CHAPTER 4

THEMES, SIMILARITIES AND DIFFERENCES IN THE STORIES OF THE INFORMANTS

An analysis of the interviews identified nine separate themes which appear to have had a distinct impact on the participants. These themes, as listed hereunder, were mentioned by the women as affecting their quality of life and typified their experience of living with AD/HD.

DIAGNOSIS AS ADULTS

All of the participants were diagnosed in adulthood by psychiatrists. A likely explanation for this late diagnosis is that all of the participants were aged over 30, and, prior to 1980, the condition currently known as Attention-Deficit/Hyperactivity Disorder was thought to more commonly affect males than females, with the symptoms attenuating when the child reached puberty. In addition, up until that time, hyperactivity predominated as the primary feature of this disorder. As females tend to be more inattentive rather than hyperactive (Berry, Shaywitz & Shaywitz, 1985; McGee & Feehan, 1991; Ratey et al., 1995b), their AD/HD symptoms were likely to have been ignored or attributed to other causes. For example, Antoinette stated:

> *I've got exercise books in there from when I was in primary school ... the teacher, the nun, wrote in the book "A is lazy", "A is a dreamer", "A doesn't apply herself", "A is capable of so much more but she won't concentrate", you know. "She doesn't remember anything", and you grow up feeling like an idiot.*

Antoinette's experiences were echoed by Samantha:

> *... but I'd have a mark that would say 84 percent, and next to it would say "no effort's been made", or "is a constant disruption", or "completely hopeless".*

Similarly, Amanda reported:

> *... because I don't have hyperactivity, I was sort of the person who always sort of just sat at the back and um didn't make much trouble so I sort of didn't really get noticed a lot.*

Therefore, the female participants in this study escaped the diagnosis net in childhood. Four of the participants were diagnosed as a result of one or more of their children being diagnosed with AD/HD. Crawford (2003, p.29) reported that "one of the most common pathways to a woman being diagnosed is that one of her children is diagnosed".

Tina remarked:

> *We actually took Thomas, who is the younger one, to be tested for AD/HD. We were all tested. That's the day I came out.*

Similarly, Samantha reported:

> *I wasn't diagnosed until I was 31, after my son was diagnosed ... he was having problems which I identified in myself.*

Two women were diagnosed as a result of suggestions from their Alcohol and Other Drugs (AOD) counsellors. In Antoinette's case, she had been abusing alcohol for a couple of years and had attended Alcoholics Anonymous meetings, but had been unable to overcome her addiction. She then went to see a counsellor who referred her to a psychiatrist. She explained:

> *I went to the hospital at Hornsby to see Matthew J., who is a drug and alcohol counsellor, because I was just wiping myself out with alcohol ...and he said to me "A, I think I know what's wrong with you" and I asked him what it was and he said he didn't want to say anything ... then he made an appointment with Dr. Street for me to see him, and Dr. Street told me that, in his opinion, I had one of the worst cases of ADD that he'd ever seen in an adult my age ...*

Laura's addiction involved hard drugs and she spent some time in a psychiatric ward because of paranoid tendencies. It was when she was in rehabilitation that she was diagnosed with AD/HD. She reported:

> *...I just want to know what's wrong with me, I mean, like I've had an EEG for my, you know, what they use to diagnose you with ADD, and all that says yes, that I've got ADD ...*

Amanda was diagnosed because her mother recognised symptoms of AD/HD in her and suggested she investigate it:

> *My mum's always telling me how impulsive I am ... She originally suggested I be tested for ADD.*

The women shared the common experience of adult diagnosis for their perceived behavioural difficulties. Although the reasons which led to their diagnoses were different i.e. either the diagnosis of a child, or at the suggestion of others, the actual experience was the same. In other words, all of the women had endured a childhood, adolescence and young adulthood not knowing the reason why they had more difficulty coping with life than did other people.

