How Female Educators with Attention-deficit/Hyperactivity Disorder Experience the Teaching Profession

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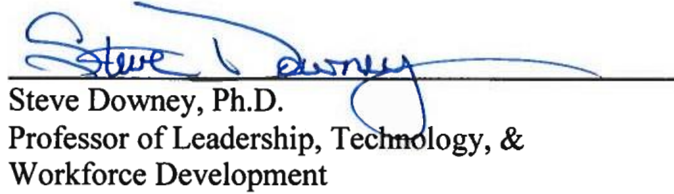

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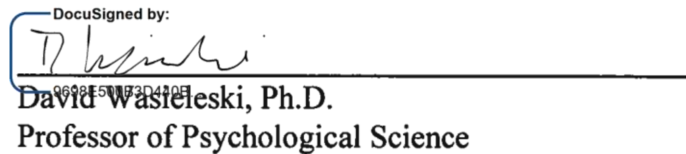

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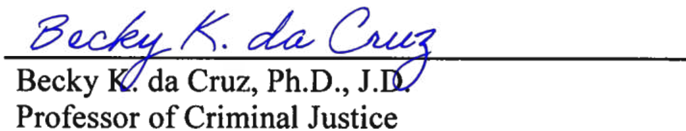

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ABSTRACT

This study examined how female educators with AD/HD experience teaching, specifically managing their classroom, interacting with colleagues, administrators, and parents, and interact socially with colleagues. Brock (2008) is the only study that specifically researching teachers with AD/HD, but her study does not investigate how female educators changed after being diagnosed with AD/HD.

I performed a hybrid study using a basic descriptive study and autoethnography. For this study, I posed three research questions: (1) how does a diagnosis of AD/HD as an adult impact a female educator’s perception of her ability to manage a classroom learning environment, (2) how does a diagnosis of AD/HD as an adult impact a female educator’s perception of her ability to professionally communicate student progress to colleagues, administrators, and parents, and (3) how does a diagnosis of AD/HD as an adult effect a female educator’s perception of her ability to interact socially with colleagues and support personnel? To answer these questions, I conducted a three-part life story interview (Atkinson, 2002). The first round of coding was performed using Emotion coding and the second round of coding was performed using Pattern coding (Saldaña, 2016). I used these coding methods to analyze my participants’ interview data and answer my research questions.

After analyzing the data, I found multiple ranges of emotions and patterns of behavior. The ranges of emotions included positive, negative, and neutral. The patterns of behavior I identified were resilience and leveraging AD/HD. After performing a comparative analysis, I found that my participants had similar experiences.

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I would like to thank my participants as without them my study would not have been possible. The wealth of knowledge that I learned from their personal experiences is awe inspiring.

CHAPTER I

Overview

Attention-deficit/hyperactivity disorder (AD/HD) is the most prevalent childhood mental illness (Brown et al., 2016; Topkin, Roman, & Mwaba, 2015), affecting between 5% and 11% of children in the United States (Hamed, Kauer, & Stevens, 2015). As children grow up, AD/HD symptoms are thought to dissipate (Fedele, Hartung, Canu, & Wilkowski, 2009); however, AD/HD symptomatology can persist when children become adults (American Psychiatric Association, 2013; Asherson et al., 2012; Brock, 2008; Tarver, Daley, & Sayal, 2014). The American Psychiatric Association (2013) includes adults in the description of AD/HD in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*; however, the American Psychiatric Association does not differentiate between childhood AD/HD and adult AD/HD symptomatology. The American Psychiatric Association contends that for an adult to be given a diagnosis of AD/HD, the adult should have displayed characteristics of AD/HD before the age of 12.

Adults have been afflicted with AD/HD, recorded as early as the 1950s (Justman, 2015), however, there are three differentiating traits that are often missed when diagnosing older teens, adults, and the elderly (Dodson, 2019). Dodson (2019) identifies these three traits as interest-based AD/HD nervous system, AD/HD emotional hyperarousal, and rejection sensitivity, which I defined and deduced how these three traits set older teens, adults, and the elderly apart from children and adolescents diagnosed with AD/HD. In the United States only 0.07% to 0.14% of adults who have AD/HD have been given an official diagnosis, although the recognition rate is much higher in different regions of the world (Hodgkins et al., 2012). At the international

level, 2.3% to 4.5% of adults suffer from AD/HD symptomatology (Asherson et al., 2012). There are conflicting beliefs as to whether AD/HD symptoms in adults linger from childhood or if adults can develop AD/HD (Agnew-Blais et al., 2016; Asherson et al., 2012; Conrad & Potter, 2000; Zalsman & Shilton, 2016).

Asherson et al. (2012) believed the reason why only a small percentage of adults have been diagnosed with AD/HD is because the diagnostic criteria, set by the American Psychiatric Association (2013), does not list symptoms specific to adults. Hyperactive symptoms tend to lessen as adolescents enter adulthood, but symptoms of inattention remain problematic for adults (Asherson et al., 2012; Asherson, Buitelaar, Faraone, & Rohde, 2016).

Women are more often diagnosed with AD/HD as adults than as children (Asherson et al., 2012). Women are not diagnosed until adulthood because society's gender expectations cause girls to internalize or hide their symptoms (Holthe & Langvik, 2017). Girls are more likely to display the less commonly diagnosed inattentive type (Fuller-Thomson, Lewis, & Agbeyaka's, 2016). Solden (1995) surmised, after years of listening to women describe their childhood, rigid routines, and strict parenting hid AD/HD symptoms, but when women manage their own household AD/HD symptoms interfere with daily routines, family relationships, and job performance. Agnew-Blais et al. (2016) concluded that adult females diagnosed with AD/HD for the first time have higher IQs, explaining why it was easier for them to manage their AD/HD symptoms during childhood.

There is a gap in the literature explaining the reasons why women can go their whole childhood and part of their adulthood not being diagnosed with AD/HD. It is

important that adults who have AD/HD receive a diagnosis because AD/HD is a mental health disorder that can have adverse effects regarding relationships with family, friends, or colleagues, and behavior choices that affect societal morality and job performance (Connolly, Speed, & Hesson, 2016; Henry & Jones, 2011; Sarkis, 2015). Watters, Adamis, McNicholas, and Gavin (2018), referring to AD/HD symptoms as a 'burden', found that their participants reported an inability to concentrate, making simple tasks, such as watching TV or reading, difficult. Watters' et al. (2018) participants also stated that their impulsive behavior made it difficult to complete one project before starting another project, with the real possibility of never completing any projects.

Despite years of clinical attention given to adults with AD/HD symptoms, many scholars agree that there is insufficient research attention given to adults with AD/HD (Asherson et al., 2016; Caye et al., 2016). The lack of knowledge and awareness about adult AD/HD, particularly for females, creates a negative outlook for female educators who may be suffering from AD/HD symptoms. For example, according to Georgia's Teacher Keys Effectiveness System (TKES), teachers need to provide a safe learning environment, model appropriate behavior, multi-task, and interact with colleagues, administrators, and parents, professionally (Georgia Department of Education, 2013). A female educator who has symptoms of AD/HD or has been diagnosed with AD/HD and is not receiving treatment will have difficulties fulfilling these TKES requirements because AD/HD symptoms cause a mental and physical strain (Brod, Schmitt, Goodwin, Hodgkins, & Niebler, 2012).

A way to generate knowledge that helps inform public policies, such as those affecting the achievement of the TKES goals, is to study female educators' personal

experiences with AD/HD symptomatology, the adverse effects the symptoms have on their careers, and why my participants decided to seek help. To that end, understanding how AD/HD symptomatology presents in females provides insight into how female educators struggle maintaining a classroom learning environment and professionally interacting with colleagues, administrators, and parents. I shared the individual experiences of female educators diagnosed with AD/HD as adults to bring awareness to the educational community, using the female educators' experiences to help other female educators who may have undiagnosed AD/HD.

I addressed the lack of research about teachers diagnosed with AD/HD, the events leading up to self-reporting, and how receiving a diagnosis of AD/HD changed how they manage their classrooms and interact with school personnel and parents. Educators who have an AD/HD diagnosis and are taking prescribed stimulants still struggle sustaining professional requirements involving student progress, required reporting, and communication (Brock, 2008). The challenges I specifically studied were female educators' difficulties managing a classroom and interacting with colleagues, administrators, and parents, professionally and socially, before and after being diagnosed with AD/HD.

Statement of the Problem

Given reported problems faced by adults with AD/HD (Brod et al., 2012), it stands to reason educators with AD/HD might also deal with obstacles and difficulties at work that might impact their effectiveness. Once we learn about how AD/HD symptoms negatively affect an educator's ability to reach their optimal performance, we can research appropriate accommodations specific to teacher effectiveness (Job

Accommodation Network, 2018; Kelly & Ramundo, 2006; MacDonald-Wilson, Rogers, Massaro, Lyass, & Crean, 2002).

There is little known about adult AD/HD (Zalsman & Shilton, 2016) and how AD/HD symptomatology presents in adults (Asherson et al., 2016). Adults with AD/HD have trouble discerning behavior patterns that are normal for their age and behavior patterns that are symptoms of AD/HD (Barkley & Brown, 2008; Watters, Adamis, McNicholas, & Gavin, 2018), so recognizing AD/HD symptoms in themselves or others is difficult. AD/HD symptoms such as losing track of time, disorganization, and the inability to control emotional responses negatively affect adults' careers (Fedele et al., 2009). Educators with AD/HD are slow to respond to unexpected problems in the classroom, have difficulties differentiating instruction for multiple students, and are unprepared for daily lessons because they did not gather the necessary materials in advance, all of which are qualities of an ineffective educator (Georgia Department of Education, 2013; Walker, 2008). Failure to maintain a level 3 or higher on Georgia's TKES can lead to an educatorbeing terminated. After extensive research, I found only one qualitative dissertation describing teachers with AD/HD who shared how they cope with their AD/HD symptoms(Brock, 2008). There are no published studies involving teachers who shared how their AD/HD symptoms negatively affected their careers before being diagnosed with AD/HD and how a diagnosis of AD/HD changed their habits in the classroom and interactions with other professionals in their field.

Purpose and Scope

The purpose of this study was to generate awareness about female educators with AD/HD and how they experienced their disorder while striving to be successful teachers.

In this study, I examined and described the effect of AD/HD symptomatology on female educators teaching for a minimum of 1 year, diagnosed with AD/HD between the ages of 23 and 65, and how they manage a classroom and the professional conduct and social interactions with colleagues, administrators, and parents.

In this study, I focused on female educators diagnosed with AD/HD as adults because of my personal experience being diagnosed with AD/HD as an adult and what I read about gender-specific AD/HD symptoms (Fuller-Thomson et al., 2016; Quinn, 2005; Rasmussen & Levander, 2009; Waite, 2009). I specifically investigated female educators' experiences before and after being diagnosed with AD/HD as an adult because the literature does not include female educators' stories about their difficulties managing a classroom and interacting with colleagues, administrators, and parents, professionally and socially. I participated in this study as one of the cases because I met the criteria for inclusion in the study's scope.

Research Questions

I used the research questions below to learn more about adult female educators diagnosed with AD/HD, examining the experiences being diagnosed with AD/HD as an adult, and provide insight as to how AD/HD symptoms affect job-related tasks.

Question 1. How does a diagnosis of AD/HD as an adult impact a female educator's perception of her ability to manage a classroom learning environment?

Question 2. How does a diagnosis of AD/HD as an adult impact a female educator's perception of her ability to professionally communicate student progress to colleagues, administrators, and parents?

Question 3. How does a diagnosis of AD/HD as an adult effect a female educator's perception of her ability to interact socially with colleagues and support personnel?

I used research question one to address the first of the three interrelated elements of being a successful educator, classroom management. Using my personal experience, I imagined that female educators' experiences being diagnosed with AD/HD as an adult effected how they thought about their classroom management strategies and how their previous behavior effected their classroom learning environment (Brock, 2008). This study's theoretical framework, described later, shaped the data collection and analysis portion of this study in that female educators need working memory, internalization of speech, reconstitution when remembering specific student behavior, how to address individual student behavior, and how to respond using appropriate words and tone of voice.

I used research question two to examine how AD/HD symptomatology effected a female educator's ability to professionally communicate student progress with colleagues, administrators, and parents. Part of what makes a teacher successful is being able to effectively communicate student progress with colleagues, administrators, and students' parents. Research question two related to the theoretical framework because female educators need to be aware of the amount of time they are spending talking to others about their students' progress, be able to stop and think about questions about their students' progress before responding, and interact professionally, all of which require working memory, internalization of speech, and reconstitution.

I used research question three to focus on how AD/HD symptomatology effected a female educator's ability to interact socially with colleagues and support personnel. When someone collaborates closely with their co-workers daily, they get to know them on a different level. The teaching profession is a social profession. Research question three related to the theoretical framework because female educators need working memory to remember key details they learned about their co-workers, demonstrating they were listening, and they care. Internalization of speech is aligned to research question three because the executive function helps adults follow rules of conversation.

Theoretical Framework

I present two theories guiding my assumptions as to why some female educators are diagnosed with AD/HD during adulthood while other female educators are diagnosed with AD/HD during childhood. I use the first theory, executive functioning theory (Barkley, 1997), to describe AD/HD symptomatology. I then follow with self-determination theory (SDT), demonstrating its relatability to female educators who are diagnosed with AD/HD during adulthood. Next, in Chapter 2, I present a summary of relevant literature demonstrating the need for research on female teachers diagnosed with AD/HD as adults.

Executive Functioning Theory

The first guiding theory in my study is Barkley's (1997) executive functioning theory. Barkley molded his theory by using the knowledge of his predecessors, demonstrating how four specific executive functions explain most AD/HD symptoms. Behavioral inhibition is the inability to stop repeating previous negative behaviors (Raiker, Rapport, Kofler, & Sarver, 2012). Behavioral inhibition directly affects (a)

working memory, (b) self-regulation of effect, motivation, and arousal, (c) internalization of speech, and (d) reconstitution, which are the fundamental tenets of executive functioning theory (Barkley, 1997). These four executive functions play a vital role in an individual's everyday functioning.

Working memory, the first executive function, is a person's ability to remember past incidents and use hindsight to react differently in the future (Barkley, 1997). Adultswith a poor working memory struggle to consistently anticipate others' behaviors, whichcauses poor reaction time. When asked to follow a multi-step task with complex directions, adults may shut down, avoiding the task until it is necessary for them to complete the task (Kelly & Ramundo, 2006). Working memory also influences a person's ability to recognize the passing of time (Barkley, 1997).

Self-regulation is the second executive function related to behavioral inhibition. The three subcomponents of self-regulation are motivation, arousal, and affect (Barkley, 1997). Motivation is referred to as goal-directed behavior. Arousal pertains to a person desire to continue working towards a given goal. Self-regulation of affect is a person's ability to remain neutral or calm when an event piques an inappropriate emotional response (Barkley, 1997).

Internalization of speech, the third executive function, involves self-reflection, problem-solving, and adhering to social norms (Barkley, 1997). Self-reflection is choosing a specific event, thinking about the event and your response to the event, and deciding if there was a better way to respond to that specific event (Barkley, 1997). Problem-solving is difficult to do if an adult cannot reflect on previous events, discerning whether their reaction was appropriate (Barkley, 2010). Violating social norms is

common in adults who have AD/HD because they lack the ability to recognize which behaviors are appropriate for a given social situation (Barkley, 2010).

Reconstitution, the fourth executive function, involves breaking down language or behavior and rebuilding the language or behavior, creating a unique response (Barkley, 1997). Individuals who have good reconstitution can respond quickly and suitably when speaking to others. Additionally, reconstitution affords individuals with the ability to behave respectfully in social situations (Barkley, 1997).

My research questions are tied to the executive functioning by representing a before and after contrast of how a female educator manages her classroom, professionally communicates with colleagues, administrators, and parents, and interacts socially with colleagues and support personnel. Working memory, self-regulation, internalization of speech, and reconstitution all effect how any teacher manages their classroom and interacts with either professionally or socially with their colleagues, administrators, and students' parents. I used the research Barkley (1997) conducted on executive functioningtheory to investigate the changes in behavior for female educators diagnosed with AD/HD as adults.

Self-Determination Theory

The second guiding theory for my study is Self-Determination Theory (SDT). According to Deci and Ryan (2000), SDT is a guiding principle for self-motivation and personality development. SDT is comprised of intrinsic and extrinsic motivation. Intrinsic motivation refers to a person's willingness to complete a task because the task is interesting to them. Extrinsic motivation refers to the factors controlling why someone

completes a task, such as compliance or understanding that the task is beneficial (Ryan & Deci, 2000).

People are intrinsically motivated from the beginning of their life, however, as people age the activities that intrinsically motivate them change (Ryan & Deci, 2000). Intrinsic motivation has been looked at in two different ways. One way to view intrinsic motivation is by assessing whether the task is interesting enough to participate in. The other way to view intrinsic motivation is by assessing a person's satisfaction from participating in a task (Ryan & Deci, 2000).

Extrinsic motivation is the opposite of intrinsic motivation and has four types. The four types of extrinsic motivation are external regulation, introjection, identification n,and integration (Ryan & Deci, 2000). I use the four types of extrinsic motivation as another guide to my research, helping me understand how myself and other female educators like me persevered despite AD/HD symptomatology working against our best efforts.

I used SDT to explain how a female educator with AD/HD can manage a classroom environment, the topic of Research Question 1. Intrinsic and extrinsic motivation can be used to directly explain why a female educator is able to manage a classroom. Intrinsic motivation may explain that despite the difficulties a female educator with AD/HD faces daily, she may be driven to succeed because educating children is a passion. Extrinsic motivation may explain the reason a female educator withAD/HD strives to manage a classroom environment because of the external benefits, suchas earning a paycheck or earning high marks on a classroom observation.

Author Disclosure Statement

When I started teaching, I thought I was prepared for all aspects that are related to teaching: lesson planning, classroom management, managing my time, and interacting with school employees and parents. I quickly became overwhelmed, but I kept my feelings to myself and kept performing to the best of my ability. For me that meant arriving an hour before work and leaving when the custodians turned the lights off in the building, a behavior that has become routine. I would go home and spend the rest of my evening working on individual student data reports and lesson plans. I spent my weekends preparing materials for the following week. I thought I was prepared for the following week, but I still made mistakes and had a difficult time remembering what I planned to do with my students.

I was afraid to ask for help or to admit I was struggling because I did not want anyone to know I was less than perfect. I created an outward appearance of organization and preparedness. Despite my hard work and effort, my evaluations reflected my mistakes and shortcomings as a classroom teacher. When I spoke with colleagues or parents, my word choices did not reflect my knowledge of my student's progress and inability to behave professionally was painfully obvious. When an administrator walked in my classroom to observe me, I became flustered and forgot what I was doing. I had no idea how to fix my mistakes because I did not know why I continued making mistakes.

In 2014, the school system where I work started using Georgia's TKES (Georgia Department of Education, 2013), a comprehensive evaluation tool. I was excited because I could upload evidence supporting my hard work and effort. I used the narration feature on the TKES platform,writing accompanying notes for lesson plans and responding to recorded feedback for

each evaluation. Despite all the additional data supporting each evaluated standard, I wasstill missing the mark. At each summative evaluation, I asked my administrators for helpbecause I did not know how to change my behavior. They said nothing but looked at me in astonishment. I was devastated. The two people who observed my daily teaching practices did not know how to help me.

I spent the summer of 2016 reviewing my previous summative evaluations, lesson plans, individual student notes, meeting minutes, and personal memos from previous school years. I could not find my mistakes. I decided to write what I remembered about my behavior and the solutions I had tried to change my behavior. In the fall of 2016, I decided to seek medical help. After sharing my story with a clinical psychiatrist, she diagnosed me with attention deficit disorder (AD/HD), among other diagnoses (T. O'Flynn, September 12, 2016).

I started a doctoral program in Curriculum and Instruction in the fall of 2016. I had my diagnosis in the back of my mind while I worked on researching teacher evaluations and the possible subjectivity associated with teacher evaluations. I also researched AD/HD because my doctor did not give me any literature about adult AD/HD. What I found was that while teacher evaluations can be subjective, the evaluation process is not the problem. The AD/HD symptomatology caused me to continuously make mistakes at work. I am curious about other teachers with AD/HD. I want to hear other teachers' stories of being diagnosed with AD/HD as adults.

Adults with AD/HD struggle daily to functionally conduct basic tasks (Solden, 1995). Female educators with AD/HD have many responsibilities, including managingtheir classroom and interacting professionally with administrators, colleagues, and

parents (Azer, 2005). Due to the lack of knowledge about adult AD/HD (Zalsman & Shilton, 2016), adults with AD/HD do not know what is causing them to forget appointments, speak without thinking, and behave in a socially unacceptable manner. Due to the stigmatization of AD/HD (Lebowitz, 2016; Mueller, Fuermaier, Koerts, & Tucha, 2012), female educators with AD/HD are afraid to ask for help. I hope to identify common symptoms of AD/HD by studying the experiences of female educators who have AD/HD. I want to bring awareness to other teachers and administrators, so they can help and support female educators who have AD/HD.

Summary of Methodology

The research design employed in the study is a basic descriptive study-autoethnography hybrid. I shared both my story and my participants' stories in the finalchapters. Due to the nature of the location of my participants, I did not have a specific site. I used criterion sampling because I had strict demographic requirements for my participants. I advertised my study on an AD/HD Internet forum. I used the demographic requirements to include only females that meet my criteria.

The data collection methods I used were interviews and personal memory data. I used a demographic survey when choosing my participants. I used Atkinson's (2002) lifestory interview protocol. I interviewed my participants three times. Each interview took between 60 and 90 minutes. At the completion of the first and second interview, I scheduled the next interview, making sure to schedule the next interview no more than 7 days after the preceding interview.

I analyzed the interview transcripts using Emotion Coding for the first round of coding and Pattern Coding for the second round of coding (Saldãna, 2016). After I had

separately analyzed the transcripts, I performed a cross-analysis, searching for similarities and differences within the data.

Research Goals

Personal

My personal goal is to learn about myself and how this experience has changed my teaching and professional conduct by comparing my experience with other female educators who have had similar experiences. By doing this learned about how other female educators have changed their classroom management strategies and how they interact with administrators, colleagues, and parents, professionally. I used their experiences to reexamine my own behavior modification strategies.

My decision to learn about other female educators diagnosed with AD/HD as adults is because I am leery about discussing my AD/HD diagnosis with colleagues and administrators due to many negative experiences with colleagues and administrators before being diagnosed with AD/HD. I also do not want my administrators to have anyreason to doubt me as a capable educator. I decided that the only way to learn about other educators' experiences without ruining my reputation was to interview female educators in other districts, learning more about AD/HD in adults and how AD/HD symptoms specifically prohibit female educators from reaching their highest potential.

Practical

When I began struggling maintaining my classroom, writing lesson plans and individual education plans, and interacting with my colleagues in a professional manner, I did not know the inconsistencies were out of my control. My administrators noticed that something was off with my performance, but they did not know why. By interviewing

other female educators who have had similar experiences, I hope to find similar experiences. I used those similar experiences to map out a pattern of behaviors, finding common and possibly uncommon experiences among female educators with AD/HD. That knowledge can be used to enlighten administrators of the otherwise unrecognizable symptoms of adult AD/HD in female educators. Administrators can then use their new knowledge, helping female educators who may not recognize the symptoms of adult AD/HD in themselves.

Intellectual

I want to add to the literature about females diagnosed with AD/HD as adults. Having been diagnosed with AD/HD at the start of my matriculation in a doctoral program, I took advantage of the unlimited access to research journals, trying to educate myself about adult AD/HD. While there is a fair amount of literature regarding the mental health and wellbeing of educators, teachers with a mental health diagnosis have not been discussed in length (Brock, 2008). I found three self-help books (Barkley, 2010;Kelly & Ramundo, 2006; Solden, 1995), but none of them provided specific guidance foreducators.

Significance of the Study

The significance of this study is to increase the knowledge and awareness about adult AD/HD and how it presents in female educators. By learning how AD/HD presentsin adults, teachers and administrators can identify symptoms characteristic of adult AD/HD and offer guidance to teachers who do not recognize the presentation of symptoms in themselves. In addition, administrators can provide appropriate accommodations to educators diagnosed with AD/HD helping them retain a successful

career in education. In this study, I added to the small amount of literature about adultAD/HD and how AD/HD symptoms can interfere with job success.

Definition of Terms

The following terms are used throughout this study. For clarity in their use,definitions are provided for each term.

1. Attention Deficit/Hyperactivity Disorder is defined as "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (American Psychiatric Association, 2013, p.97).
2. Symptomatology is defined as a list of symptoms associated with a mental illness (American Psychiatric Association, 2013).
3. Comorbidity is defined as "co-occurring mental, neurodevelopmental, medical, and physical conditions" (American Psychiatric Association, 2013, p. 40).
4. Executive Function is defined as "a set of mental processes that help us connect past experiences with present action" (Barkley, 2013, p. 3).
5. Self-Determination is defined as "free choice of one's own acts or states without external compulsion" (*Merriam-Webster's collegiate dictionary, 2019*).
6. Self-report is defined as "an individual completing a questionnaire, rating the frequency with which they experience AD/HD symptoms" (Neely et al., 2016, p. 3204).

7. Classroom Management is defined as “the wide variety of skills and techniques that teachers use to keep students organized, orderly, focused, attentive, on task, and academically productive during a class” (Great Schools Partnership, 2014).
8. Learning Environment is defined as “the diverse physical locations, contexts, and cultures in which students learn” (Great Schools Partnership, 2013).
9. Professional Conduct is defined as “conduct that follows generally recognized professional standards and preserves the dignity and integrity of the education profession. Unethical conduct includes but is not limited to a resignation that would equate to a breach of contract; any conduct that impairs and/or diminishes the certificate holder’s ability to function professionally in his or her employment position; or behavior or conduct that is detrimental to the health, welfare, discipline, or morals of students” (Georgia Professional Standards Commission, 2018, p. 4).
10. Social Interactions, for the purposes of this study, is defined as the interactions between colleagues outside of the work environment.

CHAPTER II

Literature Review

In this literature review, I provide an overview of adult AD/HD. I discussed one existing theory related to AD/HD symptomatology. The second theory I discuss is used to speculate how certain female educators diagnosed with AD/HD are persevering as teachers. I then provide an overview of AD/HD, including childhood and adulthood. I follow the overview with a discussion of research differentiating between childhood and adulthood AD/HD symptomatology. I also provide differing views about gender and rateof diagnosis, subtype, academics, behavior, and comorbid illnesses. I discuss the current knowledge about adult AD/HD in the medical field and among the general population. I present how diagnostic difficulties cause underdiagnosis and misdiagnosis of female AD/HD. I expound on treatment options available to adults with AD/HD. I provide evidence supporting how seeking medical help is beneficial for adults with AD/HD. I then list adult AD/HD symptoms and provide examples of how AD/HD symptoms interfere with adults' daily functioning and the negative implications AD/HD symptomatology has on an educator's career. I conclude my literature review with inferences for the study.

Conceptual Framework

A conceptual framework is composed of experiential knowledge, existing theories and research, a pilot study, and thought experiments. I included experiential knowledge, as an author's disclosure statement, in chapter 1. I discussed two existing theories in the theoretical framework. I presented current research about AD/HD in general and adult

AD/HD, specifically. I am not including a pilot study because I was unable to find participants that met my research criteria and were willing to participate.

Theoretical Framework

In chapter 1, I gave a brief overview of the two theories comprising the theoretical framework used in this study. The following passages explain the two theories in greater detail. I use the two theories to postulate how a female educator can be misdiagnosed or not diagnosed with AD/HD until adulthood. I use the first theory, executive functioning theory (Barkley, 1997), to explain the outward appearance of AD/HD symptoms. I use the second theory, Self-Determination Theory (SDT), as a positive indicator of how female educators who are diagnosed with AD/HD have managed to maintain their careers in education. I present a summary of relevant literature establishing how my research topic is necessary in the education field, specifically for teachers diagnosed with AD/HD as adults.

Executive Functioning Theory.

The first theory I use to guide my study is Barkley's (1997) executive functioning theory. He developed his theory using research from theorists that came before him, explaining how executive functions relate to AD/HD symptomatology. Behavioral inhibition is the inability to stop oneself from repeating the same behavior and control current behavior (Barkley, 2010). Barkley theorized that behavioral inhibition influences (a) working memory, (b) self-regulation of effect, motivation, and arousal, (c) internalization of speech, and (d) reconstitution, which are the fundamental tenets of executive functioning theory. These four executive functions help regulate an individual's emotions, problem-solving ability, and morality.

Working memory, the first executive function, is a person's ability to remember and think (Barkley, 1997). An individual who has a strong working memory can remember past events or situations and use those memories to guide their decision making for future events. Adults with a poor working memory struggle consistently anticipating others' behaviors, which causes adults' poor reaction time. Working memory affects an individual's ability to complete complex and detailed tasks (Fuermaier et al., 2013).

Keeping track of time is also a challenge (Barkley,1997). Individuals with AD/HD are thought to leave projects unfinished when they lose interest which can lead to procrastination, negatively impacting their job (Laskey et al., 2016). Those same individuals can also become hyper-focused on one project and fail to notice the passage of time (Adamou et al., 2013).

In terms of its application to this study, working memory affects a diagnosed female educator's ability to manage their classroom environment, the focus of the first research question in my study. One example of how AD/HD symptomatology can affect classroom management is interfering with adherence to classroom schedules. This is problematic because educators with AD/HD need a good sense of how quickly time passes. When teaching a lesson, teachers allot a certain amount of time with some wiggle room; however, allowing constant distractions will cause a lesson to go over and inadvertently short-change another lesson or cause the class to be late for a building-related event such as lunch.

Self-regulation, the second executive function, is broken up into three subcomponents: motivation, arousal, and affect (Barkley, 1997). The first subcomponent

is self-regulation of motivation, which relates to an individual's drive to accomplish tasks no matter how mundane, difficult, or complex. The second subcomponent is self-regulation of arousal is an individual's ability to desire to start a task. Low arousal in adults causes them to appear lazy (Barkley, 2010). In actuality, the individual cannot conceptualize how to begin a project, so they avoid starting the project (Kelly & Ramundo, 2006). The third subcomponent is self-regulation of affect, which has to do with awareness of controlling emotional responses (Barkley, 1997).

When considering motivation, it is apparent when a female educator with AD/HD waits until the last minute to post lesson plans or meet with students' parents (Barkley, 2010). Other areas that can may cause a female educator to be lacking in motivation include not being prepared for daily lessons, such as having materials and manipulatives readily available for students when the teacher has finished teaching a lesson to the entire class. A third sign of a diagnosed female educator's lack of motivation is participating as little as possible during faculty meetings or events that require teacher participation (Barkley, 2010).

When considering arousal, a female educator with AD/HD can become overwhelmed when asked to complete a complicated task because she cannot break down the task into smaller parts (Barkley, 2010). One such example is learning how to use and implement a new source of technology into daily lessons. A female educator with AD/HD who has been teaching for a short amount of time is expected to master the existing technology while learning how to use new technology. Each piece of educational technology is different in terms of how to create student accounts, assign work, and read student reports. This task can be overwhelming for any educator.

However, female educators with AD/HD who are required to implement multiple technology resources at once may resort to learning how to use one technology resource, hoping that their administrators will not notice. This example directly relates to research question one because knowing how to effectively implement technology resources directly relates to classroom management (Barkley, 2010).

When considering self-regulation of affect, female educators with AD/HD may appear to be overreacting to student behavior instead of regulating their emotional response (Barkley, 1997). While it can be difficult to address negative student behavior, female educators with AD/HD are already predisposed to having overt emotional responses (Barkley, 1997). What is hard for female educators with AD/HD to do is showa neutral response, a concept designed to place the responsibility of a behavior choice back towards the student (Fay & Funk, 1995).

The concept of self-regulation of affect directly relates to research questions two. While the majority of a teacher's time is spent in the classroom, educators are required to interact with colleagues, administrators, and students' parents while keeping a professional demeanor (Barkley, 1997). When speaking with parents about sensitive information about their students, female educators with AD/HD invariably struggle using an even, supportive tone. The Georgia Department of Education (2013) requires teachersto maintain a professional demeanor. Female educators with AD/HD may not outwardly appear to maintain a professional demeanor in front of parents and colleagues (Barkley, 1997).

Internalization of speech, the third executive function, involves reflecting and reasoning (Barkley, 1997). Adults with AD/HD are guilty of interrupting others because

they forget to stop and reflect on what other people are saying (Asherson et al., 2016). This can be problematic for an educator with AD/HD meeting with students' parents because the educator can come across as rude and unprofessional. Adults who struggle with internalizing speech struggle solving complex problems (Barkley, 2010). Teaching is not a job where an educator can input a problem and receive an immediate or appropriate solution. Each student is different, thus requiring teachers to use multiple interventions and accommodations while teaching a group of students. Internalization ofspeech is also affected by working memory because adults cannot remember how they previously solved similar problems (Barkley, 1997). There are situations in education that may seem similar but require different solutions. A female educator with AD/HD may have difficulties differentiating between those similar situations, possibly causing detrimental consequences.

Research question two is partially based on internalization of speech because of professional interactions. It can be very hard for a female educator with AD/HD to listen to what their colleague, administrator, or student's parent is saying because the female educator has an immediate thought that may disappear as quickly as the thought came to them (Barkley, 1997). Interrupting the person is not an appropriate behavior for a femaleeducator with AD/HD but taking notes and writing down comments will not be considered rude behavior (Barkley, 2010).

Reconstitution, the fourth executive function, involves the analysis of an individual's behavior, responding quickly and appropriately with speech and behavior, and adhering to behavior rules (Barkley, 1997). Analyzing individual behavior means thinking about past behavior choices and possible behavior choices in a current situation

(Barkley, 1997). This is where impulsivity of AD/HD directly links with reconstitution because adults with AD/HD often make behavior choices without thinking about the consequences (Barkley, 2010). Reconstitution relates back to working memory because adults with AD/HD cannot quickly and appropriately respond verbally or physically because they do not remember their previous behavior choice and the outcome that followed (Barkley, 1997).

The focus of the third research question in my study is social interactions, which are affected by internalization of speech and reconstitution. Educators with AD/HD havepoor internalization of speech and reconstitution (Barkley, 1997).

The four executive functions directly affect motor control, fluency, and syntax (Barkley, 1997). Adults without AD/HD can generally be interrupted when they are in the middle of talking to someone or completing a task, respond to the interruption appropriately, and then go back to what they were doing; however, adults with AD/HD have difficulty returning to a previous conversation or task when they are interrupted (Barkley, 1997).

Executive functioning theory explains the behavior of all educators who are diagnosed with AD/HD (Barkley, 2010). I am interested in the implications of my participants' behaviors that lead them to 'self-report' (Asherson et al., 2012). Self-reporting is common among females because, culturally, women are more likely to seek help when something is wrong (Arnett et al., 2014). I want to know if female educators with AD/HD can conceptualize the symptoms of AD/HD using executive functioning theory and relate those symptoms to their experiences with AD/HD symptomatology before and after they were diagnosed.

Self-Determination Theory

The second theory I use to guide my study is Self-Determination Theory (SDT). Deci and Ryan (2000) state that self-determination is a key construct for healthy social development and life-long success. SDT is a guiding principle for self-motivation and personality development. SDT entails intrinsic and extrinsic motivation.

