

CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

INTRODUCTION

Attention-Deficit/Hyperactivity Disorder (AD/HD), characterised by impulsivity, an inability to sustain attention and/or hyperactivity (American Psychiatric Association, 1994), was previously believed to be a disorder of childhood, with the symptoms attenuating greatly during adolescence or early adulthood (American Psychiatric Association, 1994). However, over the past decade or so, this view has been challenged and a number of scientific studies have shown that the symptoms of AD/HD persist throughout adolescence and into adulthood (Barkley, 1998; Goldstein, 1997; Nadeau, 1995; Quinn, 1997; Sudderth & Kandel, 1997; Wender, 1995). It has been estimated that between 3% and 5% of all children suffer from AD/HD (Barkley, 1998) and, considering that the disorder continues into adulthood, it is estimated that between 30% and 50% of AD/HD children become AD/HD adults (Barkley, 1998; Biederman et al., 1994). This would mean that between 50,000 and 180,000 of the Australian population could retain a diagnosis of AD/HD as adults (deHass & Young, 1984; Prinz & Loney, 1974). A further challenge to diagnosis is that the data have suggested that there are three subtypes of this disorder: those with overt hyperactivity, those without overt hyperactivity, and those with a combination of both. The core symptoms appear to be inattention/lack of concentration and impulsivity (American Psychiatric Association, 1994).

There is still some controversy as to whether the condition known as Attention-Deficit/Hyperactivity Disorder actually exists. It has been argued that the problem with disruptive children is caused by bad parenting or some form of illness or toxicity (Church of Scientology, 2001). This view, and the resulting media reports, prompted 75

renowned scientists in the field of AD/HD studies to issue an International Consensus Statement verifying the validity of the disorder (ADDults with ADHD, 2002). In part, the statement reads:

AD/HD is not a benign disorder. For those it afflicts, AD/HD can cause devastating problems. Follow-up studies of clinical samples suggest that sufferers are far more likely than normal people to drop out of school (32-40%), to rarely complete college (5-10%), to have few or no friends (50-70%), to under perform at work (70-80%), to engage in antisocial activities (40-50%), and to use tobacco or illicit drugs more than normal. Moreover, children growing up with AD/HD are more likely to experience teen pregnancy (40%) and sexually transmitted diseases (16%), to speed excessively and have multiple car accidents, to experience depression (20-30%) and personality disorders (18-25%) as adults, and in hundreds of other ways mismanage and endanger their lives (p.4).

This chapter will explore the literature surrounding AD/HD and self-esteem in women to demonstrate the need for a qualitative study to help in understanding the experience of self-esteem in women who have been diagnosed with AD/HD.

HISTORY OF AD/HD

The symptoms of what is now known as Attention-Deficit/Hyperactivity Disorder (American Psychiatric Association, 1994) have been reported in scientific journals for over a hundred years (Barkley, 1998; Goldstein, 1997). In a series of lectures to the Royal College of Physicians, London, in 1902, George F. Still described the behaviour of 20 children who were often aggressive, excessively emotional, had impaired attention and were hyperactive (Barkley, 1998; Quinn, 1997; Still, 1902; Sudderth & Kandel, 1997; Weiss & Hechtman, 1993; Wender, 1995). Still believed that these children had a "defect in moral control" and suggested that their symptoms could have had a biological basis (Still, 1902, p.1008). According to Sudderth and Kandel (1997), the symptoms that Still described in his patients could, today, be categorised as AD/HD, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD).

In North America, the interest in AD/HD stems from an encephalitis epidemic in 1917-1918 (Barkley, 1998). The children who survived this illness exhibited many of the symptoms of AD/HD, such as impaired attention, inability to regulate activity, and reduced impulse control. Barkley (1998, p.6) comments that "the disorder was referred to as postencephalitic behaviour disorder, and was clearly the result of CNS damage".

Over the years since that time, AD/HD has been variously known as: Brain-injured Child (1940s), Minimal Brain Damage (1950s), Hyperkinetic Impulse Disorder (1950s), Minimal Brain Dysfunction (1960-1970s), Hyperactive Child Syndrome and Hyperactive Reaction of Childhood (1960s) (Barkley, 1998). In the 1980s, the need to find a suitable name to describe this disorder prompted the American Psychiatric Association to change the terminology from the DSM-II's Hyperactive Reaction of Childhood (American Psychiatric Association, 1968) to Attention Deficit Disorder with or without Hyperactivity in the DSM-III (American Psychiatric Association, 1980). The new terminology allowed for greater emphasis to be placed on the inattentive and impulsive aspects of the disorder, whereas, prior to this, hyperactivity appeared to be the defining feature. The DSM-III-R (American Psychiatric Association, 1987) retained most of the DSM-III's criteria for the disorder and renamed the condition Attention-deficit Hyperactivity Disorder. Under this categorisation, if signs of impulsivity and hyperactivity were not present, a diagnosis of Undifferentiated Attention-deficit Disorder was given. In 1994, with the publication of the DSM-IV (American Psychiatric Association), it was recognised that the disorder did not always involve excessive hyperactivity, and the terminology was again changed to allow for this. The DSM-IV defined AD/HD as "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development" (1994, p.78). The classifications in the DSM-IV are: Attention-Deficit/Hyperactivity Disorder, Combined Type, Attention-

Deficit/Hyperactivity Disorder, Predominantly Inattentive Type, and Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type.