AD/HD SYMPTOMS

All of the participants had sufficient symptoms to warrant a diagnosis of AD/HD. They all claimed to be impulsive, have attention/concentration problems, were easily distracted from tasks, and disorganised. The four participants who were interviewed in their homes made a point of telling this researcher that they had made a special effort to tidy up but that their houses were not always so neat. As Laura explained:

> *I'd start cleaning the house ... I'd start in one room and then I'd end up in another room and then another room ... I'd stand there and look, and think "I've done it all" ... and the house would be all upside down .. I'd just be so disorganised all the time..*

Later in the interview, Laura reported that taking Dexamphetamine had helped her in *keeping on focus.* In the same vein, Samantha, who was one of the women interviewed in her home, responded to the question regarding being disorganised as follows:

> *Gee, take a look around! Yes, disorganised, definitely. That frustrates me.*

The other three participants who were interviewed elsewhere also made mention of the fact that they believed they were disorganised. For example, when asked whether she considered herself an organised person, Jane stated: *Not at all. Not on a personal level, but I can pull things together.* Likewise, Patricia said that she over-prepared for eventualities. When asked if disorganisation would diminish her self-esteem, she replied:

> *Yes, and even though I say I do all that preparation, I'm really disorganised. Everything's all over the place.*

Most of the women in this study admitted to being impulsive in various ways. This generally involved spending money and buying things that they did not need. For example, Antoinette reported:

> *I had five cars in one year. This year I've had three.*

Likewise, Amanda commented:

> *I'll see something and it's like "Oh, I've got to have that". And I sort of don't - I don't really think about it a lot and then, of course, I've bought it and I think "Oh, why did I buy that, I shouldn't have bought it".*

All of the participants mentioned that they had difficulty with attention/concentration, as the following quotes illustrate:

> Jane: *...I have trouble with the written stuff, and it's not that I'm a bad writer, I'm a really good writer, it's - it's like stopping the flow of things, so once that flow's been interrupted, it's often very hard for me to get back into it.*

Antoinette: *One of the downfalls of having ADD we tend to talk too much, and we tend to interrupt people constantly because we're thinking about what we're going to say next because if we don't say it, we forget it, and we don't know what we were going to say.*

Samantha: *... reading is an issue for me, I mean, I can read, but I can't recall from what I've read.*

Amanda: *Umm - there was something else I was going to say, but it's slipped my mind and I can't think of it, which I suppose is another thing, another challenge.*

Patricia said that taking the medication, Ritalin, helped with *focusing, completing stuff, staying on task, stops my mind wandering*. This participant also admitted that her husband and her secretary kept her *on track* and helped her to organise her day, which was not an advantage available to most of the other women in this study.

The symptoms of AD/HD, as experienced by the women interviewed, were very similar and caused them a varying degree of distress in their daily life. Every one of them had found ways of coping with their problems of disorganisation, attention/concentration, distraction and impulsivity, and, thus, had managed to cope with the demands of home and family, employment, and social interaction. In most cases, participants attributed their ability to cope to taking psychostimulant medication which helped them to focus on tasks and to better relate to other people. However, not all AD/HD sufferers benefit from such medication (Barkley, 1998). The only participant who was not taking medication admitted that she had only tried Dexamphetamine which did not have a beneficial effect on her, but had not tried any other medication. This woman said that she still had problems with AD/HD symptoms but coped by avoiding things which caused her difficulty. She reported:

Yeah, yeah, very much avoiding ...I find I do it a lot, just find anything - find anything to except what I'm supposed to be doing.

LOW SELF-ESTEEM

All of the participants admitted to having low self-esteem. Perhaps this was because they knew the nature of the research topic and volunteered because it matched their feelings about themselves. The causes of their opinions about themselves varied, but mainly was related to how they perceived that other people treated them. In a number of cases, the women acknowledged that they knew that self-esteem should come from within themselves, but their experiences with others had influenced their opinions. For example, Amanda said:

> *Someone with high self-esteem respects themselves without having to put someone else down to do it .. I used to get picked on a lot, so I think a lot of (low) self-esteem came from that.*

This participant also admitted that:

> *I'm one of those people that really looks to other people for validation of my own self-image, which is probably wrong, because I know you shouldn't do that.*

In like manner, Laura compared herself to her siblings and found herself wanting:

> *My self-esteem's always been really low, um. I think that comes from my upbringing, my parents, or my mother, she's a physio, so she's the academic, and my brother's a lawyer, he's academic, and my sister's um done an Arts degree at Uni ...*

Patricia's feelings of self-esteem were very family oriented:

> *... my self-esteem is linked to my children. When they're not coping that diminishes my self-esteem, and um that can be a problem.*

The participants' low self-esteem influenced their view of themselves and led to a reduction in self-confidence. Illustrative of this was Samantha's comment when asked to describe the characteristics of someone who has low self-esteem:

> *What was my name again? Samantha* (laughs) ... *I wouldn't say - I'm certainly not a confident, healthy, happy person who couldn't care less about what people think* ...