Intrinsic motivation explains individuals' innate desire to accomplish personal goals (Deci & Ryan, 2000). People who are intrinsically motivated have the desire to learn and be challenged (Ryan & Deci, 2000). Despite the fact that people are born with intrinsic motivation, intrinsic motivation must be continually fostered in order for people to maintain this internal drive (Ryan & Deci, 2000).

Cognitive evaluation theory (CET) is a subtheory of SDT that is associated with intrinsic motivation (Ryan & Deci, 2000). The premise of CET is that a person's intrinsic motivation can be fostered or hindered, depending on their association with others. There are different ways a person's intrinsic motivation can be fostered or hindered. One way to nurture intrinsic motivation is through positive feedback. A second way to nurture a person's intrinsic motivation is by allowing them autonomy in their job. Alternatively, one way to hinder a person's intrinsic motivation is to provide a person with negative feedback about their work or productivity. Removing job flexibilityby enforcing mandatory due dates can also squelch a person's intrinsic motivation (Ryan & Deci, 2000).

Based on this theory, it would seem almost impossible for female educators diagnosed with AD/HD to be intrinsically motivated. Adding to a lack of self-regulation of motivation, Ryan and Deci (2000) believed that a lack of autonomy diminishes

intrinsic motivation. Educators diagnosed with AD/HD find repetitive plans and stationary routines mundane. The lack of autonomy depletes intrinsic motivation, causing female educators with AD/HD to become extrinsically motivated (Ryan &Deci, 2000).

Procrastination also hinders intrinsic motivation (Barkley, 2010). Adults with AD/HD are already guilty of procrastinating (Kelly & Ramundo, 2006). Female educators with AD/HD may wait until the night before her lesson plans need to be posted to complete her lesson plans. This rushed state of mind can cause a female educator with AD/HD to make mistakes or post incomplete lesson plans. In the state of Georgia, teachers are evaluated on the thoroughness and content in their lesson plans. If a female teacher with AD/HD is actively using an incomplete or sloppy lesson plan she posted, she is not going to fully teach the standards or concepts. Additionally, the female educator with AD/HD's administration may believe the female educator with AD/HD is not adequately preparing her students for success in the next grade.

Regarding the focus of research question one, managing a classroom learning environment, I want to know if female educators with AD/HD are intrinsically motivated now that they know what is hindering their ability to manage their classroom learning environment consistently. It may be possible for the female educator to share their diagnosis of AD/HD with their administrators, finding that their administrators now sympathize with the female educator, creating a supportive work environment. If this is not the case, the female educator diagnosed with AD/HD may need to find another nurturing form of intrinsic motivation that helps them move past the lack of autonomy.

The opposite of intrinsic motivation is extrinsic motivation, external forces that control how and why individuals accomplish goals. Deci and Ryan (2000) break down extrinsic motivation into four types, external regulation, introjected regulation, identified regulation, and integrated regulation. I use the four types of extrinsic motivation to guide my research as I formulate interview questions to help me understand how myself and other female educators like me persevered despite AD/HD symptomatology working against our best efforts.

The first of the four types of extrinsic motivation is external motivation. When someone is externally motivated, they are completing a task with the expectation that they will receive something in return (Deci & Ryan, 2000). Children may expect a tangible reward whereas adults may expect a paycheck. External motivation is like an input-output system, but what makes the behavior external is that the individual wouldnot bother completing the task if there was no reward in return. The task does not holdpersonal value (Deci & Ryan, 2000).

Adults with AD/HD are plagued with lack of motivation (Barkley, 2010). Somehow female educators with AD/HD manage to remain employed (Fletcher, 2013). This could be due to extrinsic motivation of many kinds. The first example of motivation is a paycheck. Another motivating factor is earning high evaluation scores. A third motivating factor could be recognition for doing something good, such as producing a standards document that is actively being used to guide fellow colleagues lesson plan writing. These examples demonstrate an extrinsic motivation for female educators with AD/HD to continue teaching even though teaching may not hold personal meaning for

them. Research question one is addressed here because there may be an external force motivating a female educator with AD/HD to continue to strive for success.

The second of the four extrinsic motivations is introjected regulation. Introjected regulation happens when an individual completes a task to either feel good about themselves or to avoid feeling anxious or guilty for not completing a given task (Deci & Ryan, 2000). The individual's internal feelings can control whether they will complete a given task (Deci & Ryan, 2000).

Individuals with AD/HD regularly experience anxiety (Katzman, Bilkey, Chokka, Fallu, & Klass, 2017; Murphy & Barkley, 1996; Secnik, Swensen, & Lage, 2005). Female educators with AD/HD regularly experience introjected motivation (Deci & Ryan, 2000). Female educators with AD/HD have poor working memories and self-regulation of motivation (Barkley, 1997) which have multiple possible results. The first result is forgetting to write lesson plans. The second result is procrastination which in turn leads to making mistakes on the lesson plans because they could not remember key components. The result is introjected motivation: guilt and anxiety as the motivating factors for writing the lesson plans.

The procrastinating behavior described can be found in other areas of a female educator's, diagnosed with AD/HD, daily routine, negatively affecting other areas of her career. One such area is interacting with parents, one of the subgroups mentioned in research question two. Interactions also include notifying parents about what is going onin the classroom in the form of newsletters, emails, or technology-based reminder tools. If a female educator with AD/HD is not keeping track of events coming up in her

classroom or what units are next to be taught she will not be able to inform parents of those upcoming events or units, hence communicating ineffectively with parents.

The third extrinsic motivation is identified regulation. When an individual is regulated through identification the task has meaning or value that is personal to the individual (Deci & Ryan, 2000). The individual understands that completing a given task will help them in the long run. Female educators with AD/HD may not be motivated to participate in professional development, but they may realize that their participation could result in developing better teaching practices.

Identified regulation will help me identify behavioral traits characteristic of female educators with AD/HD. An example of an educator using identified regulation inforcing themselves to learn how to use new technology and classroom resources when they know that their school system will require all faculty members to use those new technology and classroom resources on a regular basis. This may be a practice among other female educators with AD/HD, realizing that the only way to continually maintain their classroom environment, the subject of research question one, is by actively participating in professional development individually or with colleagues.

The fourth extrinsic motivation is integrated regulation. Integrated regulation happens when an individual realizes that a given task conforms with their personal interests and values. An example of integrated regulation is an individual accomplishing a goal that aligns with their personal needs. Female educator with AD/HD may be inclined to advance their education because an advanced degree is necessary for a promotion. This behavior, even though it is similar to intrinsic motivation, is an external reason for a female educator, diagnosed with AD/HD, to continue her education.

During the course of a school year, all educators learn about their individual students' interests, strengths, and weaknesses which in turn can cause an emotional response. If a teacher cares about their students' individual successes, then they may develop personal professional goals meant to support their students, causing an integrated motivational response. Integrated motivation can be applied to research question one because an integrated motivational response can create a positive learning environment, necessary for classroom management.

Overview of AD/HD

The American Psychiatric Association (2013) defines AD/HD as an inability to maintain sustained attention, having excessive energy, and acting impulsively. Child-onset versus adult-onset AD/HD differs in the presentation of symptoms (Conrad & Potter, 2000). Also, raters, such as a parent or teacher, recommend children for psychological testing whereas adults more typically self-seek help (Asherson et al, 2016). Childhood AD/HD has been a recognized mental health disorder for many years; however, according to Apter (2018), adult-onset AD/HD is still relatively new and not very well understood by medical professionals.

The International Statistical Classification of Diseases Eleventh Edition (ICD-11) and the DSM-5 lists attention deficit disorder under Neurodevelopmental disorders (Reed, et al., 2019). Hodgkins et al. (2012) performed a review of articles from multiple countries and found that medical professionals using the ICD diagnosed fewer adults with AD/HD compared to medical professionals using the DSM-5 (American Psychiatric Association, 2013). What makes the ICD's criteria more rigorous than the DSM-5 criteria for diagnosing AD/HD adults is that the individuals must exhibit symptoms of

inattention and hyperactivity/impulsivity while, according to the DSM-5 (American Psychiatric Association, 2013), individuals can display hyperactive symptoms, inattentive symptoms, or hyperactive and inattentive symptoms. The American Psychiatric Association lists three subtypes, those being (1) Attention-Deficit/Hyperactivity Disorder, Combined Type, (2) Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type, and (3) Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type, demonstrating that it is possible for individuals to display both hyperactive-impulsive characteristics and inattentive characteristics. Additionally, individuals seeking a diagnosis of AD/HD must display symptoms in a minimum of two situations such as at home, work/school, and other environments, meaning the behaviors cannot be situational (Hodgkins et al., 2012).

Conrad and Potter (2000) summarized the beginning of AD/HD, first called attention deficit disorder. In 1987, attention deficit disorder became Attention-Deficit Hyperactivity Disorder. AD/HD is documented in children as early as the 1970s. AD/HD has been documented in adults starting in 1994. In the late 1980s and early 1990s, adult-specific AD/HD clinics were founded. Originally, AD/HD was thought toaffect boys more than girls. As the mental disorder criteria changed, more girls met thecriteria for the inattentive subtype of AD/HD. Such medicalization is due to continuedresearch, the expansion of the disorder, social media attention, and medical advocacy (Conrad & Potter, 2000).

Lange, Reichl, Lange, Tucha, and Tucha (2010) completed an extensive review of literature, focusing on the history of AD/HD. Lange et al. found evidence in the literature describing symptoms of hyperactivity, impulsivity, and inattention in children dating

back 200 years. Early on the symptoms of AD/HD were thought to dissipate before children became adults. Lange et al. found a story written by a physician in 1844 that depicted two young boys displaying symptoms of hyperactivity and inattention, what are now considered two subtypes of AD/HD. As early as 1902, a disproportionate gender sample (n = 20; 15 boys and 5 girls) in a study of children displaying symptoms of AD/HDwas recorded (Lange, Reichl, Lange, Tucha, & Tucha, 2010), similar to most recent studies in the 21st Century.

Despite continued research, mental health professionals cannot provide a medical explanation as to how individuals develop AD/HD (American Psychiatric Association, 2013; Brock, 2008; Caye et al., 2016; Tarver et al., 2014). Early on there was debate as to how children and adults develop AD/HD (Franke et al., 2012: Lange et al., 2010). Hayman and Fernandez (2018) examined specific genes associated with AD/HD and neurological development, however, more research is needed to positively identify genes associated with the development of AD/HD. Conrad and Potter (2000) found research claiming that AD/HD is indeed genetic. Conrad and Potter cited evidence of neuroimaging of the brain to demonstrate the presence of AD/HD in adults. Woodruff, El-Mallakh, and Thiruvengadam (2011) researched a potential diagnostic blood test using membrane-potential of blood cells to identify AD/HD in individuals who have and have not been diagnosed with AD/HD. The blood test results showed a high potential for positively identifying AD/HD in both children and adults (Woodruff, El-Mallakh, & Thiruvengadam, 2011).

In relation to my study, understanding the characteristics of AD/HD and possible diagnostic tools is crucial for identifying individuals who have AD/HD. Regarding all

three research questions, knowing what identifying characteristics are that are representative of AD/HD can help female educators diagnosed with AD/HD identify specific behavior characteristics from the time of diagnosis.

Childhood versus Adult AD/HD

When I began researching AD/HD in adults, I learned that there are opposing views regarding adults suffering from AD/HD symptoms continuing from childhood (Resnick, 2005) and adult-onset AD/HD (Moffit et al., 2015). There is a plethora of research regarding childhood AD/HD, but there are few published articles explaining why some adults are not diagnosed with AD/HD during childhood yet have suffered from AD/HD symptoms their whole lives (Halleröd, Anckarsäter, Råstam, & Scherman, 2015). There is also the possibility that adult-onset AD/HD is a separate entity altogether (Moffit et al., 2015). Henry and Jones (2011) reported that researchers and medical professionals do not understand adult AD/HD. Many scholars suggested that more research is needed to understand AD/HD in adults (Mueller et al., 2012; Wolraich, 1999; Zalsman & Shilton, 2016). As an adult with AD/HD, I want to learn about AD/HD as a mental illness and how the symptoms impact my job performance as an educator.

Children diagnosed with AD/HD have a supportive network of people, those being parents, teachers, and doctors, guiding them through the challenging symptoms (Conrad & Potter, 2000). Adults diagnosed with AD/HD are not always given the same resources promoting a positive long-term prognosis (Halleröd et al., 2015). Children are diagnosed because their parent(s) and/or a teacher noticed abnormal behavior that was impeding the child's social and academic success (Topkin et al., 2015). Adults self-report their AD/HD symptoms (Asherson et al., 2012).

Examining the difference between childhood and adulthood AD/HD is important for my study because adults generally do not know what behaviors are characteristic of AD/HD symptoms. Also, adults are responsible for their own health and wellbeing. Adults can choose to seek help for medical conditions or ignore negative symptoms indicative of poor health, whether it is physical or mental. I do hope to learn why the female participants in my study chose to seek help from a mental health professional and share their stories.

AD/HD Symptomatology

Although there are no specific all-inclusive symptoms that encapsulate AD/HD, there are general inattentive and hyperactive/impulsive symptom-related behaviors for both children and adults (American Psychiatric Association, 2013). School-age children generally follow a daily routine and have a consistent environment which makes AD/HD symptoms noticeable (American Psychiatric Association, 2013). Adults, on the other hand, have much more autonomy in their daily routines and environment which is why it is harder for adults to recognize AD/HD symptoms in their own behavior (Apter, 2018).

Childhood Symptomatology

The presentation of childhood and adult AD/HD symptoms are different (Apter, 2018). Common childhood AD/HD hyperactive-impulsive behaviors include calling out in class, a child running around when (s)he should be seated, or uncontrollable fidgeting (American Psychiatric Association, 2013). Childhood inattentive symptoms appear as daydreaming, inappropriate emotional responses, not paying attention to changes in their immediate environment, an inability to remember new skills, or handing in incomplete assignments. These behaviors often negatively impact school progress, healthy social development, and, in some cases, personal safety (Spencer, 2006). Adolescents tend to

show more inattentive symptoms such as failing to do their chores, procrastinating on schoolwork, and appearing lazy by zoning out in front of television all day (Spencer, 2006). The idea that children grow out of their AD/HD is false, according to Barkley (2019). Instead, the majority of children continue to suffer from AD/HD symptoms.

Explaining what AD/HD symptoms look like in children is necessary for my study because, as I explain below, childhood symptoms appear differently. One reason I postulate that it is difficult for adults to recognize AD/HD symptoms in themselves is because adult AD/HD symptoms can be excused as misguided behavior due to stress, the absence of self-care, or the lack of a balanced life (Roeser, et al., 2013).

Adulthood Symptomatology

There was once an assumption that adolescents out-grew their AD/HD symptoms (Asherson et al., 2012; Zalsman & Shilton, 2016). However, AD/HD symptomatology can continue into adulthood, meaning adults who have childhood diagnoses may still be suffering (American Psychiatric Association, 2013; Asherson et al., 2012; Tarver et al., 2014). In fact, Biederman (2005) reported that 4% of adults internationally have been diagnosed with AD/HD. Brassett-Grundy and Butler (2004) completed a longitudinal study, finding that both men and women diagnosed with AD/HD during childhood continued to suffer from AD/HD symptoms as adults. Barkley's (2019) most recent article agrees with Brassett-Grundy and Butler's (2004) debunking the belief that many adults diagnosed with AD/HD as children no longer suffer from AD/HD symptoms.

When the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* was published in 1980 adults were

recognized as having AD/HD due to the change in exclusionary symptoms (Conrad & Potter, 2000). An adult can be given an AD/HD diagnosis if they display six or more inattentive or hyperactive traits (Asherson et al., 2012). AD/HD traits in adults include disorganization, constantly losing or misplacing work or home-related items, sloppy or incomplete work, inconsistently completing work or home-related tasks, forgetting appointments, appearing to ignore people when spoken to, losing track of time, and easy distractibility (American Psychiatric Association, 2013). Adult AD/HD symptomatologycreates a negative long-term outlook as cited by Fuller-Thomson, Lewis, and Agbeyaka (2016), Dias et al. (2013), Hamed, Kauer, and Stevens (2015), and Harpin, Mazzone, Raynaud, Kahle, and Hodgkins (2016). Also, after extensive research, Matheson et al. (2013) and Asherson et al. (2012) state that there is limited knowledge and support regarding adult AD/HD.

Adults' presentation of AD/HD symptoms is different than how children experience AD/HD symptoms. Adults display more inattentive symptoms, unlike children who typically display both inattentive and hyperactive symptoms (Zalsman & Shilton, 2016). While children may run around a room uncontrollably, adults display their fidgety behavior by tapping pencils, needing constant movement, or bouncing their knees while seated (Millstein, Wilens, Biederman, & Spencer, 1995). Adults with AD/HD are also known to talk excessively compared to adults without AD/HD. Adults who have AD/HD appear impatient compared to adults who do not have AD/HD (Millstein et al., 1997). Emotional responses in adults can be more extreme, causing alienation, consequences at work, and harsher punishment such as jail time (Zalsman & Shilton, 2016). Adults are responsible for keeping track of their own time, but adults

with AD/HD have a poor sense of time and may miss an appointment, pick their child(ren) up from school late, or forget they are cooking resulting in burned food, or worse, cause a small house fire (Barkley, 2010). The forgetful behavior also applies to misplacing items, sometimes in plain sight. Sometimes this behavior is harmless, but there are times being overly forgetful can get an adult with AD/HD in trouble (Barkley, 2010). One such example is by misplacing their wallet or house or car keys.

Later in this literature review I cite examples of how adult AD/HD symptomatology can negatively affect a female educator's teaching career. I hope to share the behaviors recognized by the female educators with AD/HD in my study to demonstrate how different adult AD/HD is when comparing childhood AD/HD.

AD/HD and Gender Differences

There are reported gender differences when comparing males and females during childhood and adulthood. The rate of diagnosis differs for males and females at all ages; the ratio of diagnosis by gender narrows in adulthood. There is a gender difference when comparing the three AD/HD subtypes. There are reported academic performance differences among males and females diagnosed with AD/HD. Males and females diagnosed with AD/HD display different behaviors as children and as adults. Previous studies demonstrate that there is a difference between males and females with reference to comorbid illnesses. Below I demonstrated these differences, justifying why it is appropriate to focus my attention on female educators diagnosed with AD/HD.

Rate of Diagnosis

One of the premises of this study is the exclusion of males because males are more often diagnosed with childhood AD/HD (Fuller-Thomson et al., 2016). In fact, the

ratio of boys to girls diagnosed with childhood AD/HD is 3:1 (Arnett, Pennington, Willcutt, DeFries, & Olson, 2014; Holthe & Langvik, 2017). Holthe and Langvik (2017) stated that, as adults, the ratio between men and women with AD/HD is almost1:1.

Mowlem et al. (2018) analyzed data gathered from a twin study in Sweden and concluded that more males having been clinically diagnosed with AD/HD than females. Among children diagnosed with AD/HD, males scored higher in inattention. Males and females scored the same for hyperactivity and impulsivity. Regarding symptom severity, both male and female participants were just as likely to be clinically diagnosed with AD/HD and prescribed with AD/HD medication. Mowlem et al. (2018) analyzed sex differences in reference to clinical diagnosis and medicinal treatment and found that boys are more often diagnosed with AD/HD than girls.

Williamson and Johnston (2015) found that, after an extensive literature review, there is a difference between the ratios between childhood and adulthood and males and females. When examining childhood prevalence, there is a higher rate of boys diagnosed with AD/HD than girls. When examining the difference between community samples and clinical diagnosis of males and females with AD/HD, the ratio is closer to 1:1 in clinical samples (Williamson & Johnston, 2015). Bitter, Simon, Balint, Meszaros, and Czobor (2010) found similar results, demonstrating that when comparing childhood cases and AD/HD cases among adults, the ratio is closer to 1:1. Supporting both Bitter et al. (2010) and Williamson and Johnston's (2015) findings, Sassi (2010) states in his short literature review that there are more similarities than differences when comparing adult males and females with respect to AD/HD symptoms and diagnosis. Sassi believes that the change in the diagnostic ratio is due to the fact that, as males age, they are less

likely to be diagnosed with AD/HD, whereas women who do have AD/HD are more likely to be diagnosed accordingly. This combined research supports my reasoning for choosing only females to participate in my study because females are more often diagnosed with AD/HD as adults.

Aside from receiving a diagnosis, the type also differs between genders. According to Mowlem et al. (2018), girls display more inattentive behaviors. Gaub and Carlson's (1997) research also suggests that girls are more often diagnosed with inattention while boys are more often diagnosed as being hyperactive. Similarly, Sassi (2010) found that to be true. Rucklidge (2010) found that boys and adult males are both more hyperactive than girls and adult women. Brod, Schmitt, Goodwin, Hodgkins, and Niebler (2012) interviewed a group of older individuals (mean age = 66 years old) and most reported having inattention-type symptoms and half reported having hyperactive/ impulsivity-type symptoms, which does not agree with Rucklidge's (2010) findings.

Brod et al.'s (2012) study had a small sample size (*N* = 24) and there were more males than females. I expanded on this idea when I discussed the difficulties females face when being diagnosed with AD/HD or being misdiagnosed with a learning disability instead.

Academic Differences

Gaub and Carlson (1997) performed a meta-analysis comparing boys and girls with AD/HD. When analyzing intelligence, girls have a lower verbal, performance, and full-scale IQ, however, there is no significant difference in academic performance. Rucklidge (2010) also found that in children with AD/HD, girls have lower IQs than boys. Rucklidge also found that girls with AD/HD have more cognitive

impairments compared to girls without AD/HD.

When comparing males and females, Williamson and Johnston (2015) did not find differences between males and females in academic achievement and the attainment of higher education. Babinski et al. (2011) found the same to be true after comparing males and females with AD/HD vs. females without AD/HD. Brod et al.'s (2012) study also concluded that the majority of their participants had at least a college degree; however, due to the small sample size these results are not comparable to larger sample sizes.

Behavioral Differences

Gaub and Carlson (1997) discovered that, behaviorally, girls diagnosed with AD/HD internalize more and are less aggressive towards their friends. Also, boys with AD/HD are more hyperactive. Internalizing behavior can cause doctors to misdiagnose a girl with a learning disability, which in turn would cause them to continue living with untreated AD/HD symptoms. In Sassi's (2010) literature review and Rucklidge's (2010) research, they both found that boys typically display externalizing symptoms, such as hitting and pushing. Skogli, Teicher, Andersen, Hovik, and Øie (2013) studied gender differences in AD/HD symptoms and executive functioning and found that females display more anxiety-related behaviors compared to males. Results from parent surveys showed that males are more likely to violate rules. In general, children diagnosed with AD/HD were more likely to have social problems compared to the control group (Skogli, Teicher, Andersen, Hovik, & Øie, 2013).

Disregarding any mental health illness, adult females report that their lives are more difficult; adult males do not (Williamson & Johnston, 2015). Solden (1995) studied women who had not been diagnosed with AD/HD as children. What Solden

discovered was that, while these women's childhood somewhat masked their AD/HD symptoms, their current day to day routines were overwhelming, causing their AD/HD symptoms to surface (Solden, 1995). Cahill et al. (2012) researched the frequency of AD/HD in prison populations and found that 10.5% of males and 15.1% of females incarcerated met diagnostic statistics for AD/HD, compared to what Asherson et al. (2012) found, those percentages being between 2.3% to 4.5%. Cahill et al.'s (2012) study suggests that adults with AD/HD have more trouble functioning in society. WhileCahill et al.'s study is on the extreme side of the level of behavior, their study clearly represents how the negative side of AD/HD symptoms dramatically effects adults with AD/HD. I use Cahill et al's (2012) study to demonstrate how misdiagnosed or undiagnosed AD/HD can negatively affect the lives of adult females.

Comorbid Illnesses

Comorbid illnesses can affect females being diagnosed with AD/HD until adulthood because, when diagnosing a child or an adult with AD/HD, medical professionals must also look for symptoms similar to other comorbid illnesses (American Psychiatric Association, 2013; Faraone & Kunwar, 2007). An individual who experiences comorbid illnesses has two or more mental health conditions simultaneously. There are many mental illnesses that have similar symptoms to AD/HD (American Psychiatric Association, 2013). These commonalities can cause medical professionals to misdiagnose children and adults suffering from AD/HD symptoms (Biederman, Newcorn, & Sprich, 1991; Faraone & Kunwar, 2007). Females, who may actually be suffering from AD/HD symptoms are often diagnosed with other mental illnesses or

learning disabilities due to the fact that females internalize their AD/HD symptoms (Faraone & Kunwar, 2007).

It is common for children who have been diagnosed with AD/HD to be diagnosed with at least one comorbid illness (Efron, Bryson, Lycett, & Sciberras, 2016). Efron, Bryson, Lycett, and Sciberras (2016) found that 77% of the children in their study who were diagnosed with AD/HD were also diagnosed with one or more other mental illnesses. Tung et al. (2016) found that girls diagnosed with AD/HD have a higher rate of also being diagnosed with anxiety disorders, depressive disorders, oppositional defiant disorder (ODD), and/or conduct disorder (CD). Opposingly, Martell, Gremillion, and Tackett (2014) found that boys are more likely to be diagnosed with comorbid conduct disorders. Yoshimasu et al. (2012) found no differences in gender regarding the comorbid disorders that can occur with AD/HD, however, Yoshimasu et al.'s study was 75% male.

Common comorbid illnesses are mood and anxiety disorders (Biederman, 2005). Mood disorders include depression and bipolar disorder (American Psychiatric Association, 2013). Anxiety disorders cause extreme stress and worry, creating physiological symptoms, more so than what an average individual would experience (American Psychiatric Association, 2013). Watters' et al. (2018) research is similar to Biederman's (2005) in that 72% of the participants diagnosed with AD/HD were also diagnosed with a mood disorder and 45.5% were diagnosed with general anxiety disorder. Approximately half of the participants in Ahnemark et al.'s (2018) study had been diagnosed with anxiety and depression. Tung et al. (2016) concluded that girls who are diagnosed with AD/HD are more likely to also be diagnosed with either ODD, CD, an

anxiety disorder, or depression. Sassi (2010) discovered that the only relevant difference between males and females is the number of and severity of comorbid illnesses.

Skogli et al. (2013) researched the differences between male and female AD/HD symptoms and executive functions and found that females reported more symptoms of anxiety. Children diagnosed with AD/HD also had poorer executive functioning skills compared to the control group. This information is significant because one of my theoretical assumptions is that executive functions are directly related to AD/HD symptomatology.

Current Knowledge of Adult AD/HD

In the following section, I discuss literature that is available to but does not adequately educate the general public, medical professionals, and adults with AD/HD. Also, there is not enough research to explain why, with continued researched, medical professionals are unable to accurately diagnosing adults, specifically females, with AD/HD opposed to other comorbid illnesses with similar characteristics. There is medicine, behavioral modification therapy, and alternative treatments for adults. Researchers have explored the long-term outcome for adults with AD/HD.

Diagnostic Difficulties

Williamson and Johnston (2015) explored gender differences in adults with AD/HD, including clinical referrals and diagnostic criteria. What Williamson and Johnston found was that boys with AD/HD are recognized by their hyperactive/impulsive symptoms. Girls who display inattentive symptoms are less noticed because inattentive symptoms do not disrupt surrounding people. Williamson and Johnston surmise that, adult females who have undiagnosed childhood AD/HD may receive a diagnosis as an

adult for two reasons. The first reason is that adults can seek medical help for mental health conditions without another adult supporting their claims. Secondly, AD/HD is thought to be genetic. If a female's child is diagnosed with AD/HD and the father has never been diagnosed with AD/HD, the female may seek medical advice which could lead to a diagnosis of AD/HD.

After studying females with AD/HD for many years, one of Solden's (1995) conclusions is that females raised in a home with strict guidelines and unyielding routines and schedules do not have the opportunity to show signs of AD/HD. When those females move out of their parents' house, they are no longer forced to keep a regular schedule. Also, with the combination of increasing adult responsibilities, signs of AD/HD will become noticeable at home, work, and social situations (Kelly & Ramundo, 2006). Adults, much like children, thrive using regular routines and schedules (Barkley, 2010).

One possibility as to why female educators with AD/HD are able to successfully manage their classroom to a degree is because their day is mediated by a schedule. Also, teachers collaborate with their colleagues for planning purposes. If a female educator with AD/HD is collaborating with colleagues who are expecting them to share resources and lesson plans needed for the near future, female educators with AD/HD may become hyper-focused, enabling them to complete their share of the work.

Treatment Options

There are a variety of treatment options for people diagnosed with AD/HD. A common treatment option is medication (Cunill, Castells, Tobias, and Capella, 2016). There are several medications om the market. Cognitive behavioral therapy is a growing treatment option (Ramsay, 2017). Alternative treatment methods have been presented by multiple researchers.

Medication.

The most common treatment option for AD/HD is medication. Adults with AD/HD are prescribed a stimulant or a non-stimulant, and/or an anti-depressant. Whenadults are diagnosed with AD/HD, their doctor may prescribe stimulants, lessening thesymptom severity (Deshpande, Ostermeyer, Lokhande, Abid, & Shah, 2017). Cunill, Castells, Tobias, and Capella (2016) researched the use of nine different medications, both stimulants and non-stimulants. The conclusion of their research was that adults taking the prescribed medications during their study did not continue with the drug treatment due to “medical adverse events” even though there was evidence that the medication decreased the AD/HD symptoms.

McIntyre et al. (2013) studied the effects of lisdexamfetamine dimesylate in treating adults with comorbid bipolar disorder and AD/HD. The effects were positive decreasing AD/HD symptoms. Pohl, Van Brunt, Ye, Stoops, and Johnston (2009) found that, due to comorbid illnesses, it is common for adults with AD/HD to take a variety of medications, treating multiple mental illness simultaneously.

Smith, Martel, and DeSantis (2017) examined the side effects of psychostimulants used to treat AD/HD. Common side effects of psychostimulant medication experienced by males and females are “loss of appetite, insomnia, and rapid heart rate” (p. 549). The female participants reported nauseous, dizziness, headaches, and increased anxiety, whereas male participants reported increase sweating and absent sex drive (Smith, Martel, & DeSantis, 2017). When I was taking medication to manage my AD/HD symptoms I would notice when the medication was wearing off because I would become unexplainably agitated and nervous. Patients may believe that the side-effects and benefits are unbalanced when taking medication used to treat AD/HD, Brams, Weisler,

and Findling (2012) concluded that, in order for medicinal treatment to be effective, continual use is necessary to experience long-term benefits. Brock (2008) stated that educators diagnosed with AD/HD who are taking prescribed stimulants will still struggle sustaining professional requirements involving student progress, required reporting, and communication.

Rosler, Casas, Konofal, and Buitelaar (2010) performed an extensive review of literature, examining various aspects of AD/HD, including drug therapy. The most common type of medication used to treat AD/HD in adults is stimulants, however, long-term use of stimulants can have an adverse reaction to an adult's heart. Additionally, long-term use can cause strokes and heart attacks in children and adults (Rosler, Casas, Konofal, & Buitelaar, 2010).

Cardiovascular problems, caused by regular use of a stimulant, can negatively affect an adult's ability to maintain a safe learning environment (Elia & Vetter, 2010). St. Amour, O'Leary, Cairney, and Wade's (2018) study demonstrated that children have increased blood pressure while taking stimulant medications to treat AD/HD. Hammerness et al. (2013) concluded that the raise in blood pressure among participants was not significant to warrant cautioning use over a long period of time. Adults who cannot take a stimulant to control their AD/HD symptoms need alternative options. Arnold (2001) concluded in his research that Zinc, Iron supplements, and magnesium are vitamins that can help alleviate AD/HD symptoms, but there is no clinical research to support this claim.

Cognitive Behavioral Therapy.

Cunill et al. (2016) discovered that along with drug therapy, adults used Cognitive Behavioral Therapy (CBT) to treat their AD/HD. Ramsay (2017) states that CBT is very

effective in treating cognitive and emotional impairments associated with AD/HD. CBT is a program that can be implemented individually or with a group. CBT is designed to help adults with AD/HD develop coping strategies and skills used to manage AD/HD symptoms.

Alternative Treatments

Adults who have AD/HD need accessible support services that teach them symptom management and coping strategies (Deshpande et al., 2017). Only two participants in Brod et al.'s (2012) study reported talking to a psychologist. Kraft (2010) reviewed a book written by a psychiatrist and wrote specifically about complementary and alternative treatments (CAM) used by adults with AD/HD. The CAM treatments suggested are, acupuncture, mindfulness meditation, light therapy, massage therapy, vision therapy, interactive metronome training, repetitive transcranial magnetic stimulation, vestibular and cerebellar exercises, chiropractic treatment, and mirror feedback (Kraft, 2010). Roeser et al. (2013) studied mindfulness training as an aide to help teachers reduce stress and found that mindfulness was effective. Kraft (2010) stated that light therapy was the only alternative that had been tested on adults with AD/HD. Additionally, light therapy only improves inattentive-type symptoms.

With reference to my study, it is notable that continual long-term stimulant use has a negative effect on children and adults' cardiovascular systems. Teachers need to be healthy to safely manage their classroom and perform all necessary duties.

Long Term Outlook for Adults with AD/HD

An adult with undiagnosed AD/HD may not be aware of AD/HD related symptoms that are causing a negative impact on their job. If adults with undiagnosed AD/HD do not know what symptoms are negatively affecting their job performance, they

will not know how to improve their job performance. The research regarding adults with AD/HD focuses on whether adults with AD/HD hold a job (Babinski et al., 2011; Greene et al, 2001; Waite, 2009) instead of focusing on the quality of their job performance. Asherson et al. (2016) stated that adults who display AD/HD symptoms may be viewed as apathetic towards their job. Winter, Moncrieff, and Speed (2015) found that social media portrayed AD/HD as an excuse supporting women who cannot keep up with the multitude of career and family responsibilities.

Barkley (2010), Kelly and Ramundo (2016) and Solden (1995) documented evidence demonstrating executive functioning impairment hinders individuals who have AD/HD because they struggle keeping and maintaining employment. Additional consequences include unsatisfactory job performance, multiple absences, and socially unacceptable behavior (Andreassen, Griffiths, Sinha, Hetland, & Pallesen, 2016; Fletcher, 2013; Forbes, 2014; Sarkis, 2015).

Social impairment is also an ongoing struggle for adults with AD/HD, often starting during childhood. Gallichan and Curle's (2008) study focused on adolescents' experiences coping with AD/HD and found that they have a hard time fitting in, socially. Owens, Zalecki, Gillette, and Hinshaw's (2017) research focused on women who had been diagnosed with AD/HD as children. They found that these women still had trouble functioning in social situations. Female educators with AD/HD are teaching in a perpetual state of social interactions. Without exploring social skills training options, female educators with AD/HD will always struggle to act normal around their colleagues, administrators, and students' parents.

Many researchers stress the importance of receiving a correct mental health diagnosis, especially for females who have AD/HD symptoms (Asherson et al., 2012;

Fleischmann & Miller, 2013; Newark, Elsasser, & Stieglitz, 2016). There are implications for adults who do not receive help for AD/HD symptoms (Hamed et al., 2015). These implications include adverse impacts on social interactions, relationships with family and friends, job performance, and health (Asherson et al., 2012). Williamson and Johnston (2015) found evidence in previous research articles demonstrating a positive correlation between AD/HD symptomatology and lower academic achievement beyond high school, poor social skills, and lack of attention towards general appearance. For me, the negative implications were what made me seek help.