There was not much research conducted on this disorder prior to 1960 but, between 1960 and 1975 there were over 2000 articles published (Weiss & Hechtman, 1993). Since that time, AD/HD has become one of the most researched disorders of childhood. Prevalence rates have been estimated at between 3% and 5% of pre-adolescent children (American Psychiatric Association, 1994), with symptoms persisting into adulthood in 11% to 50% of cases (Barkley et al., 1990; Fargason & Ford, 1994). Most of the studies have focused on boys because it is estimated that the disorder affects boys more frequently than it does girls. The male-to-female ratio has been variously estimated to be from 3:1 to 9:1 (American Psychiatric Association, 1994; Mannuzza & Gittelman, 1984). However, these figures may be misleading. A study by Achenbach et al. (1990) indicated that there were no significant differences between boys and girls based on parent reports. It is often because of teacher reports, rather than concern by parents, that children are referred for treatment. McGee, Williams and Silva (1987) and Berry, Shaywitz and Shaywitz (1985) theorised that boys may come to the attention of teachers more often because they tend to have more behaviour problems. It may be for this reason that the clinic referred male-female AD/HD incidence ratio of an average of 6:1 drops to 3:1 or less in the community (Arnold, 1996; Ernst et al., 1994). Research has shown that girls are more likely to be underrecognised and underdiagnosed because they tend to be inattentive rather than hyperactive-impulsive (Berry, Shaywitz & Shaywitz, 1985; McGee & Feehan 1991; Ratey et al., 1995b) and, therefore, present fewer behaviour problems in the classroom.

NEUROPHYSIOLOGY OF AD/HD

Over the past 20 years, a great deal of research has been conducted to try to find a biological basis for AD/HD but, to date, no single defect has been found to explain all the symptoms of AD/HD (Quinn, 1995; Seidman et al., 1997b). It was originally hypothesised that the disorder was caused by the faulty functioning of the neurotransmitters dopamine and norepinephrine in the brain, as indicated by the effectiveness of the psychostimulant medication used to treat the disorder (Quinn, 1995). In 1990, Zametkin and his colleagues published the results of their study which measured the glucose metabolism in people who had a childhood history of hyperactivity and who continued to exhibit symptoms as adults. They found that the glucose metabolism of these subjects was lower than in normal controls. The areas of the brain which showed the greatest reduction in metabolism were the premotor cortex and the superior prefrontal cortex (Zametkin et al., 1990). Quinn (1995, p.23) noted that these are "areas already thought to be responsible for the control of attention and motor activity". Research has shown that the global cerebral glucose metabolism (CMRglu) in AD/HD girls is 15% lower than in normal girls, and is 19.6% lower than in AD/HD boys (Ernst et al., 1994). In 1998, these same researchers reported the results of another study which "implicates the dopaminergic system and the prefrontal and nigrostriatal regions in the pathophysiology of attention deficit hyperactivity disorder" (Ernst et al., 1998, p.5901).

Other researchers have found differences in both the frontal brain areas and in the corpus callosum (Hynd et al., 1991) and there is a suggestion that the brain stem, specifically the reticular activating system and the locus coeruleus, may be implicated in the etiology of AD/HD (Quinn, 1995). Quinn (1995, p.22) further notes that "it now is generally believed that ADHD is the result of a disinhibition of the frontal lobes, where the frontal lobes fail to inhibit emotional responses, inappropriate cognitive or

psychological responses, and behavioural impulses". Barkley (1997) observes that children with AD/HD were unable to inhibit behaviour and, as inhibition of behaviour is central to AD/HD, the inability to control this tendency results in an impulsive style of behaviour. A recent study by Sowell et al., (2003, p.1699), identified "abnormal morphology in the frontal cortices of patients with attention-deficit hyperactivity disorder, with reduced regional brain size localised mainly to inferior portions of dorsal prefrontal cortices bilaterally". These findings lend support for a biological basis for the disorder.

Barkley and colleagues (1992) reviewed 22 neuropsychological studies of frontal lobe functions in children with Attention-Deficit Disorder with and without hyperactivity, and found inconsistent results explaining the difference between the two subtypes. In their own study, they concluded that there were few differences between these subtypes. They stated that: "a unique pattern of frontal lobe deficits for each ADD subtype was, therefore, not established" (p.183), leading to the conclusion that both AD/HD with and without hyperactivity may have the same aetiology.

Evidence from family, twin and adoption studies suggests a genetic component to AD/HD (American Psychiatric Association, 1994; Barkley, 1998; Biederman et al., 1991a; Biederman et al., 1992; Faraone et al., 2000; 1992; Hechtman, 1996; Morrison, 1980). Faraone and his colleagues (2000) found a 57% prevalence of AD/HD among children of AD/HD adults, and did not feel that their results could be accounted for by psychiatric comorbidity or report bias. Adults would be aware of the symptoms of AD/HD and there could be a tendency to exaggerate or overidentify with the symptoms. This was found not to be the case. Milberger et al. (1995) studied the familial transmission of AD/HD and concluded that a significant number of the parents of the AD/HD proband had a history of AD/HD. The results from twin studies have shown

that there is a 79% to 91% concordance rate of AD/HD among monozygotic (identical) twins compared to a 29% to 66% rate for dizygotic (fraternal) twins (Gilger et al., 1992; Gillis et al., 1992; Levy et al. 1997), adding further weight to the argument for familial transmission of the disorder.