This lack of self-esteem and self-confidence in these women has engendered feelings of alienation. Six of the participants expressed an opinion of feeling "alienated", "different" or being perceived by others as being "different" throughout their lives. This ranged from childhood to adulthood, but especially during their school years. Tina felt that she *grew up with being different*. Antoinette said that she felt that people had a negative image of her:

...*everybody thinks I'm quite eccentric*, and ... *they all think I'm a lunatic.*

While not all of the women in this study described themselves in such negative terms, they all felt that they were "different" to what they perceived as the norm, and none of them said that they valued this "difference". Most of them did not say that they allowed this to greatly interfere with their adult life, and appeared to hold the belief that, if other people did not like them, it was their (the other person's) problem. This view is similar to that expressed by the adolescents in the Krueger and Kendall (2001) study. Five of the women in this study expressed a belief that they lacked confidence in themselves. The two participants who did not express such an opinion may have had an erroneous view because one was having difficulties with the management at her workplace over a conflict of opinion and the other had recently lost her (casual) job but did not know the reason.

All of the participants in this study expressed a belief that they lacked an adequate sense of self-esteem. Although they had managed to cope with their lives, their sense of confidence in themselves varied. Patricia admitted that, at school, she had no confidence in her abilities, and thought that she must have been "lucky" to have done well enough in her final exams to have been accepted for University. As she said:

I didn't see myself as smart ... I'd stand up and say something really stupid and it wasn't what I meant.

Samantha and Patricia acknowledged their husbands as contributing to their improved belief in themselves. The other five women did not specifically identify their partners or immediate family as having a significant impact on their sense of positive self-esteem and, in fact, as in Amanda and Laura's cases, felt that they themselves did not measure up to an idealised standard of functioning as epitomised by their families and peers.

As with most people who have self-esteem problems, whether AD/HD or not, most of the participants in this study looked to other people as a gauge of self-worth. The difference between them and other sufferers was that the AD/HD women did not appear to know what they were doing wrong and why they were not accepted. In relation to the aspect of low self-esteem, all of the participants exhibited more similarities than differences. While some of them may have attributed their self-esteem to the influence of others, ultimately they all realised that they themselves were responsible for the way that they felt about themselves.

COMORBIDITY

All of the participants said that they felt depressed and five admitted that they were taking antidepressant medication currently. One participant was self-medicating with recreational drugs and one participant said she was not on any medication at all but was willing to try herbal preparations rather than psychotropic medication. Shekim et al. (1990) suggested that the prevalence of depression that they found in their study may be the result of a chronic sense of failure and low self-esteem in adults who were not diagnosed and treated for AD/HD in childhood. The same could be said of the seven women in this study who all admitted to feelings of low self-esteem and a belief that, for the most part, they had not achieved their potential, especially in the employment

sphere. For example, Samantha said that she had had *various* jobs, such as *secretarial, market research coder, Woolie's check-out chick, a hospital kitchen hand,* but was, at the time of the interview, completing a double degree in Speech and Hearing Sciences with Honours, as well as Science Psychology with Honours. She laughingly commented *I thought I was stupid.* Another emotional feature of the lives of these women who are living with AD/HD is anxiety. As Solden (1995, p.142) noted: "You can develop anxiety disorders just from living with ADD".

In Jane's life, she admitted to being claustrophobic:

> *I won't get in the back of a 2 door car because I'm scared shitless that something's going to happen and I won't be able to get out. So I don't like being in a lift on my own. I absolutely loathe walking down the emergency stairs in a building on my own unless I've been there with somebody and know that the doors aren't locked.*

Patricia said:

> *I've always had a bit of social phobia. I hate shopping. I hate crowds, but I can cope ...*

In a similar vein, also related to social phobia, Amanda admitted:

> *...I find it hard to talk to people, certainly approaching people is very hard for me.*

Amanda's comment more than likely resulted from her negative school experiences, but the majority of women had similar school experiences. There was only one participant who differed from the group in that she did not report any specific negativity from schoolmates or teachers, and did not attribute her lack of self-esteem or self-confidence to outside sources. However, this participant had suffered from anxiety since she was young and was treated for clinical depression as an adult.

The fact that all of the women interviewed admitted to having some form of co-morbid mental disorder is in accord with the literature (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). While these disorders afflict almost everyone with low-self esteem, these AD/HD women appeared to have developed their negative emotional states because of their experiences with their families, schooling, peer relationships, employment careers, and evaluations of themselves.