Halleröd, Anckarsäter, Råstam, and Scherman's research (2015) explored the experiences of adults diagnosed with AD/HD and found that a range of emotional responses from having a better outlook on life to not knowing who they are anymore. These accounts are what happened after being diagnosed with AD/HD as an adult (Halleröd et al., 2015). Conrad and Potter (2000) warn against adults with AD/HD making excuses for their behavior. Their belief that adults blame their AD/HD on their behavior choices is irresponsible (Conrad & Potter, 2000). Matheson et al. (2013) stated in their conclusion that mental health professionals need more education about AD/HD inadults. Brock's (2008) research focuses on teachers with AD/HD coping strategies and towhom they go for support.

In my research, I explored the different experiences of female educators before and after they were diagnosed with AD/HD. Researchers have shown that medical treatments are effective at managing AD/HD symptoms in adults, but long-term use can reduce an adult's quality of life (McIntyre et al., 2013; Rosler, et al., 2010; Smith et al., 2017).Alternative treatments have not been fully explored in clinical trials (Kraft, 2010), but are physically safer for female educators with AD/HD.

Female Educators and AD/HD

AD/HD symptoms negatively affect adults' career success and social life (Barkley, 1997; Kelly & Ramundo, 2006; Solden, 1995). Swanson, Owens, and Hinshaw (2014) extend this list of possible negative consequences to include criminal behavior, accidents, and development of other psychiatric conditions. While the above statements present a dark and gloomy outlook for educators with AD/HD, there is a positive side to my study. My participant sample includes only female educators who are currently teaching which demonstrates that despite multiple researchers' reports of less than favorable long-term outlooks (Fredriksen et al., 2014; Ginsberg, Quintero, Anand, Casillas, & Upadyaya, 2014; Hodgkins et al., 2012; Kupper et al., 2012: Nadeau, 2005), there is evidence that adults can have successful careers. In this study, I examine the connection between educators who have AD/HD and an educator's job requirements. Aneducator's professional environment necessitates those educators keep their composure, display socially appropriate behavior, remember important job-related details and tasks, follow a daily schedule, and provide a safe and challenging environment, effectively promoting positive classroom management (Georgia Professional Standards Commission,2018).

Classroom Management

Asherson et al. (2012) pointed out that adults with AD/HD are easily distracted which has a direct impact on their job performance. Educators witness several student behaviors in their classroom at any given time. Female educators with AD/HD struggle managing their classrooms because of the many distractions that take their attention and focus from what they should be doing at the time. One example, from personal

experience, is reading a story to my students. When I am reading a story to my students, for the purpose of teaching reading comprehension skills, I can barely stay focused because students are untying and retying their shoes, talking to someone next to them, orplaying with a piece of paper they found on the carpet. I find that I frequently stop and ask specific children to please listen to the story. This, in turn, causes me to lose my trainof thought or remember where I left off in the story, hence my poor working memory (Barkley, 2010).

Asherson et al. (2016) listed adult-appropriate traits associated with AD/HD symptomatology. One of the traits Asherson et al. (2016) listed is poor time management. Female educators with AD/HD struggle managing their time in the classroom. They are distracted by individual student behavior, emails, or tasks that could be left undone until the end of the school day when the students are gone. These distractions cause female educators with AD/HD to spend less time teaching students.

Another adult-appropriate trait is disorganization (Asherson et al., 2016). Female educators with AD/HD struggle keeping an organized classroom. This negatively affects their classroom management in many ways. One example is creating a messy learning environment by allowing clutter to accumulate on the counters, tables, and desks, making it hard for female educators with AD/HD find the resources they need to teach their students. The clutter can also make it difficult for students to find resources they need to learn.

An important aspect of classroom management is disciplining students while helping students learn from their mistakes. Fay and Funk (1995) stress the importance of keeping a calm voice and even tone when speaking with a student about mistakes the student made. Female educators with AD/HD often show their true emotions, sometimes

overreacting, when disciplining students causing students to shut down and stop listening (Fay & Funk, 1995). This, in turn, causes a communication break-down between the teacher and the student (Georgia Department of Education, 2013). Communicating effectively is key for promotinga positive and trusting learning environment for all students.

Professional Conduct

Kelly and Ramundo (2006) and Barkley (2010) recognized that adults with AD/HD struggle with social interactions. One reason for this is poor self-motivation of affect (Barkley, 1997). When meeting with colleagues, administrators, and parents about student progress, emotions can run high. Female educators with AD/HD get overly emotional in any (or all) social interaction. Asherson et al. (2012) stated that adults with AD/DH are known to overreact when frustrated. The extreme emotional responses can cause colleagues, administrators, and parents to lose faith in the female educator with AD/HD (Georgia Department of Education, 2013).

A second reason female educators with AD/HD struggle interacting with colleagues, administrators, and parents in a consistent professional manner is due to poor internalization of speech (Barkley, 1997). When discussing student progress with colleagues, administrators, and parents, teachers may be asked difficult questions. Female educators with AD/HD may become flustered, emotional, and confused causing an inability to answer the question(s). Their emotional response may seem confusing to others because they cannot understand why the female educator with AD/HD is unable to answer the questions since they should be prepared to meet with their colleagues, administrators, or students' parents.

A third reason female educators with AD/HD struggle interacting with colleagues,

administrators, and parents in a professional manner, is due to poor reconstitution. (Barkley, 1997). Working memory effects reconstitution (Barkley, 1997). If female educators with AD/HD cannot readily remember specific details about individual students they will be unable to respond quickly to questions from colleagues, administrators, and parents. This may cause female educators with AD/HD to respond inappropriately, causing them to demonstrate evidence of poor self-motivation of affect.

Social Interactions

The teaching profession is a social environment. Working closely with colleagues and support personnel creates friendships; however, if an individual consistently displays socially unacceptable behavior others will exclude them from social gatherings (Kelly & Ramundo, 2006). Using my personal experience, female educators with AD/HD are lonely because their behavior has alienated them from social gatherings. Female educators with AD/HD know the rules for social settings; however, female educators with AD/HD cannot appropriately respond to what others are saying or read nonverbal behavior cues of others.

Asherson et al. (2012) listed antisocial behavior as one of the adult-appropriate symptoms of AD/HD. An individual that displays antisocial behavior will manipulate a situation purposely to insure a favorable outcome. Teachers work as grade-level team members, sharing resources and ideas for the great good of their students. If an educator is displaying antisocial behavior, they may only care about themselves and ignore the needs of their students. One such example would be an educator not caring about the feelings of their students while providing feedback on an assignment.

There are several articles regarding the struggles and success of females who have AD/HD. These articles provide encouragement and hope for female educators

with AD/HD because, for the most part, AD/HD has a negative long-term outlook (Brassett-Grundy & Butler, 2004). Palmini's (2008) article focuses on five adult individuals, all ofwhom are college graduates and have been successful despite having been diagnosed with AD/HD.

Inferences for Forthcoming Study

Watters et al. (2018) concluded that adults who receive a first-time diagnosis of AD/HD should be interviewed. The gap in the literature is that no one has asked educators why they even thought to seek help. I know why I found help, but my reasons may not be similar to other educators. Also, each person displays AD/HD symptoms differently. The areas of my job where I struggled may not be the same for other educators. They may have already been diagnosed with a mental disorder and realized that the coping strategies they used were no longer working. This information isalso pertinent because of the variability of symptom presentation. Learning about how AD/HD symptoms present themselves in females who are educators is worth sharing with the education community and mental health professionals.

Summary

The first part of this chapter presented a theoretical framework, depicting how executive functions are closely linked to AH/HD symptomatology (Barkley, 1997) and theorizing that SDT may be the reason certain teachers diagnosed with AD/HD have persevered (Deci & Ryan, 2000). I provided a brief overview of AD/HD. I compared childhood and adult AD/HD and gender differences with relation to diagnosis, academics, and behavior. I discussed how comorbid mental illnesses can cause females to be misdiagnosed or not diagnosed with AD/HD at all. I included a review of the current knowledge about adult AD/HD. I provided examples of treatment options,

including the short term and long-term effects of continued use of stimulants. I have demonstrated how the long-term outlook for adults with undiagnosed AD/HD has negatives implications for their future. I have given specific examples of how AD/HD symptomatology effects a female educator with AD/HD's classroom management, professional interactions, and social interactions. I concluded by identifying the gap in the literature, the lack qualitative research interviewing adults about their reactions after receiving an AD/HD diagnosis as an adult.

CHAPTER III

Methodology

Research Design

The research design I used to share the participants' and my stories is a basic descriptive study-autoethnography hybrid. Using this hybrid approach, I examined individual experiences in a case study format as well as my own experiences using an autoethnography approach. In doing so, I compared my experiences to those of peer educators and looked across cases to identify unique events and forms of compensation/adaptation, within cases as well as identified common threads of experiences, emotions, and self-realizations (Jones, Adams, & Ellis, 2013; Stake, 1995).

The foundational design I used was a basic descriptive study because I studied my female participants' interpretation of the events that took place leading up to their diagnosis of AD/HD as an adult, their initial reactions of being given a diagnosis of AD/HD, and how their teaching practices have changed since being diagnosed with AD/HD. I used a key component of collective case study, comparing each case with one of the other cases (Baxter & Jack, 2008). While it was unlikely that my participants had the same experiences before and after diagnosis with AD/HD, I expected there to be similarities and differences that provide viable explanations as to how female educators with AD/HD have persevered in their teaching careers. The demographic characteristics of my participants, which I discussed further in this chapter, helped support my decision for choosing a basic descriptive study because I wanted to illustrate how a diagnosis of AD/HD can change the life of any female educator (Stake, 1995). The unit of analysis was a female educator diagnosed with AD/HD as adults.

The secondary design I used was autoethnography because I wrote about my personal

experiences as one of the study cases and the subculture of females diagnosedwith AD/HD as adults (Ellis, 2004). I justified using autoethnography as a secondary design because I included myself as a participant. In order for a qualitative study to be considered an autoethnography, the researcher must write about their experiences, usingtheir participants' experiences as researched-based evidence (Chang 2008). I used the stories of my participants, analyzed, and explained the identified culture, female educators with AD/HD, who were the focus of my study (Chang, 2008).

Autoethnography is a style of research and writing meant to evoke emotion, sympathy and/or empathy in the reader, to make the reader believe they are experiencing the event(s) that took place in the writer's and the writer's participants' lives (Ellis, 2004). I am using Ellis's (2004) autoethnography protocol to shape my data collection methods. Also, presenting my results using an autoethnographic format makes it easier to read, opposed to qualitative results written in a technical format (Chang, 2008). I explained further how I combined case study and autoethnography when analyzing the data.

Participant Selection

The sampling technique that I employed was criterion sampling, a subcategory of purposive sampling (Given, 2008). The criterion sampling method allowed me to choose participants based on specific participant requirements I used to select my population. I set strict participant requirements for my population due to the quality of data I needed to gather to answer my research questions.

Demographic Survey

I created a demographic questionnaire (see Appendix A for Demographic Survey for Potential Participants) using the criterion sampling method (Given, 2008). When I started advertising, I attached the survey link to the bottom of my study announcement making it readily available for interested female educators to complete the survey.

My participant requirements were supported by research and my personal experience. The first participant requirement was that the individuals were female because of the inconclusive research supporting why females are not usually diagnosed with AD/HD until adulthood (Quinn, 2005; Waite, 2009). The second participant requirement was that the individual was an educator because there is only one research study to date specifically examining female educators with AD/HD (Brock, 2008). The participant did not have to be actively serving as a teacher. The third participant requirement was age of diagnosis, which is between 23 and 65, because I was specifically interested in females who were diagnosed as adults, not emerging into adulthood (Fleischmann & Miller, 2013; Fuller-Thomson et al., 2016; Henry & Jones, 2011; Matheson et al.,2013; Waite, 2009). My final participant requirement was that the individual had taught for at least 1 year because, in hindsight, I experienced symptoms of AD/HD early in my teaching career. My participants could be retired. Also, my participants did not have to be actively serving as a teacher as long as she had taught for at least 1 year. By setting specific participant requirements I addressed selection validity before I began collecting data from my participants.

I asked participants to state who diagnosed them with AD/HD. Their choices were (a) general practitioner, (b) psychiatrist, or (c) others. In doing this, I protected the

validity of my study, ensuring that my participants had been given a diagnosis of AD/HD and not using a self-diagnosis as a means to participate in my study.

I linked the demographic survey to the email address I created specifically for my research allowing me to receive notifications when a potential participant had completed the demographic survey. I reviewed the potential participant's answers and responded within 24 hours. If the potential participant did not meet my selection requirements I sent an email to the individual, thanking them for inquiring about my study and explaining that they do not meet the selection requirements.

If the potential participant did meet my selection requirements I used their preferred method of contact, asking the potential participant when the best time was to contact her to set up an initial meeting to discuss the details of the study and the informed consent form. I explained to my potential participants that there is no incentive or compensation for participating, other than their personal experience will be shared in my dissertation and possibly published in a journal. I discussed the different interview platforms, which were electronic communication, Google Meet, or face-to-face interview for those who live relatively close to me. I sent an electronic copy or emailed a copy of the informed consent form within 24 hours if the potential participant agreed to participate in my study.

I was the only immediately accessible participant for my study. With permissionfrom New Hope Media, I started advertising my study on the ADDitude Facebook Group page and ADDitudemag.com forum after I received approval from Valdosta State University's Institutional Review Board (see Appendix B) I specifically advertised for female educators who were interested in sharing their personal experiences being diagnosed with AD/HD as an adult. Initially, I posted the

advertisement on ADDitude's Facebook page and online magazine forum for 1 month. I checked the Google Form I attached to the advertisement daily to see if anyone has answered my advertisement. Myminimum required number of qualified participants had not been met so I reposted the advertisement for a second month, checking daily for more responses from qualified participants. I did not have to post the advertisement after the second month as I had metthe minimum number of qualified participants. None of my participants dropped out so Idid not have to readvertise my study.

Another defining characteristic of qualitative research is a small sample size (Given, 2008). I did not intend to generalize my results. I intended to understand the lives of female educators diagnosed with AD/HD as adults. According to Patton (2015), the sample size of a study depends on the what the researcher's goals. In this study, my goal was to learn about other female educators' experiences being diagnosed with AD/HD as an adult. I elected to have a minimum of five participants, including myself because I wanted to learn about multiple female educators' experiences being diagnosed with AD/HD as an adult. Henry and Jones (2011) were able to collect sufficient data to complete their research. The maximum number is 8 even though that is 2 less than the average number of participants in the qualitative studies I found having similar topics regarding my research (Brock, 2008; Henry & Jones, 2011; Matheson et al., 2013; Schreuer & Dorot, 2017; Watters et al., 2018). Eight participants were sufficient to protect myself from participant dropouts.

Data Collection

The data collection methods I used were interviews and personal memory data. I described each data collection method in more detail below. I interviewed each participant three times, analyzing the transcripts after each interview, and later cross-

analyzing participants' cases. I used my personal memory data (Chang, Ngunjiri, & Hernandez, 2013), memoing my personal experiences as a female educator diagnosed with AD/HD as an adult. I reached data saturation when redundancy in themes occurred,and I could answer my research questions.

Interviews

My second data collection method was life story interviewing. Atkinson (2002) stated that a life story interview comprises the participants whole life but can also start wherever the participant decides to start telling their story. I interviewed my participants, asking about the time in their lives leading up to being diagnosed with AD/HD, their initial reaction, and what their lives are like now. Another key feature of life story interviews is that the participant's story has similarity to the interviewer's life (Atkinson, 2002). The similarity that my participants and I shared is that we are all female educators diagnosed with AD/HD as adults.

In his book, *The Life Story Interview*, Atkinson (2002) provides step by step instructions on how to interview an individual, learning about their life in the fullest detail. The first step is deciding who I want to interview. I chose to interview female educators who were diagnosed with AD/HD during adulthood. Atkinson then recommends explaining to the participant the reason I chose the topic for interviewing and why I specifically chose them as my participant. I completed this step when I reviewed my research goals and participant requirements before beginning the interview process of my data collection phase.

My interaction with each participant was electronic videoconferencing. Atkinson (2002) says that the more comfortable an interviewee is, the more they seem to share about their life. Before the day of the interview, I made sure my chosen recording device

worked and was ready to use when I began the interview(s), as suggested by Atkinson (2002). If participants choose to participate via videoconferencing, I ensured that they had access the Internet, owned headphones with an attached microphone or had a computer with an internal microphone and had electronic video conferencing capabilitiesto use Google Meet. I chose Google Meet because I could record the session. Also, by turning on the captions, the interview was transcribed.

Atkinson suggests allowing my participant(s) time to prepare before the day of the interview by giving the participant(s) a set of sample questions, giving them time to think about past events. At the end of the first and second interview, I set up a time to complete the next interview. I explained to the participant that I would like to complete the next interview within 14 days of the previous interview. The reason I wanted to keep the interviews, at most, 14 days apart is because their recall of the previous session may be weak because of the possibility that they have poor working memories (Barkley, 1997).

I prepared my interviews by writing detail-oriented questions, using my research questions as my guide. I addressed instrumentation (content) validity by sharing the interview questions and topics with my committee (Given, 2008). The interview questions were open-ended, allowing my participants to respond freely. My job as the interviewer was to listen and extend my participants the liberty to share what part of their story is important to them (Atkinson (2002). If I believed my participants were straying too far from the topic, I politely brought them back to what was relevant. If I did not understand an answer, I asked my participants to further explain themselves, so their responses were clear. In this particular study, I anticipated emotions of sadness, embarrassment, and frustration to present themselves during the interviews. When this arose, I allowed time for my participants to compose themselves (Atkinson, 2002). I also

reassured them that I had some level of empathy for what they have gone through.

With reference to my research questions, I began each interview by exploring the following time life phases: (1) when my participant(s) started noticing problems with attention and focus, relevant to adult AD/HD symptoms; (2) when my participants decided to self-seek help from a mental health professional; and (3) life after receiving a diagnosis of AD/HD. Lauritzen and Trotter (2017) have a small book containing open-ended questions designed to help an interviewer learn about their interviewee's life.

Atkinson (2002) states that there is no given number of interviews needed to properly gather the data needed to complete my research. I interviewed my participants three times (Seidman, 2013). The first round of interviews lasted an average of 83.5 minutes. The second round of interviews lasted an average of 83.5 minutes. The third round of interviews lasted an average of 88.75 minutes. I allowed my participants enough time to provide me with the necessary details needed to answer my research questions (Seidman, 2013). My reasoning for interviewing each participant three times is to be sure that I have gathered enough data to answer my research questions.

The first interview consisted of questions/topics about the participant's teaching background leading up to their being diagnosed with AD/HD (see Appendix C). I explored my participant's background because I wanted to know what AD/HD symptoms they displayed and how the AD/HD symptoms affected their classroom management, professional interactions, and social interactions. The second interview topics/questions focused on the female educator's reason for self-seeking help from a mental health professional and initial reaction to being diagnosed with AD/HD regarding experiences with classroom management and professional and social interactions (see Appendix D). The reason I focused on these topics is because they

directly relate to my research questions. The third interview topic/questions focused on the female educator's experiences with classroom management and professional and social interactions after being diagnosed with AD/HD (see Appendix E). The third interview topic/questions also relate to my research questions. At the completion of my interviews, I created a table of each interview date and start and stop time (see Appendix F).

Personal Memory Data

My third data collection method is personal memory data. Since I am the researcher in my study, I cannot interview myself. Instead, I wrote about my personal experience being diagnosed with AD/HD as an adult. Chang, Ngunjiri, and Hernandez (2013) point out that using personal memories as a data source could be unreliable as personal memories may not be accurate; however, I need to include my personal memories. This data collection is completed separately.

I answered the interview questions in a story-format at the end of each round of interviews. The reason I wrote my personal memories at the end of each round is so that my personal biases do not influence my ideas or interpretation of my participants' own stories. I included my stories when I cross-analyze my participants' interview transcripts.

Data Analysis

I transcribed each interview using the transcription tool on Google Meet. I then edited each transcription, correctly identifying when I was speaking and when each participant was speaking. Next, I identified each question I asked. Then I identified each participant's answer. Once I had identified each question and answer, I started writing the narrative for each participant's three interviews and participant profiles. To ensure that I interpreted my participants' experiences correctly, I used respondent validation

(Maxwell, 2013). I asked participants to read the narrative, participant profile I created, and my analysis of each interview to be sure I understand the meaning of their individual experiences as a female educator diagnosed with AD/HD as an adult.

I used Saldaña's (2016) coding techniques to analyze the data. I stated how I tested for assumptions. I defined the unit of analysis for each research question. Before I began the first cycle of coding, I performed a dry read of each transcript and pre-coded, highlighting sections of each transcript that were note-worthy (Saldaña, 2016).

Initial Round of Data Analysis

For the first cycle of coding and to address each of my research questions, I chose Emotion Coding (Saldaña, 2016) because this coding method is designed to help the researcher delve into the emotional side of the participant's experiences. I explored my participant's answers to each interview question, notating when my participants used emotion words to describe their experiences and when I inferred emotion based on the tone of my participants' voices, their body language, and phrases or descriptions of experiences where emotion could be inferred. Saldaña (2016) stated that people cannot separate themselves from the emotional. In the first round of coding, I found this to be true.

I used the results of the Emotion Coding to address additional topics/questions for the second and third interviews and to generate themes during the second round of data analysis (Saldaña, 2016). The unit of analysis for each coding was participant-level because I coded participants' interview transcripts separately.

I performed each emotion coding on each transcript, making a new copy in Microsoft Word and adding comments to the right margin, assigning an emotion and making notations to each code. I also made memos in the right margin while coding each

transcript reflecting on my participants' emotional reactions (Ellis, 2004). I incorporated my participants' emotional reactions into my coding process by generating themes.

Second Round of Data Analysis

For the second round of coding and to address each of my research questions, I used Pattern Coding to "develop major themes from the data" and "examine… human relationships" (Saldãna, 2016, p. 236). I used the results of the Emotion Coding, generating themes in the data and addressed additional topics/questions for subsequent interviews. I searched for similar word choices and phrases to group together, identifying the major themes in the data (Saldãna, 2016). The unit of analysis for each coding is group-level because I compiled the themes from each interview transcript to examine the themes for the group.

After completing the second round of data analysis, I used Stake's (2006) Worksheet 3. Analysist's Notes While Reading a Case Report (see Appendix G) tosummarize each individual case, record reoccurring themes, and overall findings .Summarizing each individual case and recording my findings was helpful for organizing the individual cases before I began my cross-case analysis.

Cross-Case Analysis

I performed a cross-case analysis of each individual case in my study. I included my stories when I conducted the cross-case analysis on my participants' interview transcripts. For me to truly answer my research questions, I needed to explore how the individual cases were related and different. I used Stake's (2006) guide and the worksheets provided in his book, *Multiple Case Study Analysis*.

I used a collection of worksheets found in *Multicase Study Analysis* (Stake, 2006) because the worksheets are designed to help organize and manage the data used to

analyze each case. To start, I used the themes generated from my research questions, organized on Worksheet 2. The Themes (Research Questions) of the Multicase Study (see Appendix H). I then listed the similarities and differences between each case. I identified the similarities between cases so that I could classify them under each reoccurring theme. I analyzed the differences in each case study to determine why the characteristics stood out among the other case studies.

Validity Threats

Using Maxell's (2013) knowledge of validity testing, I chose the following validity checks: researcher bias, reactivity, rich data, respondent validation, and comparison. I also included instrumentation (content) validity and participant selection (Creswell, 2014). I explained how and why I used each validity check below.

I chose researcher bias because it can change how I collect and interpret the data (Maxwell, 2013). My bias going into the study was that I have a personal interest in AD/HD and can empathize with my participants. I addressed my researcher bias by writing my personal memos before each round of interviews to avoid obscuring my experiences with my participants' experiences.

Reactivity is unavoidable in qualitative research but can be used to the researcher's advantage (Maxwell, 2013). My personal experiences guided my research, thus influencing my research questions that directly influence my interview questions and topics. I used open-ended interview questions and avoided leading questions, refraining from negative reactivity. I chose reactivity because I showed empathy or tried to interject a comment while my participant was speaking, creating a threat to the data I collected during the interview.

Rich data is obtained by detailed and varied data (Maxwell, 2013). To obtain detailed data,

used verbatim interview transcripts, the notes I transcribed during each interview based on my participants' answers and their body language during the interview. I varied my data by using the verbatim interview transcripts, transcribed notestaken during each interview, reactive memos transcribed while reading interview transcripts, the themes generated from two rounds of coding, and my personal memory data. I chose rich data because I needed rich data to fully answer my research questions.

Respondent validation includes my participants when I interpret their responses to my interview questions (Maxwell, 2013). Once I transcribed each interview, I wrote my interpretation of my participants' responses and created a participant profile. Then I shared my interpretation and participant profile with my participant, eliciting feedback. I chose respondent validation because I wanted to protect my interpretation of the data from my personal biases and misinterpreting the data.

Comparison, Maxwell (2013) stated, is used more often in qualitative studies but can also be used to analyze interview data from participants with similar characteristics. Icompared the interview transcripts of each participant with each of the other participantslooking for similar trends and anomalies. I also compared the interview transcripts with literature about my topic of study. I performed participant-to-participant comparisons andcurrent data-previous literature comparisons so that I made informed explanations and interpretations of my data.

Instrument (content) validity (Creswell, 2014) is how I addressed the validity of my interview questions. Before I interviewed my participants, I submitted my interview questions to my dissertation committee for review. By doing so, my committee was able to question my thought process behind each interview question and suggest changes to increase the validity of each interview question.

Participant selection (Creswell, 2014) refers to how and why I selected each participant in my study. I used purposive sampling (Given, 2008), a sampling technique designed for choosing participants based on a specific list of requirements. I created a list of participant characteristics based on previous research about females diagnosed with AD/HD as adults, addressing gender, date of birth, how many years the participant has taught, and age of diagnosis.

Limitations

There are several limitations that potentially affected the validity of my study. The first limitation was how the different interview formats affected my research findings. People behave differently in person than when they are being recorded in a video chat. Also, I limited the distractions during a face-to-face interview because only my participant and I should be in attendance. I made sure I was alone in a room in my house. Video conferencing has two locations, my home and my participant's home. I cannot control interruptions that happen at my participant's home.

My second limitation is that due to poor working memory (Barkley, 1997), my participants' ability to accurately recall events is impossible. My participants may not want to recall the events they clearly remember due to the emotions attached to each event.

CHAPTER IV

Participant 1: ALC

In this chapter, I will introduce ALC, providing demographic information and a background of her teaching experience. I will provide ALC's interview responses in a narrative format.

Participant Profile

ALC is a 42-year-old white female who has taught for 18 years. She has taught elementary and middle school. As a middle school teacher, she has taught technology, special education, and math. ALC has a master's degree in educational technology and a specialist degree in educational leadership.

ALC has taught in several states across the country. At the beginning of her career, she taught middle school science while working on her master's degree in educational technology. At the end of the school year, ALC moved to a western state. She taught eighth grade math for one year. The following year she moved to another western state. ALC served as a paraprofessional for one year. The second year she lived in the western state, she taught CTE, a technology class at a junior high school. Then she moved to a southeastern state, where she served as a special education and regular education teacher. The first year ALC taught a collaborative third grade class, and the second year ALC taught a collaborative fifth grade class. Her final year in the southeastern state, ALC taught kindergarten. ALC then moved to her current state where she has since resided.

ALC's first teaching position in her current state was at a middle school serving special education students in multiple grades in a self-contained learning environment. ALC taught for three years at the middle school and resigned at the beginning of her

fourth year for reasons I will go into detail later in this chapter. Her second teaching position was at an elementary school working as a special education teacher serving students in multiple grades in a self-contained learning environment. After three years, ALC was hired in the city school district in which she lived as a home-bound teacher and then as a regular education middle school sixth grade math teacher in a nearby school district. ALC is currently serving in the second role.

Interview Results

ALC told me about her first visit to a doctor inquiring about her mental health. ALC described how her symptoms interfered with her teaching and interactions with colleagues, administrators, and parents. She went into great detail, sharing stories, traumatic memories that plague her even to this day. I end with her thoughts about sharing her diagnosis with others and her opinion about raising awareness.

ALC was diagnosed with AD/HD when she was 36 years old by her general practitioner. ALC had been teaching for 13 years when she realized she needed to consult a medical professional about her AD/HD. When asked to describe her first visit with a medical professional concerning AD/HD symptoms, ALC stated that she was nervous the first time she discussed the possibility of having AD/HD with her doctor. She kept making excuses not to make the initial appointment. ALC was afraid her doctor would not believe her when she described her symptoms. In her exact words, ALC said, “I knew I needed to see her (scary doctor lady), and I was worried that it would be taken as, Oh, you're just asking for medication.” ALC’s doctor gave her a survey to complete while at the office. After reviewing ALC’s answers, her doctor diagnosed ALC with AD/HD, not to ALC’s surprise.

While ALC purposely went to her doctor about symptoms related to AD/HD, she

did not tell anyone in her family except her husband, one of her children, and her sister. When asked why, ALC stated that AD/HD seems to be the popular mental health condition to have because it seems that everyone is being diagnosed with AD/HD. Also, ALC believes there is a negative stigma associated with having AD/HD as an adult. Also, ALC did not want anyone to know that she was taking Adderall, a commonly prescribed medication for AD/HD.

ALC's doctor prescribed her with Adderall and did not mention any other treatment options. ALC's doctor did not discuss AD/HD and what AD/HD looks like in adults' behavior. Also, she was not given any information about AD/HD to read on her own. Furthermore, ALC was not told where she could research AD/HD, such as the Internet, but she was free to do her own research.

ALC researched the side-effects of Adderall. A positive side-effect, ALC quipped, was possible weight-loss. Possible negative side-effects included raised blood pressure and anxiety or increased anxiety. ALC was nervous about taking Adderall for other reasons. She described a student of hers developing a tick as a side-effect. When she learned that the tick would never subside, even after stopping the medicine, ALC became even more nervous.

Originally, ALC did not want her children to know she had been diagnosed with AD/HD, but she eventually confided in one of her children. ALC's husband knew she was seeking medical attention for AD/HD. Her children and husband both addressed her

change in behavior, telling ALC they did not like the side-effects of the medication. After taking Adderall for one year, ALC decided to discontinue the medicinal treatment. She researched other therapy options. ALC learned that exercising daily was a safer alternative treatment. She has employed exercise as her treatment of choice to this day. When asked to specifically describe how exercise helps her, ALC responded that, "It clears my brain. It calms my heart, my anxiety. It helps me refocus. It's like a reset." She will even exercise when she has a limited amount of time to do so. This, in turn, causes her anxiety to rise, defeating one of the benefits of exercising.

ALC decided not to share her diagnosis with anyone outside of her family, saying that "It's an excuse for me. Everybody has it now." She never discussed her diagnosis with her principal, at the time of her diagnosis. She never told her colleagues, past or current. Also, she kept her diagnosis a secret from her close friends. ALC firmly believes that telling anyone would cause people to think less of her or think she only wanted a stimulant-type of drug to increase her output at work and home.

ALC took time to reflect on epiphanies she had about her previous behavior, mentioning that initially, after starting medication, she was able to focus and get work done. She started getting one task done at a time, instead of starting multiple tasks and becoming overwhelmed because there was no way she could get everything done in one day. She also believed to have more control over her classroom environment, seeming more comfortable with her students working in groups. ALC added that she was not bringing as much work home at night and on the weekends. She had more time to meal prep and exercise. In the evenings, preparing for bed, ALC would work herself up thinking about what she needed to do the next day, wondering if she was prepared. Then

she would think about what she could have done, preparing for the next day and wonder why she wasted her time exercising instead.

When asked about her professional interactions with colleagues, after beginning medicinal treatment, ALC stated that nothing changed because the teachers at the school she was employed kept to themselves, not even interacting with each other at lunch. ALC stated her relationships with her students' parents did not change because the parents of her students did not generally like talking to their child's teacher, avoiding phone calls and meetings whenever possible. Her relationship with her principal did not change. Her principal already had a high regard for ALC and had entrusted her with tasks meant for an assistant principal.

During the interview process, ALC took time to reflect on the answers she gave for the first and second interview. When asked how she explains being able to function with AD/HD for as long as she has, she noted that her biggest epiphany is her constant struggle with relationships, whether they are personal or professional. ALC stated, "Relationships weren't good because I was very controlling." She admitted that her controlling nature was what got in the way of her relationships. ALC gave a specific example of having a conversation with a colleague early in the day and spending the rest of the day thinking about that conversation. The conversation had not gone well, saying "I felt like I was just not mixing well with people, and it was my fault, and I didn't know what was wrong with me." She believed it was her fault and she did not know what was wrong with her. She mentioned that the relationship she struggles with the most is between herself and her stepmother.

Results Analysis

Symptoms that ALC mostly struggles with are focusing on getting things done, organization, time management, anxiety, and uncontrollable emotional responses. ALC's problem with not being able to get planned tasks completed was because she over planned. Her inability to manage her time was due to her lack of focus. While she tried to create an organized classroom, ALC's classroom was a mess. Her anxiety was due to the above symptoms, causing her to have extreme emotional responses.

Focus

The first ADHD symptom I highlight is focus. I define focus as the ability to remain steady with one task until the task is finished, or one has reached a sensical stopping point. Besides being a common theme throughout each interview, someone diagnosed with AD/HD typically has a difficult time keeping their focus on one task at a time.

ALC was unable to focus on one task, causing her to leave tasks unfinished while moving on to something else. Motivation to complete tasks has been a problem mainly because ALC has many ideas about how to get started writing lesson plans, for example, but she does not know where to begin. Instead ALC jumps from topic to topic, those topics being small group instruction, individual student education requirements, and resources and materials necessary to meet the needs of her students as a class, in groups, and individually. Once she has been working for a while on her lesson plans, she becomes anxious because it is taking her longer than she realized simply because she cannot focus on one part at a time. The anxiety crosses over into her home environment,

causing her to put her responsibilities as a wife and mother to the side so that she can focus on completing her lesson plans.

Organization

The second reoccurring theme was organization. I define organization as being able to keep teaching materials, student work, and student-related papers and finding those items at a moment's notice. Organization matters in my study because a cluttered classroom does not bode well for student learning. Also, disorganization is a common trait among adults diagnosed with AD/HD.

ALC admitted to piling ungraded student work around the classroom. ALC hung up curtains to cover up shelves that were messy. When asked if she had more examples of a time when she was not in complete control of her classroom management, ALC described a time when she misplaced a worksheet in her classroom. She was teaching math and had gotten to the part of the lesson where her students were to apply what they learned individually. A typical day would not have caused her to become upset with misplacing a worksheet, however, she was being observed at the time. Her principal was in the classroom watching her every move, constantly jotting down notes about ALC's instruction. ALC did admit that she found the worksheet after making an impromptu change in her students' assignment even though her principal had already docked her points for not having her instructional materials easily accessible.

Time Management

The third reoccurring theme is time management. I define time management as the ability to keep track of the amount of time spent on one task without running over into another assigned time. While ALC did not provide a lengthy example, time management is important to my study because it is an important part of a teacher's

dailyroutine.