Research has indicated that there is a genetic explanation for AD/HD, and various other theories have been put forward to account for the neurological origins of the disorder, such as: pregnancy and birth complications, maternal smoking, toxins, minimal brain damage, and inconsistent or impulsive caregiving. However, there has been no consensus of opinion on one defining explanation for the disorder (Arnold, 1996; Barkley et al., 1990; Barkley, 1998; Lavenstein, 1995; Milberger et al., 1996; Quinn, 1995). Children with AD/HD have been reported to have experienced more school failure, learning disability, intellectual impairment, and neuropsychological dysfunction than control children, leading to the belief that there are underlying neuropsychological deficits "that may be enduring" (Seidman et al., 1997a, p.154).

COMORBIDITY

As well as the core symptoms of distractibility, motor restlessness, difficulty sustaining attention, impulsivity, hyperactivity and difficulty with task completion, AD/HD patients have been found to suffer from a number of comorbid disorders. These disorders include learning difficulties, oppositional defiant disorder, and conduct disorder as well as anxiety, depression and low self-esteem (Barkley, 1998; Biederman et al., 1987; Hinshaw, 2002; Hoza et al., 1993; Pliszka, 1992; Shekim et al., 1990; Solden, 1995; Tzelepis et al., 1995; Weiss & Hechtman, 1993). In the Weiss and Hechtman (1993) study, at the 15-year follow-up their hyperactive subjects had had more court appearances and problems with aggression than a matched control group. This result is consistent with other studies that show that hyperactive children are at

substantially higher risk for negative outcomes in the areas of psychiatric, social, legal, academic, and family functioning than controls (Barkley et al., 1990; Mannuzza et al., 1989).

AD/HD subjects often experience work problems and difficulties in their interpersonal relationships because of their learning difficulties and social skills problems (Barkley, 1998; Fargason & Ford, 1994; Gualtieri et al., 1985; Krueger & Kendall, 2001). It has been found that, by the time that an AD/HD child has reached adulthood, she/he is more at risk of drug and/or alcohol abuse, dysthymic disorder, generalised anxiety disorder and cyclothymic disorder (Shekim et al., 1990).

Owing to the core symptoms of attentional problems, impulsivity and/or hyperactivity, AD/HD children often suffer more academic difficulties, have more grade repetitions and attain lower marks in all subjects than their peers (Barkley, 1998; Biederman et al., 1991b; Weiss & Hechtman, 1993). Hinshaw et al. (2002) found that their female AD/HD subjects suffered significantly more deficits of executive functions, such as organization, planning, decision making, working memory, and inhibitory control than normal comparison girls. Consequently, AD/HD children experience a decrease in self-esteem and tend to "give up" when tasks appear too difficult (Milich & Okazaki, 1991). They tend to become defiant and to defend their failures (Milich et al., 1991). Krueger and Kendall (2001, p.67) reported that the boys in their study "denied caring whether they connected well or were admired by others and often blamed other people for their difficulties".

ADOLESCENTS AND AD/HD

Most research on AD/HD has involved children because the symptoms of the disorder must be present before the age of seven for a diagnosis to be made (American

Psychiatric Association, 1994). It was believed that the symptoms attenuated or disappeared at the onset of puberty. However, more and more research over the past ten years has shown that the disorder persists into adolescence and beyond in 30% to over 80% of cases (Barkley, 1990; Goldstein, 1997; Sudderth & Kandel, 1997; Weiss & Hechtman, 1993).

Barkley and his colleagues (1990) followed the progress of 123 hyperactive children over an eight year period and found that over 80% retained symptoms of AD/HD at the completion of the study. In addition, 60% had either oppositional defiant disorder (ODD) and/or conduct disorder (CD). They reported that these children were at "substantially higher risk for negative outcomes in the domains of psychiatric, social, legal, academic, and family functioning than a control group of normal children followed concurrently" (Barkley et al., 1990, p.555). In another study, it was noted that "childhood ADHD may be related to later antisocial and criminal behaviour only when childhood conduct problems and aggression are also present" (Fischer et al., 1993, p.330). This premise has been supported by Biederman et al. (1987) who reported that childhood antisocial disorders may be linked to hyperactivity rather than the syndrome of AD/HD.

Weiss and Hechtman (1993) also followed a group of AD/HD children over a number of years in order to ascertain the course of the disorder. They evaluated the progress of their subjects at intervals of 10 and 15 years and reported that a significant percentage (25%) had been involved in selling non-medical drugs, had more court appearances than controls, and had more problems with physical aggression than a comparison group of adolescents. These researchers acknowledge that not all AD/HD children develop antisocial behaviours and that it was mainly the hyperactive subjects that were significantly more likely to come to the attention of law enforcement agencies.

However, nearly all of the adolescents reported poor school performance, poor peer relationships and low self-esteem. Other researchers have reported similar findings (Biederman et al., 1995; Faraone et al., 2000; Krueger & Kendall, 2001; Mannuzza & Gittelman, 1984).