POOR SCHOOL PERFORMANCE

Only two participants said that they did well at school. However, one attributed this to having good teachers and going to a superior school rather than to her own ability, and the other left school after Year 10 to become an air hostess. This particular woman admitted that she did have learning difficulties, but attributed this to external factors. She said:

> *I used to think that my reading difficulties were because I went to three different schools in the first year, because of family sickness or whatever.*

Of the other five women, their school years were not positive. They all reported negative experiences from teachers and peers which had a profound effect on their self-esteem. As noted by Owens and Hoza (2003, p.680) "ADHD children are likely to experience repeated failure and receive frequent negative feedback in the classroom, which are likely leaving them feeling less competent than their peers". In a couple of the cases, the treatment meted out to these women could be regarded as child abuse. For example, Antoinette reported being beaten by a teacher on numerous occasions, as well as suffering other indignities, which led to her lack of scholastic attainments. She said:

> *... the nuns were very, very cruel ...I had welts on the back of my calves for the whole two years I was there...*

Samantha said she was locked in a cupboard four or five times with another student in primary school for being unruly. She explained:

> *I had teachers who told me that I would never be any good at anything, or whatever, or I was just a pain in the neck, and being locked in a cupboard with a boy ... we were in fifth grade I think ... never --never being accepted at school, never was accepted.*

As a consequence of, or maybe because of it, only one of the seven participants finished their education with sufficiently high marks to be able to undertake tertiary studies. At the time of these interviews, two other participants were pursuing tertiary studies as mature-age students and were doing well in their studies, and another participant was undertaking studies leading to a career as a security officer, of which she commented:

> *I've undertaken a, um, a security course just recently, and I got through that, I found a bit of confidence in myself.*

Of the other three participants, one had found a definite career path (as an employment trainer) after retiring from her job as a flight stewardess, but she commented:

> *I mean, my children in the top five percent in the world! They could do medicine! I haven't been diagnosed (tested) but, I mean I haven't had - had it done, but I've had - done different tests, I mean, I know that I could have done pharmacy, I could have been a psychiatrist, I could have been a doctor, could have done all those things.*

The remaining two women were still exploring various avenues of employment but had not found permanent jobs. Antoinette said that she used to be a sales manager but was *between jobs* at the time of the interview, and Jane admitted that she was *very sporadic with work.*

Four of the participants said that they became rebellious at school and, of those four, three started using drugs and/or alcohol in order to cope. In two cases, this method of coping became chronic and led to severe substance abuse, necessitating rehabilitative

intervention. Another participant became socially withdrawn and found it very difficult to relate to others, as her words explain:

> *As I said, I don't make friends very easily, so I tend to think that happened at school, probably because I was very, very isolated. I was made to feel like I was the outsider.*

For all of the women in this study, their school experiences were not positive and did nothing to enhance their feelings of self-esteem and self-confidence. Even the participant who did well enough to attend University did not express a belief in herself or her own abilities, despite evidence to the contrary, and despite the fact that she did not have the expressly negative experiences of most of the others. This finding could lead to the speculation that a component of the experience of AD/HD involves the inability to understand what is required for effective functioning and, thus, a feeling of confusion about life. This would explain why this particular participant did not recognise her strengths, and why the other participants have had difficulties in achieving success.

NEGATIVE FAMILY OF ORIGIN EXPERIENCES

The relationships of the seven women in this study to their parents were problematic in six of the seven cases. Only one participant did not say very much about her family but felt that, overall, they were *pretty good.* The fathers of the other women appeared to be an important factor in the development of their self-esteem. They describe their fathers variously as: distant, critical, rejective, volatile, depressed, and not supportive. Antoinette said:

> *My father - um - always put me down when I was a child and - um - he ridiculed everything about me - the way I looked, my legs were too skinny, he used to call me chooklegs ...*

Samantha described her father in the following way:

> *My father was a workaholic, he was ADHD as well, as we found out later, a very volatile man, very angry man.*

One participant did not know her father as he had left the family when she was very young.

The mothers of four of these women were described as "critical" and "abusive". Samantha had this to say about her mother:

> *She was very heavy-handed, and she was very abusive with her mouth and hand, and in a way almost sexual abusive as well because she used to share an awful lot with me about my father and her's relationship, with a 7 or 8 year old child.*

Jane thought that her mother was *one of life's victims* and was *more of a negative effect* on her. Only one participant felt that her mother was encouraging and a positive influence, one did not mention her mother specifically at all, and one said that her mother suicided when the participant was about 10 years old.