In the classroom, she struggles with managing her time. She would over plan and become agitated when she could not fit the planned tasks and assignments, she wanted to accomplish in one day. She also admitted to bringing work home on the weekends and soliciting her sister's help because she over-planned.

Anxiety

The fourth reoccurring theme is anxiety. I define anxiety as severe conflict of emotion and stress, causing fear when presented with a similar future situation. While ALC does not directly say she is anxious, her words and the emotions she portrayed during the interviews could not be ignored in my study.

ALC described her classroom management as predictable. Her students knew what was expected of them. She preferred to keep all classroom activities structured because unstructured time or group time caused ALC great anxiety because she could not control every aspect of her students' behavior. In these instances, ALC would raise her voice or even yell at her students if they were not paying attention to her while she was teaching, a response to her anxiety due to her inability to control every aspect of the learning environment. Her anxiety would become problematic when she could not get things done or if student data did not reflect her teaching ability.

ALC shared a story when her anxiety bested her. ALC served as a one-on-one paraprofessional, daily aiding a kindergarten student. ALC stated that the student's teacher expected ALC to keep the student calm and quiet, never allowing him to disrupt the classroom learning environment. The student's behavior was deemed erratic, causing ALC undue stress when faced with challenging situations brought on by the student. One such situation was when the student brought a Samurai sword to school in his backpack,

unbeknownst to ALC or any other adult associated with the student. ALC's lack of observation of the student's personal possessions caused her supervisor and thestudent's teacher(s) to waiver their confidence in ALC's ability to competently control the student's behavior. Additionally, ALC's inability to apply previous solutions concerning the student's behavior to current situations caused her colleagues to be frustrated with ALC.

Despite multiple incidences of the student's inability to behave appropriately in a regular education learning environment, ALC continued to be conflicted with whether she was handling the student's behavior in a professional manner. In turn, ALC would become anxious, creating an unwanted emotional response. This became a cycle, only ending when ALC resigned her position at the end of that school year.

Three weeks after starting her medicinal treatment for AD/HD, ALC admitted she became more controlling over her students and her work environment. At work, ALC was able to keep her temper from flaring up when she was around her colleagues; however, she was very short-tempered with her family. Small things would cause ALC to become agitated, ALC stated. She involuntarily lost her temper with her family. Additionally, her level of anxiety increased, causing her to have more panic attacks than before taking Adderall. Additionally, her blood pressure increased, concerning her doctor.

Emotion

The fifth reoccurring theme is emotion. I define emotion as outward reaction to a situation or event, whether the event is positive or negative. ALC expressed her emotions in words and in the tone of her voice during the interview. Emotion is important to my study because ALC allowed her emotions to frequently guide her throughout her teaching

career.

ALC's professional conduct with her colleagues has been a problem since she first started teaching. She stated that her colleagues found her to be mean, grumpy, and with a lack of sympathy towards students. Her colleagues also thought she yelled at her students too much and was not a team player. In October of that school year, her colleagues' negative attitude towards ALC resulted in them avoiding her during lunch and other noninstructional times of the day. By November of that school year, her mentor teacher also withdrew from her company.

One sensitive event happened in January, on her birthday. It was customary for her teammates to make a birthday cake for other team members on their birthday. The team member that made ALC's cake presented it to her with disgust, ALC described. ALC stated that she was embarrassed and equally heart-broken because it was her birthday. That event solidified ALC's relationship with her team members. She finally understood how her colleagues viewed her, not only as a fellow educator, but also as a person.

Despite how her seasoned colleagues treated ALC, she did manage to make one friend at her school. Her only friend that school year was another first-year teacher, who had bonded with ALC over the fact that they were both first-year teachers. ALC did have trouble managing her emotional responses when confronted by administrators. The principal at her first school addressed ALC' choice of clothing, stating that her clothes were too tight. He told her that could be considered suggestive toher middle school-aged male students. At the time, she had gained weight and did not have money to purchase new clothes that would fit her. ALC cried in front of her principal instead of professionally discussing her situation with him.

Based on our discussion, ALC explained that environments with rigid expectations and strict guidelines proved to be condemnatory for her career. When faced with situations that cause strong emotional responses, ALC was unable to respond in a manner that was considered becoming of a professional educator. One such example was when she was serving as a special education teacher, serving students in a self-contained learning environment. Her students' qualifications for special education services ranged from learning impairments, emotional-behavioral disorders, to physical disabilities. On this day, ALC described being faced with a predicament, keeping her students safe while removing a student from the learning environment who was becoming a potential threat to do harm to the other students in the classroom.

A particular student became agitated, showing behavioral signs that their behavior could quickly escalate. ALC noted that she had a medically fragile student in the classroom and feared that the agitated student would harm the medically fragile student. ALC moved her students to one side of the classroom, opposite the agitated student. Next, ALC called for the administrator whose primary job was to handle student behavior. The administrator was unable to help ALC. She called for other administrators but was unable to receive help from anyone else because the remaining administrators were attending the basketball game currently in progress. She then asked her paraprofessional to stay in the room while ALC went to find another adult to help ALC de-escalate the situation.

When ALC left the classroom, the agitated student followed ALC into the hallway. ALC thought she might convince the student to calmly walk with her to the office, but instead the agitated student became angry. The student did not agree and responded by raising ALC up with both hands, violently shaking her, pushing her against

the wall, and choking her. The student yelled that ALC was not going to take him to the office. Then he released ALC, causing her to fall to the ground.

Shaken and scared for her physical well-being, ALC ran away from the student, all the while trying each door in the hallway until one opened. The only office unlocked was the special education office where her lead teacher was currently working. Not considering ALC's disheveled clothing and that she was crying, the special education lead teacher asked ALC why she abruptly stormed into her office. ALC explained what happened between herself and the student. The special education lead teacher responded by asking ALC if she completed a specific style interview, a standard protocol when special education students behave in an extreme manner. ALC answered that she did not interview the student, nor did she follow through with the rest of the protocol which was to calm the student down and reenter the student into the learning environment.

Upset with ALC's response, the special education lead teacher unwillingly contacted the school principal, informing him of the events that took place. ALC's interpretation of her principal's response was aloof and uncaring. He responded that he was at the middle school basketball game but would meet ALC and the agitated student in the front office.

The principal asked the Student Resource Officer (SRO) to join him, ALC, and her student in the principal's office. The principal began by asking both ALC and the student to share their individual sides of the story. ALC was shocked, interpreting this questioning as her principal's disbelief that her student did in fact assault her. When questioned by the principal and the SRO, ALC's student admitted to assaulting ALC.

Next, the principal asked ALC if she was okay and told her to take her student back to class. Numb by his response, ALC did as she was instructed. Once ALC

returned to her classroom with her student, the special education lead teacher reminded ALC to complete a specific style interview with her student. Even though ALC did not feel safe with the student in her presence, she completed the interview with her student. The student calmed down and remained calm for the duration of the school day. When the student's parents picked the student up from school, the principal did not inform the parent of the events that took place that day.

The following day, ALC stayed in bed, traumatized by what happened the previous day and by how her principal handled the situation. That evening, ALC's husband took her to the emergency room because he was concerned with ALC's reaction to what happened. ALC later admitted to her husband that her principal's reaction to what transpired between herself, and her student brought back disturbing memories from her childhood.

The following Monday, ALC informed her principal that she was refusing to allow the student back in her classroom. She was terrified of the student and worried thatthe lackadaisical response by the principal in front of the student would serve as encouragement for the student to possibly assault ALC again. The principal responded by placing the student in another self-contained learning environment. As a result, she was called uncooperative and not a team-player. For the remainder of that school year, ALC experienced panic attacks when driving to work. Additionally, ALC started seeing a therapist, working through her traumatic experience.

Further, ALC was asked to write about her experience that would later be shared at the manifestation meeting related to the incident. When she was asked to read her statement, she noticed that the words had been changed, lessening the extent of what happened to her that day. ALC became visibly upset in from of the students, their parent,

and the committee.

Overall, the incident changed how ALC was viewed by her administrator and special education supervisor. The special education supervisor did not believe ALC could handle her emotions in stressful situations. Moreover, if ALC did not make herself available for unscheduled meetings, she was deemed uncooperative and not a team-player. Yet even though most people held supervisory positions over ALC, there was one person who recognized the brevity of the events that culminated the entirety of ALC's first year at that middle school. One of her vice principals acknowledged what ALC had experienced that school year, apologizing for not advocating for her rights as a teacher.

The final event that caused ALC to resign was a mistake that could have been handled differently, noted ALC. During preplanning, ALC was preparing her notes intended to inform the regular education teachers about each special education student they would be teaching that school year. Instead of meeting with each teacher individually, ALC grouped each grade-level in an email, sharing detailed information about each special education student entering that grade for the current school year. ALCdid not think her actions were faulty. However, at the end of that day her assistant principal told her to gather her personal items and leave the building immediately after informing her that her emails to her colleagues violated her students' HIPAA rights.

ALC later found out her special education lead teacher reported her to the special education supervisor at the board office. ALC believes that her special education lead teacher could have spoken with her about the incident. However, her lack of professional confidence in ALC created a spiral of events which, in turn, ALC voluntarily resigned her position as a special education teacher at the middle school.

Later in her teaching career, ALC was still letting her emotions control her career. ALC also stated that she would become emotional and cry when she was stressed or believed her workload was more than she could handle. Despite that realization, ALC was unable to tell colleagues and administrators no. As a result, ALC was the committee leader for Relay for Life, Math Bowl, and ran a booth at her school's annual fall festival.

Positive Experiences

I decided to include positive experiences because, despite the many unfortunate events that have happened throughout ALC's career, she has been able to experience positive interactions with her students, colleagues, and administrators. I define positive experiences as an event or situation that has brought happiness to the individual who has experienced the event. I have heard many sad stories during my interviews with all of my participants.

An autonomous teaching environment boded well for ALC. Years later, ALC taught CTE, a technology-based elective at a middle school. ALC flourished because shewas given full autonomy to create technology lessons based on the state standards. ALCwrote minilessons and accompanying assessments without the hinderance of someone restricting her creativity. Not being held to a rigid structure helped ALC relax and worryless about what she might be forgetting. She also provided technology training sessions for her colleagues. The only stressor she encountered during her training sessions was if she was faced with a question she did not know how to answer. ALC recalled becoming flustered and embarrassed instead of realizing that it was okay not to know the answer toa question.

ALC described the overall environment at the middle school as relaxed, professional, and trusting. Her administrators did not micromanage her teaching and

planning. Also, her relationships with her colleagues were positive. ALC attests that was due to her own anxiety levels being low. Her student-teacher relationships were also much better than they were when she taught in South Carolina. ALC believes the reason for this was because CTE, a technology class, was an elective. ALC was not pressured to prepare her students for an end-of-the-year state exam.

ALC's rapport with her students' parents was positive. As would be natural, not every parent was happy with ALC as a teacher, however, ALC was able to maintain a professional demeanor in all her parent interactions. ALC stated that she did not have any specific stories to share regarding her professional relationship with students' parents.

Socially, ALC did not consistently interact with her colleagues outside of work. When she was teaching in Washington, she regularly spent time with her colleagues in a social situation. When ALC lived in Georgia, she had a small group of friends who would regularly interact with her socially. When she moved to Tennessee, she did not interact with her colleagues at the first school she worked at, as her friends lived quite a distance away from ALC. At her second school and current school, ALC recalled having made some friends at work and even socializing with them regularly.

Coping Strategies

Coping strategies is another reoccurring theme throughout my interviews with ALC. I define coping strategies as a corrective behavior created to overcome AD/HD symptoms. Before receiving a diagnosis, ALC did not know she was behaving in a hindering manner, keeping her from flourishing in her career. As ALC reminisced, she started to realize that she was consciously and subconsciously implementing strategies, helping her improve her work life.

As a response to her above epiphany about an example of her previous behavior, ALC now makes a daily habit of cleaning her classroom, organizing collected papers, recording student data, and adding to lesson plans for the following week so that by the end of the day on Fridays she can leave work at work. She has even implemented a system where her students help her clean the classroom daily by wiping down their personal areas and cleaning up the floor underneath their seats and tables. ALC even went on to say that her students enjoy helping her clean up after themselves, as if it is a great privilege.

Another area of struggle for ALC is forgetfulness. When asked how she combats this, she said she makes a list. Also, to keep herself from losing her list(s), she keeps her list(s) next to her and takes them with her when she leaves. She noted that if she does not adhere to her items on her list(s), she becomes scatterbrained and starts jumping from thought to thought.

ALC admitted one of her areas of weakness was time management. A strategy she has employed to help her get more done within a class period is enlisting her students as helpers. One example ALC gave was choosing students to stamp homework cards of other students once ALC has seen that her students have completed their homework. This strategy has helped ALC get through her beginning class routine quicker so that she can maximize the time she needs teaching during that class period.

When asked how she changed her interactions with parents, ALC simply stated that she does not talk unless necessary. ALC said that is the only way she can stay focused and keep her emotions in check in case the parent meeting has a possibility of causing emotion reactions. Also, when parent meetings include all the teachers on her grade-level team, ALC stated that it is best to remain silent because there are stronger

personalities on her team. If ALC was to say something contradictory in front of another team member, other team members have been known to lash out in front of parents. If ALC wants to share something specific with parents before the entire team in present, she will arrive early to the meeting and discuss the student's performance in math.

There are times, ALC admitted, that she has had to meet with parents individually. I asked her how she stays on tract, keeping herself from straying off subject. She admitted that she must make a list and refer to the list throughout the meeting. When frustrated during individual parent meetings, ALC stated she takes adeep breath and pushes forward.

When asked if there are changes in how she responds to student behavior, ALC admitted that she employs a classroom management strategy where the student is forced to take responsibility for their own actions. ALC said this change has helped her anxiety when concerning student behavior. She believes consistency with this strategy has also helped her students change the way they behave, treat her, and treat each other in her classroom.

Finally, one area people would not think to research to help them in their current place of employment, is being knowledgeable of the Americans with Disabilities Act (ADA). ALC stated she never thought about ADA and her situation. She assumed a diagnosis of AD/HD did not qualify for support from ADA.

CHAPTER V

Participant 2: DLG

In this chapter, I will introduce participant two, DLG, providing a brief background about her demographics. I will narrate DLG's answer to questions from three separate interviews. The narration will follow the flow of each interview.

Participant Profile

DLG is a 33-year-old white female who has taught for six years. She has taught middle school and high school age students. She is employed at a Canadian school, educating middle school and high school students. DLG's previous employment was waitressing. She stated in the second interview that waitressing prepared her for handling middle school and high school-aged students.

DLG had a normal childhood, raised by both her mother and father. She has one brother who is also been diagnosed with AD/HD as an adult. DLG said her school year were normal. She is not married. DLG lives with a roommate.

Interview Results

DLG shared her first visit to a doctor, inquiring about her mental health, adding details about how her country's mental health circuit works. DLG described how her symptoms interfered with her teaching and interactions with colleagues and administrators. She shared stories about her emotional reactions. I end with her thoughts about sharing her diagnosis with others and her opinion about raising awareness.

DLG was diagnosed with AD/HD when she was 28 years old by a therapist specializing in diagnosing AH/HD. DLG had been teaching for two years when she realized she needed to consult a medical professional about her AD/HD. The medical professional she originally met with told DLG she needed to relax and gave her a card as a friendly reminder to breath. While the card may have helped other patients, DLG knew she needed to consult a different medical professional.

DLG sought help a second time. Before her initial appointment, DLG was given forms for herself and her parents to complete regarding symptoms related to AD/HD. DLG brought the completed forms and childhood report cards with her to the initial appointment. DLG stated that the doctor, a family practitioner who happened to be an expert in AD/HD, diagnosed her with AD/HD at the end of her first appointment. Even though the family practitioner was willing to see DLG for her initial diagnosis, he was not able to take her on as a patient because his practice was full. DLG met with a more promising doctor, a therapist who specifically worked with adults diagnosed with AD/HD as adults. After her initial consultation, DLG was also diagnosed with anxiety and depression. When asked to describe her reaction to being diagnosed with AD/HD, DLG stated she was relieved. Initially, she was worried that the doctor would think she was exaggerating her symptoms or that she would appear whiny. Instead, she left the appointment feeling validated.

Following the diagnosis, the doctor prescribed DLG a stimulant, and advised her to take the medication daily. DLG did not like the idea of taking a stimulant, but she was willing to trust the doctor’s advice. During the appointment, the doctor did not tell DLG what AD/HD looks like in adults, but he did give her a website about AD/HD, sponsored

by the Canadian government. At the end of the appointment, the doctor scheduled an appointment for the following week. DLG met with a doctor weekly until the doctor found a medication that was best suited for DLG.

DLG did visit the Canadian government's website about AD/HD, learning more about AD/HD in adults. She also subscribed to podcasts about AD/HD. While she found researching AD/HD in adults was helpful, DLG did not make it her mission to learn everything there was to know about adult AD/HD.

DLG said, since disclosing her diagnosis with her colleagues, they seem to give her the benefit of the doubt when she makes mistakes, showing sympathy instead of intolerance. She said they also respect her more now that they realize that DLG knows how to teach her subject area, whereas before they would dismiss her ideas and suggestions.

I asked DLG if any of her colleagues ever mentioned anything to her about the possibility of having AD/HD. She commented that no one said anything about AD/HD, but her administrator did discuss with her how she handled stressful situations as work. Her administrator suggested that DLG see a therapist.

While some AD/HD symptoms were troublesome for DLG, she admitted that she had a better connection with students who also have AD/HD. DLG empathizes with her students who also struggle with AD/HD symptoms. She reminisced about how, before being diagnosed with AD/HD, certain student behavior reminded DLG of herself.

I asked DLG if she had any initial epiphanies about changes in her behavior once she started taking medication. DLG answered that she first noticed that she was able to get more work done throughout the day but did not notice a difference in her teaching

abilities. She also started noticing that her thoughts were not racing anymore. Previously, especially during faculty meetings, DLG recalled thinking about multiple topics at once and having conversations about these topics in her head to herself. She now wonders if anyone else had those same behaviors.

Before starting medication, DLG was adamant about trying to fix everything in her professional life. She would try to learn and master every aspect of her job. After starting medication, DLG decided to pick one area of her career at a time to decrease her anxiety. She decided to make technology her first area to master. She admitted that she used to work from the moment she woke up in the morning to the point when she fell asleep at night. She said she no longer works that hard, but she believes that she still works harder than her colleagues.

DLG notices when her medication is wearing off. She recalls her mind beginning to race again, jumping from topic to topic. This happened while she was driving home from work. The mind racing scared her because she was not able to concentrate on driving. On the other hand, when her medication was working, DLG recalled that her superpower, being able to catch students' misbehavior while she was teaching or talking with individual students, was now gone. She stated that her students even noticed that her superpower was gone.

DLG's interactions with her administration has not changed much since she was diagnosed with AD/HD. She did share are diagnosis with her administration. DLG recalled that one of her administrators did not believe her, but her other administrations responded sympathetically. DLG has become more confident when asking for appropriate accommodations for an adult with AD/HD.

Results Analysis

DLG struggles with AD/HD symptoms, making her job more difficult. The first area of struggle is organization. The second area, not mentioned by DLG but surmised from the interview, is anxiety. While it may seem as though DLG displays only two AD/HD symptoms, lack of organization and anxiety have created a perfect storm in her career.

Organization

DLG commented that she has an extensively long checklist for each major daily activity or task. Before she leaves for work every morning, she completes a checklist of 30 tasks. She has multiple checklists she adheres to throughout the school day. If she does not follow her checklists, she stated her day will become chaotic.

DLG digital files were disorganized. She has tried different strategies to organize her digital files for each of her classes. She will create a Google slide presentation, embedding links to other files or websites needed to teach her students. Despite her efforts, DLG admitted that her digital files are still a mess.

Anxiety

Multiple school day disruptions cause her to become frazzled, causing her anxiety level to rise. One such example is fire drills. They are not usually planned, so when DLG must stop her classroom teaching to escort her students outside, she becomes anxious. Her anxiety stems from not remembering where she was when she stopped her lesson and becoming frustrated that those students must now catch up on lost time, compared to their peers.

Another example is the phone in her classroom ringing multiple times during instructional time. I asked her if she could ignore the phone or even unplug the phone. DLG said she must answer the phone in case someone has something important to tell her about a student. A week before Christmas, DLG stated the phone in the classroom kept ringing. Every time she answered the phone, someone had something unimportant to tell her. She became overwhelmed and cried in front of her students. She decided to turn the ringer off. DLG did not turn the ringer on the phone back on until January.

Technology causes frustration for DLG. There are many technology resources available for teachers thought to help teachers improve their instructional output, sorting data, and time management. However, for DLG, the wealth of what is available is too much for her to digest all at once. One Internet-based program is PowerSchool. PowerSchool is used to track student attendance, demographics, and grades. The within PowerSchool used to track grades is called Power Teacher. DLG loathes Power Teacher. There are multiple steps necessary to create one assignment, while also connecting the assignment to multiple student groups or class periods. DLG admitted that she has an extensively long list of directions she follows when creating assignments and entering grades for the assignments. If DLG is distracted, she will make a mistake, having to start over at the beginning.

Despite the improvement in her task completion, DLG admits that she lacks motivation in certain areas of her job. She hates creating assessments and testing students. This is due to her loathing attitude towards Power Teacher. When she grades assessments, she puts off inputting the scores in Power Teacher because the process creating assignments is lengthy. Also, DLG stated she is always making mistakes in the

program causing her to start the process over again. This problem is why she is always late submitting her grade reports.

Managing student behavior was a breeze for DLG, but managing extra activities associated with her job was not. She admitted that keeping track of faculty meetings, extra-curricular activities, and other teacher duties caused her to become overwhelmed frequently. She was stressed making sure she arrived at meetings on time, which she said was hard to do. Eventually, the constant stress would cause DLG to cry.

DLG stated that her colleagues have all seen her cry at least once. However, DLG said her colleagues and grade level team members were very supportive. Her team members have even spoken up for her when DLG was confronted by administration or supervisors. One example was when DLG was late inputting her classroom grades. Her team members expressed sympathy for DLG's actions, causing DLG's supervisor to also have sympathy for her.

The sympathetic behavior extended to DLG's administrators; however, she did not believe her administrators understood her predicament. She had three meetings duringher fifth year concerning her inability to complete grade reports by the due date. DLG eventually admitted to her administrators that she has AD/HD and asked for accommodation.

DLG was required to attend multiple faculty meetings about the same topic(s) because she taught students at the middle school and high school level. At the beginning of the school year, DLG asked to only attend one faculty meeting a week, as an accommodation. She admitted to feeling anxious about even asking for this accommodation because she was afraid the request would be taken negatively. DLG was

very careful not to appear as though she was asking for a favor or a special exception. DLG countered by receiving a brief summary of the faculty meetings she did not attend, from a colleague. To date, this is the only accommodation DLG has asked for.

I mentioned to DLG that she stated that her colleagues have been very supportive of flaws. I asked her about her social interactions with her colleagues. She stated that she is aware that some of her colleagues do not like her. They do not take her seriously because she comes across as lackadaisical and naïve. DLG described a time she was contributing to a conversation at a faculty meeting. The person in charge brushed her comment off and asked for other suggestions. Another colleague repeated what DLG said. The person in charge responded positively to DLG's colleague. DLG's colleague retorted that was DLG's suggestion and asked why DLG's suggestion was not taken seriously. DLG stated that the conversation became awkward.

Positive Experiences

Also, distractibility was a blessing to her. She would catch student misconduct because off task behavior distracted her. DLG chuckled about her students' reactions to her catching them off task, asking DLG how she caught them. One student even asked DLG if she was a witch.

DLG has not had negative responses from her administrators when she has cried in front of them. She stated her administration has become accustomed to DLG's emotional responses to being overwhelmed. Thankfully, her administration has yet to admonish her behavior.

When asked about changes in her professional interactions with her colleagues, DLG said she does not let her colleagues treat her like a doormat anymore. She is more

assertive during faculty and team meetings. DLG felt more confident in herself when providing input at meetings.

I asked DLG about parent interactions and DLG responded that she always felt comfortable with parents and that she has been lucky. Her attitude was that she was providing a service to her students and the parents owed her respect. If parents were cross with her, she never believed that it was because of something she did or said. She compared parents with restaurant customers. While she provided good customer service, DLG was transparent about what the service she was providing her students. From experience, DLG has found that direct interaction with parents has proven more effective than emailing parents about student behavior or academics.

DLG also shared her diagnosis with colleagues she had a closer relationship with. She stated they were also sympathetic. Some of them even said the diagnosis made sense thinking back on DLG's behavior. Her department head shared her experience as a mother of a child diagnosed with AD/HD. Another colleague gave her a name of a man who had written many books about AD/HD and adults, suggesting that DLG read some of the books. DLG never expected to have so much support from her colleagues.

After DLG's first three years DLG said her colleagues started taking her seriously. She recalled a time she was confused because the guidance counselor was asking her for help concerning a student. DLG said she was caught off guard. Then she asked her colleague why she was asking her for help. The colleague stated that she believed DLG could offer significant insight into the student. Surprised, that was when DLG realized her colleagues were beginning to think of her as a tr. ted colleague.

Coping Strategies

When asked what strategies DLG has implemented to help her improve her time management, she said she sets timers for every classroom activity. When she finishes explaining an assignment, she will set the timer on the Smart Board where everyone, including her, can see it. When she is lecturing to the whole class, DLG will give a kitchen timer to one of the students in the front row. They are instructed to inform her when she has is almost out of time.

DLG admitted that she has not implemented strategies to control her emotions whenmeets with colleagues. Instead, she brings busy work to meetings, while only half-listening to her colleagues talk.

Parent interactions have not changed. Parents are allotted a certain amount of time to meet with teachers. DLG stated that she likes that strategy because parent meetings cannot go over a certain amount of time because there is another parent waiting to meet with the teacher. DLG admitted that she does not meet with parents very often. Most of her communication with parents is done through email. She has implemented a process for how she responds to parent emails, rules DLG follows when responding to different parent concerns. DLG admits that it took years before she homed in on the best protocols for responding to parent emails.

When asked if she changed her classroom management strategies, DLG stated thatshe always had good classroom management skills. She attributes this to years of waitressing. DLG compared students to drunk adults. She said you cannot reason with adrunk adult as equally as reasoning with an upset child. Additionally, DLG uses a behavior flowchart to guide her decision-making regarding student behavior. The

behavior flowchart is very scripted, taking the guess work out of most student misconduct.

DLG admitted that she has only met with one administrator about accommodations that may help her function better with AD/HD. The only accommodation she has specifically asked for is to only attend one faculty meeting a week. She stated she is too timid to broach the topic with other administrators or ask for other accommodations.

Connecting with Other Teachers Diagnosed with AD/HD

Finally, I asked DLG if she has ever raised awareness or thought about raising awareness about adults with AD/HD. She admitted that she is on Reddit. She answers questions when someone asks about adult AD/HD.

My last question in the second interview was if DLG had connected with other teachers who had also been diagnosed with AD/HD as an adult. She said she shared her diagnosis with her brother, who was a band teacher at the time. He decided to see a doctor concerning symptoms related to AD/HD. He admitted that after starting medication, teaching music became easier.

CHAPTER VI

Participant 3: JAD

In this chapter, I will introduce participant three, JAD, providing a brief background about her demographics. I will narrate JAD's answer to questions from three separate interviews. The narration will follow the flow of each interview.

Participant Profile

JAD is a 52-year-old female. She has been teaching for 20 years. JAD has taught in traditional and nontraditional settings. The nontraditional teaching position JAD held was serving as a parent educator for a local social service agency. The traditional teaching position JAD held was serving as a special education teacher and a paraprofessional.

JAD recalls being lively and active throughout her school years. Her parents were never concerned about her learning ability because she always excelled in her classes and did very well on tests. She had many friends and was well liked.

When she was 18 years old, she became pregnant with her first child, a boy. Her parents remained supportive, evening helping her while she attended college. After JAD was married, her life became difficult. Not sure what the cause was, she made accommodations, trying to manage her marriage, her toddler, and her first job.

JAD and her husband worked with a marriage counselor to save their marriage, but in the end, JAD divorced her first husband. During this transition in JAD's life, JAD noticed that her son was having difficulty in school, academically and socially. JAD sought help for her son, not knowing that AD/HD is genetically passed from parent to child.

JAD has had a variety of jobs. After her divorce, she left her first job as a special education teacher. Her next position, atypical of a traditional educator's job, was working for a nonprofit organization, serving parents and their children at their private residences.

Interview Results

JAD shared her first visit to a doctor, originally inquiring about her son's mental health. JAD described how her symptoms interfered with her teaching and interactions with colleagues and administrators. She included details about how her symptoms have negatively affected her interactions with colleagues and administrators. I end with her thoughts about sharing her diagnosis with others and her opinion about raising awareness.

JAD had been teaching for two years when she started the process of seeking help, but she did not think at the time she may have AD/HD. She believed she was suffering from postpartum depression. JAD was working part-time as a parent educator for a local social service agency, but she was struggling to maintain her quality of work while also taking care of a two-year-old child.

JAD described her first visit to a medical professional as ineffective. She had a two-year-old at home and was working part-time. She had become overwhelmed with work and her day-to-day tasks and was no longer able to keep up. She describes that time in her life as chaotic. She decided to visit her regular doctor. His diagnosis was that she was suffering from postpartum depression and prescribed her a common antidepressant. JAD was told that the medication needed to be in her system for at least 14 days before she could validate its effectiveness. She said after the second day she stopped taking the antidepressant. She was functioning worse than before starting the antidepressant.

Instead of going back to her doctor, she decided to make accommodations for her work and home life, hoping that she would eventually recover.

Unsure of what to do, JAD decided to deal with her situation and make accommodations for her behavior. She found that allergy medication helped her focus. She started making rules for herself, related to work. One such rule was that she could not leave her vehicle until she had finished annotating the home visit she completed.

JAD did not see a doctor about her AD/HD symptoms again until she took her son to a specialist. While she was listening to the doctor diagnosis her son, the doctor was also observing JAD's behavior. At the end of the appointment, the doctor informed JAD that AD/HD is genetic and asked her if she had ever been diagnosed herself. JAD answered no. The doctor started describing JAD's behavior she noticed during the appointment and shared her medical opinion with JAD.

Suddenly JAD did not think she was crazy. The doctor validated what JAD had been experiencing for years but did not know how to verbalize her symptoms to another person. Taking time to reflect, JAD never realized that her behavior was abnormal. She assumed everyone experienced lulls in energy levels, the inability to think clearly, regular procrastination, and a messy, disorganized house. Referencing work, she assumed that it was normal for people to regularly procrastinate on assigned tasks. She believed that everyone had ups and downs with their supervisors and colleagues. JAD was relieved to have someone notice her symptoms and offered her help.

Years before JAD was diagnosed with AD/HD, she had a different opinion about AD/HD and children. She had only experienced children who were hyperactive. Prior to her extensive research on children and AD/HD, JAD thought those children needed

more structure and guidance about how to behave properly. Fast-forward to her first appointment with a doctor concerning her son's AD/HD, she never realized that there was an inattentive type and that she fit the description.

JAD's doctor prescribed her the same medication she prescribed JAD's son, a stimulant commonly prescribed, alleviating symptoms of AD/HD. Her doctor was supportive of JAD's decision to try different medications when JAD shared that the side-effects were more troublesome than dealing with the AD/HD symptoms.

JAD's doctor did discuss behavior medication therapy as an alternative option, but only for her son, saying that medication and behavior modification therapy are the best treatment plan. JAD was not offered any treatments aside from medication. Additionally, JAD was given a pamphlet about AD/HD and a list of foods to avoid when taking her medication. She stated that she only goes to medication checks once a month. JAD did add that her psychiatrist will answer as many questions as possible during JAD's 15-minute session.

JAD said she was very thankful to have a doctor with a wealth of information about AD/HD and that the doctor took the time to share with JAD what AD/HD looks like in adults. However, aside from being willing to help JAD find the medication that wasright for her, the doctor did not share any more information, nor did she give JAD directions about where to learn more about adult AD/HD.

JAD first started researching information about stimulants. She did not realize that there are foods you should not eat if you are taking a stimulant. Every time JAD or her son would experience a new side-effect to their simulant, JAD would read about the

long-term effects and whether she should continue taking the current stimulant. She even came to realize that name-brand medications work better than generic medications.

JAD also started researching AD/HD in adults and children. One resource she uses often is Attitude Magazine. What JAD stated she likes the most about Attitude Magazine is that there is also a website. Within the website there are discussion groups. JAD likes learning about how other people accommodate different symptoms and how other people are adjusting to various stimulants. It was on the Attitude Magazine website where she learned about a blood test specifically designed for detecting which AD/HD subtype someone has. The results from the blood test are used to prescribe the best medication for that person. JAD also learned about brain scans that validate AD/HD as a mental illness and that it is treatable.

JAD obtained a copy of the Conners Comprehensive Behavior Rating Scale (Conners CBRS). JAD is a firm believer that people must advocate for themselves. She has used what she learned about her son and herself to obtain appropriate treatment. JAD knows the right words and phrases to use when describing her symptoms to a new doctor. JAD had read many stories of girls and women who had been misdiagnosed with other mental health disorders, mainly because the girls and women did not know how to describe what was going on and how they felt throughout the day.

Another resource JAD found was a website about brain health. The doctor featured on this website is known for reading brain scans and interpreting the type of brain someone has. Also, depending on the type of brain a person has, they should eat a certain diet. This website is where JAD learned about food and drug interactions and what foods to avoid when taking stimulants that control AD/HD symptoms.

Surprisingly, JAD's research and self-advocacy has had a negative impact. She admitted to loathing new doctor visits because she must prove to the new doctor that she does in fact have AD/HD. The frustrating part is that she believes she knows more about AD/HD when visiting new doctors. JAD gets the impression that the new doctors speculate that she is vying for a diagnosis so that she can be prescribed a stimulant. Interestingly, JAD shared that not all therapists she has visited believe AD/HD is a real mental health disorder. Additionally, she is frustrated when therapists do not know the symptoms of adult AD/HD.

When JAD received a diagnosis of AD/HD, she said she was furious. She wondered how no one realized this about her. JAD knew something was different about herself compared to her friends when she was in high school. Her teachers spoke to her parents about her daydreaming because her grades and test scores were always above average. As an adult, she wishes she had been diagnosed years earlier so she could do something different with her life. JAD admitted to mediocre performance her whole adult life becau6se she was overly cautious about her behavior. She believes if she knew at a young age that she had AD/HD, she would have strived to have more in her life. On a positive note, JAD was able to assess her strengths and weaknesses regarding work, home, and interpersonal relationships.

JAD admits that, as she ages, she has noticed that the chaos is becoming harder to live with. She is not able to multitask and complete multiple tasks by a given deadline. Additionally, JAD cannot balance her home life and her work life, giving equal attention to both. Currently, her work life is good, but her home life is more chaotic than she would like to admit. She chooses her work life for now because she needs her job. Her family has grown accustomed to waiting for her to cook dinner, keep up with the laundry, and clean

and organize the house. JAD's family cannot fire her because she is falling behindon house management, whereas her administrator can fire her if she continually proves inept at her job.