Many AD/HD adolescents reach adulthood with a less promising future than their non-AD/HD peers because of the negative accumulative effects of academic and social failures these adolescents have experienced over a number of years. However, as already noted, not all of these children have a negative outcome. Shekim et al. (1990, p.422) found that "some of them can actually function at a higher occupational level than the general population". They concluded that many of their patients had found strategies and ways to cope with the negative effects of the disorder. These researchers attributed this to the fact that their subjects came from high socioeconomic backgrounds, were of above average intelligence and self-referred for this study rather than being referred because of behaviour problems. When the adult participants in the Weiss and Hechtman (1993) study were asked what had helped them to cope with their AD/HD difficulties during childhood, a large number reported that an individual person (a parent, a teacher, a counsellor, or a friend) had been the most beneficial.

It appears that male AD/HD sufferers tend to show more (so labelled) "deviant behaviour" in adolescence and adulthood than do AD/HD females (Gualtieri et al., 1985), and this, therefore, because of the difference in symptomatology has given rise to the belief that only a small proportion of women retain the AD/HD diagnosis into adulthood. However, Seidman et al. (1997a, p.371) found that adolescent girls with AD/HD "performed worse on the various tasks of attention, intellectual performance, and achievement". This study also found that girls with AD/HD had significantly higher rates of learning disability than a group of normal comparison non-AD/HD girls,

and suffered more mood and conduct disorders and school failure than their non-AD/HD peers. Such cognitive deficits in females are less likely to be noticed because they do not constitute disruptive or antisocial behaviour (Biederman et al., 1994; McGee & Feehan, 1991).

WOMEN AND AD/HD

Research has indicated that AD/HD without hyperactivity is much more common in women than in men (Arnold, 1996; Cantwell & Baker, 1992; Fargason & Ford, 1994; Gaub & Carlson, 1997; Ratey et al., 1995b; Solden, 1995). Women are rated as having fewer behavioural and conduct problems (such as aggressiveness) than men (Barkley, 1998), but tend to suffer more school failure and cognitive impairment (Biederman et al., 1994) and greater peer rejection (Berry et al., 1985). They tend to exhibit the same symptoms of impulsivity, distractibility and impaired attention span, which, in childhood, contribute to underachievement in scholastic attainment, leading to less well paid employment in adolescence and adulthood. Having AD/HD does not mean that the sufferer cannot be successful in their chosen occupation, but it can interfere with fulfilling one's potential (Murphy, 1995). Thus, AD/HD females reach adulthood with the often comorbid disorders of anxiety, depression, and lower self-esteem (Ratey et al., 1995b). In the Weiss and Hechtman (1993, p.386) long-term study, "adults with a childhood history of AD/HD had more symptoms of psychopathology, lower self-esteem, and impaired social skills". Although McGee and Feehan (1991), Biederman et al. (1994) and Horn et al. (1989) found few important gender differences in either the primary (impulsivity, inattention, and overactivity) or secondary (learning problems, externalising symptoms, internalising symptoms, peer relationship difficulties, and self-perceptions) symptomatology of AD/HD, women have other problems which are uniquely female in nature.

Ratey et al. (1995b) report that AD/HD females seem to have more problems with premenstrual syndrome than did a control group of females. They note that the neurochemical problems caused by AD/HD are greatly compounded by hormonal fluctuations and can cause greater mood swings, hyper-irritability, and emotional over-reaction. Although there have been no studies as yet that have researched the effect of menopause on AD/HD women, Nadeau (1996) considers it reasonable to assume that the hormonal fluctuations experienced at this time would exacerbate the AD/HD symptoms of emotional reactivity.

It has been reported that AD/HD girls suffer more as a result of peer rejection than do males with AD/HD and were more likely than their female peers to have few or no friends (Berry et al., 1985). Social relationships are a difficult problem for all AD/HD sufferers but, while boys tend to relate to their peers in a more boisterous and aggressive manner, AD/HD girls are more withdrawn and feel isolated from the group (Murphy, 1995; Green & Chee, 1994).

Ratey and Johnson (1997) note that AD/HD females have difficulty in forming close relationships because they misinterpret the social cues that other women see from the start. Consequently, these women often choose partners who are unsuitable. They note: "for many mildly ADD women, 'bad' men were highly stimulating in every way, up to and including her brain's biochemistry" (p.192). However, many AD/HD women do not experience such disastrous relationships and work hard at maintaining their marriages. Problems such as interpersonal conflicts, difficulties in intimate relationships and boredom with relationships generally all tend to be encountered by AD/HD women (Ratey, Hallowell & Miller, 1995a).

As women are still expected to be nurturers and homemakers (Haralambos, 1980; Solden, 1995), AD/HD women find these roles difficult to accomplish because of their problems with organisation, distractibility, and inability to remain on-task. Having to look after children and housework can cause frustration for these women and, as a result, they will often feel "bombarded by things that need doing" (Ratey & Johnson, 1997, p.194). The need to successfully fulfill the demands of the family can be very stressful for an AD/HD woman because of its inherent lack of structure, and can lead to feelings of depression and low self-esteem (Barkley, 1998; Dixon, 1995; Solden, 1995).

