, depending on the resources of the counseling center.
These domain results point to the tremendous multifaceted presentation of ADHD and how this impacts readiness to handle college life and academic rigor. Academic problems may be the tip of the iceberg, so to speak, but it is critical to understand the layered history of symptoms, treatment, family and school experience, and associated problems and pathologies in order to help the student. While the counselors in this study were all invested and interested in treating ADHD, can this be said broadly for all college counselors? Counselors will typically have an understanding of core symptoms, but will they recognize the adult manifestations of these symptoms in the college environment? Can they catch the students who need diagnostic evaluation? Can counselor help with the individual nuances of the disorder and comorbidities as they appear for each student? The literature review mentioned internal and external pressures and the nuanced differences between subtypes (Norwalk et al., 2009; Rabiner, et al., 2008). These were mentioned only tangentially by some of the counselors in terms of subtypes. None of the counselors mentioned the unique problems of students with high IQs and ADHD as a special category, but this was a concern in the research (Brown et al, 2008, Brown, 2013).

Domain four reflects what was stated clearly in the research—that counselors do not receive training on how ADHD impacts the college student and how to help and support (Ramsey & Rostain, 2006). This reflects what was stated in the research by Boyd et al. (2003), that counseling centers need updated professional practice changes. Counselors have been mostly self-trained and have learned through personal clinical experience about what works and does not work with college students with ADHD. They all generally do cognitive work, psychoeducation, and they stress skill building and
behavioral strategies. All have clued in to the underlying self-esteem issues that may influence student motivation and persistence. I was impressed that they were all aware and concerned about the challenges of students with ADHD. But their approaches were individualized as none had ever attended training specific for college students with ADHD. The counselors in this study were all self-motivated to learn independently about ADHD treatment, but is this common practice amongst college counselors?

But counselor education was not the only concern. The findings indicate that students themselves, their parents and families, and others in academia such as professors hold faulty or scanty understanding of ADHD. As the research indicated, illuminating the challenges of adult ADHD has been fairly recent and adults manifest symptoms differently (Knouse et al., 2008). And there are still misconceptions such as thinking about ADHD as a problem children and adolescents (Weyandt & DuPaul, 2008) or assuming people will outgrow the problem and lackluster performance is a matter of willpower. ADHD lies within the larger umbrella of all disabilities such as learning and medical disabilities, and autism spectrum students. While accommodations are offered, do counselors and others in academic who interact with these students truly understand the challenges and know how to support these specific disabilities? As the research stated, the symptoms of ADHD are distinct from learning disabilities in subtle ways but counselors and others who interact with students may not understand this (Reaser et al., 2007). There is a gap in training and attitude about disabilities for mental health professionals in college (Goad & Robertson, 2000; Oslund, 2014; Thomas et al., 2011;).
None of the counselors in this study had formal training on treating disabilities in general, or treating college students with disabilities specifically.

It is important to note, as stated by Hunt and Eisenberg (2008), that college counseling centers are experiencing a significant increase in the severity or psychological problems among their students. There are significant variations in standards of care (Hodges, 2001). College counseling center resources are stretched, while demand for services and increased expertise is a reality. Some may not even want to treat ADHD if there are limited resources or if they subscribe to short-term models for counseling.

Domain five and six, related to stigma and advocacy, are related to the problem of training and education for students, parents, and others in academia. The negative self-talk and cognitive distortions related to ADHD are frequently exacerbated by parents, teachers, and others who see the symptoms as laziness or lack of effort. Feeling the confidence and right to advocate for self is legitimized by psychoeducation about ADHD. But proper treatment such as CBT to address these underlying issues is critical. Many students with ADHD may need counseling and may not be accessing services. They may need more encouragement and support from others such as parents, teachers, and tutors to seek help for the negative feelings about self related to ADHD. Chronic underachievement robs students of their potential.

Domain seven is interesting in that it reflects the various specific treatments that counselors use. All recognized the value of pharmacological intervention but they also recognized that proper use of medication takes time and that compliance differs among students. The research supports the opinions of participants in this study that medication
management is complicated and not all respond to medication (Wadsworth & Harper, 2007). There was also the caution about the possibility of stimulant abuse and this is supported in the research (Arria & DuPont, 2010).