Two of the women in this study reported incidents of sexual abuse from family members, but this was not the norm, and incidents of emotional abuse were more common. For example, Jane said:

> *... my father, I think, has had the more damaging effect on me, he's very controlling ... he's the sort of person who if you ask him for advice and you don't take it, he doesn't want to know, or if he helps you it always has strings attached to it.*

Many of the ideas we have about ourselves were acquired prior to adulthood, and parents provide the foundation for how a person will view themselves in relation to their environment (Sanford & Donovan, 1984). If a child is unconditionally accepted for who they are, they will develop a healthy respect for themselves. The women in this

study did not report that they were unconditionally accepted by their families, especially by their fathers and, in some cases, by their mothers. The reason for this may have been that, because AD/HD has been shown to be hereditary, their fathers may have also suffered from AD/HD, (as, indeed, a number of women reported) and found it difficult to relate to their child. The behaviour of the AD/HD child would have been alien to a non-AD/HD mother and, therefore, led to conflict between them. Only one participant did not talk about her family to any great extent and this could have been because she was more focused on her peers than on her family.

SELF-SABOTAGE AND COPING STRATEGIES

Six of the seven participants provided examples of how they sabotage themselves in their daily lives. This ranged from being too opinionated and critical of their bosses to finding other things to do rather than what they were supposed to be doing so that they had an excuse for any failure on their part. This comment from Samantha illustrates this point:

> *I used to deliberately sabotage myself, I used to deliberately do something so that I could fail something and then I could say "well, that's right, there you go, that just shows you. That just proves it. I am hopeless and useless and everything else".*

Amanda also reported finding other things to do when she was supposed to be working on her university assignments:

> *Like, recently I was fixing up my website and, you know, I spent a lot of time on it ... and I knew that I should be spending time working on my uni stuff instead of something like this ...I have been known to do that, I have been known to - I don't know, almost sabotaging myself...*

Antoinette also felt she had a tendency towards self-sabotage:

> *I started acting out destructive behaviour, as if I was sabotaging myself, and proving to me that I was no good.*

While there was a tendency towards such negative behaviour in these participants, they also mentioned that they had developed various strategies in order to cope with the problems. Some of these strategies were positive, but the majority were very negative and ranged from social withdrawal in two cases to reliance on drugs and alcohol in two other cases. However, the women in this study showed their resilience by finding ways of circumventing their handicaps.

Patricia found ways of coping with her school and university studies by anticipating which questions she might be asked in exams:

> *... I know I'm not good at this. I have to work out a way to cheat. I don't mean in the word sense ... I could listen for clues, you know, with teachers, you know - you know what they, their special interest was, you'd pick up these clues, you knew what they emphasised...*

Laura admitted that she had difficulty finishing things, and made this comment:

> *... best thing to do for me is to write notes for myself, you know ... and then I get things done ... and then I say to myself if I don't get everything done on the list today, that's OK, I can do whatever's left tomorrow.*

Tina and Samantha turned to religion as a means of coping with their difficulties, as the following quotes illustrate:

> *... I used to be the black sheep, and then I became a Christian, and I was the white sheep.* (Tina)

> *I have fairly strong beliefs in God ... I went off to Christian counselling. I had a fairly big turning point, a fairly big catharsis with that group...*(Samantha)

The three other participants had also found various ways of overcoming AD/HD handicaps which were, mostly, as positive as those mentioned above, and which had enabled them to cope with their lives. For example:

> *... doing some of the development workshops made me realise that I could actually - I could change the way I thought about myself ...*(Jane)

> *... the only thing that has got me by is my high intelligence ...*(Antoinette)

> *... (AD/HD support group) the feeling that there was someone who knew what I was going through, just the whole feeling that you're not alone ...*(Amanda)

This ability to find coping strategies was in accord with that found by Shekim et al. (1990, p.422) in their study of AD/HD adults, in which they reported that: "some of them can actually function at a higher occupational level than the general population and that having the diagnosis of ADHD, RS (Residual State) does not always mean poor outcome".

LIVING WITH AD/HD

Five of the participants admitted to having social skills problems. They reported incidents of being unable to relate to others, as Amanda stated when asked about the special challenges of AD/HD:

> *... interacting with people I think is probably the main one, just learning how to learn those social skills ...*

Solden (1995, p.119) observed that AD/HD women often avoid small talk because they "experience difficulty with finding the words they want to say when they want to say them ... They are also prone to interrupt, blurt out or shut down". Echoing this, one of the participants reported that she was, at one time, socially phobic and would not accompany her husband to work-related functions because she said that she did not know what to say to other people even though they were in the same field of employment as herself.