It has been found that AD/HD is a genetically transmitted disorder (Biederman et al., 1991c; Faraone et al., 1991). Consequently, there is a considerable likelihood that an AD/HD mother will have one or more AD/HD children. The need to manage the problem behaviour of the child by someone who experiences just as many problems can be overwhelming for AD/HD women. "Even children who are not naturally difficult to manage can become more so when reared by a parent who is impatient, inconsistent, easily frustrated, or moody" (Dixon, 1995, p.244). Over the past two decades, more and more women have been required to fulfil, not only the more traditional roles of wife and mother, but also to juggle the demands of the family with a full time career (Nadeau, 1996). If a woman is unable to successfully cope with her dual roles, she is likely to consider herself a failure, and her self-esteem will be considerably depleted.

SELF-ESTEEM

Self-esteem could be defined as "the extent to which one prizes, values, approves of or likes oneself" (Chatham-Carpenter & DeFrancisco, 1998, p.468). Romans et al. (1996, p.696) describe self-esteem as "how you measure up to your desired image". A number of studies on this subject have indicated that one's sense of self and personal self-esteem are constructed in a social environment (Bandura, 1997; Crocker, 1999; Cuff & Payne,

1981; Festinger, 1954; Haralambos, 1980), and that "we develop our sense of who and what we are from our observation and interpretation of the responses we receive from others" (Crocker, 1999, p.90). Abramson et al. (1978) noted that a major determinant of attitudes towards the self is comparison with others. Sociologists refer to this process as "the looking-glass self" (Mead, 1934), while psychologists prefer the term "social comparison" (Festinger, 1954), but both of these disciplines recognise that one's sense of self-esteem, self-worth or self-regard depends on the feedback one obtains from one's immediate environment and from society as a whole. Because of the nature of AD/HD, this feedback is often negative.

Studies show that AD/HD children develop low self-esteem from an early age (Barkley, 1998; Brown, 1995; Slomkowski et al., 1995; Weiss & Hechtman, 1993), and there appears to be a further marked decline after puberty (Romans et al., 1996). The constant academic difficulties, peer rejection, as well as the behavioural problems experienced by AD/HD sufferers, have a debilitating effect on self-esteem. Children who encounter failures on a daily basis are at risk of developing a learned helplessness response style (Milich & Okazaki, 1991). It is the attributions that a child makes about her/his lack of success that determines the generality and chronicity of her/his helplessness deficits as well as her/his later self-esteem (Abramson, Seligman & Teasdale, 1978). These authors suggest that "so much real-life helplessness stems from social inadequacy and rejection" (p.58), and this is an area where AD/HD children, adolescents and adults experience considerable difficulties.

Although it has been suggested that the symptoms of AD/HD decline over time (Hill & Schoener, 1996), Slomkowski and associates (1995) found that the AD/HD subjects in their study had lower self-esteem than the control group, regardless of whether they still retained the AD/HD diagnosis. It has been documented that AD/HD girls, in particular,

suffer more social rejection and social isolation than do AD/HD boys (Berry et al., 1985). Consequently, as it is known that social rejection leads to self-esteem deficits (Abramson et al., 1978), adult AD/HD females are at higher risk of developing low self-esteem, depression and anxiety as a result of their childhood experiences (Faraone et al., 1991). Romans and colleagues (1996) report that the predictors of low self-esteem for women include childhood temperament, a poor relationship with their mother, low qualification attainment, psychiatric comorbidity and, only when it is most intrusive, childhood sexual assault. These researchers found that “it was only the intercourse type of CSA which was found to be an independent predictor of low self-esteem, although the whole CSA group had lowered total self-esteem” (p.703). Solden (1995) notes that the behaviour of abuse survivors can mimic the symptoms of AD/HD in certain ways, such as concentration problems, distractibility, anxiety and depression, and it can be difficult for the clinician to provide the correct diagnosis. However, the other predictors that Romans et al. (1996) mention are particularly pertinent to AD/HD. Hojat et al. (1990) agree that a poor relationship with a parent tends to contribute towards low self-esteem, and, as it is possible that the parent may also have AD/HD and/or some comorbid disorder (Biederman et al., 1991a; Faraone et al., 1993; Morrison, 1980), the parent/child relationship is likely to be less than secure, leading to the development of poor self-esteem.

Research by Tice (1991) found that people with low self-esteem tend to self-handicap in order to protect themselves against the threatening implications of failure. As an AD/HD adult has experienced failure on many occasions since childhood, there is the likelihood that they will attempt to mitigate the effects of their lack of success by denying that they care (Krueger & Kendall, 2001). Newman and Wadas (1997) reported that people with unstable self-esteem are especially likely to use a self-handicapping strategy in order to protect their psychological integrity. They noted that

"people with unstable self-esteem have more intense cognitive and affective reactions to failure and success" (p.230).

Poor self-esteem is common in adults having AD/HD (Fargason & Ford, 1994) with the majority also suffering from co-existing mood disorders. Rucklidge (1997) found that significantly more women with AD/HD compared to her control group had an internal-uncontrollable attributional style. This would suggest that these women blamed themselves for their difficulties, leading to feelings of hopelessness and helplessness to change their lives. However, these women had a more external locus of control than the control group. Linn and Hodge (1982) and Lufi and Parish-Plass (1995) found that AD/HD children had a significantly higher external locus of control, and felt that they were "out of control" in such situations as academic pursuits and social situations. In the Linn and Hodge (1982) study, this lack of control was attributed to the fact that the child had to rely upon significant others to control his/her medication and, therefore, the child felt that he/she had no responsibility for his/her conduct. The participants in the Lufi and Parish-Plass (1995) study were not on any medication, but the findings were in accordance with the previous study, and these researchers reported that their subjects had encountered repeated academic failure and frequent social difficulties and, also, felt that they had little control over their ability to change their lives