One counselor uses an evidence-based manual that focuses on CBT, and all use CBT to some extent. The research indicates this is a standard intervention (Knouse et al., 2009; Safren et al., 2010; Solanto et al., 2010). Ramsey and Rostain (2006) wrote about coping fatigue that occurs when the typical strategies such as CBT fail to work. None of the counselors mentioned this as a possibility, though it may have been present with students in the form of avoidance or procrastination, which was mentioned by counselors. A couple counselors in the study mentioned readiness to change (Murphy et al., 2010) so there was consideration of student internal motivation.

All the counselors in this study emphasized skills and strategies as foundational. But there is no real standard on best practices. Resources that were specifically mentioned were not tailored to the college population. None of the counselors mentioned DBT or mindfulness practice as possible treatments, even though there is some research that supports these (Fleming et al., 2012; Zylowski et al., 2008). Assert stated that he uses coaching-type encouragement but this is not actually coaching with regular supportive contact. Again, there is research that supports this intervention as helpful (Allsopp et al., 2005; Field et al., 2010; Swart et al., 2005). Possibly, linkage to outside ADHD coaches would be a good collaboration with counselors. Also, it would be useful to look at the longitudinal effect of interventions. What works for whom? Do students persist in practicing the good strategies and skills learned in therapy?
Domain eight captures counselor concerns about the pre-college preparation that occurs in high school and the post-college concern about careers. To these therapists, both are deficient. While counselors can’t do much about the condition of students when they arrive, they do play a part in guiding them through career preparation. This is a typical senior year stress and counselors can be instrumental in helping students identify careers that play to their strengths. I specifically asked about career preparation and this is a critical goal of a college education, and there was little research on career preparedness for students with ADHD. While it was not a general finding, it is valuable to think about the lifelong trajectory of managing ADHD and what happens after college (Reilley, 2005). The research indicates career guidance needs more attention (DiPeolu, 2011) and this is supported by some of the counselors in this study.

Domain nine illuminates multicultural and social justice concerns. Counselors need more training in gender differences as they may play out with ADHD. More outreach is needed to minority and international students. The counselors in this study saw more Caucasian males than any other group. They had never assessed or treated international students. ADHD may not be recognized in other countries and there are cultural barriers to accessing mental health. Given the school representation of the sample—public schools, private schools, and a community college—this was an interesting finding. There appears to be little specific outreach to students from other countries and ethnicities who may have disabilities such as ADHD. And, of course, depending on the school, access to evaluation and treatment is uneven. Poorer students will not have access. The results
confirm what is stated in the research, specifically the DSM-5, that there is a culture and gender gap (DSM-5, 2013).

Domain ten focuses on the recognition of strengths, but the degree to which these are a focus in therapy is not known. And, how do students learn to not only recognize their strengths but use them effectively in their college lives? Successful role models are a helpful intervention but in this group it was not a predominant response. There seems to be a gap between recognition of strengths and how to apply them. The literature review showed that an intervention such as coaching with an intentional strengths-based approach can be helpful (Allsopp et al., 2005; Field et al., 2010; Swart et al., 2005), but this was not a specific regular practice amongst the participants in this study.

The predominant emerging overall theme from this study is variability. A college counselor may have institutional supports or may be a “lone ranger” of sorts. This counselor may be a social worker, counselor, or a psychologist and this counselor will probably have little specific training in assessing and treating adult ADHD, or disabilities in general. With uneven access to diagnostic services and medical support, differing degrees of compliance when medicine is used, differing reactions from families and professors, differing degrees of buy-in and motivation from the students themselves, differing environmental factors, and various comorbid factors, treatment is complex. So, in addition to each counselor adopting an individualized-type approach, each student is quite unique in how ADHD impacts his or her life. This is not a one-size-fits-all type of diagnosis and the nuances of symptom presentation demands varying responses. Of course, the nature of the diagnosis which entails problems with memory, focus, attention,
and time management also makes treatment challenging for any counselor. Students with unmanaged ADHD are frequently forgetful, late, and resistant to change that makes treatment more challenging. Counselors may not be able to see students with sufficient frequency to create lasting behavioral change and treatment regularity depends on the institution. Medication treatment and maintenance may require long-term support, and those who do not take medication may need extra support. As the literature showed, the stakes are high and a significant number of students with ADHD are coming to college, but presentation of symptoms, assessment and treatment is variable and uneven.

Finally, in this section, it is salient for me to reflect upon how I have grown and changed in the process of doing this research. I feel an increased passion to serve students who struggle with this diagnosis. I want to continue to improve my skills and I hope to contribute to research on practices that are effective. As a clinician, scholar, and counselor education, I think I should use what I have learned to share with colleagues. I have already begun this process. I have presented at three professional conferences this semester on ADHD in college. In addition, I also presented to faculty at Denison as part of a faculty workshop series. As this dissertation has stated, it is incumbent on counselors to help other staff understand the complexities of ADHD and to understand how students with ADHD learn. In my recent conference experience, I am getting the feedback that college counselors are indeed interested in this topic. I hope professors will also be interested.