Once JAD started taking medication, she admitted that she noticed her behavior and habits. JAD admitted that when she was unmedicated, she had a difficult time communicating with colleagues and parents. Also, she realized that she had been unconsciously making accommodations for her daily routines and at work. She started making rules for herself, regulating her work habits and interactions with colleagues and administrators or supervisors. One rule JAD created for herself, mentioned earlier, was not leaving her vehicle until she had completed her home visit response forms, specifically writing everything she said or did at a home visit.

JAD reflected on her responses to the first and second interview questions. JAD believes that there are many reasons she was able to live a successful life before she was diagnosed with AD/HD. She started by describing her homelife as loving and supportive. She had her first child when she was 19 years old, but her parents supported her so she could go to college. JAD described her adult life as adaptive. She has always been a problem-solver. She admits that her life has always been chaotic, but JAD insisted that chaos works for her. JAD is thankful that she was diagnosed with AD/HD instead of a learning disability or mental illness that would be hard to accept. She has embraced her diagnosis because she has learned more about herself and understands her previous behavior choices.

When asked if her colleagues or administrators ever recognized symptoms of AD/HD, JAD answered no. She pondered if any of her colleagues would give her graceif they now knew JAD was diagnosed with AD/HD. She said she noticed symptoms of AD/HD in one of her previous administrators, but she never mentioned anything to them.

JAD admitted that her relationships with her colleagues did not change; nor did her interactions with parents. She commented that other people do not understand. Also, it is difficult to explain what is going on inside her head. Instead, JAD avoided her colleagues when she thought she might have a negative interaction with them. When avoiding her colleagues was impossible, JAD would be mindful of how she spoke to her colleagues and choose her words carefully.

As far as sharing her diagnosis with colleagues, JAD is guarded. She realizes there is still a stigma surrounding AD/HD and does not want others to think less of her. She is more apt to talk to special education teachers about her diagnosis because special education teachers have some knowledge about AD/HD. When she shared her diagnosis with her administrator at the time, her administrator was open to listening. Eventually, JAD's administrator was also diagnosed with AD/HD. JAD would share herdiagnosis with her administrator or supervisor at each new workplace, but only if she deemed it appropriate. JAD shares her diagnosis with colleagues only if she can trust them or it is appropriate at the time.

During the first interview, JAD shared that she avoids her administrators. JAD still avoids her administrators. Regardless of her new-found knowledge about herself as a person, she has not found a solution to controlling her mouth. Also, unless she knows why she is meeting with her administrator or supervisor, she is leery about how the meeting will end. JAD admits, while she tries to be mindful of her interactions with colleagues and parents, she is unsure whether her behavior has been misconstrued.

JAD has always believed that people, those being her colleagues and administrators, have always underestimated her ability to do her job. However, JAD believes that does not attribute that to having AD/HD. She attributes that to her

unconscious choices in her behavior. Interestingly, JAD admitted to purposely underachieving because she would rather appear to be amazing at her job instead of being average at a job that she is qualified to do. She is aware of her strengths but is fearful of making enough mistakes and that she loses her job. JAD believes that if she was employed ina position that is qualified for, a position that expects a high level of achievement, she will not be able to live up to that expectation every day. However, being employed in a position with mediocre expectations, she knows she can far exceed the basic expectations for that job. Also, she knows she can last longer in a mid-level position, making it to her six-year mark. JAD confessed that she changes jobs, at most, every six years. She believes that by then she has overstayed her welcome and her administrators are tired of her mistakes.

Results Analysis

JAD suffers from multiple AD/HD symptoms. She also admits to being forgetful. JAH needs to be stimulated, avoiding consistency in her daily life. She also had a bad habit of procrastinating.

Forgetfulness

JAD admits to forgetting her passwords to her phone, email, work email, and computers all the time. Her husband has a copy of her passwords. Additionally, JAD constantly loses items. She has lost her work badge numerous times. When JAD workedas a parent educator, she was terrified of losing parent documents. To accommodate this behavior, JAD never took the documents out of her car unless she was taking them into her office.

JAD shared a story about the time clock at work. JAD does not know why she constantly makes mistakes when operating the time clock. She added that she has been

counselled many times about how to use the time clock. Also, she has a hard time remembering to clock into and out of work each day, even though she said she passes the time clock when she enters the building. Recently, her building changed the door that the faculty and staff enter which is not near the time clock. JAD said it is even more of a struggle to remember to clock into work because she must make a conscious effort to go to the time clock when she arrives at work.

Another story JAD shared was about documentation. JAD prided herself on the quality of her home visits and the wealth of knowledge she was able to share, but she admitted she was horrible about documenting the home visits. When she did remember to document her home visits, she would still forget necessary details. Examples of missing details are the number of hours spent as a home visit, the services she recommended to the parents, and what lessons she taught the parents.

Lack of Mindfulness

Another symptom JAD struggles with mindfulness in her relationships with others, especially colleagues and supervisors. Later, in this narrative, I discussed how JAD's lack of mindfulness caused her to sour her relationships with colleagues and supervisors. Due to JAD's lack of mindlessness, she has left many jobs, stating that sheknew she had to leave before she completely burned bridges.

JAD's AD/HD symptoms negatively affected her teaching career starting with her first year of teaching. JAD, her colleagues, and a group of parents were having an academic discussion about educational policies. JAD inserted herself into the conversation, unknowingly insulting one of the parents. JAD did not realize what she mentioned came across as rude. No one said anything to her after the conversation either. She was not informed of how her comment offended the parent until the end of the school

year. During her final evaluation, her administrator spoke with her about the incident. Then she gave her a reprimand that was added to her personnel file.

JAD confessed that dealing with student behavior on the spot is difficult. JAD admitted that her stubborn nature causes her to choose the wrong battle with students. She must constantly remind herself that she is an adult and to act like an adult. One recent incident involved numerous students at once. One student protested that they would not complete their work until they could speak to the principal. When JAD tried interacting with the student, the student became more upset, disrupting the classroom environment. JAD did not want to involve the principal because she believed that the student would make this type of behavior a regular part of her daily routine if she was given what she wanted. JAD decided to ignore the student until it was necessary to involve the principal. The child did go to recess, but she refused to play. When she and her classmates returned, she started disrupting the class again, demanding to see the principal. JAD removed herself because she needed to calm her nerves. She saw the principal in the hallway and informed the principal of the student's behavior. Then JAD walked away, washing her hands of the situation.

When asked to describe how her AD/HD symptoms have affected her professional conduct with her colleagues, JAD immediately responded that she speaks too freely. She is blunt and straightforward when she talks to her colleagues. JAD admitted that her colleagues have taken offense at what she has said to them many times. Also, when asked for input, JAD unconsciously takes over the conversation, creating a bossy or overbearing appearance. She admits to having a big mouth. In more recent years, JAD has tried to listen silently, breath, and wait for someone to specifically ask her for her input. Then she tried to be mindful that her colleague only asked for her input,

not for JAD to take over the conversation.

As a response to JAD's story, I asked her if she ever apologized to colleagues when she realized she overstepped and how her colleagues responded to her apology. JAD said she did have colleagues who would never accept an apology from her. They honestly though JAD was simply rude and did not know how to behave in a professional environment.

JAD is especially timid around her administration. While she lives to serve them, JAD adamantly avoids her administration. She knows that she cannot control what she says. If she sees one of her administrators out in public, JAD will hide so she will not have to speak to them. The thought of speaking to one of her administrators in public causes her anxiety. With that said, JAD still managed to sour her professional relationship with her administrators enough to leave her position before she is asked to leave. A specific story JAD shared was about her last administrator. JAD had worked asher administrator for six years, at a private school. JAD knew her time working at the private school was coming to an end. JAD realized that she had soured the relationship enough that she needed to leave before it negatively affected her career. Instead of being formally asked to leave her position, JAD's administrator informed her the school could not afford her position the following school year. JAD is not completely sure what she said, nevertheless she realizes that she most likely overstepped the boundaries between faulty and administrator.

Other incidents have occurred, most of them when she was a parent educator. Parents were given the opportunity to complete a survey, sharing their experience, being visited by a parent educator. Most of the time, JAD said parents called her pushy or insistent, even when the parents voiced that they did not agree with her suggestions.

What bothered JAD about these surveys was that she was never able to fix her mistakes regarding specific home visits.

JAD's inability to read other people's emotions has caused her strife among parents as well. JAD recalled many times meeting with parents about their children and believing her advice and help was well received. On the contrary, JAD would learn from her supervisors that the parents were upset with how JAD presented her advice and help. What frustrated JAD was that she did not know until well after the parent meeting. Her supervisors would chalk up the poor meeting as JAD not being a good fit with the family.

JAD would later reflect on these parent meetings, trying to figure out what went wrong. She admitted that she may have appeared sloppy in appearance, causing her to appear disorganized. Additionally, she believed she may have been long-winded at her visit, over-staying her welcome. Also, there were times she came to an appointment unprepared, asking the parents if they could supply necessary items for her demonstration(s). JAD believes her lack of self-awareness resulted in parents viewingher as unprofessional.

Need for Stimulation

JAD struggles with the boring, monotonous daily routine that never changes. Even though JAD knows young children need structure and consistency, she would change up the daily routine in her preschool classroom regularly. When JAD served as a parent educator, she struggled with documenting each visit. She would procrastinate until she had to submit her reports. By that time, JAD could not remember what she did on each individual home visit. To remedy this problem, JAD would not leave her vehicle until she finished documenting the home visit she completed.

When asked to share memories related to her classroom management, JAD

boasted that her inability to stay focused helped her as a preschool teacher. A couple of her students seemed to have odd behaviors, otherwise noted by the other teacher. JAD did not see the students' behavior as odd. When she was supposed to be assessing students, she noticed that three of her students stood out. One student was color blind and was not able to differentiate between the colors. Another student had poor hearing. The third student was displaying gifted tendency. JAD was distracted by the students' behavior so much that she obsessed about them until her co-teacher agreed to notify the students' parents.

JAD chuckled when I asked her if she ever struggled with being motivated to complete basic tasks, having to do with teacher responsibilities. She said she has alwaysfound everything about those tasks mundane and therefore difficult to complete. Her response to completing those tasks is to procrastinate when she can and complete othertasks, she has created a rule for, such as staying in her car until she has completely documented a home visit.

Positive Experiences

On a positive note, JAD has made lasting relationships with parents. She shared a story about a parent who willingly listened to JAD when JAD pointed out a quirky behavior she noticed while interacting with her client's baby. JAD was accustomed to parents dismissing her advice, not wanting to hear negative or unordinary behavior about their baby. JAD was delighted that the parents were open to what JAD noticed. The parents took JAD's advice, taking the baby to a doctor. Years later the parent called JAD,telling her that JAD was in fact correct that there was something off about the baby's vision.

Those instances gave JAD renewed confidence that, despite her AD/HD

symptoms hindering her ability to always remain professional, she was still able to make a connection with families, creating a positive outcome. JAD admits that she has connected with many parents, sharing her story and showing empathy for the parents and their children. By doing this, JAD has helped many parents seek medical advice concerning their AD/HD symptoms. As a result, many of those parents have been diagnosed with AD/HD as adults.

Coping Strategies

JAD has instilled many strategies to combat her forgetfulness. The first strategy is never wavering from her daily routine. Her morning routine does not change. If she must make a change, she inevitably forgets something. When JAD has lost something, she automatically goes to the spot where she usually places the lost item. When the item is not there, she is at a loss and enlists others to help her find her lost item. At work, JADhas a bin where she places unnecessary paperwork. When the bin is full, she makes herself clean out the bin. Often JAD finds paperwork that was important, but she forgot she had placed the paperwork in that bin. However, when JAD is stressed, it does not matter how many fail safes she has in place. JAD will completely forget what she needs or where to find something she needs.

Another strategy JAD uses, combating her forgetfulness is taking pictures of anything that pertains to work. She has taken pictures of the yearly calendar, the daily schedule, and other important items that she can save with a picture. However, she admits to forgetting she has taken pictures of important notices causing her to scramble when a deadline is near. A backup fail safe for this strategy is attaching important notices to the back of her front door, making those notices hard to ignore when she is leaving for work.

One of JAD's weakest areas of forgetfulness is passwords. JAD has used the same password for everything that requires a password for three years. When she is required to change her password, she creates a new combination of letters, numbers, and symbols while trying to keep the overall password the same. If she forgets what her new password combination is, she refers to her husband. JAD shares her password combinations with her husband because she knows he will not forget.

JAD also uses her husband's help when she loses her phone, which she admits happens frequently. Her husband has an app on his phone that he uses to track JAD's phone. If her phone is charged and on, her husband can find her phone.

JAD has an interesting strategy for managing her classroom. She wears a lanyard and on that lanyard is a cheat sheet of everything she needs to know at a moment's notice, information about her students, and her daily schedule that includes times and places. She also keeps a slip of paper containing codes and passwords because she said can never remember her passwords. When JAD is not wearing her lanyard, she keeps her lanyard in her car. She has a strict rule to leave her lanyard in the car, no exceptions. However, she has broken that rule a couple times. She was substituting in a classroom and had forgotten her lanyard at home. She could not remember the daily schedule. She said she would have set timers on her phone, but her phone is never charged because she frequently forgets to charge her phone.

JAD's inability to remember to charge her phone has caused her to be creative in how she keeps track of time changes. She regularly assigns a student to be her timekeeper. Extending on that classroom management accommodation, JAD tries to keep a schedule that is self-correcting. For instance, if there are warning bells for

changes in the daily schedule, JAD will plan her teaching around those warning bells. Additionally, her students will remind her when it is lunch time because they are hungry.

JAD has created numerous rules for herself, helping her control her emotions and stay focused when meeting with colleagues. The first rule is that she only allows herself to raise her hand, asking a question, one time during meetings with colleagues. When she does add to the conversation, she only allows herself so much time to talk, fearing she will inevitably take over the meeting. Secondly, JAD brings candy to suck on so that she has something to do with her mouth, keeping her from rudely interjecting comments. JAD brings a notepad, taking notes or drawing, helping her stay focused and listen to what others are saying.

JAD expressed that she is amazing at diffusing emotional responses when discussing student progress. JAD does not become emotional when meeting with parents. She did state that there are many times when parents become emotional with her because she shared something she probably should not have shared. Luckily, JAD knows how to calm parents down before leaving a home visit.

JAD has tried to make her work life more efficient. When she has a meeting to attend in the future, she will start preparing for the meeting ahead of time. She will file thepaperwork she needs. Next, she will place the paperwork in the same filing cabinet she always uses so that she will not misplace the paperwork. While JAD keeps a list of what she needs to address at a home visit; howbeit, that does not stop her from uncontrollably talking. She admits to being unaware of body language when someone wants her to stop talking. Also, she desires to share her wealth of knowledge, even if her sharing is unwarranted. As mentioned earlier, JAD lacks time management. Her solution, trying toavoid longwinded home sessions, is to set an alarm for 90 minutes.

When the alarms sounds, JAD quickly ends the home visit.

JAD has asked for accommodations in the workplace, but usually when she knows she is in trouble. Knowledge unknown to me, adults can request 504 plans. A 504 plan is developed for individuals who need assistance at work. Previously, I thought 504 plans where only available to school-age children. JAD has used a 504 plan, helping her with procrastination, tardiness, and interacting with colleagues and administrators. She was given a liaison, guiding her through the process of implementing a 504 plan.

]Connecting with Other Teachers Diagnosed with AD/HD

JAD has not thought about raising awareness about adult AD/HD, but she wishes she could go back in time with what she now knows and change parts of her life. She did say if she did raise awareness, she would use the Attitude Magazine website. JAD said Attitude's website has forums where people can post questions. She has read and responded to the forum questions, but she has not created her own forum question. JAD mainly wants to help educate girls and women about adult AD/HD, sharing symptoms and early signs so that girls and women can receive the correct treatment.

In this chapter, I introduced JAH, the third participant in my study. I provided her interview answers in a narrative format, providing insight as to how an adult female educator functions with AD/HD. JAH's responses have provided me with more insight into myself.

CHAPTER VII

Participant 4: JRH

In this chapter, I will introduce participant four, JRH, providing a brief background about her demographics. I will narrate JRH's answer to questions from three separate interviews. The narration will follow the flow of each interview.

Participant Profile

JRH is a 65-year-old female. She taught for over 30 years. JRH earned her college degree, studying different facets of education around the world. JRH taught elementary and middle school. Her first position was at an elementary school. Her second position was at a middle school, where she spent 21 years teaching English.

JRH has been married to her husband for almost 40 years. She has three children, two girls and one boy. Her son was diagnosed with AD/HD when he was a child. JRH also has two grandchildren. JRH describes her childhood as loving, raised by both parents. JRH raised her children the same, encouraging her children to take chances. Additionally, JRH taught her children that if they wanted something, they needed to do what was necessary to get it.

Interview Results

JRH talked about her first visit with a psychiatric nurse practitioner, stating the visit was not what she expected it to be. JRH described how her symptoms interfered with her teaching and interactions with colleagues, administrators, and parents. She shared personal stories, some sad and some triumphant. I end with her thoughts about sharing her diagnosis with others and her opinion about raising awareness.

JRH taught for 21 years before she sought medical help for her AD/HD symptoms. Her first visit to a counselor was not due to her AD/HD symptoms though. JRH's first visit to a counselor was because her body was negatively reacting to the stress she was experiencing from her job. Her counselor referred her to a psychiatric nurse practitioner who diagnosed her with AD/HD. JRH informed me that in the state she resides, psychiatric nurse practitioners can diagnose and prescribe narcotic grade medication. JRH shared that she is happy with her psychiatric nurse practitioner.

JRH described the paperwork she completed before her initial appointment as more daunting than the appointment. JRH stated that the paperwork was 'extensive and intimidating'. There was a section that focused on relationships with parents and siblings, which caused JRH anxiety. Despite the paperwork, the initial appointment went very well. The appointment lasted 90 minutes. While the psychiatric nurse practitioner (PNP) asked pointed questions, she had an easy-going personality, JRH stated. The calm and relaxed environment helped JRH become calm and relaxed at each of her appointments. At the beginning of the appointment, JRH tried hard to stay still and refrain from fidgeting. However, near the end of the initial appointment, JRH said the PNP asked JRH if she was always very squirmy because JRH was constantly moving around. JRH laughed at the memory because she thought she was sitting still the whole time.

JRH's first reaction to being diagnosed with AD/HD was relief. Then she started reflecting on her own children. She remembered that her son was diagnosed with AD/HD when he was in second grade. JRH figured he had inherited it from someone, so she guessed her son inherited AD/HD from her. Then her mind wandered back eight to

10 years when she had an interesting conversation with one of her students. JRH's student described how his thoughts would hop from one idea to the next for 30 seconds until he realized that his first thought had no connection to his last thought. JRH assumed that was normal because that was how her brain was also wired. JRH calls her random unconnected thoughts the chirping cricket noise. She said the chirping cricket noise starts as soon as she wakes up in the morning and continues well after she has gone to bed but has not actually fallen asleep.

JRH's was prescribed Vyvanse as an initial treatment option. JRH was not thinking about her teaching at the time. JRH was concerned with her general life. The chirping crickets became quieter. She was less agitated. She no longer felt overwhelmed at work. JRH no longer needed to leave her classroom, taking a break because she was tense and needed to leave the room. Within one week, JRH saw the benefits of the prescribed medication.

JRH's PNP did not provide her with information about AD/HD, nor did she talk to her about the possible side-effects of taking Vyvanse. However, JRH did research on her own. First, JRH found an AD/HD quiz online, and in her words, "passed it with flying colors." Then she sent the test to her sister and her sister responded that JRH fits the AD/HD profile. Then JRH's sister reminded JRH that she asked her about herself several years before when JRH's son was diagnosed with AD/HD. JRH had completely forgotten about the incident. When asked if any of JRH's colleagues or administrators ever recognized AD/HD symptoms, she said no one did.

JRH learned that AD/HD has a genetic link, which she already figured out when her son was diagnosed with AD/HD. The genetic link caused JRH to reminisce on her

childhood, going back to how her parents behaved. JRH believed that both of her parents probably had AD/HD. JRH and one of her other siblings were diagnosed with AD/HD as adults. Additionally, JRH has nieces, nephews, great nieces, and great nephews that have been diagnosed with AD/HD. She believes there are additional younger members of her family that should have been diagnosed with AD/HD.

Next, JRH began researching adult AD/HD. What she learned was that AD/HD is a brain wiring problem. Also, any adult that is diagnosed with AD/HD for the first time as an adult has had AD/HD their entire lives. The reason AD/HD becomes a problem in those adults is that their coping strategies are no longer effective, JRH stated. JRH also read adult women are more often diagnosed for the first time because their AD/HD symptoms are usually not disruptive, therefore not causing an achievement and ability gap. Also, AD/HD is more clearly defined now whereas in the sixties and seventies, AD/HD was complex and had numerous grey areas when diagnosing children with AD/HD. JRH even bought a specific book titled, *You mean I'm not lazy, stupid or crazy?!* JRH recommended that book to the parents of her students diagnosed with AD/HD to help them better understand their child. Overall, JRH learned that adults with AD/HD often struggle keeping jobs, staying married, and keeping up with life in general.

JRH took time to reflect after interviews two and three. I asked JRH how she was able to function for so many years, not knowing she had AD/HD. Her response was that not functioning was never an option. She attributed growing up in the sixties and seventies when special education programs were reserved for the severely mentally and physically disabled. She remembers academic expectations for girls being relaxed,

meaning girls were not expected to earn an A on every school assignment. Her test scores fluctuated depending on how bored JRH was when she was taking tests; however, her scores were never so low that anyone became concerned about her academic abilities. JRH's parents did not expect JRH to be a model student, but they did expect her to earn passing grades and behave in school.

JRH took more time to reflect on what was going on in her life, besides her work stress, the more epiphanies she had. She described her generation as the wives and moms that also had careers. Even her husband was raised in a household where the wife was expected to take care of everything outside of work. When she was home, she was expected to carry out the traditional gender roles such as cooking dinner, shopping for groceries, managing the household chores, and taking care of her children. However, her house has always been a mess. She never balances the family checkbook. JRH basically struggled getting anything done after she left work at the end of the day. After JRH retired, she genuinely planned on cleaning and organizing her house. However, that has yet to happen.

Not only did JRH think about her family, but she also reminisced back to the beginning of her educational career. She remembered being told to sit down in kindergarten. She frequently was made to stand in the corner in first grade. JRH swallowed a crayon in third grade. She loathed writing assignments because, before the advent of computers, JRH would have to rewrite the whole paper because she found a mistake at the top of the page. She realized she had never lived up to potential her whole academic career. Although in college, JRH said everything started falling into place.

Writing papers became easier because of how easy it was to edit mistakes when typing on a computer.

When JRH graduated from high school, she was given the option of finding employment or attending college. JRH chose to attend college. Even though college was not a job per say, JRH still believed that it was her job not to fail. During JRH's first year of college, she studied local and state government in Honolulu, Hawaii for one month. During her sophomore year, JRH took a minority education class and studied at the Bureau of Indian Affairs in Arizona. JRH studied comparative civilizations in the Soviet Union during her junior year. She recalled traveling around Russia without a map or a guide and having to find her own way back to her motel even though she did not speak or understand Russian. JRH is glad she was not diagnosed with AD/HD as a child because she had to learn survival skills which helped her through life. She believes having AD/HD gave her a sense of courage and willingness to explore new places.

When asked if she shared her diagnosis with any of her colleagues, JRH responded that she told her "work wife" first. Then she shared how her urge to leave her classroom to get a Coke went away. Also, JRH said the buzzing in her head was almost quiet. Her close colleague became her biggest advocate. The next person she told was her curriculum coach, but she did not believe JRH. When she told her administrators, they responded that they have known for a long time that JRH had AD/HD. In fact, when she shared her diagnosis with more of her colleagues, all of them said they knew. They asked her why she did not already know this about herself. JRH said AD/HD people are always the last ones to know about themselves. Thankfully, sharing her diagnosis did not have a negative effect on her career. Her colleagues and administrators continued to treat her the same as they did before JRH shared her diagnosis.

Results Analysis

JRH experienced a variety of AD/HD symptoms. JRH was disorganized. Another symptoms JRH was with is focus. JRH also stated that she experiences mind-racing, something I can relate to but never knew what to call it when my thoughts continue. Another symptom JRH suffers from is anxiety. Additionally, JRH had extreme difficulty controlling what she said around other people.

Organization

JRH stated that her most bothersome symptom was organization. In her words, JRH is the “clutter queen”. She would have stacks all around her classroom containing student papers. She had difficulty keeping her parent communications and interpersonal communications with colleagues sorted and filed. Adding to the problem of having stacks of student papers all over her classroom, JRH would procrastinate grading student papers. The grading process was daunting due to the sheer volume of students. JRH had on average 160 students. When she calculated the amount of time it would take to grade all 160 essays, she could easily spend 26 hours grading student essays.

In her marriage, JRH’s husband often asked her why she is always losing things around the house. He told her how simple it is to take something from a given place, use the item, and then put the item back in the given place. JRH responded that she fully intended to do that with her belongings, but on her way to the item’s destination, JRH will get lost in her own thoughts and forget why she picked up the item in the first place,

set it down and walk away. Years of this has created a messy house. JRH admitted that she never has people over because her house is messy.

Every surface in her house is covered with stuff. JRH stated that if she puts anything away, she will forget that she has the item. JRH's classroom was the same way. She confessed that if there was a flat surface in her classroom there would always be something on that surface. Colleagues would enter her classroom and gape at the piles of papers everywhere and ask JRH how she is able to find anything. Then her colleagues will ask her for something and JRH will instantly find the item and hand the item to her colleague. JRH claims that is how she organized her classroom. Otherwise, she would not be able to find anything.

Focus

JRH admitted that she could not focus on any one part of a single essay because she would become distracted by the components that make up one essay. She would first direct her attention to the ideas in the essay. Then she would become distracted by the student's sentence structure. Then JRH would notice grammar and spelling mistakes. JRH said that she struggled to find a way to systematically address all parts of a student's essay.

Despite her creating strategies to help her keep track of meetings and class-specific work, JRH was never able to beat her mindless misplacement of objects. She was constantly losing the projection board remote control, among other objects she needed to use to teach. Even now, JRH admits, she is constantly losing objects around the house. She believes her brain is three steps ahead of her body. When she has a new

thought, whatever is in her hand is put down without her brain realizing it. Therefore, she has no recollection of what she has done with the objects she needed three thoughts ago.

JRH was terrible at time management in her classroom. During classroom discussions, students would make off-handed comments having nothing to do with the topic JRH was teaching. Instead of deterring off-task comments, JRH would entertain the students, getting off track. She justified these detractions by reminding herself that Language Arts is a subject for communication and welcomed her students to openly discuss and share their opinions. However, JRH's students knew they could easily distract JRH and took advantage of that.

Mind-racing

Another interesting symptom JRH discussed was mind-racing. Mind-racing is not an official AD/HD symptom, but JRH described mind-racing quite well. Instead of bouncing from activity to another, her mind would bounce from one topic to the next until she found herself deep in a rabbit hole of thoughts far away from where she started. After JRH started taking medication, her mind racing came to a halt.

Anxiety

One of JRH's memories about herself before she was diagnosed with AD/HD was not realized until after she started taking medication. JRH could only teach so long each class period before she became tense. She never knew what made her tense, even after starting medication, but she would get an urge to leave the classroom. Her remedy for her tense feelings was to go to the teacher's lounge, buy a Coke, and take a few sips. Then she felt calm and would return to her classroom.

JRH had a difficult time interacting with her administrators who were mostly male. JRH described her community as very conservative with the expectation that teachers were to adhere to traditional gender roles. She stated that she did not adhere to gender role expectations. JRH often spoke her option to everyone, including her male administrators. As a result, she feels her outspoken behavior negatively affected their view of JRH as a female educator.

JRH was given an indirect example of how her male administrators viewed her while she was participating in a child study team (CST) meeting. The CST meeting happened only one month into the school year. The male student, who was the focus of the meeting, stated that his male teachers never yell. However, JRH's supposed habit of yelling had caused the male student anxiety and fear when attending her class. The male administrator even implied during the CST meeting that JRH did not even like children and did not know why she was a teacher. This infuriated JRH because the male administrator had undermined her in front of everyone at the meeting, including the male student and his parents. The results of that meeting were devastating to JRH. She was not longer looked at as an adequate teacher by male student's parents. Any further misbehavior was chalked up to JRH's aggressive behavior toward the student. The results of that meeting created a storm of disrespectful behavior from the male student, his parents, and her administration, causing her body to display stress-induced physical symptoms. Her counselor, psychiatric nurse, and doctor recommended that JRH take time away from work until her health improved. She took the third quarter off that school year, returning with renewed strength.

JRH shared another similar incident of undermining and lack of confidence in her by her administrators. JRH made sure she followed the behavior flow chart given to all

faculty at her school. She had a male student who required constant redirection and occasionally was sent to the principal's office for disrupting the class. JRH described the final behavioral outburst as the last straw. The male student interrupted JRH's lesson by meowing like a cat. JRH tried to ignore the male student, but he continued, becoming a distraction. He then asked if panthers meow. JRH informed her male student that his question had no relevance to the class discussion and had him removed from her class.

Per protocol, JRH contacted the male student's parents, leaving a message because they were never able to answer the phone. The male student's parents returned by asking for a conference with the principal. At the start of the conference, JRH was informed that the male student was removed from her classroom. The male student was not reprimanded for his behavior. After the conference was over, JRH's male administrator told JRH that she needed to choose her battles when it came to the male student. JRH became upset because she had followed the behavior flow chart as prescribed, but instead of the male student being expected to change his behavior, JRH was reprimanded for how she handled the student. Additionally, every interaction JRH had with the male student was met with disrespect. She knew if she were to report any behavior infractions by the male student, those behavior infractions would be ignored.

The male student had three female teachers in a row during his school day. The other two female began reporting the male teacher's behavior to the principal. Multiple male administrators and the male counselor would observe the male student, but the male student presented himself as a model student. The female teachers continued to discipline the male student, so the male administrators decided to take a different approach. Instead of having an obvious observer watch the male student, they placed a nondescript female who blended in with the student population. During the observation,

JRH was appropriately giving positive feedback to the male student, but in return, he responded with a disrespectful comment. The female observer left the room immediately and reported the incident to the male principal, affirming that JRH was not the aggressor. The male student was the actual aggressor. Only then did the male principal start believing not only JRH, but the other female teachers of the male student.

JRH's district had a behavior policy and a system for documenting student behavior. JRH posted the behavior system on her classroom wall, above crates containing files used to document individual student behavior. When a student misbehaved the first time, JRH would hand the student a copy of the behavior expectations, have them document that they understand that they are being cited for a behavior infraction, and then file the document in the crate assigned to that class period. If a student had a second infraction, the student received a lunch ticket. The third infraction constituted taking home a copy of the behavior infractions, requiring the student to ask their parents to sign the behavior notice, and then returning the behavior to their teacher the following day.

Severe behavior infractions were immediately documented using an Internet-based program. While JRH would be documenting the severe behavior infraction, her students would get off task. The documentation process on the Internet-based program required several steps to complete the process. JRH said you would not have more than one dialogue box open at one time. Instead, she had to toggle between sections until she was finished. Then she had to print two copies, giving one to the student and filing one in the behavior crate for that class period. The entire process took more than five minutes. When she finished, JRH could spend another five minutes calming down her students and getting them back on task.

JRH said that meetings with her colleagues were short and to the point. However, when JRH was on the district leadership team, she and the other representatives had differences of opinion. A school board member told JRH that the middle school was the red-headed stepchild of the district. JRH would fight for the needs of the middle school, trying to convince the other committee members that the elementary, middle, and high schools have different needs. JRH stated that these meetings would get tense and she would not back down. She would then have a difficult time controlling her emotions if she did not think her opinions and concerns were being heard. If JRH was unable to control her emotions, she would become quiet for the rest of the meeting. When the meeting concluded, JRH would quickly leave and spend the rest of the day playing the meeting over in her head.

Lack of Verbal Control

JRH's AD/HD symptoms affected your professional conduct with colleagues in a negative way. People knew who she was before she met them. She had a reputation for blurting out. JRH thought her behavior was normal. One instance when JRH thought she was being appropriate was while attending an in-service professional learning meeting. Sitting in the back of the library, JRH would blurt out questions or comments, thinking she was being smart and sharing an opposing view. However, JRH's timing was not always on point. After lunch, her principal approached her, asking her to stop asking questions and blurting out as everything JRH was saying was not appropriate and was ill-timed.

When asked to share a specific story, JRH shared a moment when she was meeting with her colleagues. She was teaching at a small school, and she admitted that the faculty at the school was close. During the gathering, JRH make a sexual comment

thinking it was hilarious and her colleagues would react the same way. In her mind, she saw her colleagues reacting the opposite of how they did. After hearing the comment and seeing her colleagues' reactions, JRH removed herself from the room. JRH confessed that was not an unusual cycle of events. She had difficulty keeping inappropriate comments to herself and found herself immediately regretting her words and leaving the room often. Then she would avoid her colleagues until she believed the comment was forgotten by all. When JRH knew she had somehow irritated her colleagues, she would isolate herself. She would eat lunch alone in her classroom. JRH would avoid her colleagues in the hall or say a polite greeting before retreating in the opposite direction.

JRH's parent interactions were not much better. JRH loathed making parent phone calls simply because she could not see or hear how the parents were reacting to the news JRH would share with parents. JRH shared that students' parents yelled at her on the phone. Parents called her at inappropriate times and on inappropriate days making requests that could not be met. Parents stated that if JRH was not so strict, their children would perform for JRH. Some parents even asked that their students be taught by a male teacher.

Another reason JRH's relationship with parents was difficult was because JRH was not able to be concise in her thoughts and share her ideas plain and simply. This would cause JRH to appear unprepared and a rambler. Also, JRH seemed to enter parentconferences with guns blazing, ready for a fight. She was always on the defense becauseof her reputation as being a mean teacher.

One parent incident stemmed from a comment JRH made to a male student in her class. The class was starting a test and the students were allowed to use their notes. The male student came unprepared and asked to check his locker for his notes. When he

returned, he explained that he could not find his notes. JRH proceeded to compare the forgetful behavior to an analogy. She said it you touch a hot burner, and it hurts, you will remember not to touch the burner again. JRH did not say anything else to the student. However, the student told his parents about JRH's comment, making his parents upset. The parents reported JRH's comment to the principal but did not request that their son be changed to a different English class. Instead, the male student's parents would not address their son's behavior in her class for the rest of the school year. JRH said that made for a long school year and showed other students that they could undermine JRH as well.

As the representative for the middle school, JRH was required to attend a board meeting, discussing disciplinary issues at the middle school. She was asked a pointed question concerning what the middle school teachers needed. JRH answered that the middle school teachers needed something to hold their students accountable for their behavior and their academics. One of the board members responded that the middle school teachers need better classroom management strategies. JRH shared her concerns at a later board meeting. After that incident, her principal was asked to remove JR from the committee because JRH was seen as being aggressive with her concerns.

Positive Experiences

JRH's reputation for being a serious teacher flowed into her interactions with colleagues. Per chance, one of her colleagues called her one evening before spring break, asking her if she would like to join a few of her colleagues on a cruise during spring break. She decided to join them and ended up having an amazing time. Her colleagues were pleasantly surprised to see another side of JRH. She became the life of the party. From then on, she and her colleagues would get together periodically and have fun. Also,

JRH became known as a prankster. She even pranked her students once by showing up to school with purple dyed hair.