In the Rucklidge (1997) study, over 70% of women reported feeling depressed, and this is in accordance with other research on AD/HD (Barkley, 1998; Biederman et al., 1993; Nadeau, 1995; Weiss & Hechtman, 1993). Abramson et al. (1978) report that individuals tend to show what they term "helplessness depression" when they believe that they cannot perform tasks that others can, and, consequently, this affects their sense of self-esteem. They note: "the phenomena of self-blame, self-criticism, and guilt (a sub-class of the self-esteem deficits) in helplessness (and depression) follow from

attribution of failure to factors that are controllable" (p.62). In other words, if other people can complete a task, it must be manageable and, therefore, the AD/HD person will feel deficient if they are unable to do likewise. "If a person expects that nothing he or she does matters, why try?" (Abramson et al, 1989, p.362). This is in accord with other research (Lufi & Parish-Plass, 1995; Hoza et al., 2001; Milich & Okazaki, 1991) that has found that AD/HD people tend to give up easily if a task appears too difficult or does not provide a significant reward in terms of increased self-esteem. Rucklidge (1997) found that low self-esteem was not necessarily an artefact of having AD/HD, and that "low self-esteem may not be directly related to AD/HD, but rather may result from some of the other consequences of AD/HD" (p.195).

SIGNIFICANCE OF THIS STUDY

This chapter has looked at the history of the condition known as Attention-Deficit/Hyperactivity Disorder, and at the various research studies that have investigated the validity and possible causes of the phenomenon. Evidence is pointing to a biological basis for the core symptoms of AD/HD (Ernst et al., 1994; Sowell et al., 2003; Zametkin et al., 1990), which are inattention, lack of concentration, impulsivity, and/or hyperactivity. However, less definite evidence has been found to support the biological origins of such co-existing conditions as depression, anxiety and self-esteem.

It is obvious that there is a gap in the literature with regard to the experience of self-esteem in women with AD/HD. The relatively few studies of AD/HD in adults have been conducted using quantitative analysis and are based on a medical model. This process does not allow for the unique experiences of AD/HD women who were not diagnosed in childhood to be vocalised and evaluated. For this reason, a qualitative research method was chosen as this method has the potential to gather a rich amount of

personal data to provide a better understanding of the complicated connection between self-esteem and AD/HD.

A further motivation for this research arose as a result of a telephone conversation between this researcher and the President of the ADDult support group (which was then called the ADDult and Family Association (NSW) Inc.), during which it was disclosed that a number of AD/HD women had mentioned various difficulties that they had encountered during their lives, such as relationship problems, comorbid symptomatology and self-esteem issues, and had wondered why there had been no, or little, research conducted which addressed their concerns.

This present research is not intended to explore the medical model, which is only one aspect of the phenomenon known as AD/HD. Rather, it will address the social impacts on the participants' emotional lives that may have contributed to their negative emotional symptoms. This study is an endeavour to ascertain the connection between adult women's self-esteem and their experience of AD/HD in all aspects of their lives, as well as to explore the participants' reaction to their diagnosis of AD/HD, i.e. whether this explanation for their difficulties has improved the way they think of themselves and altered their self perceptions, or whether they feel diminished by being diagnosed with a DSM-IV disorder.

CHAPTER OUTLINES

The next chapter will describe why a qualitative approach is used to collect the data for this study, and will also describe how the participants were chosen and give examples of the questions asked of the participants.

Chapter 3 will present the individual profiles of the seven women included in this study. These profiles detail the life experiences of the participants and allow the women to explain in their own words the events which shaped their feelings of self-esteem.

Chapter 4 will explore the various similarities and differences in the experiences of the participants, and how these may provide an understanding of the self-esteem problems expressed by the women. There were a number of factors which were common to most of the women and, indeed, contributed to their feelings of self-worth.

The final chapter draws together the various themes to encapsulate the findings of this study. A discussion on the possible other causes of self-esteem problems, apart from the diagnosis of AD/HD, is addressed. Also discussed is the implications for future research.

CHAPTER 2

RESEARCH DESIGN

This chapter will explain why a qualitative approach was chosen, and will describe the informants, how they were chosen, the research design, the procedure for the interviews, and the data analysis process.

CHOICE OF A QUALITATIVE APPROACH

In this study, which aims to explore the connection between AD/HD and self-esteem, the most appropriate method for eliciting the most relevant information from the informants is by means of qualitative research in the form of in-depth interviews. The term “qualitative research” means “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification” (Strauss & Corbin, 1990, p.17). People have experiences which are both similar and different, but no two people have the same experiences. Each person assigns a meaning to her/his experiences which may not be seen in the same light by another person. Therefore, the qualitative researcher “seeks answers to questions that stress how social experience is created and given meaning” (Denzin & Lincoln, 1994, p.4) by the informant.