I also feel some frustration as I realize that diagnosis is indeed uneven and access to treatment depends on many factors, such as family financial means and the particulars of
the institutional resources. I fear the international students are completely overlooked, and in addition, there are many cultural barriers to mental health overall. While the gender differentiation is less than several years ago, I do think many women have been overlooked. I feel a sense of sadness when I think about people who struggle with self-esteem issues and loss of potential and life dreams because they do not understand how their brains may be different. Who gets assessment and treatment is very much a social justice issue that needs to be a priority for colleges. I believe that counselor educators must continue to focus on multicultural education in all our training programs. For students with no financial means for testing and treatment, we need to fill the gap.

I also know there are excellent models out there for students. And this speaks to the importance of a positive psychology strengths-based approach. ADHD is described as a deficit but we fail to see that it may just be a different brain. Our American culture, which influences the high-stakes and high-pressure style of college life today, has created a generation of exceedingly anxious college students. There is tremendous pressure to compete, compare, and perform. There is not much room for academic exploration, mistakes, flexibility, and varying learning styles. With technology and the unending temptation of the Internet, social media, and related distractions, I think learning is more challenging overall for all students. In some ways, it feels like everyone has ADHD in the sense that there are so many distractions that were not present just ten years ago. Plus, students truly vary in their maturity and ability to transition to college. The ADHD brain tends to develop slower, so these students are typically less developed and mature in their frontal lobe area. I think we have to understand college learning and ADHD in this much
broader context of individual maturity/readiness, cultural values, and technological change. I think we need to honor divergent, longer pathways to getting a degree. I wonder if a rigid four-year model is the best model for adult education.

Having worked at two colleges, I have seen the substance abuse and stimulant diversion at close range. I wonder how many students are self-medicating and falling into judicial trouble and academic failure because of undiagnosed and/or improperly treated ADHD or some other mental health condition. I also think of friends and family who struggle outside the college arena. ADHD does not go away in adulthood, but the skills to manage are paramount for successful adult life management. For all students, especially those who have a disability, I believe it is so critical to emphasize wellness and a holistic approach to self-care and good lifestyle management.

So while my research was narrowly focused on eight interviews, I think I walk away from the research with a broader view of the need and an increased motivation to help all students who struggle, but especially those with disabilities. I hope my research participants experienced increased interest and motivation as well as a result of having participated in my study. My research team offered feedback that review of the research data increased their understanding of ADHD.

**Limitations and Delimitations**

The present study has some limitations. Being a qualitative design with a purposeful sample, the results cannot be generalized to the entire population of college counselors. The eight therapists who chose to participate in this student may have had a special interest in this population of students and they may have a more positive attitude toward
disabilities. As Thomas et al. (2011) pointed out, college counselors are less aware of the obstacles and prejudices faced by students with disabilities. Others who did not respond may have not been as invested in knowing about ADHD in college.

Also, the participants worked at different types of institutions. The size, resources, location, type of students, and type of institution creates a different experience for the therapist. In this study, it became apparent that different types of postsecondary institutions serve students with ADHD differently. Also, different paradigms for training and experience is important. The particulars of the student population and the staffing and financial resources of the institution, depending on size, are different for each institution and this impacts treatment. The counselor serving at a community college was an outlier as these students had fewer environmental supports and experienced more personal challenges such as outside work and family responsibilities than typically occurs for non-traditional students. These external environmental factors may have influenced responses as the experiences were different per institution. For example, the one counselor who did not cite substance abuse as a problem served a unique kind of small private liberal arts school.

I did not ask questions about stimulant abuse. This adds another aspect to treatment of students in college. Given the seriousness of the problem on campuses, medication treatment, compliance, and diversion is an important topic. Also, while medication is frequently used and was discussed by participants, this study does not specifically address treatment interventions with students with ADHD who do use medication as opposed to those who do not.
It is not conclusive, either, about what actually constitutes successful practices among college counselors for supporting students with ADHD. To a great extent, treatment still is determined by counselor experience and interest, and the individual presentation of the student. The study shows some interventions have worked for individual counselors but ADHD continues to be a controversial and complex diagnosis. A large-scale student with outcomes measurement would be needed to guide counselors in the best interventions.