JRH did not have one specific story to share about her interactions with her colleagues. She shared multiple stories. One of her favorite stories was when she and her colleagues were pranking their principal during his last year. One morning, before the principal arrived at school, she and her colleagues covered his office in sticky notes. Every square inch of his office was covered. Another time, she and her colleagues filled his office with blown up balloons.

Coping Strategies

From the beginning of JRH's teaching career, she had been using coping strategies, helping her keep student papers organized. JRH started teaching before Post-it notes were invented, so she was using a different technique to organize each group of student papers. JRH would take a small piece of paper and note who was absent, who did not have their assignment, and the date she collected the assignment. The first available opportunity, JRH would transfer these notes to her gradebook. She would then use those notes to inform parents about student assignments. Even though JRH used this strategy religiously, she would still manage to lose student papers.

When asked about changes to her classroom management, JRH responded that she has always had excellent communication with her students. She believed in being up front and honest about her classroom expectations. She also believed in students and teachers being honest with each other. When she was diagnosed with AD/HD, JRH decided to tell her students. JRH started using her symptoms as guiding principles for teaching students how to deal with distractions. She also provided alternative behaviors to those students who were the ones creating the distracting learning environment.

JRH addressed how her interactions with her colleagues changed. Firstly, she stopped taking it personally when male colleagues male colleagues commented on her messy classroom. The reason JRH had been taking her colleague's comments personally was because she felt like a complete failure. Once she understood how AD/HD affected her classroom organization, JRH decided that if someone had a problem with her messy classroom that was someone else's problem. If she could understand her organization system, then that was all that mattered. Secondly, JRH became aware of her emotional responses directed towards her colleagues. If she had to meet with her colleagues, JRH would mentally talk the meeting through, preparing herself for possible outcomes. While attending meetings with her colleagues, JRH started listening more and reacting less. This strategy worked, keeping her emotions under control. JRH also used this strategy when interacting with her administrators.

JRH's interactions changed with parents for the better, also. JRH was more comfortable sharing behavioral traits of her students with their parents. She started including the parents in strategizing how to help their students' focus and attention in class. When JRH thought there was more to a student's behavior than normal middle nonsense, she was no longer afraid to list behavioral tendencies related to AD/HD. Also, when parents rejected the idea of medicating their child, JRH would share her personal story with the parents, helping to ease their fears about stimulant medication.

JRH also spoke with the parents of students who were already diagnosed with AD/HD. JRH does not like 504 plans because students with AD/HD opted out of trying to behave. This was frustrating for JRH before she was diagnosed with AD/HD. After her diagnosis, JRH talked to the parents of students diagnosed with AD/HD who also had 504 plans. She explained to the parents that the symptoms are not going away. Instead

of allowing their child to make excuses for their behavior, why not teach them strategies to cope with their AD/HD symptoms instead. Additionally, JRH suggested to parents to take their child to an emotional health counselor because the child needs someone to help them realize what normal behavior looks like. Also, if the parents are not able to connect with their child, their child needs to have someone they can connect with, someone that understands what they are going through. Again, JRH shared her story, stating that she sees a counselor once a week and that counselor has helped her understand her own behavior.

Motivation was not a problem, according to JRH, if the activity had a creative outlet. JRH was great at implementing new ideas on the spot. Per contra, anything that was standard practice for a teacher, JRH struggled completing the task. One example was planning writing and language assessments. To put this in context, JRH admitted that she was a horrible writer in school, but when she applied for her first teaching position, middle school language arts was the only open position. She struggled decidingwhat she was going to assess and how to create the assessment. The next struggle was grading writing assessments. There are several elements to a piece of writing which include grammar, content, and handwriting. It was hard for her to ignore grammar mistakes while reading each student essay for content alone. JRH started using writing rubrics as a guide, focusing on one area at a time. She would highlight the gradient for each category on the writing rubric. Next, JRH would use her red pen, circling the grammar mistakes in the essay. This practice worked in her favor for both her students and her students' parents. JRH explained to her students that when someone else reads their writing sample, the reader will inevitably get lost in the grammar and spelling mistakes, making it hard for the reader to get to the meat

of what the student is writing about. The parents appreciated the blunt grading because they were able to see exactly where their child was struggling and were able to help them at home.

JRH combatted her forgetfulness by making lists for her weekly and weekend tasks. She called it her priority list, making sure she would complete the necessary items first. When she completed a task, she would cross it off, making her feel productiveand motivated to keep moving forward. JRH taught her students this strategy, helping those students who needed guidance in prioritizing. Next, JRH would physically attach graded papers to her gradebook and stapled post-It notes to sections of her grade book, helping her remember things related to specific classes.

Her anti-forgetfulness strategies extended to meeting reminders and classroom organization. JRH stuck post-It notes to her computer screen as reminders for meeting notices. Additionally, JRH color coordinated each class, using file folders. Each class was assigned a different color so she would not accidentally lose student papers and attendance notices. When she was teaching math, JRH would use different color dry-erase markers to write equations on the board, signifying the different parts of an equation. This was a great visual for her and her students, JRH stated.

JRH admitted during her first interview that time management was problematic. JRH's first strategy she used to set a timer. JRH found a timer in a Scholastic catalog that was big enough so that she would not be able to lose it. She placed the timer at the front of the classroom, on a bookshelf where she and her students could see it. JRH set the timer for the amount of time she planned to discuss a given topic. This was the only strategy JRH said worked, keeping her focused throughout her lesson. When JRH started taking medication, she was able to stay on task without as much help from her timer.

JRH hated parent communications. JRH felt parents expected her to justify her comments and the grades she assigned to her students' work. She believed this was because of her AD/HD and always doubting herself. JRH made sure she had evidence, providing proof for student grades and behavior. Additionally, JRH never knew when to stop talking, making parents mad. Eventually, JRH would not meet with parents unless she had another adult in the meeting, helping JRH stay on topic and get to the point. If felt herself become emotional, JRH would count to 10, calming herself down. She would also talk to herself, silently saying what she wanted to say, but could not say out loud. When the parents left the meeting, JRH let go of her emotions. JRH used the same strategy when she became emotional in front of her students. Sometimes she would pair a funny voice, bringing humor to the situation.

JRH did not have a difficult time managing student behavior and disciplining students on the spot. She never realized her behavior in the classroom kept students frommisbehaving. When JRH was lecturing, she would walk around her classroom while looking around at her students. One of her administrators pointed this behavior out, stating that it was an excellent strategy to manage student behavior. The students had to focus and pay attention because it was impossible to know when JRH would be walkingby. If students did misbehave, JRH would subtlety correct student behavior by making eye contact with the student and silently mouthing to the student, telling them to stop.

Other techniques included lightly snapping her fingers at a student, clearing her throat, or tapping on a student's desk. If a student continued to misbehave or disrupt the class, JRH would stop talking, get the student's attention, and ask them to stop disrupting the class.

JRH taught students how to address other students when they were disturbing

fellow classmates. Not only did this help her classroom management, but students also learned how to address people who are annoying them. JRH told student to be specific when describing the offensive behavior, be polite, and then turn around. The second time students were being annoying, she instructed her students to turn around, inform the offending student that they have been asked to stop, ask them again to stop, and then turn back around. If the offending student continues, the annoyed student is to stand up, look at the offending student in the eyes, say loudly, "Stop!", and sit back down. At that time, JRH said she would get involved, asking the offending student if they heard their classmate ask them to stop. Teaching her students to stand up for themselves helped curtail bullies from continuing their behavior in her classroom. Also, JRH realized at the end of the first school year she implemented that strategy, she was also teaching her students to speak up for themselves. Helping her students stand up for themselves helped JRH because she could not remember day to day who were the offending students.

When I asked JRH if she asked about work accommodations, she joked that she created her own 504 plan. Her plan included a cat therapy room and alcoholic beverages. JRH disliked 504 plans because she believed students used 504 plans as an excuse to misbehave. Honestly, JRH would have appreciated leniency for missing deadlines and having a messy classroom. Also, when she taught elementary school, JRH would have appreciated a 504 plan because there were so many little things to keep track of and daily schedule changes. JRH believes, as an elementary teacher, she would have better coped. As a middle school teacher, being responsible for one subject, having a daily schedule that never changed, and a structured work environment full of the repetition and consistency positively benefited her.

Connecting with Other Teachers Diagnosed with AD/HD

Finally, I asked JRH if she ever connected with other teachers diagnosed with AD/HD, JRH admitted that she started talking to her school counselor about her diagnosis. She only got as far as helping the school counselor seek a diagnosis for himself. After my second interview with JRH, she found a Facebook page created by and for teachers diagnosed with AD/HD. She took the time to read and found that teachers with AD/HD were afraid to share their diagnosis with their colleagues, administrators, parents, and students. Bothered by the stories she read, JRH was proud of herself for sharing her story with select colleagues, her administrators, student parents, and her students. JRH especially wanted her students to realize that she could relate to what her students were going through.

CHAPTER VIII

Autoethnography

Autoethnography uses "personal experience to examine and/or critique cultural experience" (Jones, Adams, & Ellis, 2013, p. 22). My autoethnography will add to the one known research study specifically about teachers diagnosed with AD/HD, a dissertation written by Brock (2008). AD/HD is defined as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development (American Psychiatric Association, 2013). I participated in my study, sharing my story, similar to my participants. Autoethnography is not an ordinary narrative, a platform for sharing a personal story (Jones, Adams, & Ellis, 2013). Instead, I used an autoethnographic platform, enhancing my participant's personal experiences of being a teacher diagnosed with AD/HD.

As you read my story below, you may be confused by my presentation of my life events that have made me the person, the teacher, I am today. You may think you are reading my personal thoughts and experiences meant only to be written in a diary and kept in a secret place only for me to find (Jones, Adams, & Ellis, 2013, p. 659). You may find it difficult to read my story. You may be embarrassed for me and think my story is inappropriate for a scholarly paper. Authors of autoethnographies mean to invite their readers inside their personal life experiences, sharing multiple emotions throughout their story (Jones, Adams, & Ellis, 2013, p. 660). The only reason I was able to share my personal stories with you is because I am not sitting next to you while you read.

In my first section, I describe my experience of meeting with a psychiatric nurse practitioner and her diagnosing me with AD/HD, general anxiety disorder (GAD), and obsessive-compulsive disorder (OCD). I also share how I reacted to my given diagnoses. Additionally, I explain how taking medication to control my AD/HD symptoms helped me but had a negative reaction with my colleagues.

My Diagnosis

I was diagnosed with AD/HD when I was 36 years old. I knew something was off about myself for quite a number of years, but I was never able to put my thoughts into words. I contacted a local psychiatrist inquiring about AD/HD diagnosis in adults. I purposely scheduled my appointment after work so I would not have to explain to my colleagues or administrators why I showed up later in the morning or was leaving early. When I arrived at the psychologist's office, I was glad to see that I did not know anyone in the waiting room. I did not want anyone to see me and living in a small town, it is nearly impossible not to see someone I know everywhere I go.

When the psychiatric nurse called me into her office, I turned around to see a short, overweight woman with skin tags covering her entire face. I followed her in, noticing her gait, sort of a labored side to side waddle. Her office was dimly lit, one lamp near me and one lamp next to her desk. I also noticed that the room was well furnished. There was a desk, two lamps, a love seat, a giant single-seater chair, and a large rug covering the floor between the chair I sat in and her desk.

Once she could see that I was settled, she introduced herself, but I do not remember her name. I remember that she told me her office title, which is psychiatric nurse practitioner. I felt uneasy about that. I thought only crazy people went to

psychiatrists. I asked to see a psychologist. Either way, I was there so I decided to make the most of the appointment. She started the conversation by simply asking me why I came to visit her today. Her question as like pulling the pin out of a grenade and throwing it as far as she could. In just a couple seconds, I exploded into my response, taking over the next hour.

I have been told I am a chatty person, talking too much, and never realizing that people around me would very much like me to stop. Thankfully, here was a place I did not have to worry about that. However, I did not know how much time I had so I spoke fast. I told her about my memory problems, paying bills two and three times over in one single month because I did not know if I already paid the bill because the payment had not posted to my bank account yet. I shared that my lesson plans were 30 pages long for one week when other teachers' lesson plans were only five pages at most. I explained that my lesson plans had to be that long because I needed to write everything down, such as what I needed to teach each lesson, which students needed tiered assignments, when I was supposed to start and stop each lesson, and lastly, what I was going to say, word for word. I told her how I worked every weekend that my administrators would open the building. I was constantly cleaning my classroom and by cleaning, I mean throwing things out because I had more junk that needed the space. Embarrassed, I explained that I did not have any friends at work because somehow, I had alienated myself, but I had no idea how. At one point, my administrators had faith in my ability to help them, but that faith was lost when I was no longer able to keep my emotions on the inside. I went on to tell her that if my classroom, home, or car did not look to a certain level of cleanliness, I

was distracted. I could not let go and move on. I had to fix the 'problem' before I could continue teaching, driving, or go to sleep.

I stopped talking and stared at her, expecting some negative outward emotion that would make me feel pathetic and stupid. Thankfully, her expression was of compassion and sympathy. I was good with the compassion, but not the sympathy. I did not want her to feel sorry for me. I wanted her to tell me how to fix me. Her fix came in the form of medication. I was prescribed Adderall and Paxil. That was the end of the appointment. She bid me goodbye until next time. I left thinking, "Drugs is all there is to this? But how do I stop being me who works so much just to be the person who has zero friends who cannot keep up with her colleagues?"

My next appointment was one month later. I was glad to see the same psychiatric nurse. She was very nice the first time and she did not make me feel like a crazy person. We talked for an hour, her being interested in what I had to say. She even interjected, making the conversation exactly that, a conversation. I loved having someone to talk to, someone who understood me as if we had been friends since kindergarten. As strange as she looked on the outside, I was equally strange on the inside, so I completely relaxed in her presence. I saw the psychiatric nurse for 18 months. She informed me that the psychiatrist that ran the clinic was dropping all patients who were no longer taking stimulants. I had stopped taking Adderall because the crazy woman on the inside was even crazier when the medicine wore off, which was every day by 2:30 pm. At 2:30 pm, I still had one and a half hours of my workday, but I could not keep hold of my emotions. I was very sad to go because the psychiatric nurse was the first and last person that I

could be myself in front of. There had not been any single person before or after her that I could pour my heart out to, feeling safe and secure no matter what I had to say.

My initial thoughts when I received my AD/HD diagnosis was relief followed by frustration. I had a diagnosis, a label, but I was not given any information to help me understand the mental disorder. The characteristics I knew about AD/HD involved children. I did not run around my classroom, scream in other people's faces, cry uncontrollably, or verbally or physically abuse people. Having been given nothing, I took advantage of the access to an endless supply of research articles. I read about how AD/HD appears in adults and then reflected on my own behavior. I had epiphanies like fireworks going off in the sky. I finally understood my behavior, but then I realized that the damage was done. People already knew me for how I behaved. Sharing a diagnosis of AD/HD with anyone seemed like digging my professional grave. I kept my diagnosis to myself and focused on changing my behavior. Medicine helped me change my behavior. I no longer lolly-gagged after students went home. Alternatively, I stayed in my classroom, diligently writing lesson plans, imputing data, contacting parents, and preparing for the following day's lessons. Unbeknownst to me, my colleagues were having a negative reaction to my new behavior. I no longer 'bothered' people around the building. I stopped working late and offering to open the building on the weekends. I was short but professional with my colleagues when it was imperative that I meet with them. At the end of that school year, my team leader approached me, asking me why I was treating everyone differently. I exposed my truth, waiting for the inevitable snarky comment. Instead, I received more backlash, admonishing me for no longer trying to talk with anyone after school and for keeping my emotions under control. I was

flabbergasted. I did not know how to respond, so I silently returned to my classroom, closing my door behind me. My colleague told other teachers in the building, and, just as I thought would happen, my professional grave started digging itself.

Medication was like unleashing my worries and cares about everyone around me. I was confident in my ability to do my job, even though I would still occasionally make mistakes. I was no longer able to cry for any reason at all, a side-effect of the medication making me feel like a monster because there were times when it was perfectly acceptable for me to cry. Instead of being sad that I did not have any work friends, I avoided my colleagues aside from forced professional interactions. I also avoided my administrators knowing they would eventually see a change in my behavior and question me.

Behavior Changes with Parents

I have shared how my interactions changed with my colleagues after being diagnosed with AD/HD. I did not share how my interactions with parents changed. I was more confident. I started sharing only the facts about my students when talking with their parents. I would even go so far as to type up the conference, highlighting what I wanted to discuss leaving room at the bottom for the conference outcome. Parents are more satisfied since changing my meeting format. I would invite them into my classroom, sit on one side of my kidney table, slide the conference form across to my student's parents, asking them to read the conference form. To my amazement, my medication helped me sit quietly. When the parents were finished reading, I would ask them if there was anything they would like to discuss, add, or change. I would type changes into the form, print to form, sign both forms, and give one copy to my student's parents. My meetings lasted at most 15 minutes. I no longer trapped parents in my

classroom for 45 minutes to an hour, talking nonstop. I will say that I would schedule parent conferences as early in the day as possible because my medication usually wore off my 3:00 pm, daily. My mood and emotions would be heightened, causing me to embarrass myself.

I eventually shared my diagnosis with my administrators. My vice principal at the time did not understand what AD/HD and Obsessive-Compulsive Disorder (OCD) looked like in adults. She once told me I should understand one of my students better because he also has OCD. Another time, my principal asked me if I had taken my medication that day. I had, but I was taking a new medication and it was not working as well. I was embarrassed because she asked me in front of my colleagues.

Sharing my diagnosis with my current principal and her seeing how different I am, taking medication, changed our professional working relationship. She often told me that I am too professional, too blunt, and share information like I am serving bran muffins. I am afraid to relax and be myself because being myself is not very professional. I thought if I shared information with a smile, being short and to the point, my colleagues would like me better.

Not Responsible for Myself

How did I get to the point in my life where everything started to fall apart? I am not sure about the exact date, but I can tell you that it was a long time coming. I was born to a family of two parents, two brothers, and one sister. To be exact, my one sister at the time was my twin sister and she was born four minutes before me. My oldest brother was 4 years old and has Down Syndrome. My second brother was 1 year and 1

day older than my twin sister and me. My second brother was a handful. My oldest brother was also a handful, but for obvious reasons.

At an early age, I was getting into things, sometimes knowing better and doing wrong anyway and sometimes my trouble was an accident. My first memory that could easily explain my poor decision making was when I was either three or four years old. My sister and I were outside playing in the front yard. The neighbors to the left of us lived in a pea green house with a covered porch. The neighbors were never home during the day, never locked their front door, and I was a nosey child. I convinced my sister to go inside the neighbors' house exploring what the house looked like on the inside. Reluctantly, my sister followed me. The curtains were drawn, making the house very dark. There were items left out, plates on the kitchen counter, and doors open to each room in the house. I found red paint and a paint brush in the neighbor's son's room and red nail polish on the coffee table. When my sister and I left the neighbor's house, I suggested that we paint their house red because red was my favorite color. Not asking my sister, I started painting her white high-top sneakers red. She went screaming inside our house, waking up our mother. My mother sprayed the red paint off of the side of the neighbors' house with water, rinsed off my sister's shoe, and spanked me. However, I did not learn my lesson.

A second vivid memory was when my sister and I decided to run away. I do not know why we wanted to leave our mother. She was always sleeping during the day. My sister and I were left unattended after our brothers caught the bus to school. My mother never fed us lunch because she was asleep. Also, we never took naps, but that was because my mother did not want to remake our beds. She did not physically abuse us,

but she never spent time with us either. One day, my sister and I decided that we were going to live on our own and decided we needed to pack grown-up items. Without waking our mother, we quietly stuffed some of her 'big-girl' clothes, makeup, and shoes into a black trash bag. Next, we wrote a 'run-away note' on my dresser. My dresser was light brown. We used a black marker to write our note. I know we could not actually write words at our young age. I imagine that the note looked like black wavy lines from the left to the right of each dresser drawer. On our way out the front door, our mother woke up and caught us. I do not remember what happened between then and when my father arrived home. I do remember my father kneeling down in front of my sister and I, holding his belt, ready to swing the belt across our backsides. However, he did not hit us that night. Instead, showing us his disapproval by making his mad face, he asked us why we wanted to run away from him. My father's mad face made him look like a monkey. He would tuck his tongue below his bottom lip, making a bulge above his chin. My brothers, sister, and I coined that face the monkey face. We knew if our father was making his monkey face, we had better run. We told him we did not want to run away from him. We wanted to run away from her, our mother.

At some point, my family moved to another house. My memories of this house are of fire and stitches. I am terrified of fire. If I smell smoke when there is no reason for smoke, I have a panic attack. I do not remember if I started the fire. I remember playing behind the wood-trimmed brown floral couch that I pulled away from the wall. There was something inside the outlet and for some reason the carpet was wet. Then I saw a small spark and smoke. I pushed the couch back against the wall thinking nothing would happen. Then I saw the fire rise up above the back of the couch and up the wall.

My dad grabbed me and ran outside. I was dazed and confused. The house was on fire. My brothers and sister asked me what happened. I did not answer them. The fire truck came. Then everything went black.

My fourth vivid memory about my childhood was also cut short. One morning, my brothers, sister, and I were playing while my mother was sleeping. I was very early in the morning but not too early because my dad had already left for work. The house was quiet, and somehow we knew that the house needed to remain quiet. We took our fun to the back porch. We were playing house. My second brother was the dad, my sister was the mom, my oldest brother was the child, and I was playing the role of the family dog sticking my tongue out to be believable. I was the last one to walk into the screened-in back porch walking on my hands and knees. My oldest brother did not see me and slammed the sliding glass door on my tongue cutting my tongue in half. I remember running into my parents' bedroom, blood pouring out of my mouth and onto my mother's side of the bed. My mother started screaming. Then everything went black. I woke up at the doctor's office. I remember the doctor saying something about sewing my tongue back together. Then everything went black again.

Childhood

In this section I articulate how a change in my daily routine, starting school, and a change in parental care helped limit the potential for me to misbehave. My childhood shaped my daily routine in that my stepmother dictated every minute of every day, even weekends and holidays. School was awkward for me in that I was socially inept and did not know how to properly interact with people my age.

My life changed in kindergarten. My mother left my father. My siblings and I did not know she was gone. I woke up to find my dad crying in his recliner chair. I crawled into his lap, asking him what was wrong. He said my mother left and would not becoming back. My siblings and I took over cleaning the house and folding laundry. We slept in our dad's bedroom because he was afraid one of us would leave the house looking for our mother.

Not even one year later, my dad married my stepmom. My stepmom brought her daughter to live with us. I moved into my twin sister's bedroom. My stepsister was given her own bedroom. My stepmom was nice in the beginning; however, the ambiance in the house drastically changed over the next couple of weeks. My stepmom ran our house like a tight ship. There were now five children living under one roof. My stepmom assigned each of us a colored towel, a flavor of oatmeal, a drinking cup, and a seat at the breakfast table. Before leaving for the bus stop, we had chores to complete in the morning. When we returned home after school, we had to read for one hour, write our spelling words five times each, and complete any assigned homework. Then we had to get our backpack packed for the following school day, pick out what we were going to wear, and make our lunch. Then we had to complete the evening chores. After our chores were complete, it was usually dinner time. After dinner we took turns taking our baths. If there was any time left, we could watch TV. We usually only had enough time to watch one sitcom before our 8:00 pm bedtime. I share the above story because I did not have time to make mischief when my stepmom was around. I also could not make any mistakes or forget to do anything because my stepmom was always there checking behind me and everything I was supposed to get done.

School was different from home because my teachers could not spank me for my misbehavior. The earliest solid memory I have of elementary school was fourth grade. My classroom was in a portable. The teacher's desk was at the front, the bookshelves were at the back, and the desks were in the middle. We sat in rows of three. I was not nice to the people who sat next to me, and I do not remember why. What I do remember was performing a cartwheel down the middle of the classroom. Also, I stapled my finger. Both incidents occurred when my teacher was out of the portable classroom. There were boys in my class that seemed to take joy in tattling on me. I was in trouble, but I do not remember what my punishment was.

Most of my remaining memories about elementary school and middle school are muddled, but I do remember my teachers always being annoyed with me. I do remember earning good grades, mostly As. I earned an F once, in third grade. I thought my parents would not think to ask for my report card even though my four siblings at the time each gave their report cards to my stepmom. I remember never doing very well on state tests. My stepmother would tell me that I was more than capable of earning high scores, but I never did.

Additionally, the last solid memory I have from elementary school was laughing uncontrollably during lunch. I would start laughing for no apparent reason. My classmates thought it was funny, but the lunch ladies did not. One time my teacher pulled me out of lunch and threatened to spank me if I did not stop laughing. I told my teacher she was not allowed to spank me. My teacher must have called my stepmom because I got a spanking when I got home from school that day.

My only consistent memory about middle school was that I was an emotional mess. I wore big glasses, was super thin, and always did great on assignments and tests. All of those characteristics made me the target of my so-called friends. I believe they lived to make fun of me. I wrote a poem about suicide in English class because I thought I was safe to write down whatever I wanted, and no one would read it. My English teacher referred me to the guidance counselor. I told them nothing. They asked about my home life. I did not tell them that my dad was an alcoholic and that he regularly beat my second brother. I did not tell them that my stepmom would not let us talk to or visit our mother or family members. I was terrified that the guidance counselor would tell my parents and I would have hell to pay.

High school brought on an additional challenge. I was on the dance team. Other team members and I often joked that the dance director was related to Hitler. She was strict. She was demanding. She yelled. I was a freshman in high school when my twin sister and I made the team. The dance director treated my twin sister and I horribly. I rarely performed my first year disappointing my dad. The main reason was because I was forgetful. I forgot uniforms, costume pieces, and dance routines. I never grew accustomed to my dance director yelling at me. It became my normal, but I was always on pins and needles around her. My team members even scoffed at me when I made a mistake, making me feel even worse. I decided to combat my forgetfulness of uniforms and costume pieces by always having two of everything. Eventually, everyone on the team knew that if you forgot something, Mary undoubtedly had an extra. Something clicked at the beginning of my sophomore year. I was better at remembering dance routines, but I never cured my forgetfulness when it came to uniforms. To this day, I

always have more than I need in my classroom in case someone else has forgotten something.

I remember one time when having extra of everything almost did not work in my favor. One afternoon, I was already dressed out, warming up in the dance room. One of my teammates came in and asked me for help. I followed them to the locker room, finding that the team captain had forgotten her uniform of the day. That was the only time I did not have an extra practice uniform. Being used to the dance director always being upset with me, I gave my team captain the correct uniform for the day, what I was already wearing, and put on the incorrect uniform. When I returned to the dance room, the dance director asked me why I changed into the wrong uniform. I simply told her that the team captain needed my uniform, and I was probably out of this week's performance, so it did not matter if I was wearing the correct uniform or not.

My childhood is a similar description to other women's accounts (Solden, 1995). After my stepmother and father married, they had two more children, totaling seven children under one roof. We each had monthly chores, a scheduled bedtime, and were allowed to attend an after-school activity once a week. We deep cleaned the house every Saturday. We were expected to keep our bedrooms spotless at all times. There were times when my stepmother would wake me up if she did not think I completed one of my chores correctly. My stepmother would make me redo my chore until she was satisfied that my chore was completed. As an adult, I had freewill to stay up as late as I liked, clean my apartment whenever I wanted, and live alone.

Adulthood

Now, as an adult responsible for my own well-being, I have no explanation for how I have managed to keep my job, not alienate myself from every colleague in my

building, and earn average and sometimes above average performance ratings. To the unknowing person, I come across as super organized and energetic. What they do not know is that I have fail-safes in place for everything that could go wrong. I use all my energy during my workday doing my job, and, when I return home at night, I crash.

I had been teaching for 10 years before I was diagnosed with AD/HD. I never understood why other teachers seemed to work less than me, not that the other teachers did not work as hard as me. My colleagues made teaching look easy. While their classrooms were cluttered with teaching materials, my classroom was sparse. I only took out what students would need to use that day. I hid everything behind cabinet doors, curtains, and inside filing cabinets. To the naked eye, my room looked neat, clean, and organized; however, I had stuffed piled of papers everywhere around the room. My classroom closets were crammed full so much that they did not close unless I tied the two door handles together. It did not matter to me though because I could find anything I needed.

I was full of energy. I had to have energy because I taught kindergarten for the majority of my career. I would start the day with an alphabet song and dance, followed by an hour of reading centers, engaging each student on their individual level. Next, my students would leave for specials, and I would continue getting my plans and materials ready for the following week. I would check my lesson plans, paranoid that I was forgetting a key component. I would scour through every available resource, collecting what was relevant for the following week's lessons. Then I would pick my students up from specials, take them to lunch, and then recess. I would play with my students, pushing them on the swings, sliding down slides, and climbing the monkey bars with them. Following recess, I would take my students inside for story time and math. Then

came dismissal and my afternoon planning hour. That is when I would start to get off task. Trying to stay focused all day on my students always makes me drained by the end of the day. I would walk around the building, looking for people to talk to. If I found someone, I would talk their ears off. Then I would go back to my classroom, clean up themess my students left and lay out everything I needed for the following day. I would always spend about an hour between the two activities. Then I would leave around 5:30 pm, much later than any of my colleagues. When I would return home, I would cook dinner, start a load of laundry, clean my cats' bathroom, vacuum the house, make my lunch and pick out my outfit for the next day, and load my car with whatever I had taken home, but did not touch. I knew if I sat down to rest, I would not get off the couch but instead fall asleep. That was my day, start to finish. I never complained though becauseI thought that was normal to be that exhausted at the end of each day.

Life is so much different when I take my medicine. When I forget to take my medicine, everyone around me can figure it out pretty quick. I am moody, goofy, unaware of my surroundings, and spacey. Funny how people ask me why I cannot remember to take my medicine every day. I always answer that I am taking medicine that helps me remember, so I may forget to take my memory medicine once or twice a month. The symptoms that plagued me the most are forgetfulness, organization, and self-awareness. I made many blunders simply forgetting important things such as dates, lesson plan components, and administering important tests. Whenever I would create a plan to organize my classroom, files, or student papers, I would spend days implementingmy plan only to quit because I could not figure out how to break up my plan into smallerparts. Self-awareness is truly my nemesis. I cannot read people, their

expressions, their body language, or their tone of voice. I am what some would say a social retard. Not only could I not read people, but I would also explode into verbal diarrhea, sharing thingsabout myself that I should have kept private.

Forgetfulness had been a severe problem my entire life. When I started wearing glasses, I would forget to put them on before I left my bedroom. Once, as an adult, I forgot to turn my car off, leaving my car running for 4 hours while I went out of town for a bridal luncheon. Also, I left my oven on for two days. My husband reminds me to turn off the oven and the stovetop even when he is not home. Another time, even older, I left for work and completely forgot to shut my front door. When I arrived home, my two cats were laying in the front yard like jungle cats. As I sit here now, I am struggling to remember more instances where I have forgotten something.

I should not have the ability to remember stories of forgetfulness, but the stories I do remember have created strong emotions of horror and embarrassment. An embarrassing memory is from my first year teaching in the school district I teach now. I had an Individual Education Plan (IEP) meeting scheduled for what I thought was on a certain day. I gathered up everything I needed for the IEP meeting and canceled my student services for the block of time I had scheduled for the meeting. When it was time, I was confused as to why no one else was there. I emailed the principal, the speech pathologist, and the grandmother of my student. The grandmother and the speech pathologist became furious with me for not informing them of the meeting. I shot back a strongly toned email to the speech pathologist, showing her the meeting invitation. Only then did I realize that I was a day early. I tried to apologize to the speech pathologist, but it was too late. She emailed the principal, reiterating what happened and shared her opinion of my incompetency as well. Thankfully, the following day, the grandmother

was not so put out with my forgetfulness.

A couple of horrifying stories, to me anyway, involve student testing. The fall of my first year in my current school district, I was handed a common assessment. I did not know what to do with the assessment, so I put the test under my desk. I forgot all about the test because no one asked me about it again. My instructional specialist did not ask for my students' scores. I remembered the test months later when I was cleaning out my classroom. Afraid to say anything, I threw them away. A second horrifying story involves IEP accommodations. One of my students needed to have an accommodation, use of a calculator, added to her IEP for testing. I had forgotten to add the accommodation. As a result, a letter was placed in my file for failure to provide appropriate assessment strategies.

A specific memory, relating to organization, that I will never forget was when I was working in my classroom on a planning day. I wanted to clean out my cabinets, filing cabinets, and shelves hidden behind curtains. The way I clean out anything is to pull everything out and sort through the mess. I was in the middle of that when my principal and vice principal walked into my room, seeing what I was up to. The picture they got was of me eating a crostata, a giant pastry filled with fruit, rolled up. The pastry looks like a small pie. All around me was a mess of papers, manipulatives, and classroom supplies. The look on their faces was pure shock. My principal scanned the mess while my vice principal asked what I was eating. Between munches, I answered myvice principal while wondering what question my principal was going to ask next. I decided not to give my principal the opportunity, simply telling her I was spring cleaning.The ladies looked at each other, turned, and left my classroom.

Organization has become easier for me over the last three years. I taught for six

years in the same classroom; a classroom infested with mold. I was always getting sick, but I had no idea why. I would recover from a cold, be healthy for one week, and then I would get sick again. As a quick fix, my administrators placed two dehumidifiers in my classroom, reducing the moisture and stopping the mold growth. The dehumidifier drain buckets had to be emptied at least twice a day. I was told to leave them on over the weekend because the sensors would turn the dehumidifiers off when the drain buckets were full. I returned one Monday morning, finding that half of my classroom carpet was soaked. My classroom smelled of garbage and a full Porta Potty. I worked in that room for four days before my administrator let me move out. I changed classrooms three more times that school year. At the end of that school year, I was informed that I would be moving again. Instead of moving all of my classroom supplies and personal items to my new classroom, I took everything home. I decided that I could organize everything better at home because no one would see what an incredible mess I made before figuring out what to do with everything. In the end, I made three piles. One pile was my keep pile. The second pile was the Habitat pile. The third pile went to the garbage. When I moved into my new classroom the following year, I barely had any of my own personal items.My classroom decorations were sparse, less for me to worry about. I vowed to only usewhat the school district provided for my teaching materials. To this day, I have not changed my classroom setup, except that I now have classroom theme: cats.

Now, let me introduce my nemesis, self-awareness. She hates me with a passion. I doubt I will ever develop a superpower, or the pharmaceutical companies will develop a pill, which will conquer self-awareness. I have been unaware of my surroundings for my entire life. For instance, I pushed a boy down on the playground in first grade because I wanted to kiss him. He fell down in a mud pile that smelled like poop, but I kissed him

anyway. I had no idea that he did not like me. I thought he was just playing hard to get it. In middle school, I would talk nonstop, unaware that my teacher and the students in the classroom had all gone silent and were staring at me. As an adult, self-awareness has alienated me from most of my colleagues. I have lived a rather lonely life.

My lack of self-awareness has created a lonely existence. I have been called rude, weird, mean, an airhead, ditzy, and unprofessional. "Sticks and stones may break my bones, but words will never hurt me," is untrue. I have always been bothered by what people say or think about me. Howbeit, my unknowing actions have been more damaging to myself, alienating me from my colleagues.