Adapting the model of grounded theory in qualitative research as proposed by Strauss and Corbin (1990), the verification of the data is conducted throughout the interview and analysis process. The raw data is “open coded” to discover basic themes to which all, or most, informants have a connection, and then, through “axial coding” to interrelate these themes in order to describe a phenomenon. Following this procedure, the researcher “returns to the data and looks for evidence, incidents and events that support or refute the questions” (Creswell, 1998, p.209). Such coding in the present

research incorporates such items as: AD/HD and family, AD/HD and schooling, AD/HD and peers, and can be incorporated under the axial category of “AD/HD and early influences”. In like manner, the items of self-esteem and family, self-esteem and schooling, and self-esteem and peers can be subsumed under the category of “early self-impressions”. The researcher must take the informants’ subjective remembrances at face value, respecting their perception of their experiences, regardless of preconceived ideas, theories or culture. In this way, the “voice” of the participant is heard. The coding was derived from the words spoken by the informants, such as “sabotage”, “abuse”, and “self-esteem”.

INFORMANTS

The informants were women who have been identified as suffering from AD/HD and were willing to discuss their perceptions of self-esteem. Although they cannot be said to represent the entire population of adult female AD/HD sufferers, they do represent a cross-section of the population in that their demographic incorporated: married/single, employed/unemployed, parent/no children, and intact parents/step parents. The small number of participants in this study limits the findings but does not invalidate the study.

The seven informants were recruited as a result of an advertisement placed in the ADDults With ADHD (NSW) Inc. support group bi-monthly newsletter (Appendix 1) and through personal representation at an ADDult group meeting. This researcher was made aware of the support group through attendance at a workshop presented by Dr. Russell Barclay, a prominent contributor to Attention-Deficit Hyperactivity Disorder research, in 1994 in Sydney. Originally, there were twelve informants but five were not included because of various extenuating circumstances. One informant was going overseas for an indefinite time and a suitable opportunity could not be found for an interview. Another informant was deemed to have a serious psychiatric condition

which necessitated hospitalisation at that time. A further informant lived in country New South Wales and was unable to attend an interview, nor did this researcher have the resources to travel. Another informant was under the age group required for this study, and the final informant decided that she would decline because, previously, she had had no feedback from researchers regarding their research projects, even though she was assured by this author that she would be kept fully informed and would be sent a copy of the final results.

PARAMETERS FOR INCLUSION

The criteria for inclusion in this research required that the participants were female, were undiagnosed with AD/HD during childhood, were of mature age (i.e over the age of twenty-one) at the time of interview, and had been subsequently diagnosed with AD/HD by a medical practitioner, preferably a psychiatrist, using the DSM-III (American Psychiatric Association, 1980), DSM-III-R (American Psychiatric Association, 1987), or DSM-IV (American Psychiatric Association, 1994) diagnosis of the three types of AD/HD: AD/HD, Predominantly Hyperactive/Impulsive Type, AD/HD, Predominantly Inattentive Type, or AD/HD, Predominantly Combined Type.

The seven participants who were chosen for this study were aged between 31 and 49, of Anglo-saxon heritage and from working class and middle class socioeconomic backgrounds. All but one had at least one child and five of the women had been, or were at that time, married. Two participants were living in defacto relationships. None of the participants received any financial remuneration for their participation in this study.

Based on the literature review reported in Chapter 1, this research was predicated upon the following propositions:

- i) That women with AD/HD probably have low self-esteem,
- ii) That self-esteem is not an artefact of AD/HD.
- iii) A qualitative, rather than a quantitative, method of enquiry was chosen for this study because the research was necessarily descriptive and subjective, and focused upon the collection of data relating to the life experiences of the participants as told by them.

The framework for this research was based on a modified "grounded theory" approach (Strauss & Corbin, 1990) in that the analysis to account for the experience of self-esteem issues in AD/HD women is "inductively derived" (p.23) from the material collected and recorded in a "bottom-up" approach rather than a "top-down" style.

The basic research questions, which were asked of all participants, were derived from the Chatham-Carpenter and DeFrancisco (1998) qualitative study of self-esteem in women. These are as follows:

1. What do you think of when you think of self-esteem?
2. Describe the characteristics of a person who has high self-esteem.
3. Describe the characteristics of a person who has low self-esteem.
4. How would you describe your overall self-esteem now, and why?

Following from the responses to these questions, further in-depth probing was employed to elicit the participant's life history and possible causes of her positive or negative self-esteem perceptions. The material was initially, intentionally, collected with a minimum of (semi) structure to give the widest possible potential for "grounded" theoretical post-hoc formulation. The interviews were semi-structured in nature in order to elicit the maximum amount of data, and were intentionally open-ended. This would allow the researcher to rephrase or reinquire if a question was misunderstood or unclear.

PROCEDURE

Approval for this research was granted by the University of New England Ethics Committee on 1 November, 2000 (Committee Approval No.HE01/002). After the recruitment of volunteers for this study, the participants were contacted by phone to arrange interview times and dates. Each participant was interviewed separately so that they could relate their individual life history and disclose their experiences in a confidential and non-judgmental environment. They agreed to take part in a tape-recorded interview of one hour to one and a half hours duration at a location convenient for them. Ultimately, three interviews were conducted in the participants' homes, two were held in this researcher's office, one took place at the participant's office, and one was conducted in a café in Sydney at the request of the participant. As a means of protecting the confidentiality of the women, they were each requested to choose a nom-de-plume to which they would be referred throughout the study. None of the women withdrew from the study prematurely or requested that any of their responses be deleted.