**Recommendations**

There are four recommendations for future research and practice. First, more intentional preparation prior to college needs to occur, especially for students with diagnosed ADHD. High schools and colleges need stronger links and onboarding when serving students with disabilities. Parents and school counselors can be thoughtful about a “best fit” for the student based on the size and resources of the college. Student maturity, time management, organization, self-efficacy and ability to create personal structure and handle change is important. Some students may require a gap year or a year at a commuter college before going to a residential college. Students need to be informed about and know how to access resources on campus. This may entail parental involvement and outreach by the college. Information about the students’ disabilities should be accurately communicated to the college. When a highly successful high school student declines academically the first semester of college, it be devastating to the student’s confidence. Improved awareness and thoughtful planning for each individual student can prevent this kind of initial setback.
Along with this, each college needs to identify its mission and student needs according to the type of institution. This will help families plan. Staff at a private school versus a public school or a community college will need to think strategically about access to outside providers, internal resources within the college, and the training of staff. It is important for departments both in student development and the academic side to share a concern and vision for how to support students with disabilities such as ADHD. Looking at the overall big picture of more students coming to college with disabilities, it is incumbent on institutions to consider if they are providing adequate support for these students to succeed. It may be, for example, that a traditional four-year path is not reasonable for some students. Are institutions staffed to provide sufficient counseling, academic, and career planning support for promising students with certain disabilities who are admitted to college? Is retention a bigger challenge for students with disabilities? Are families fully informed about what the school can offer? While it is desirable for more students with disabilities to have access to a college education, postsecondary institutions may not be keeping up with the needs. The students are admitted but the infrastructure to support them to degree completion may be inadequate. More research is needed to examine outcomes for students with disabilities who attend college, the graduation rate, and the problems for students who fail to complete their degrees.

Second, more psychoeducation is paramount. Student and parents require accurate psychoeducation. Staff in counseling centers need to have more education about ADHD in particular and disabilities in general. As the research indicated, counselors are more focused on mental health and less aware of the obstacles faced by students with
disabilities. Nor are they uniformly knowledgeable about ADA law (Gordon et al., 2002). With ADHD, training in screening and assessment as well as various treatment interventions needs to be communicated to this group. In terms of procedure, counseling centers may consider their intake forms and determine if they are capturing symptoms that may reflect undiagnosed ADHD, and then ensure all counselors are trained to do initial assessment. Standard screening assessments may be used to enhance diagnosis.

Collaboration with other departments is important. Student issues related to ADHD will be encountered by student support services, teachers, and career services. Many of these colleagues have limited and outdated conceptions of adult ADHD. Counselors can educate them individually and sponsor some group interdisciplinary educational seminars. These professionals can be instrumental in referring students to counseling for support. In addition, their referral may start the process of evaluation if the student is undiagnosed. As Goad and Robertson (2000) stated, maintaining an active liaison relationship with the office that provides accommodations is also critical.

Third, and this is related to the second recommendation of improved psychoeducation, scholars need to develop high-quality training programs based on evidenced-based research to teach best practices for supporting college students with intellectual and developmental disabilities. If counselors are offered high quality training programs, this sample indicates that they are interested in attending. Counselors can be catalysts for educating others in their academic communities about adult ADHD, and the special challenges for students in college with this diagnosis. They can work with other departments to coordinate support for these students. They can improve individual
success for students with ADHD both in college and improve the bottom line on student retention in their institutions.

A corollary of this, of course, is that more research is needed to know how to best treat college students with ADHD, and studies need to be conducted that measure outcomes both short-term in college and long-term in life. Given the burden on college counseling centers, best practices for treatment are needed to facilitate therapy. More studies need to be conducted on group therapy specific to college, coaching, and mindfulness to determine if these improve outcomes. This qualitative study shows the student need is there and college counselors are interested in learning interventions to help these students. Yet, the research indicates this a sorely understudied population (Weyandt et al, 2013).

Fourth, the findings of this study suggest that women and definitely students from other countries may be underserved. The unique ADHD presentation of women (Fedele, 2012; Kelley, 2007) was acknowledged in this study but not every counselor was tuned in to the gender difference. There was generally an understanding that more male gendered students were diagnosed, but symptom presentation and treatment for women was not understood. No one in this study worked with students from other countries on ADHD-related issues, and no one had made an initial diagnosis of ADHD with this population. The gap in diagnosing and treating students from other cultures and countries was the most surprising result. And, as the study indicated, most college counselors simply lack training in multicultural concerns overall. College counseling centers must provide
training for all staff on ADHD to develop core competencies with special attention to the needs of students from other cultures and ethnicities and women.