I used to be a social butterfly. I used to have friends. Then I transitioned to adulthood, begrudgingly responsible for my own existence and survival. I was more concerned with paying my bills and keeping my job than I was about my outward behavior in front of/towards anyone. I thought I was being professional, friendly, and polite. That is what I thought, anyway. I will provide you with an example. I never knew how to politely interrupt. Instead, I would stand to the side in complete silence until the person noticed me standingthere, like a weirdo. Then I would pose my concern(s). Afterward, I would chatter like a crazy squirrel until that person, and whoever else was with them, left the room. When I thought I was taking the initiative, I was actually perceived as bossy, short, curt, and a know-it-all. I thought I was merely moving the conversation and task along, getting to the point, and sharing what I knew about the given topic.

Rumors of my impolite behavior and overly chattiness spread like wildfire. When my colleagues saw me coming, they would close their classroom doors, quickly walk in the opposite direction, or bluntly tell me they did not have time to talk to me. The

sympathetic colleagues would offer a sad smile and a shake of their head before making themselves scarce as well. Once my administrators got wind of my colleagues' temperament towards me, they lost faith in me. My administrators stopped asking me for help, took me off of committees interacting with parents and other stakeholders, and were more precise on their evaluations of my overall ability to manage a classroom and provide effective teaching. When I asked to share new researched-based strategies, I was denied the opportunity.

Next, I started losing control of my emotions, crying in front of my colleagues and administrators. However, I was always able to keep it together in front of my students and parents. I would cry over anything. I would cry if my evaluation was not returned to me as quickly as my team members. I would cry if I was told to leave work at school and rest over the weekend. One of the times I cried, I thought I was doing well enough for my principal to notice, trying to win back her favor. I was sponsoring an afterschool club and creating a mural for an assigned committee outside of my basic responsibility, teaching. My principal pulled me aside after school, chastising me for working so hard. I was beyond upset, but I kept it together until I returned to my classroom. My team leader was still in the building, and she heard me sobbing. I told her what happened. I realized that whatever negative impression I have given my principal was stronger than any positive impression I had made or could ever make in the future. I was devastated. After that school year, I stopped volunteering and extending my help in the eyes of my administrators. There was nothing I could do that would change their opinion about me as a person or as a professional educator.

As I have mentioned, my self-awareness has created a lonely existence, even to this day. When I was teaching at a different school in my school district, my colleagues

were not shy about what they thought about me. When I taught first grade, my team would plan without me and hide from me during lunch. I attended church with one of my first-grade team members. She avoided me, pretending that I was not sitting behind her during the 'passing of the peace of Christ' part of the service. I started sitting at the very back of the church, hiding my face when I saw her enter the sanctuary, lessening my embarrassment. When I taught kindergarten, my team would also hide from me during lunch. One time I went looking for my team. I found them eating in the dark in my team leader's classroom. Another time, one of my team members said they would eat lunch with me, but they never showed up. During my early years at my current school, my team would dodge me on planning days, sneaking out to lunch. I would ask each of them if they would like to have lunch with me, but they gave me excuses. They would then return with take-away cups from the places where they lunched. After three separate times of asking, I figured out that they did not want to go anywhere with me. As a way to save what was left of my dignity, I stopped asking and packed a lunch on planning days.

My defining moment, unleashing my craziness onto my administrators, I asked for help during my summative evaluation at the end of the school year, the year previous to my AD/HD diagnosis. My two administrators sat across from me, both looking solemn. I remained silent because I at least knew the looks on their faces was not going to lead into a pleasant conversation. Their remarks about the totality of my performance for that current school year were weak and followed with buts. When I am upset, my mind goes blank. I cannot comprehend the situation or give an intelligent response. The words that do leave my mouth are unsyllabic and elementary, not reflection of my actual intelligence. I responded that I needed help. Something is wrong with me, but I cannot put words to my worries. My principal and vice principal looked at each other and then

back at me. Their faces conveyed their words before I even heard them. “What do you mean you do not know what is wrong with you?” I decided to abruptly end my summative conference, thanking them for their ‘help’, and left the conference room. As I walked back to my classroom, I thought about packing up my classroom and calling my husband, informing him that I am no longer fit to teach.

I cannot leave my parents out of my story. They have shaped the way I interact with their children and the amount of effort I take in avoiding parental contact at all costs. To be brutally honest, I hate my students’ parents. I loathe their very existence. My first serious run-in with a parent happened during my third year teaching in my school district. I stepped on a pre-K student’s heel and apologized to the student, only to receive a very hateful response. I saw the child’s mother the next day and apologized to her, thinking I was doing the right thing. That blew up in my face. The parent thought I said I stepped on her child to make him move faster. By the next morning, I was in the principal’s office alongside the parent and the parent’s advocate. The parent suggested I be forced to take time off and should let the parents in the school district know all children are unsafe as long as I am teaching in the school district. In hindsight, I should have kept my mouth closed.

My social ineptness is responsible for the specific attention I have received on my location’s Navy Wife Facebook page. Apparently, there is a group of Navy wives that despise me more than I loathe parents. I was ignorant of the group until a friend of mine, outside of work, mentioned to me her original leeriness of her child being placed in my kindergarten class. My poor choice of explanatory words while teaching has led students going home confused and scared; however, the parents never came to me about their child’s misunderstanding. Instead, they vented their frustration and concern on

Facebook.

One such incidence was when a parent described her child's school and teacher, citing that I was not fit to teach children. The conversation that preceded the Facebook post is as follows. I discussed with my students that their responsibility is to go to school, essentially their job. This discussion came about because I was teaching a lesson about Labor Day. The only possible job related to school was that children to go to school. I discussed further the importance of being on time. One child took this to heart, creating an inner anxiety that poured out one day when his mother was running late getting him to soccer practice. The child thought his mother was going to jail. To this day, I have no idea how the child made such a leap from the importance of arriving to school on time to going to jail if you are late to anything that has a hard time. The following morning, my principal mentioned that the child's mother was waiting in the front office, requesting a conference with the principal. A colleague of mine forewarned me about the parent's Facebook post, so I decided to meet with the parent first, confronting them about their unprofessional comment and not providing me with an opportunity, explaining her child's misconception of the Labor Day lesson. Honestly, I was angry that the parent lashed out at me online, so I offered to meet her request of sending her child to a differentschool in the district. The child's mother was shocked that I knew about her post and began retracting her comments. The final conclusion of the meeting was that the student would remain in my class and the mother would retain her opinion about me, that opinionbeing that I am unfit to teach children.

My lack of self-awareness has crossed over into my husband's livelihood, serving in the Navy. The last year I taught kindergarten I received a new student. The family was attached to my husband's boat and moved down before getting settled ahead of time. The student's mother introduced herself on the Navy Wives Facebook page, sharing that

her children were zoned for my school. Once she received her children's teacher assignments, she shared the names on the Facebook page. A parent commented that she should request a different teacher because I was a mean person and had no business teaching. The parents did not request a change of teacher and the child had a successful second semester of kindergarten. I learned about this the following school year when I befriended my parents. She shared this story with me, shocking me to my core. My friend shared another story with me two years later about another parent of two sisters I had when they were in kindergarten. The parents had nothing nice to say to me. Thankfully, I truly have a friend because she stood up for me, making the parents back down andstop bad-mouthing me to other parents.

My New Normal as I know It

When I started reflecting on myself and then continued on, making this my first major work of written art, I thought about my four participants and how I am only sharing one major similarity with two of them: nonacceptance of AD/HD. While I am happy to know what is wrong with me, I am aggravated by my AD/HD symptoms daily. Saying something is wrong with me is not a put-down, but a fact. AD/HD is not right. It is not right to interrupt people. It is not right to forget unless you are of senior age where it is perfectly acceptable. It is not right to chatter on like a circus monkey. It is not right to spend my days preparing for what I think could go wrong instead of preparing for what my students need to learn. Self-awareness, the worst trait of them all, I loathe the most as I mentioned above. My lack of self-awareness keeps me from going out after work. My lack of self-awareness keeps me from making new friends for fear that they will meet the real me, the me I do not like.

It is not my lack of self-awareness that keeps me from striving for more than I

have right now. It is my forgetfulness, organization, and fail-safes that keep me from applying for my dream job, working on the research and development side of education. I am afraid that I will mess up. If I do, I will have to come back to teaching and explain what happened. What happened is that I was diagnosed with AD/HD, and I work harder each day covering up my symptoms than I do working as an educator.

Chapter IX

SUMMARY OF RESULTS

In this chapter, I will first present a table, displaying the participant demographics. I will discuss my research findings sharing my themes compiled after Emotional and Pattern coding each interview. Following my individual analysis, I will perform a cross case analysis discussing the similarities and differences between each participant and myself. My findings are used to answer my research questions.

Participant Demographics

The table below represents the participant data in my study. As shown below, there are a range of ages, years of teaching experience, and age diagnosed. The average age of the participants is 46.6. The average age the participants diagnosed with is 36.2. The average years taught is 20.2. The participants taught pre-kindergarten, kindergarten, first grade, second grade, fifth grade, sixth grade, seventh grade, eighth grade, and ninth grade. The participants taught in Georgia, Tennessee, South Carolina, Washington, Hawaii, Kansas, Idaho, and Canada.

Participants Demographics

Initials	Age	Age Diagnosed	Years Taught	Grades Taught	Places Taught
ALC	42	36	21	K, 5, 6, 7, 8	West Coast & Southeast
DG	33	28	7	5, 6, 7, 8, 9	Canada
JAD	51	29	25	Pre-K, K	KS
JRH	65	51	31	5, 7, 8	ID
MAC	42	37	17	K, 1, 2, 3, 4, 5	TN, GA
Average	46.6	36.2	20.2		

Coding

I performed two rounds of coding, Emotion Coding and Pattern Coding, for each participant's three interviews. When using Emotion Coding, I discovered positive, negative, and neutral themes, which represented the emotions conveyed throughout each interview. I used Pattern Coding to search for repetitive consistencies of behavior related to classroom management and social behavior among colleagues inside and outside of work. I used the pattern coding results to "lay the groundwork for cross-case analysis by generating common themes and directional processes" (Saldaña, 2016).

Emotion Coding Results

I divided my participants' emotions into three themes: positive, negative, and neutral. I found that my participants' positive emotions became evident after they were diagnosed with AD/HD and had time to grow as an educator as their careers progressed. All of my participants displayed negative emotions, however some more than others. My participants all displayed neutral emotions, but at different times in their careers.

Theme 1: Positive Emotions. I define positive emotions as a reaction from an experience that brought the person joy. Throughout the interview process I asked each educator to describe and give examples of their experiences. Each participant described different experiences that brought joy to their career. Themes for positive emotions are asense of belonging, pride, happiness, and gratefulness.

I define a sense of belonging as being included in activities inside and outside of work and being surrounded by colleagues that care about one's well-being. Out of the five participants, I found that ALC and JRH contributed to a sense of belonging. I shared an example from JRH's interview data. JRH admitted that she did not hang out with

colleagues outside of work. She assumed it was because she was always serious at work and her colleagues did not think she was capable of relaxing. One evening, a colleague of JRH's called her asking her if she would like to go on a cruise over Spring break. She accepted the invitation. JRH said she had so much fun and that her colleagues stated theydid not know JRH would be so much fun to spend time with. After that vacation, JRH and her colleagues would get together after work. Sometimes she and her colleagues would pull pranks on people at work. JRH recalled those memories as being one of her happiest memories from her teaching career. JRH reflected, saying spending time with her colleagues outside of work is what she misses most about her job.

I define pride as how someone feels when they realize they are able to do their job correctly and without needing constant reassurance. Out of the five participants, I found that ALC and JAD contributed to pride. I share an example from ALC's interview data. ALC was proud of her ability to teach technology at a school in Washington. She was given the autonomy to create lessons for her students. Additionally, she was asked to lead a professional development, highlighting her knowledge of technology in the classroom. At another school, ALC was given charge of Relay for Life, a fundraiser supporting Cancer research. She was very excited when she learned that her efforts had earned her school an award for being the school that raised the most money. While these accomplishments are all positive and career-enhancing, ALC described her need to stay busy as a coping mechanism. While staying busy, ALC stated that she was able to stay on track with her job, her family, and her mental health.

I define happiness as being delighted with aspects of your job and your ability to successfully do your job. Out of the five participants, I found that DLG, JAD, and JRH

contributed to happiness. I provide an example from JAD's interview data. One of my favorite quotes said by JAD is "I think everything I do is awesome." JAD was referring to her role as a parent educator, one of her first roles as an educator. JAD would visit parents in their home, make observations of the child(ren), complete a full assessment, and make recommendations and provide services. During these visits, JAD routinely saw abnormalities in child(ren) behavior. She stated that sometimes the parents were not open to hearing what JAD had to say or accepting referrals for outside services. Other times, JAD was overjoyed when parents listened to her advice.

I define gratefulness as being happy with another person's reactions to your need of help. Out of the five participants, I found that DLG, JAD, JRH, and MAC contributed to gratefulness. I provide an example from DLG's interview data. DLG felt grateful after disclosing her diagnosis with her colleagues because her colleagues "give her the benefit of the doubt" now and are trusting her when she shares information with them. JRH referred to one of her colleagues as her "work wife" saying she was grateful to have someone she could confide in when she was having a rough day. One such day, JRH left a meeting with a male administrator who was upset with how he was treating her. Her "work wife" saw JRH in the hall and, seeing how upset JRH was, went to console her. Her "work wife" convinced her to set up a meeting with their union representative and even agreed to go with JRH to the meeting. When JRH and her colleague were meeting with the union representative and the male administrator, her colleague stood up for JRH because her male administrator was being condescending towards JRH. MAC was grateful when a friend stood up for her when a parent started talking negatively about

MAC's teaching career. MAC's friend quietly listened to the parent and then informed the parent about MAC's years of experience and dedication to teaching.

Theme 2: Negative Emotions. I define negative emotions as a reaction from an experience that brought the person stress resulting in a depressive state. Throughout the interview process I asked each educator to describe and give examples of their experiences. Each participant described different experiences that had negative effects on their careers. The themes for negative emotions are loneliness, anxiety, and frustration.

I define loneliness as not having anyone you can go to for support. All five of the participants experienced loneliness in their careers. I provide an example from ALC's interview data. ALC experienced loneliness throughout her teaching career was loneliness. ALC recalled a memorable moment in her career that she experienced loneliness was when she moved from Washington to Tennessee. Because she was new to the area, she was unsure of how to connect with new colleagues because her teaching career was unique compared to teachers who had taught for as long as she had. "…that was the year my depression got really bad because I had nobody here. Like I didn't have my military family. I was all by myself, and I was in a school with liberals who hate the military."

JAD displayed loneliness throughout her career. JAD experienced loneliness during her career when she experienced the loss of a colleague, she thought was a friend. JAD had worked for her friend as an aid in the classroom for many years. Additionally, JAD also performed secretarial work for her friend. Her friend served as JAD's boss. JAD admitted during this conversation of the interview that there were times in her career when she had realized she had worn out her stay as an employee and started looking for

other employment before she was asked to leave. However, this time JAD was blindsided. She did not know that her boss, colleague, and friend had become tired of her. Instead of admitting how she felt about JAD as an employee, she told JAD she was downsizing the number of employees at her school and could not afford to retain JAD as an employee. JAD accepted her friend's reasoning and left quietly. JAD still believed that she and her boss were friends outside of work and tried to retain that friendship. However, JAD learned from mutual friends that it was not that her old boss and friend, so JAD thought, needed to downsize her small school. JAD sorrowfully admitted, "I guess the thing that she needed to get rid of was me." Her loneliness was due to loss of friendships due to people not fulling understanding her as a person.

MAC experienced loneliness at each school she worked. Being a new teacher in the school system, MAC went out of her way to make friends. She left her first school without any friends. Not only did she not have any friends, but teachers were also openly rude and condescending. At her third school, MAC's teammates would hide in the dark during lunch to avoid MAC's company. At MAC's current school and the school she has been at the longest, she has only just started making actual friends and being invited to hang out outside of working hours.

I define anxiety as a reaction to being overwhelmed or stressed about something in the work-environment. Out of the five participants, I found that DLG, ALC, and MAC contributed to anxiety. I provide an example from DLG's interview data. DLG experienced anxiety numerous times throughout her teaching career. DLG did admit to crying in front of her colleagues and administrators enough that they were accustomed to DLG's emotional response to stressful situations. However, rarely did DLG appear overly upset about anything to do with her teaching. If anything, DLG would become

overwhelmed and upset by outside distractions related to her other responsibilities as a teacher.

One example of DLG's frustration with other responsibilities as a teacher is technology.

> My Google drive is a disaster. I have like at the start of the school, I made a folder that's called archived. And when I go put everything else into that folder and I started fresh, because everything is named and titled, there is, there's so many empty folders. It's such a hot, stupid mess.

DLG later admitted that she set a personal goal for herself regarding technology. Instead of trying to learn everything at once, she would choose one technology resource each year to learn and master.

I define frustration as a reaction to a situation where a teacher is misunderstood, or experiences are not given the appropriate attention. I found that all five participants contributed to frustration. I provide an example from ALC's interview data. ALC experienced a horrific encounter with a student, fearing for her safety as a result. She described the result of the incident, describing how frustrated she was following the assault. ALC described the reactions of her team leader. "…she (Terry) didn't care. She just cares about herself. She was not, she wouldn't help me." Additionally, when students on ALC's case load were reassigned to classes that did not match their specific academic needs ALC became upset and frustrated because ALC would be blamed for the student's classroom environment change.

> I pull up and I asked because he (the student) was a language that was being served for language. And you can't put them in plot math, but just dump kids in that class because she didn't care. And she arranged to have her jumps in that class. And I got blamed for it because I was his case manager and she wanted to yell at me about it. As parents could assume that you put him in that, that more restrictive environment. So, I wrote her a nasty email that afternoon, like how dare you yell at me about this? And here's my documentation. So, when I asked for help, either situation, you're yelling at me, and I don't appreciate that. And that was unprofessional.

ALC admitted that communication was a common problem when she was working with Terry, her building specialist.

Theme 3: Neutral Emotions. I define neutral emotions as a reaction from an experience that did not cause a strong emotion but did cause the person to ponder the event long enough that the event stayed in their memory. Throughout the interview process, I asked each educator to describe and give examples of their experiences. Each participant described different experiences that were memorable but did not evoke a strong emotion. Distractibility was the only theme that I repeatedly saw among my participants.

I define distractibility as losing focus on a current task and moving attention to what is going on around that person. Out of the five participants, I found that DLG, JAD, JRH, and MAC contributed to distractibility. I provide an example from JRH's and JAD's interview data. JRH taught English for the majority of her career. She acknowledged that grading papers was the most tedious part of her job. Her

distractibility caused her to look for multiple aspects of writing and grammar, taking her much longer to grade individual papers. Combatting this behavior, JRH created a system so that she would look for one part of the rubric at a time. Additionally, JRH would try not to spend more than 10 minutes grading each paper. When JRH was describing this process to me, she sounded focused and relaxed. JRH started with explaining that there are several elements to a piece of writing which include, grammar, content, and handwriting. JRH said she started using writing rubrics as a guide, focusing on one area at a time. She would highlight the gradient for each category on the writing rubric. Then JRH would use her red pen, circling the grammar mistakes in the essay. In the end, her students and parents appreciated her feedback on student writing samples.

JAD stated that her distractibility caused her to forget to clock into work or make mistakes clocking into and out of work. JAD partially blamed her school's change in entrance doors because the time clock was no longer just inside the door she used to enter the building. Secondly, JAD said it was nearly impossible to avoid people while walking to the time clock and would begin conversations and completely forget to clock in for the day.

Pattern Coding

I found multiple reoccurring themes while pattern coding my participants interview data. The first reoccurring theme is resilience. The second reoccurring theme is using AD/HD to enhance their careers.

Theme 1: Resilience. I define resilience as an educator's ability to continue teaching despite the difficulties AD/HD symptoms can have on a teaching career. Each

participant displayed a level of resilience throughout their career. The two ways my participants displayed resilience was by using coping strategies and being confident.

I define coping strategies as developing skills that make doing one's job and interacting with others easier. Out of the five participants, I found that ALC, DLG, JAD, and JRH contributed to coping strategies. I provide an example from ALC's, DLG's, and JAD's interview data. ALC mentioned several coping strategies she implemented throughout her career. She tried taking medicine but then decided that exercise suited her better. ALC tried to organize her classroom and supplies making teaching easier for both her and her students. ALC would allow her students to help keep her on task and move the classroom period along in an organized fashion.

JAD said her lack of mindfulness continued when she worked at different schools as a teacher and as a paraprofessional. JAD would often interrupt or take over meetings which caused her colleagues to view her as unprofessional. JAD created a coping strategy. She made a rule for herself, allowing herself three comments or opportunities to talk during meetings with colleagues and parents. JAD would bring a notepad to draw in and chew gum, which kept her from blurting out.

I define confidence as being sure of yourself in your ability to do your job successfully. Out of the five participants, I found that DLG, JAD, and JRH contributed to confidence. I provide an example from JRH's interview data. JRH displayed confidence by owning her personality and disorganized classroom. JRH stated that her forwardness with parents and administrators was considered intimidating by her male colleagues and administrators. Despite her male colleagues' and administrators' remarks,

JRH continued to manage her classroom and interact with parents with a straightforward optimistic attitude.

Theme 2: Leveraging AD/HD. Each participant used their AD/HD diagnoses to leverage their career except ALC. DLG used her diagnosis to ask for help in her career. JAD used her extensive knowledge of AD/HD symptoms to curb her behavior around her colleagues and administrators. JRH used her knew found knowledge of AD/HD to help her students cope with their own AD/HD symptoms. MAC used her access to research to learn about adult AD/HD and how to function despite dealing with AD/HD symptoms. My participants leveraged AD/HD by researching and sharing knowledge about AD/HD.

I define researching AD/HD as actively reading and learning about AD/HD symptomology and new information about AD/HD. Out of the five participants, I found that JAD, JRH, and MAC contributed to researching. I provide an example from JAD's interview data. JAD was diagnosed with AD/HD when she was 29 years old. JAD extensively researched AD/HD. She learned about how her behavior affected her relationships with colleagues, bosses, and administrators, and how she performs her job. JAD realized what position in education she is best suited. She has also used her knowledge to help parents and students understand AD/HD.

I define sharing knowledge about AD/HD as being able to help others understand AD/HD. Out of the five participants, I found that JAD and JRH contributed to sharing knowledge. I provide an example from JAD's interview data. JRH took the opportunity to speak with parents when she had students with 504 plans. In her opinion, JRH believed that 504 plans served as a crutch for student behavior instead of helping students develop coping skills. When students would misbehave and respond with, "I have AD/HD," JRH would take the time to teach those students appropriate ways to handle

their behavior.

Comparative Analysis

I performed a cross-case analysis of each individual case in my study. I included my stories when I conducted the cross-case analysis of my participants' interview transcripts. I explored the individual cases' similarities and differences. I used Stake's (2006) guide and the worksheets provided in his book, *Multiple Case Study Analysis* to accomplish this task.

My participants each had very different backgrounds as children and as adults. Their family sizes are different. They had different experiences as children, which shaped the way they behave as adults. They have all lived in different states, and none of them have lived in the same state. The highest degree attained is a specialist in education. Their marital statuses are different. One has been married twice, one has never been married, and three have been married to the same man. Two participants have never had children. One participant has four children. Two participants have two children. Two participants have over six siblings. Two participants prefer dogs while three participants prefer cats. Three participants have lived in the same area they grew up in while two participants have moved multiple times as adults. Two participants have only taught at the elementary level and three participants have taught middle school, high school, or both.

Aside from the backgrounds of my participants, I learned a great deal about how each of them have coped with their AD/HD symptoms, how they interacted with parents, colleagues, and administrators, and their personal reflections about what it is like having

AD/HD as a female educator. One of my participants was diagnosed early on in her career allowing her years to learn about AD/HD symptoms and how to use her AD/HD symptoms to her advantage. The rest of the participants were diagnosed within the last five years or were diagnosed much later in their careers, not allowing much time to adapt before they retired. There were similarities in the descriptions of how the participants described parent interactions. Administrator interactions were more negative than positive. Interactions with colleagues at work were also more negative than positive; however, interactions with colleagues outside of work were more positive than negative.

Comparative Analysis of Research Question One

I use the similarities and differences of my participants to answer my first research question, “How does a diagnosis of AD/HD as an adult impact a female educator’s perception of her ability to manage a classroom learning environment?”. Below are the similarities and differences of my participants.

Similarities. All four educators and I reported having epiphanies after being diagnosed with AD/HD. All four educators and I reported noticing outlying behaviors that we previously had not realized until starting medication. All five educators and I also reported that medication was a relief and helped to alleviate AD/HD symptoms. Consistently, each participant described clear thinking, organized behavior, and focused attention while lesson planning and teaching while taking medication. Two of the five participants shared that stimulants increased their anxiety instead of helping them remain calm and focused. Additionally, each participant was able to complete their afternoon tasks quicker resulting in leaving work earlier than they were used to doing.

Differences. Each educator provided examples that differed from the other participants. ALC said while taking medication helped her complete her lesson planning in record time, the side-effects of the medication were affecting her personal life so much that her children and husband spoke with her about alternatives to medication. DLG stated that her superpower, being able to catch students misbehaving while she was teaching, disappeared. DLG's students even noticed and mentioned to DLG that she was not pointing out student misbehavior as often. JAH realized that she was no longer as forgetful and sloppy when documenting home visits. Additionally, JAH realized that she spoke too freely, which offended colleagues and maddened administrators and bosses. JRH recalled no longer being agitated and could leave her classroom to take a break. Also, her students were no longer as successful at leading JRH into off-topic discussions. I noticed that I no longer socialized with colleagues after work. Instead, I stayed in my classroom and finished my responsibilities by the end of my contract time every day.

Comparative Analysis of Research Question Two

I use the similarities and differences of my participants to answer my second research question, "How does a diagnosis of AD/HD as an adult impact a female educator's perception of her ability to professionally communicate student progress to colleagues, administrators, and parents?" Below are the similarities and differences of my participants.

Similarities. Communicating parent progress to colleagues, administrators, and parents was easy for ALC, DLG, and JAH. Each participant described having a positive rapport with parents. They each also described always having detailed notes and agendas ready when presenting student data and behavior to administrators and colleagues. ALC

and JAH were successfully able to share their information with colleagues regarding student success with lessons and curriculum materials.

JRH and I both had difficulty working with colleagues, administrators, and parents when reporting or sharing student data and behavior. JRH and I were unable to notice when colleagues, administrators, and parents became uncomfortable with the length of conferences because we were unable to stay on topic. Also, we were unable to notice when parents were upset with something we unintentionally said or did to parents, not realizing our professional mistake unless someone told us.

Differences. ALC, DLG, and JAH enjoyed meeting with the students' parents. JRH and I loathed meeting with parents and were always prepared for a meeting to end on a negative note. ALC and JRH's colleagues respected their professional opinion regarding teaching and learning directly involving student academics. DLG, JAH, and I did not have the respect of colleagues regarding student learning and data sharing. ALC has spent the majority of her career in good favor with her administrators. DLG's administrators are sympathetic. JAH, JRH, and I have avoided our administrators or bosses because our administrators were frequently upset with a parent interaction involving us.

Comparative Analysis of Research Question Three

I use the similarities and differences of my participants to answer my third research question, "How does a diagnosis of AD/HD as an adult effect a female educator's perception of her ability to interact socially with colleagues and support personnel?" Below are the similarities and differences of my participants.

Similarities. ALC, DLG, and I reported that our social interactions with colleagues improved the longer we taught. JRH stated that one aspect of teaching that she missed is the social interactions with her colleagues that only started to improve closer to her final years teaching.

Differences. JAH remarked that she has never been able to keep a colleague as a friend. While ALC, DLG, and JRH thrived on their colleagues' friendships; I am still uncomfortable socializing outside of work because I am afraid to embarrass myself, change my colleague's impression of me as a professional educator.

Summary

In this chapter, I shared the coding I used to qualitatively measure my participants' interview data which was Emotion and Pattern coding. I found that my participants displayed three levels of emotions throughout the interviews which were positive, negative, and neutral. I further described specific positive, negative, and neutral emotions, and gave examples of how my participants displayed those emotions. I described two themes, resilience and leveraging AD/HD, and provided examples supporting the themes. Finally, I completed a comparative analysis of each research question, describing the similarities and differences between my participants' interview data.

CHAPTER X

Discussion

In this final chapter, I start the discussion with an overview of the study. Then, the findings of the two rounds of coding are used to answer the three research questions. Next, the limitations of the study are discussed and how they have potentially affected my study. I follow with recommendations to identify ways that the results can be applied to helping female educators who are experiencing symptoms of AD/HD seek help and for administrators and colleagues recognize female colleagues who need help managing their AD/HD symptoms as an educator. Lastly, the implications for further research on this topic are presented before the conclusion.

Study Overview

In this basic descriptive-autoethnography hybrid study, I focused on female educators diagnosed with AD/HD as adults. Many states require teachers to provide a safe learning environment, including requiring aspects such as modeling appropriate behaviors, keeping students safe, and interacting with colleagues, administrators, and parents professionally (Georgia Professional Standards Commission, 2018). Female educators who have AD/HD symptoms or who have been diagnosed with AD/HD and are not receiving treatment will have difficulty meeting state performance requirements (Georgia Department of Education, 2013). Watters et al. (2018) concluded in their study that adults diagnosed withAD/HD have difficulty completing one task before moving to another task, eventually never completing tasks they started. Further, Solden (1995) reaffirmed that undiagnosed females tend to struggle as adults, managing a home, children, a marriage, and a job.

To date, there is only one readily available research study focusing on female educators diagnosed with AD/HD (Brock, 2008). The difference between my study and Brock's study is that Brock's interests were centered on coping strategies while I focused on female educators who were diagnosed with AD/HD as adults and how they managed their classroom and interactions with administrators, colleagues, and parents in professional settings and interactions with colleagues in social settings. Brock (2008) discovered that her participants relied on other educators, friends, and family for support as a coping strategy. Their use of coping strategies is what made it possible for Brock's (2008) participants to continue teaching. I am interested in how my participant's personal epiphanies shaped their career after being diagnosed with AD/HD.

My purpose for completing my study was to raise awareness about female educators diagnosed with AD/HD and their struggles to successfully meeting professional teaching standards and requirements. Also, there is only one readily available study to date, that one being Brock's (2008) dissertation, describing coping strategies recalled by female educators diagnosed with AD/HD. Previous research regarding adults diagnosed with AD/HD highlight the lack of symptoms specific to adult (Asherson et al., 2016; Caye et al., 2016). In order to bring awareness to school administrators regarding female educators who may or may not be diagnosed with AD/HD and are suffering from symptoms, a clear description of what AD/HD symptoms are needed to make AD/HD symptoms obvious to those who misunderstand or are not familiar with adult AD/HD symptomatology. Recognition of how AD/HD symptoms effect a female educator's ability to successfully carry out their classroom responsibilities and interact with colleagues, administrators, and parents professionally can aid in helping female educators

seek help, understand their behavior, and make necessary accommodations to classroom management strategies and professional interactions.

The basic descriptive study-autoethnographic hybrid was adapted from Stake (1995) and Ellis' (2004) research procedures. I had a total of five participants, including myself. I completed three separate interviews with each participant. I answered each set of interview questions using my own personal experiences. I analyzed the interviews using Saldaña's (2016) coding methods. The first round of coding was completed using Emotion coding and the second round of coding was completed using Pattern coding. Finally, I completed a comparative analysis of the interviews and my answers to the interview questions.

Relationship between the Findings and Research Questions

In the following section, I describe how my findings and research questions are related. I used the data, themes generated from coding participants' interview transcripts, and the comparative analysis to answer the research questions.

Research Question One

The first research question was, "How does a diagnosis of AD/HD as an adult impact a female educator's perception of her ability to manage a classroom learning environment?" Research question one refers to how female educators manage their classrooms and responsibilities as a teacher.

Each participant described their perception of their ability to manage a classroom learning environment before diagnosed with AD/HD. Each participant had an epiphany about their ability to manage a classroom learning environment after being diagnosed with AD/HD.

ALC recalled not knowing what was wrong with her because of her inability to relax and stay organized and focused during classroom lessons. The resulting consequence was that her beginning years as a teacher were difficult. ALC is glad to have a reason for her behaviors, now knowing that her behaviors were a result of AD/HD symptomatology. ALC's personal accommodations and years of teaching experience helped her maintain her teaching career. ALC was not given information about adult AD/HD, so she researched adult AD/HD symptoms on her own.

Initially, ALC decided to take medication, controlling her AD/HD symptoms, and alleviating her anxiety. Eventually, medication was not helpful, as the side-effects were more cumbersome causing her more anxiety. ALC decided to research alternative treatment methods such as exercise, diet, and relaxation techniques. ALC found that exercise only helped if she had time and was not overloaded with work she took home. ALC admitted that her diet was easy to control but did not make a difference in her symptoms. One of the relaxation techniques she used is yoga, which she found helpful only at the end of her day.

DLG described her classroom management before being diagnosed as easy when managing student behavior. The constant distractions such as the phone ringing, the intercom buzzing, and meetings during her planning time is what caused her anxiety and frustration. Her inability to keep organized records using online technology resources made her planning more difficult. DLG was frustrated and anxious over the amount of technology resources that she was required to use because technology was not her strong suit.

DLG's perceptions about her ability to perform her job as a classroom teacher changed for the better after she was diagnosed with AD/HD. She was happy to have a reason for her behavior and anxiety. Additionally, DLG welcomed the relief from her symptoms provided by medication. Also, DLG mentioned that her students noticed her change in behavior. DLG recalled that her superpower, being able to catch student misbehavior while teaching, had gone away. DLG did not complete comprehensive research regarding AD/HD or symptoms, but she did change her behavior. Instead of trying to learn everything that was new to teachers in her school each year, DLG decided to choose one new program each year to master.

JAH was making accommodations for herself, rules as she called them, starting at the beginning of her teaching career. She was not diagnosed with AD/HD until her son was diagnosed, which was after she started teaching. Her epiphany came when her son's doctor informed JAH that AD/HD is often hereditary, meaning that one or both of the child's parents also has AD/HD. All of her behaviors and resulting rules were due to her AD/HD symptoms.

Once diagnosed, JAH started researching and has continued researching AD/HD symptoms, medications, alternative treatments, and updated information regarding childhood and adult AD/HD. JAH's perception of her job changed with respect to regarding her symptoms and how she can best perform her job as an educator. Instead of working as a teacher, she prefers now to serve as a paraprofessional because JAH knows she can handle the responsibilities as a paraprofessional better than she can handle the responsibilities as a classroom teacher.

Before being diagnosed with AD/HD, JRH would become agitated throughout the school day, was aggravated by her students' behaviors, and was aggressive with parents concerning their student's behavior. This behavior caused her strife with her male administrators, leading them to believe she was not a kind and caring teacher towards her students. Also, her classroom was cluttered, but that never bothered JRH because she said she was always able to find anything she needed. When grading papers, JRH was constantly distracted by student errors causing her to spend so much time grading papers that she needed to spend her weekends grading papers if she was going to give her students timely feedback.