> *...I felt uncomfortable in a group. I still do. I hate going to parties or social functions ... I just can't talk to people ...*

This particular participant virtually separated her personal and professional personas in order to cope with other people, as she explained:

> *... um I have these two roles I play. I can be Dr. A or Mrs. W. W's my married name, you know, and I can be stupid if I'm Mrs. W but if I'm Dr. A I can't be, so um I use - I sort of interchange things when I need to.*

Two women said that they found friends through their involvement in their religious affiliations, but one admitted that she had to *work at it*. Most of the other women said that they had only a few female friends because they tended to find that they did not relate very well. Antoinette remarked:

> *I've always had women jealous of me and I couldn't understand it.*

Patricia noted:

> *... most of my best friends were male because I don't, I mean, girls always talked about stupid things, um, you know, make-up and, you know the sort of things girls talk about, I was never into that ...*

Relationships with males were important in all cases and over half the women said that they got on better with males than females. For example:

Jane: *I've never had problems relating to guys, and sometimes it's easier.*

Patricia: *I find males easier to talk to.*

Four of the women were in seemingly stable relationships at the time of interview, that is, three married and one in a six year defacto relationship. Three of the seven women had been previously married (two of these had been married twice), and one woman had recently ended an unsatisfactory fifteen year relationship. Four of the seven

participants said that they had been promiscuous in their earlier life, with one woman admitting to having had an abortion at the age of eighteen.

In this area of functioning, the majority of these women did not differ significantly from each other. Only two of the women had not had problematic relationships in the past. In one case, this was because the participant had never been in a significant relationship, and in the other case, the participant had not been promiscuous during her youth. The other five women had had difficulties in their past liaisons, with three experiencing divorce (one had been divorced twice), and one had had a significant relationship with a substance abuser with whom she had had a child. The remaining participant admitted that she had been involved in a number of unsatisfactory sexual relationships prior to her marriage. This comment illustrates this point:

> *I was highly promiscuous, surprise, surprise, so - I thought that - my mother actually taught me that the only way to keep a man is to have sex with him, so - most times I ended up in bed with men.*

As mentioned in the literature, (Barkley, 1998; Solden,1995; Ratey et al., 1995a), AD/HD women tend to find it difficult to sustain relationships with both males and females. At the time of these interviews, the women in this study appeared to have developed coping strategies which allowed them to function in this area of their lives, either by forming stable relationships or by avoiding them. This may have occurred because the majority were taking psychostimulant medication which had helped them to focus on what was important in their lives.

DEFINE THEMSELVES IN RELATION TO AD/HD

All of the participants expressed a sense of relief when they were diagnosed with AD/HD. They reported that they felt it explained a lot about their problems and inability to cope. They did tend to define themselves in terms of their AD/HD and, in

some cases, used this to excuse problematic behaviour, such as when one woman had a ton of manure delivered to her ex-boyfriend's house and she explained this as her being *impulsive* because of her AD/HD. She said that other people thought that she was a *lunatic* but she blamed her AD/HD. Others used their AD/HD diagnosis to explain such events as relationship failures, school difficulties, criticism from parents and rejection by others, and their own low self-esteem.

Samantha said of her experiences:

> *The specific challenges* (of AD/HD) *is that you are so different to other people and, therefore, building relationships, building strong friendships and stuff, I've only just now begun to develop friendships.*

Likewise, Tina commented:

> *... in looking back I know that I was different. And now I know more as an adult, I know how different I am and I accept that in the last four years. But I was always different to my family.*

Laura found that her problems were compounded after the birth of her son. She explained:

> *... I mean like having ADD, you know, you have trouble - troubles looking after yourself, and so not only did I have troubles with looking after myself, I had this child that I had to be responsible for ... Now I think back on it and I think "Oh, how did I get through it".*

As has been already documented, the participants in this study had experienced difficulties in coping with their lives and had not understood why they should have had such difficulties. Amanda commented:

> *... I think there's something wrong - I think there's something wrong with me, that I wish wasn't there. I wish I could just be like everyone else.*