Counselor educators, in particular, emphasize wellness, holism, empowerment of the client, and multicultural awareness. As this study shows, the college student with ADHD experiences symptoms within a context—family, school, community, culture—and the social factors influence the how the person experiences reality. There are social justice issues related to who gets diagnosed and treated. There are multicultural issues as students from other countries and cultures are not accessing support. There are power differentials in academia, such as that between a student and professor, that may lead to increased stigma about mental health. And, simply the term “disorder” encourages certain value judgements about mental health. Because ADHD is classified as a “disability”, I also believe that there is an advocacy aspect to this research design. Frequently in our social contexts, individuals have constructed a certain worldview of what is normal and not normal. Persons who are disabled are frequently marginalized and underrepresented. Those with ADHD have a hidden disability; they may experience disadvantage and lack of advocacy and support in academia because well-meaning educators and clinicians simply do not understand the complexity of their experience of disability nor see their inherent strengths. In counselor education programs, both on the master’s and doctoral level, more attention should be devoted to adult symptoms of ADHD, assessment, and treatment. Also, directors of college counseling centers should insure that all staff have some training in ADHD so students are not missed or underserved. While research
specific for college students is limited, there are some resources available immediately that counselors can use to assist students.

In summary, the problems associated with ADHD can be devastating and people struggling with this diagnosis may mismanage their lives in hundreds of ways. In addition to the struggles of academia, functional consequences associated with ADHD can haunt a person for a lifetime (Bernfort et al., 2007; DSM-5, 2013). Yet, less than half of those with the disorder will receive treatment. The findings of this study support the need for more research and standards for best practices in helping college students with ADHD. As Hunt and Eisenberg (2010) stated, the college counseling center can have a positive effect on the life trajectory of students. There are many stakeholders and college counselors can be catalysts for improving psychoeducation, diagnosis, and support for these college students at a pivotal time in their lives.
References


Barkley, R. A. & Safren A. A. (2008). Counseling newly diagnosed adults with ADHD. In M. Gordon (Chair). *ADHD in adults-clinical management approaches.* Symposium conducted at the meeting of the American Psychological Association, Boston MA.


Nelson, J. & Gregg, N. (2012). Depression and anxiety among transitioning adolescents and college students with ADHD, dyslexia, or comorbid ADHD/dyslexia. *Journal*


As retrieved from http://www2.ed.gov/about/offices/list/ocr/transition.html


As retrieved from http://www.pluk.org/Pubs/Fed/IDEAreport_2002_4.8M.pdf


What is your age range (25-35, 35-45, 45-55, 55-70)?

What is your gender?

What is your ethnicity?

What is your type of degree and licensure?

What is your primary theoretical orientation(s)?

What is your current position and particular job responsibilities?

How many years of experience do you have as a clinician? As a college counselor?

What type of postsecondary institution do you work at?

**Figure 1.** Demographic Questions for Participants
Dear Colleagues,

Students served at college counseling centers may present with ADHD symptoms. Yet, there is little research that explores the experiences of the counselors who work with them. I am a doctoral student at Ohio University conducting a qualitative research to learn about the experiences of college counselors who do therapy with students with ADHD. My advisor, Dr. Yegan Pillay, is supervising the project.

COUNSELING COLLEGE STUDENTS WITH ADHD:
A CONSENSUAL QUALITATIVE RESEARCH (CQR) STUDY
EXAMINING THE EXPERIENCES OF COLLEGE COUNSELORS

I am interested in learning about your specific experiences, challenges, successes, and suggestions about working with this population in the postsecondary environment. Regardless of your level of knowledge or experience with ADHD, your contribution is extremely important. I hope that your participation in this study will help your practice as you work with these students. I also hope my dissertation will generate information that will improve treatment and support of college students. I am seeking eight to twelve college counselors for a 60-90 minutes interview. I am providing a $50 Amazon gift card for your time, to be given at the time of interview. I will come to your campus.

Please respond via email at gibsons@denison.edu if you are interested in participating in this study.