After starting medication, JRH realized that her usual routine of getting a Coke during class had ceased. She became more relaxed in the classroom and her students were less able to distract her with off-topic questions. JRH's epiphany was realizing her personal classroom and job accommodations had been what saved her job. Her epiphany after being diagnosed also included multiple memories. She concluded that her upbringing and life experiences actually aided her ability to manage a classroom learning environment despite AD/HD symptoms.

JRH changed some of her behaviors while keeping other behaviors constant. She was very disorganized, but she was able to find anything she needed in the classroom, so JRH decided not to clean up her classroom. JRH would take time away from her classroom lessons, teaching students how to solve their own problems and stop making excuses for their behavior. Also, after being diagnosed with AD/HD, JRH became an advocate for her students' who were diagnosed with ADD or AD/HD.

Before being diagnosed with AD/HD, I did not know why preparing for my weekly lessons, gathering materials, and writing my lesson plans took so long. Also, I was constantly trying to keep my classroom neat and organized. If there was a surface I could stack papers on I covered that surface with papers. I used my closets and shelf curtains to hide my clutter because I believed that if no one saw my mess they would think I was a very organized person. That trick worked until I had to go on leave after an emergency surgery. The teacher who was tasked with helping get work together for my students was furious with me when I returned because she had a hard time finding anything in my classroom. I was embarrassed because someone found out that I was not as neat and organized as everyone thought I was.

After being diagnosed, I was happy to have a reason for my inability to quickly get lesson plans written and prepare my classroom for each week. However, I was aggravated that I did not know I had AD/HD sooner. I had been teaching for 11 years and was anxious each year that teaching was not getting any easier for me. I was more than willing to try any medication that would help me manage my classroom. I was amazed at how quickly the medicine started to work. However, I was also sad when I realized that the side-effects only increased my anxiety causing me to lose patience with my students. I eventually stopped taking medication and have struggled with my symptoms but not as much as I did before I started taking medicine.

Each participant shared their experiences before being diagnosed with AD/HD. JAH and JRH each developed coping strategies that helped them work through their symptoms. ALC, DLG, and I experienced anxiety when our classroom environment became too difficult or stressful. After being diagnosed, we each had our own epiphanies

realizing that our behaviors and anxieties were because we were trying to cope with AD/HD symptoms. Each one of us started medication, but only three of us have continued to use medication to aid in alleviating our AD/HD symptoms.

Research Question Two

The second research question was, "How does a diagnosis of AD/HD as an adult impact a female educator's perception of her ability to professionally communicate student progress to colleagues, administrators, and parents?" Research question two refers to how females diagnosed with AD/HD perceive their professional interactions with administrators, colleagues, and parents.

Each participant described their professional interactions with administrators, colleagues, and parents differently. The participants described mostly negative interactions prior to being diagnosed with AD/HD and realizing their behavior after being diagnosed with AD/HD. Some of the participants even disclosed their diagnosis with their administrators, colleagues, and parents.

ALC reported negative interactions with administrators at the start of her career. ALC's administrative interactions were escalated due to ALC's emotional responses. ALC also stated that she has negative interactions with parents but also said they were a misunderstanding.

ALC's first negative administrative interaction was due to ALC's weight gain during her first year of teaching. ALC's administrator addressed his concern, insinuating that ALC was trying to dress inappropriately for her male students. ALC was so upset that she went shopping for new clothes after school that day. ALC's second memorable negative interaction with an administrator happened when she was attacked by a student.

Her administrator's response brought forth childhood memories causing her to have panic attacks on her way to school. Additionally, ALC requested that the student be permanently removed from her classroom. Her administrator's reaction was referring to ALC as a nonteam player. The above interactions combined with a diagnosis of AD/HD helped ALC become mindful of her emotional responses when interacting with administrators.

ALC's interactions with parents have been positive and negative depending on where she was working at the time. When she started as a paraprofessional and as a teacher in Washington, her interactions with parents were positive. When she moved to Tennessee, her interactions with parents were mostly negative. She believed this is partly due to teaching special education. Parents did not like coming in for meetings. Also, when ALC had parent meetings regarding student behavior, parents often lashed out at ALC. ALC stated that she did not have administrative support making it harder to build positive relationships with parents. After being diagnosed with AD/HD, ALC noted that she would engage with parents as little as possible, always having a typed agenda so that she would not keep the parents longer than necessary.

ALC's interactions with colleagues also seemed to change depending on which state she was working in at the time. ALC's professional interactions with colleagues as a paraprofessional were not positive. Her teachers often blamed ALC for student misbehavior. When she was teaching in Washington, her professional interactions with colleagues were all positive. When she moved to Tennessee, her professional interactions with colleagues were negative due to the time constraints her colleagues put on her. ALC refused to arrive to work earlier because she had to get her own children to

school. Also, the meetings that her colleagues wanted her to attend were unnecessary according to ALC. ALC also attributes her strained relationships with colleagues to her position as a special education teacher. ALC mentioned that regular education teachers were often uncooperative with her stating that classroom accommodations were difficult to provide. ALC attributes her improved colleague relationships not on epiphanies after being diagnosed with AD/HD but on her transitioning to regular education teacher.

DLG's diagnosis did have an impact on her interactions with administrators and colleagues but did not have an impact on her parent interactions. DLG reported being emotional in front of her administrators and colleagues. DLG stated that her parent interactions remained the same.

DLG often cried in front of her administrators so much that they were used to DLG's emotional outburst. After being diagnosed, she shared her diagnosis with her administrators. She received sympathetic reactions. DLG contemplated asking for job-related accommodations but has not at this time.

DLG's professional interactions before being diagnosed with AD/HD reflected a level of disrespect among her colleagues. DLG's emotional reactions in front of her colleagues regarding teacher responsibilities caused her colleagues to lack faith in DLG's teaching ability. After receiving a diagnosis of AD/HD, DLG only shared her news with colleagues she could trust. DLG believes that emotional regulation due to medication is what gave her confidence in her job and changed the way her colleagues viewed her as a competent educator.

When asked about parent interactions after receiving a diagnosis of AD/HD, DLG stated that her interactions with parents did not change. She always came prepared, ready

to speak with parents about their student's academic progress. DLG said that there was a time limit for each parent conference, so she was forced to stay on schedule. DLG's relationship with parents has been the same throughout her teaching career.

JAH stated that she has always had difficulty navigating her professional relationships with administrators, colleagues, and parents. She realized early in her career that she was quick with her words and slow to listen and share conversations with others. After being diagnosed with AD/HD, JAH realized why she had difficulty interacting with administrators, colleagues, and parents.

JAH admitted avoiding administrators simply because she was never sure if she had upset them with her job performance in some way. At the beginning of her career, it was her administrators that would speak with her about her parent visits, her paperwork, or her inability to properly use the time clock. After being diagnosed with AD/HD, JAH researched adult characteristics, finding that adults diagnosed with AD/HD have a difficult time with their bosses due to job performance. Sometime after being diagnosed with AD/HD, JAH created a rule for herself. The rule is that she will not stay longer than six years at any given place of employment because she believed that by her sixth year, her administrators will find a reason to release her from her position.

JAH admitted that her interactions with her colleagues often left them put off by her know-it-all behavior and choice of words. This behavior had been a constant throughout her career. Before she was diagnosed with AD/HD, JAH created a rule for how she is to behave in meeting with colleagues. JAH will allow herself to talk only a certain number of times. Additionally, JAH will bring something to chew on and something to write on keeping her mind busy and her mouth closed. After receiving a

diagnosis of AD/HD, JAH admitted to practicing mindfulness more often. Also, she resolved to accept that her personality is not for everyone. JAH desired to have a true friendship but realized she may only have familiar acquaintances.

JAH's parent interactions were rocky at best. JAH was always eager to share her knowledge and skills with parents but was never able to notice her parents' responses to what she had to say or share. Often, JAH would not know a parent visit was not well received until her administrator spoke with JAH about the parent complaint. The parent complaints would frustrate JAH because she was never given an opportunity to right her wrong. After being diagnosed with AD/HD, JAH was already serving in a role that had minimal parent interaction. JAH liked having opportunities to share with parents but wascautious of her time and how she presented herself to parents.

JRH was not diagnosed with AD/HD until much later in her career. JRH did not have as much time as the other participants to reflect and make lasting changes with how she interacted with administrators, colleagues, and parents. The time JRH did have, she tried to save some of her professional relationships with her administrators, colleagues, and parents.

JRH has always had difficult relationships with her administrators. Part of the reason, she believes, is that she is outspoken and aggressive with her words towards administrators. The part of the country she taught in still held traditional male and female roles, which JRH said she did not fit. She believed her personality was intimidating causing her male administrators to view her as rough and uncaring towards students. After being diagnosed with AD/HD, JRH did not change her behavior towards her administrators because she truly believed that if she was submissive and compliant like

the other female educators in her building, her administrators would take her less seriously.

JRH's professional interactions with her colleagues changed after being diagnosed with AD/HD simply because she shared her diagnosis with colleagues she could trust. Her colleagues reciprocated sharing about family members who are diagnosed with AD/HD, some being their own children and some being siblings. Her colleagues support of her efforts for fair treatment of educators with respect to certain administrators never wavered.

JRH's parent interactions changed after she was diagnosed with AD/HD. Before being diagnosed, JRH was frustrated with parents who thought their student's 504 plan, many based on the student being diagnosed with AD/HD, was an excuse for their student's behavior. JRH shared her diagnosis with her students and their parents hoping both would realize that there are behavior modifications that can help students develop coping strategies instead of using their diagnosis as an excuse for disorganization, late work, and forgetful behavior. Fortunately, JRH's parents were open to listening to her advice.

Each participant described their professional interactions with administrators, colleagues, and parents differently. The participants described mostly negative interactions prior to being diagnosed with AD/HD and realizing their behavior after being diagnosed with AD/HD. Some of the participants disclosed their diagnosis with their administrators, colleagues, and parents.

My initial interactions with administrators, colleagues, and parents were unprofessional. I did not understand professional boundaries with my administrators.

My colleagues avoided me because I could not read behavioral cues. Parents used to talk to each other about what an awful teacher they thought I was.

At the beginning of my teaching career, I did not know what professional boundaries were when interacting with my administrators. I used to talk to my first and second principals all the time about nonsense. I was told by another colleague that I should stop talking to my administrators and only go to them if I have a legitimate concern or need concerning students or my classroom. I avoided my third and fourth principals because I did not have a good working relationship with them. My fourth principal would not give me a chance. My fifth principal did not like me so much that she refused to give me any professional opportunities when I asked her. I have had better relationships with my previous and current principal. I told both of them that I have AD/HD. My previous principal was understanding, and my current principal has empathy.

My relationships with my colleagues have improved. Initially, I started out with one friend, and then she moved away. After her, I had a very hard time making friends at work. My colleagues avoided me after work. They hid from me during lunch. They even lied to me about why they could not have lunch with me on professional planning days and then come back from a restaurant with take-out cups. I eventually stopped asking to join anyone for lunch and brought my lunch from home.

When I started taking medication, I was able to focus on work and stopped finding people to talk to in the building. One of my colleagues was so upset because she thought I was mad at her. I told her what changed, and she calmed down. Also, I told some of my colleagues who I worked closely with that I was diagnosed with AD/HD.

None of them were surprised. I have had great relationships with my colleagues ever since researching adult AD/HD symptoms because I learned that I needed to be mindful of other peoples' time and pay attention to their body language when I am talking to them.

I was off-putting to parents at the beginning of my career. I was not mindful of their time during parent-teacher conferences. I spoke bluntly about my students and their progress to their parents. They became very upset with me, but I was not able to read their behavioral cues to know that I upset my parents. After I was diagnosed, I started trying out new ways to shorten my parent conferences. I typed the conference form before parents came to the meetings. When my students' parents arrived, I asked them to read the conference form, asked them if they had any questions or concerns they would like to add to the form, and then finalized the conference by signing the conference form.

ALC's initial interactions with her administrators, colleagues, and parents started out rough and has improved as her career progressed. DLG's initial interactions with her administrators and colleagues was strained, but those relationships have improved since being diagnosed with AD/HD. DLG's relationship with her parents have always been professional. JAH's relationships with her administrators and colleagues have and still are strained. Her positive relationships with her parents are few and far between. JRH's relationships with her administrators were always strained. Her relationships with her colleagues only improved near the end of her career and more so when she shared her diagnosis with a few of her colleagues. JRH's relationship with parents only improved when she shared her diagnosis with the parents of students who were diagnosed with AD/HD.

Research Question Three

The third research question was, "How does a diagnosis of AD/HD as an adult effect a female educator's perception of her ability to interact socially with colleagues and support personnel?" This research question relates to how teachers diagnosed with AD/HD interact with their colleagues socially.

Each participant shared their initial interactions with their colleagues in social situations. All of the participants shared that their social interactions with colleagues were for the most part nonexistent. All but one participant shared that their social interactions have improved.

ALC's social interactions with colleagues have improved throughout her teaching career. ALC has always managed to attract colleagues that had similar interests outside of work. After her diagnosis with AD/HD, ALC shared her diagnosis with close friends, but that did not change the way her friends socialized with her.

DLG's social interactions with her colleagues have not changed, even after being diagnosed with AD/HD. DLG continues to interact with her colleagues when she can outside of work.

JAH has continued to struggle with social interactions with her colleagues. After being diagnosed with AD/HD, JAH became more mindful of her interactions with her colleagues. Also, she realized that making and maintaining solid friendships with her colleagues was nearly impossible, but JAH has not lost hope.

JRH's social interactions improved later in her career, after she was diagnosed with AD/HD. JRH realized early in her career that her words were not always received well among her colleagues, making it hard for them to see JRH as a colleague they could

be social with outside of work. JRH has completed minimal research but has learned how to interact with her colleagues in social situations.

My social interactions improved much later in my career. I have only started to interact with my colleagues socially in the last two years. I get invited to lunch on professional planning days. I go to dinner with my work friends on Fridays. I even went on a spring break vacation with two of my team members. I no longer feel alone at work.

ALC, DLG, JRH, and my social interactions have improved as our careers progressed. DLG was only gaining her colleagues respect at the time of our interviews. ALC, JRH, and I have gone from not having social relationships with our colleagues to spending time outside of work with our colleagues. JAH continues to struggle to find a true friend in a colleague.

Limitations

There are three limitations that could potentially affect the validity of my study. The first limitation is the different interview formats and how they affected my research findings. I was able to conduct my interviews with participants one and two using Google Meet, giving me the ability to view their body language along with hearing their words and tone of voice during each interview. The third participant attended the first interview through Google Meet, but only attended the second and third interview through phone conversation. I lost access to my third participant's body language, limiting my ability to fully review her interview responses. My fourth participant was unable to use Google Meet for any of the three interviews. I was only able to use her tone of voice and interview responses when analyzing the data.

My second limitation is poor working memory (Barkley, 1997) and my participants limited ability to accurately recall events. When analyzing my participants interviews, I found that the majority of their recall had emotional attachments. It is impossible to know if the recall of their experiences was accurate or if their emotions guided their responses (Barkley, 1997).

My third limitation was the possibility of not having a range of ages, representing adult females early in their career to adult females closer to retiring from the teaching profession. Furthermore, I only had a total of five participants including myself. Such a small number of participants is impossible to accurately represent the majority of female educators diagnosed with AD/HD as adults.

Conclusions

I gathered three main conclusions from my study researching how female diagnosed with AD/HD experience the teaching profession. My first conclusion is that female diagnosed with AD/HD are plagued with anxiety which can cause for their behaviors in and outside of the classroom. Additionally, anxiety is related to AD/HD symptomatology, but they managed to persevere could be related to self-determination theory. My second conclusion is that female educators diagnosed with AD/HD have a difficult time interacting with administrators, colleagues, and parents in a professional manner and the reason why could be due to poor executive functioning. My final conclusion is that female educators diagnosed with AD/HD may always struggle to maintain social relationships with their colleagues, which could also be due to poor executive functioning.

Anxiety was prevalent among all the participants in my study. The coping behaviors each participant developed can be attributed to anxiety. Anxiety caused my participants to worry about the various aspects of their jobs. Classroom management caused levels of anxiety because my participants were worried about remembering lesson plan requirements, being mindful of the amount of time they were spending on a given lesson or being able to manage student behavior effectively. Professional interactions with colleagues and administrators caused more anxiety among all of my participants because they lacked social cues or were not mindful of how they were talking to their colleagues or administrators. Regardless of whether or not my participants were taking medication and/or receiving therapy to help control their AD/HD symptoms, they were always aware of their behavior causing a continuous cycle of anxiety.

Females diagnosed with AD/HD as adults have managed to maintain a teaching career, albeit they may not be voted teacher of the year. I researched different theories and found that self-determination theory (Deci and Ryan, 2000) may explain how females educators diagnosed with AD/HD persevered throughout their careers. When entering a career field, one that requires years of education and preparation, people generally want to succeed. Females diagnosed with AD/HD may be extrinsically or intrinsically motivated to keep their job. The teaching profession pay is not commiserate with the amount of time needed to prepare for students' and withstand the social expectations associated with teaching, such as being careful how a teacher represents themselves outside of the classroom. I surmised that female educators diagnosed with AD/HD are intrinsically motivated by the difference they are making in each individual student's life.

My second conclusion, female educators diagnosed with AD/HD have a difficult time interacting with administrators, colleagues, and parents in a professional manner, is due to poor executive functioning. I believe that specifically poor reconstitution, one of the four main executive functions (Barkley, 1997), is why female educators diagnosed with AD/HD have a difficult time interacting with administrators, colleagues, and parents in a professional manner. Reconstitution affords people the ability to think quickly on their feet and respond appropriately. Female educators diagnosed with AD/HD already suffer from anxiety which causes them to become flustered in stressful situations. This anxiety will create a domino effect resulting in poor reconstitution. Poor reconstitution then translates to female educators diagnosed with AD/HD being unable to successfully report student data to the appropriate audience without appearing to know what they are talking about.

The big picture that comes into focus for research question three is that all of the participants have had negative social interactions with their colleagues. Solden's (1995) extensive data regarding women diagnosed with AD/HD supports what I concluded in my study. My conclusion is that female educators diagnosed with AD/HD are going to have to work hard to maintain social relationships with their colleagues.

My final conclusion is that female educators diagnosed with AD/HD suffer from a lack of self-regulation, specifically a person’s ability to remain neutral or calm when an event piques an inappropriate emotional response (Barkley, 1997). Social gatherings are meant to be fun and relaxing, but female educators diagnosed with AD/HD can become over stimulated causing them to lose control over their behavior. The loss of control over their behavior results in their colleagues becoming uncomfortable and avoiding them the

next time a social gathering is announced. A result from my research is that being honest with close colleagues helps alleviate the pressure to maintain normal. Additionally, their colleagues may actually help rein in the offending colleague's behavior before it gets outof hand.

Implications for Practice

Using the findings in my study, I make the following implications for practice, further supporting the purpose of my study. I made implications for practice regarding administrators of teachers with AD/HD and teachers with AD/HD. Administrators of teachers are similar to teachers of students with regard to monitoring individual progress. There are a multitude of ways to monitor individual teacher progress of teachers with AD/HD helping them to become successful and productive stewards of education. My second set of implications are for educators diagnosed with AD/HD. While some are not comfortable sharing that they have been diagnosed with AD/HD, educators need to find someone they can trust to seek out help and guidance.

My first implication for practice regarding administrators is educating administrators about adult AD/HD symptomatology so that they are able to notice symptoms among their teachers during evaluations or meetings with colleagues and parents. Administrators often have some familiarity of childhood AH/HD and symptomatology. Additionally, administrators are not purposely looking for AD/HD symptomatology in their teachers. Learning about adult AD/HD will help administrators identify female educators who may not realize their AD/HD symptoms are negatively affecting their classroom management and professional interactions with colleagues, administrators, and parents.

My second implication for practice supports my first implication in that AD/HD symptoms can affect the social morale of the educators in their schools. Dodson's (2019) rejection sensitivity supports the social ineptness of female educators with AD/HD. Social interactions are important for improving morale among educators. Helping female educators diagnosed with AD/HD understand how their symptoms effect their social interactions will help those teachers learn how to positively interact with their colleagues, building the overall school morale among teachers. One such example of a program would be forming a group of teachers diagnosed with AD/HD and teachers not diagnosed with AD/HD and having them practice different scenarios of social and professional engagement.

A third implication for practice for administrators is establishing mentorship programs in their buildings not only designed for new teachers, but for teachers diagnosed with AD/HD. Generally, a team leader would help keep all of the teachers in a grade level updated with important dates for school-wide or district-wide personnel and plan lessons together but there may also be a need for someone to confide in or meet with one single teacher on their team to navigate daily tasks and classroom management concerns. Having a mentor that is sensitive to a teacher who is diagnosed with AD/HD individual needs can help build that teacher's confidence in their job and maybe alleviate some of the anxiety associated with dealing with AD/HD symptoms.

A fourth implication for practice regarding administrators of teachers diagnosed with AD/HD is allowing extra time to master new programs or technology. Teachers are constantly trying to master their craft and with the addition of a new program and/or technology-based teaching tool teachers diagnosed with AD/HD have increased anxiety.

If these teachers were able to have extra time to learn and master new programs they would have more confidence in their ability to use the new programs.

My fifth implication for practice for administrators is for administrators to be patient and supportive of their teachers who have been diagnosed with AD/HD. My personal experience has left me afraid to share my diagnosis or ask for administrative help with regards to my job because I have had previous administrators treat me differently when I shared my diagnosis and asked for help. While I have learned so much about adult AD/HD, I am not an expert. I am still learning about my behavior and practicing how to behave around my administrators, colleagues, and parents. If an educator diagnosed with AD/HD is comfortable sharing their diagnosis and trusts their administrator enough to expose their weaknesses, I implore those administrators to respond with patience and offer nonjudgmental support.

My first implication for educators diagnosed with AD/HD is to learn about accommodations related to your job. Individuals with physical disabilities are readily noticeable. Individuals with mental disabilities are obviously not noticeable. Learn about your symptoms and how they can potentially affect your ability to complete required job-related tasks. Next, advocate for yourself. Be prepared to demonstrate how an accommodation can help your job productivity and how, without the accommodation, your job productivity will be less effective.

My second implication for educators is to ask for a mentor. If you do not feel comfortable asking your administrator for a mentor ask a fellow teammate that you know and trust. It is important that educators diagnosed with AD/HD have a fellow faculty member they can go to for help and guidance.

My third implication for educators diagnosed with AD/HD is to learn your behavior triggers. For example, if I am required to spend long hours beyond my contract time I will get very tired. The tired behavior turns into me being chatty and loud. I have been told by my administrators that behavior is unprofessional. To avoid behaving unprofessionally I will pick a job that requires me to have minimal interaction with administrators, colleagues, and parents.

My fourth implication for educators diagnosed with AD/HD is joining a support group for educators diagnosed with AD/HD. Only one of my participants has actively joined an online support group and stated that she had positively benefitted from being in that support group. One of my participants did not share her diagnosis with anyone while the rest of us shared our diagnosis with educators we can trust. The group with the most trust would be a group of educators who can all emphasize being diagnosed with AD/HD. They can all share stories and suggestions for dealing with AD/HD symptoms and anxiety because they understand the mental illness.

My last implication for educators diagnosed with AD/HD is to seek professional help concerning the anxiety related to AD/HD symptoms. The anxiety related to AD/HD symptoms can be debilitating and even cause an educator diagnosed with AD/HD to leave the teaching profession. One of my participants took a medical leave of absence because she was becoming physically ill from the anxiety related to her AD/HD symptoms. Another one of my participants has chosen to employ herself as a paraprofessional because she cannot handle the anxiety related to her AD/HD symptoms.

Recommendations for Future Research

I recommend different possibilities for future research. The first is to repeat my study using males. The second recommendation is to repeat the study on small clusters of various career stages allowing including male and female participants in the same research groups. A third recommendation is to repeat the study using administrators as my participants diagnosed with AD/HD, allowing for both male and female participants in the same study. A fourth recommendation is to repeat this study as a quantitative study, using a large sample to gather more generalized feedback. A fifth recommendation would be to research anxiety among educators, not just educators diagnosed with AD/HD. The final is to follow the educators that participated in this study performing a longitudinal analysis of their careers.

I did not include male participants. My reasoning was based on research and personal choices. While most males are diagnosed during childhood there are still males diagnosed for the first time as adults (Fredriksen et al., 2014). Also, there are male teachers so it can be fairly said that there are male teachers that were diagnosed with AD/HD as an adult. Their stories may or may not be vastly different, but a comparative analysis is worth researching.

The findings in my study are small and cannot be generalized along the population of female educators who may be suffering from AD/HD symptoms effecting their classroom performance, professional interactions with colleagues, administrators, and parents, and social interactions with colleagues and support staff. Repeating the study using small clusters of each career stage may bring about different findings, one being a change in opinion of taking stimulants to help alleviate AD/HD symptoms.

Another possible study would be to examine administrators diagnosed with AD/HD as adults. Administrators mainly interact with teachers and parents on a daily basis. Before they were administrators, they were teachers. It would be interesting to learn how they overcame their social anxieties and learned how to be mindful of their interactions with other administrators, teachers, and parents.

A fourth recommendation for future research is to repeat this study using a quantitative approach. Based on the results of this study, create a survey based on professional interactions with colleagues, administrators, and parents and how anxiety has impacted their teaching career. This study could also include males and females generalizing the results for all educators.

A fifth recommendation for future research is to research anxiety among all teachers. Even though the participants in my study became aware of their various behaviors, they are still plagued with anxiety. A quantitative study could be performed by looking at all facets of what it takes to be an educator. Such facets would be time spent preparing for teaching lessons, professional interactions with administrators, colleagues, and parents, managing student behavior, and the sacrifices necessary to adequately perform as a successful educator.

A final recommendation for future research would be to complete a longitudinal study following the participants from this study. I have spoken with two of the participants in my study and have learned that they are still teaching but continue to experience challenges interacting with their colleagues and finding their best fit in their career.

Closing

In this study, each participant's interviews were analyzed, demonstrating how female educators diagnosed with AD/HD perceive their classroom learning environments, professional interactions with administrators, colleagues, and parents, and social interactions with colleagues and support staff. As you expect, each participant experienced similarities and differences to their perceptions of classroom learning environments and professional and social interactions after being diagnosed with AD/HD. I questioned if female educators diagnosed with AD/HD as adults changed as a result of their diagnosis. Each participant had different approaches to using their diagnosis to their advantage. Three participants researched adult AD/HD helping them understand their behavior and how to perceive their classroom learning environments and professional and social interactions. Two participants relied on medication or alternative methods of treatment while staying the course of their career hoping for the best. None of the teachers in this study ever reached out to other female educators diagnosed with AD/HD as an adult, a possible way to build a community of support and understanding.

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APPENDIX A: Institutional Review Board (IRB) Approval

Institutional Review Board (IRB) Approval

Institutional Review Board (IRB)
For the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

Protocol Number: 04057-2020

Responsible Researcher: Mary Ann Colgrove

Supervising Faculty: Dr. Steven Downey

Project Title: *How Female Educators with Attention-deficit/Hyperactivity Disorder Experience the Teaching Profession.*

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is **Exempt** from Institutional Review Board (IRB) oversight under Exemption **Category 2**. Your research study may begin immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

ADDITIONAL COMMENTS:

- *Upon completion of this research study all data (email correspondence, survey data, transcripts, participant name lists, etc.) must be securely maintained (locked file cabinet, password protected computer, etc.) and accessible only by the researcher for a minimum of 3 years.*
- *The Research Statement must be read aloud to each participant at the start of the recorded interview session.*
- *Exempt protocol guidelines permit the recording of interviews for the sole purpose of creating an accurate transcript. Once the transcript has been created, the recording must be deleted from all recording devises. Recordings are not to be stored and/or shared. The transcripts must be securely maintained with research data for three years.*

☒ ***If this box is checked, please submit any documents you revise to the IRB Administrator at irb@valdosta.edu to ensure an updated record of your exemption.***

Elizabeth Ann Olphie 08.06.2020

Elizabeth Ann Olphie, IRB Administrator

Thank you for submitting an IRB application.
Please direct questions to irb@valdosta.edu or 229-253-2947.

Revised: 06.02.16

APPENDIX B: Demographic Survey for Potential Participants

Demographic Survey for Potential Participants

Female Educators with AD/HD

This survey was created by Mary Ann Colgrove. Please answer each question below accurately, as your responses are an important part of this study, if you choose to participate fully. The questions marked with an asterisk are required.

1. Email address*

Your email

2. Name*

Your answer

3. Address

Your answer

4. Phone Number*

Your answer

5. Preferred method of contact*

Email
Phone
Text message

6. Gender*

Female
Male

7. Date of Birth*

Date
mm/dd/yyyy

8. How many years have you been a teacher?

1-5
6-10
11-15
16-20
21-25
26-30
30 +

9. Who diagnosed you with AD/HD?

General Practitioner
Psychiatrist
Other

10. Date diagnosed with AD/HD

Date
mm/dd/yyyy

APPENDIX C: Interview One Questions

Interview One Questions

1. How long had you been teaching before you realized you needed to consult a medical professional about your AD/HD symptoms?
2. Who diagnosed you with AD/HD?
3. What AD/HD symptoms were you struggling with the most?
4. Describe how AD/HD symptoms affected your classroom management. Werethere specific areas that were more difficult? (Ex. Lesson planning, analyzing student data, time management)
5. Describe a specific moment in time when AD/HD symptoms interfered with classroom management. What did you do? How did you react? Were there anymajor repercussions as a result? If so, what were they?
6. Describe how AD/HD symptoms affected your professional conduct with colleagues.
7. Describe a specific moment in time when AD/HD symptoms interfered with your professional conduct with colleagues. What did you do? How did you react? Were there any major repercussions as a result? If so, what were they?
8. Describe how AD/HD symptoms affected your professional conduct with administrators.
9. Describe a specific moment in time when AD/HD symptoms interfered with your professional conduct with administrators. What did you do? How did you react? Were there any major repercussions? If so, what were they?

10. Describe how AD/HD symptoms affected your professional interactions with parents.
11. Describe a specific moment in time when AD/HD symptoms interfered with your professional interactions with parents. What did you do? How did you react? Were there any major repercussions? If so, what were they?
12. Describe how AD/HD symptoms affected your social interactions with colleagues.
13. Describe a specific moment in time when AD/HD symptoms interfered with your social interactions with colleagues. What did you do? How did you react? Were there any major repercussions? If so, what were they?
14. Did any of your colleagues or administration recognize your AD/HD symptoms? If so, how did they approach you? What did they say?
15. Do you have and specific memories of embarrassing or troublesome experiences that have stuck with you? If so, can you describe them?

APPENDIX D: Interview Two Questions

Interview Two Questions

1. Describe your first visit with a medical professional concerning your AD/HD symptoms.
2. Describe your reaction to being told you have AD/HD.
3. Describe the treatment options that were presented to you. Did you think at the time they would benefit your teaching ability? Why or why not?
4. What type of information, about adult AD/HD, was given to you?
5. Did you research adult AD/HD on your own? If so, what did you learn?
6. If you took time to reflect, did you have any epiphanies about your previous behavior?
7. What immediate changes did you make to your classroom management?
8. Describe how your professional interactions with your colleagues changed.
9. Describe how your professional interactions with parents changed.
10. Describe how your professional interactions with your administration changed.
11. Did you share your diagnosis with your colleagues or administration? If so, how? What did you say?
12. If you shared your diagnosis with your administration, did that change their level of confidence in you? Your ability to do your job? If yes, how do you know?

13. If you did not share your diagnosis with your colleagues or administration, did they notice a change in your behavior? If so, how did they approach you? What did they say?
14. Have you connected with other teachers diagnosed with AD/HD for the first time, as an adult? If so, what have they shared with you about teaching with AD/HD?

APPENDIX E: Interview Three Questions

Interview Three Questions

1. Now that you have had time to reflect and review your answers from interviews one and two, how do you explain being able to function with AD/HD for as long as you have?
2. Have you ever struggled with being motivated to complete basic tasks, such as lesson planning? (Ex. Writing lesson plans, creating teaching activities, differentiating instruction, planning assessments and how to measure student success) If so, how?
3. Describe strategies you use to overcome forgetfulness.
4. Describe strategies you use to manage your time in the classroom.
5. Describe meeting with colleagues. Have you implemented strategies to help control emotions and stay focused on current discussion topics? If so, what are those strategies? Are certain strategies more useful than others?
6. Describe discussing student progress with parents. Have you implemented strategies to help you stay on topic and manage your time? If parents are upset, are you able to control your emotional response? Can you describe strategies you use to stay calm when you are upset?
7. Describe instances when you have difficulty making decisions about student behavior on the spot. What do you do to help you remember your action and reaction for future behavioral responses?

8. Have you asked for work accommodations per the Americans with Disabilities Act? If so, what are they and have they made a difference in your classroom management? Other duties as a teacher?
9. After you were diagnosed with AD/HD did you ever think of raising awareness about adult AD/HD? If so, what outlet have you used/ considered using?

APPENDIX F: Participant Interview Dates and Lengths

Participant Interview Dates and Lengths

ALC Interview Dates and Lengths

Dates	Start Time	Stop time	Total Time
9-7-2020	12:55 pm	2:21 pm	76 minutes
9-19-2020	8:39 am	9:39 am	60 minutes
9-27-2020	5:37 pm	6:38 pm	61 minutes

DLG Interview Dates and Lengths

Dates	Start Time	Stop Time	Total Time
9-16-2020	4:58 pm	6:10 pm	72 minutes
9-23-2020	5:02 pm	6:04 pm	62 minutes
9-30-2020	5:14 pm	6:16 pm	62 minutes

JAD Interview Dates and Lengths

Dates	Start Time	Stop Time	Total Time
9-9-2020	5:34 pm	7:09 pm	95 minutes
9-22-2020	4:05 pm	5:34 pm	89 minutes
9-28-2020	7:35 pm	9:51 pm	136 minutes

JRH Interview Dates and Lengths

Dates	Start Time	Stop Time	Total Time
9-15-2020	7:37 pm	9:08 pm	91 minutes
9-24-2020	6:34 pm	8:37 pm	123 minutes
9-29-2020	4:30 pm	6:06 pm	96 minutes

APPENDIX G: Worksheet 3. Analysist's Notes

Worksheet 3. Analysist's Notes

Code Letters for This Case: ____

Case Study Report Title: ________________________________

Author(s):

Analyst's Synopsis (possibly identifying the case, the sites, the activity key information sources and contextinformation)

Situational Constraints:

Uniqueness Among Other Cases:

Prominence of Theme 1 in This Case:

Prominence of Theme 2 in This Case:

Prominence of Theme 3 in This Case:

Expected Utility of This Case for Developing Theme 1: Expected Utility of This Case for Developing Theme 2:

Expected Utility of This Case for Developing Theme 3:Findings:

I.

II.

III.

Possible Excerpts for the Multicase Report (noting case report page number)**:**

Commentary (sometimes noting case report page number)**:**

APPENDIX H: Worksheet 5A. Matrix for Generalizing Theme-Based Assertions

Worksheet 5A. Matrix for Generalizing Theme-Based Assertions

	Themes							
Case A:	1	2						
Finding I								
Finding II								
Finding III								
Finding IV								
Case B:	1	2						
Finding I								
Finding II								
Finding III								
Finding IV								
Case C:	1	2						
Finding I								
Finding II								
Finding III								
Finding IV								
And so on for remaining Cases								