Hallowell (1995) noted that when an AD/HD sufferer finds out that there is a name for what they have, they feel a sense of great relief. Having an explanation for the difficulties encountered during their lives provided the women in this study with an unexpected source of self-worth in that they no longer needed to blame themselves for their shortcomings, and could more readily cope when things went wrong. Samantha explained:

> *You've been doing something for thirty-two years, writing with a blunt pencil and someone comes along and sharpens it for you. It's a whole new life, a whole new ballgame.*

Jane's comment sums up the feelings of all the women in this study:

> *The diagnosis of ADD, or AD/HD, gave me an answer about why I had been the way I had been up to that point.*

CONCLUSION

This chapter illustrates the common themes identified in the stories of the participants. Overall, there were more similarities than differences in the life experiences of the seven women, and the majority of their difficulties could be directly related to the symptoms of AD/HD. The experience of school failure, as predicted from the literature (Barkley, 1998; Cantwell & Satterfield, 1978; Slomkowski et al., 1995; Weiss & Hechtman, 1993), had a negative effect on most of the women, and only two had achieved any form of, what may be considered by society, as a successful career. Two other participants were undertaking University study but had not completed their studies or graduated at the time of the interviews. Family relationships were a major contributing factor to the participants' perceptions of self-esteem, and none of the women reported having particularly successful interactions with their immediate relatives.

The next chapter is presented as a conclusion to this research study, and will clarify how the experiences of the participants relate to the literature and the findings from other studies.

CHAPTER 5

CONCLUSION

The seven women who participated in this study grew up in various areas of Australia and overseas, had different family dynamics, and came from different socioeconomic backgrounds. However, their experiences of living with AD/HD were remarkably similar. They were all raised in a family where there was at least one parent who exhibited symptoms of AD/HD. To date, only one of these parents has been formally diagnosed, which is to be expected considering that the condition known as Attention-Deficit/Hyperactivity Disorder was not widely recognised before the publication by the American Psychiatric Association of the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III), in 1980 (Barkley, 1998; Nadeau, 1995; Sudderth & Kandel, 1997; Wender, 1995). The condition was thought not to affect adults. At that time, all of the parents of the participants would have been adults before the edition was released. In the majority of cases, it was the father whose behaviour pointed to this conclusion but, in two cases, the mother may also have suffered from the condition. This is in accord with the statistics which estimate a ratio of 4:1 or 3:1 with males predominating (American Psychiatric Association, 1994; Mannuzza & Gittelman, 1984).

A further similarity was that all of the women suffered from depression. This possibly could be related to their experiences of growing up with undiagnosed AD/HD, during which they encountered frequent failures in the academic, social and employment spheres of functioning (Rucklidge, 1997). Tzelepis, Schubiner and Warbasse (1995, p.39) noted that "a lower sense of self-esteem and the perception of personal failure may eventually lead to the clinical diagnoses of major depression or dysthymia". On the other hand, most of these participants described problematic familial relationships

which undoubtedly did have an adverse effect on their sense of self, and this is also a possible cause of their symptoms of depression. Interestingly, even the two women who did not report particularly distressing family interactions said that they also suffered from depression. This finding tends to support the literature (Barkley, 1998; Biederman et al., 1991b; Cotugno, 1995; Faraone et al., 1991; Shekim et al., 1990; Tzelepis, Schubiner & Warbasse, 1995) that depression is often a commonly-found comorbid condition with AD/HD, and leads to the question of "nature or nurture" in the experience of depression and AD/HD. Biederman et al. (1992) found that there was a high correlation between AD/HD and antisocial, mood and anxiety disorders, and that these conditions appeared to be familially transmitted. Smith and Betz (2002, p.438), noted that "the strongest predictor of depressive symptoms was global self-esteem". Although the latter researchers did not use an AD/HD cohort in their sample, their results support the strong connection between depression and self-esteem and, by implication, a three-way connection between depression, self-esteem and ADHD.

In her research, Rucklidge (1997) noted that low self-esteem was not especially an artefact of having AD/HD, but may be the result of other consequences of AD/HD. For example, not being able to pay attention in class would result in academic difficulties, leading to a lowered belief in one's intelligence level and, hence, the diminishing of one's self-esteem. Likewise, a non-supportive family environment, either because of the behaviour of an AD/HD parent or the frustration of a non-AD/HD parent, would also diminish a child's ability to understand what is required of them. Bandura (1997, p.12) notes: "Self-esteem can stem from self-evaluations based on personal competence or on possession of attributes that are culturally invested with positive or negative value ...In conflict-ridden families, parents may deprecate offspring who possess attributes resembling those of the disliked spouse". In other words, if one parent also exhibits AD/HD related behaviours which are causing difficulties within the family, the non-

AD/HD parent could, feasibly, remonstrate against an offspring who shows similar behaviour.