Thank you,

Sanda Gibson, MA, PCC-s

Figure 2. Recruitment Flyer
<table>
<thead>
<tr>
<th>Domain</th>
<th>Findings</th>
<th>Frequency</th>
<th>Type of Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Diagnosis</td>
<td>Early diagnosis is best</td>
<td>XXXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Early diagnosis can be problematic (one said early is best but also problem in some cases)</td>
<td>XX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Students frequently are ignorant about diagnosis</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Response to diagnosis varies by student and family—may or may not seek help</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Mental health</td>
<td>XXXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Environmental/emotional/learning disabilities/physical health</td>
<td>XXXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Alcohol/drug problems (two not see this in practice)</td>
<td>XXXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Self-medication of symptoms impact functioning</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Can make treatment complex</td>
<td>XXXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Must have wellness/self-care esp. if not using meds</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Concern about stimulant drug abuse</td>
<td>XX</td>
<td>Variant</td>
</tr>
<tr>
<td>School Functioning</td>
<td>Academics first sign of stress</td>
<td>XXXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Students differ in readiness to change behaviors/developmental issues impact</td>
<td>XXXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Behaviors can continue beyond college—think of lifetime functioning</td>
<td>XXXX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Hyperfocus can be problematic</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Clinician self-education about ADHD (how trained)</td>
<td>XXXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Students need education</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Families need education</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Others in academia need education</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Desires more resources and training for clinicians</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Prior residential life experience</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Need more planning time and team meetings in practice</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>About self (esp. self-esteem)</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>From parents/families</td>
<td>XXXXX</td>
<td>Typical</td>
<td></td>
</tr>
<tr>
<td>From others in academia</td>
<td>XXXXXXXX</td>
<td>Typical</td>
<td></td>
</tr>
<tr>
<td>Need psychoeducation to validate and normalize</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td><strong>Advocacy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students need to learn to advocate in academia</td>
<td>XXXXX</td>
<td>Typical</td>
<td></td>
</tr>
<tr>
<td>Students need to advocate with medical provider</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Students need to advocate with parents</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Some refuse to advocate to appear “normal” (pride)</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Parents vary in desire/ability to advocate</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Power differential with professors</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Counselors can advocate for students within academia</td>
<td>XXXXXXXX</td>
<td>Typical</td>
<td></td>
</tr>
<tr>
<td>College should be a safe place for advocacy</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ADHD can be a crutch—too much help

<table>
<thead>
<tr>
<th>Treatment-Specific</th>
<th>ADHD can be a crutch—too much help</th>
<th>XX</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has access to affordable testing</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Connects to medical</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Connects to academic services and other resources</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Stages of Change Model/Motivational Int.</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Skills Building/Strategies</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>Strengths-based</td>
<td>XXXXX</td>
<td>Typical</td>
<td></td>
</tr>
<tr>
<td>Use rewards and fun</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment is individualized</td>
<td>XXX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Uses analogies to help</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Understands learning styles</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solution-focused</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Uses technological tools</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>CBT/Behavioral Tasks</td>
<td>XXXXXXXX</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>DBT</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses manual</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social can be problematic and needs to be addressed</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperfocus can be problematic</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use toys, sensory tools</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment-Global</td>
<td>Concerns about diagnosis (over- and under-)</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------</td>
<td>-----</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>Need more prep in high school (academic and life skills)</td>
<td>XXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Need more help/coaching with career choices</td>
<td>XXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Need more role models and success examples</td>
<td>XX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Need to reduce stigma overall in institutions; more flexibility; teamwork across the institution</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td>Multicultural</td>
<td>Not aware of gender differences</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More males seen with ADHD; less females diagnosed</td>
<td>XXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>African-American under-represented; African Americans overrepresented</td>
<td>XX and</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Counselor needs more training on culture</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to medication/treatment uneven (barriers)</td>
<td>XXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Not seen international students with ADHD; culture causes reluctance</td>
<td>XXXXXXX</td>
<td>General</td>
</tr>
<tr>
<td>Privilege/private education helps</td>
<td>XX</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Strengths</td>
<td>Courage/Willpower/Motivation/Energy</td>
<td>XXXXX</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Positive outlook/perspective</td>
<td>XXX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Need healthy self-esteem—a strength if they have it</td>
<td>XX</td>
<td>Variant</td>
</tr>
<tr>
<td></td>
<td>Play to their strengths, i.e. creativity, divergent style, passion, stimulation</td>
<td>XXX</td>
<td>Variant</td>
</tr>
</tbody>
</table>
Athletes have advantage | X
---|---
Fast, flexible thinkers; intelligent; multitasking | XXXXXX Typical
Can be high achievers; accomplish more | XX Variant
Think outside the box; creativity | XXXXX Typical
Hyperfocus/impulsivity—“mixed bag” | XX Variant

**Figure 3.** Cross-Analysis of Core Ideas