At the start of the interview process, each participant was informed of the nature of the research, what it would be used for, the duration of the interview, and the qualifications of the researcher. They were assured of the confidentiality of their responses, and were informed that they did not have to discuss any topic with which they felt uncomfortable or answer any question which they did not wish to answer. In the event that they should become distressed by relating their experiences, the researcher offered to supply the telephone numbers of counselling services who could provide effective treatment. The participants were then given an "Information Sheet for Participants" describing the study (Appendix 2), and were asked to sign a Consent Form of which they were given a copy (Appendix 3). This researcher attempted to establish a rapport with the

participants prior to the interview by explaining the circumstances leading to the decision for the research topic, indulging in brief general conversation and then collecting general demographic data from them.

All of the interviews were accomplished in one session of one hour to one and a half hours duration, and no written notes were taken during the audiotaping. This researcher attempted to follow the guidelines for in-depth interviewing outlined in the literature by Minichiello et al. (1995) using the recursive model of interviewing to elicit the life-history experiences of the participants. None of the participants reported feeling distressed by their disclosures. Following the interview, the audiotapes were transcribed by the researcher. The typed transcripts together with the audiotapes were stored in a locked filing cabinet in this researcher's home.

DATA ANALYSIS

The raw data from the transcripts were carefully analysed to identify an idea, event, incident or occurrence that represented a common theme which could explain a phenomenon. Informed by the components of the diagrammatical model proposed by Strauss and Corbin (1990), the data was coded and categorised. The raw interview material was converted into individual summarised findings, and separate life history profiles were generated for each participant. As each phenomenon was identified for individual subjects, a list was generated and the data was transferred to an analysis grid (Appendix 4) which was a means of organising the data into a manageable form to provide an overall view of the responses from the participants, which could then be compared each with the other.

The emergent themes were identified and grouped as appropriate, and looked at from a “biopsychosocial” perspective, that is, from all areas of influence in the participants'

lives and as explained by the informants. The areas from which the themes emerged included family interaction, peer and social relationships, biological and psychological factors, educational functioning and vocational history. The material was then reviewed and any overlapping themes were further collapsed to form one universal category which would exemplify each sphere of functioning. All similarities and differences were noted and investigated in order to confirm their validity. The foregoing procedure led to the formulation of an overall final model inspired from a biopsychosocial perspective as proposed by George Engel (1977) who believed that “mental and social phenomena depended upon but could not necessarily be reduced to (i.e., explained in terms of) more basic physical phenomena” (Borrell-Carrio et al., 2004, p.577) such as a biomedical or psychological model (Figure 2.1).

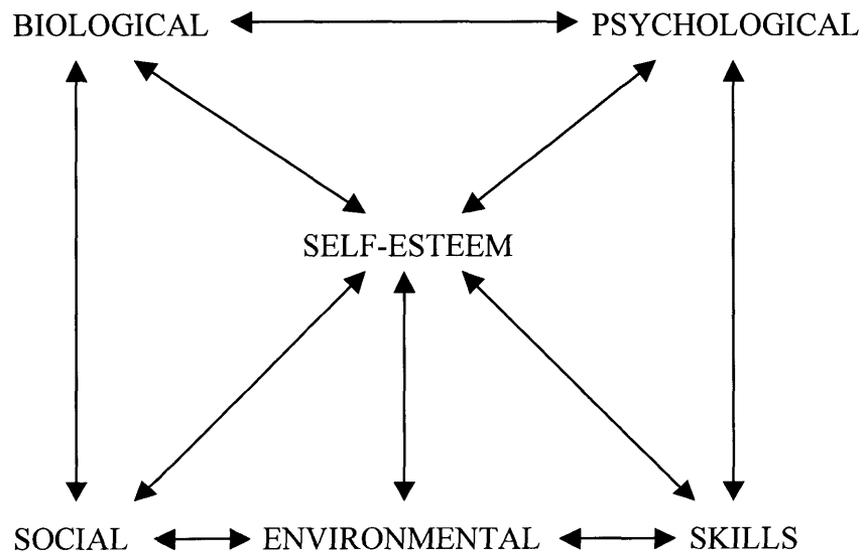


Figure 2.1: Recursive Biopsychosocial-enviro-skills Model

The most appropriate organising principle to arrange all the phenomena associated with AD/HD is self-esteem because it is both cause and effect, and it influences, and is influenced by, each of the biopsychosocial, environmental and skills components of a comprehensive holistic explanatory model for any phenomenon.

SCOPE OF THIS RESEARCH

The primary purpose of this research is to attempt to ascertain and identify factors which have contributed to the self-esteem perceptions of the participants. Since this is qualitative not quantitative research, the restricted sample and lack of a control group for comparison are not relevant criticisms. Instead, this study has emphasised situating the sample by providing a context, grounding the analysis in examples from the participants' text and seeking to provide a coherent story, all hallmarks of reliability suggested by McLeod (2001).

A life history narrative approach was used to collect the data for the topic of self-esteem, which involves the participants describing their remembered experiences. The responses were necessarily subjective. Because of the nature of the narrative approach, the researcher's understanding of, and summary of, the participants' life histories is also necessarily subjective.

One of the challenges in analysing the data is that some of the participants reported histories of attachment disruptions, childhood sexual abuse, and/or other psychological disorders which would have impacted on their sense of self-value. The problem of interacting experiences makes it difficult to fully ascertain the extent to which AD/HD contributed to the participants' sense of self-esteem.