A number of the themes identified by an analysis of the participants' interviews tended to overlap. For example, negative family of origin experiences would lead to depression which would then lead to poor academic success and difficulties in peer relationships. This lack of success would, in turn, lead to a distinct lack of belief in one's self and the development of negative self-fulfilling prophecies. Fortunately, the women in this study had all managed to circumvent the downward spiral and had developed strategies which had largely enabled them to overcome their handicaps.

The findings suggest that the relationship between AD/HD and self-esteem is complex, and that actually having the condition known as Attention-Deficit/Hyperactivity Disorder had not necessarily caused the feelings of low self-esteem in the participants in this study. In fact, the ability to be very active and to be able to do more than one thing at a time was actually an advantage for some of them as, for example, Tina said:

> *... my cousin, she just got married and had babies and stayed home. I was "no, I want to go see the world and travel" ...I was just different, didn't want to stay there, I wanted to go, I wanted to do stuff. I was always, you know, out there doing something different.*

Likewise, Antoinette reported:

> *I owned a business in Sydney for 14 years that I started on my own because I trained myself to be beauty therapist and I was doing that, I was ironing for people, I was cleaning people's houses, and I was doing this part-time job in a bank.*

The feelings of low self-esteem described by the women in this study were most likely the result of the psychosocial and environmental factors surrounding their upbringing, together with the negative attributes of undiagnosed AD/HD.

The majority of the women in this study reported that they had academic difficulties during childhood. Only two participants reported that they did well at school. An analysis of the subjects' responses indicated that most of them appear to have had the intelligence to have done better, as evidenced by the fact that two others were undertaking tertiary studies at the time of the interviews, and a third woman had successfully undertaken a number of TAFE courses. A fourth participant had been employed in managerial positions.

Some of the women reported using drugs or alcohol, possibly as a means of self-medication. This is in accord with the research which has noted that people with undiagnosed AD/HD tend to overuse alcohol, nicotine and illegal drugs as a means of ameliorating their emotional problems (Hechtman, Weiss & Perlman, 1984; Ratey et al., 1992; Rucklidge, 1997). Biederman et al. (1994) and Shekim et al. (1990) report that having AD/HD can put one at risk of alcoholism. While three of the participants in this study did report excessive use of alcohol at an earlier stage of their lives, they did not appear to have become dependent upon the substance. Since being prescribed psychostimulant or antidepressant medication, most of the participants did not admit to excessively using these addictive substances in order to circumvent their difficulties. Interestingly, only one of the participants smoked cigarettes, which is in contrast to the above research.

For all of the women, the symptoms of AD/HD appear to have been present from childhood but had not been investigated or diagnosed until later in life, and by that time, they had developed significant psychological and self-esteem issues. However, while most of the women in this study described problematic experiences in childhood, the question of whether AD/HD was cause or effect needs further investigation. Even non-

AD/HD children would be affected by the problematic behaviour of an AD/HD parent. Likewise, scholastic attainments are difficult when the teacher is non-supportive.

Every person must be looked at holistically, and, therefore, we have to take into account all of the factors of an illness or condition that affects a person. Consequently, it follows that all the aspects of a person's life, i.e. family, social, educational and vocational, are likely to be affected by AD/HD, and, in light of this research, that is certainly true, mediated through the self-defeating, dysfunctional and self-reinforcing processes of impaired self-esteem. These findings constantly underscore and emphasise that low and severely damaged self-esteem can be seen to exist in the person's life in all and every one of these important realms of family, education, career and social interactions.

IMPLICATIONS FOR FURTHER RESEARCH

This study did not find a direct relationship between AD/HD and self-esteem, however, given that the difficulties caused by undiagnosed AD/HD can lead to low self-esteem (Schaedler, 1999; Shekim et al., 1990), this topic is worth further investigation. Future research might focus on a larger number of subjects and include a comparison group of non-AD/HD women who also profess to have low self-esteem, in order to ascertain whether the core symptoms of AD/HD, that is, impulsiveness, inattention, distractibility, disorganisation, and/or hyperactivity/restlessness, may be the significant contributors to a sense of failure and low self-esteem in AD/HD women. As previously discussed, if a woman is impulsive and disorganised, and compares herself unfavourably to her peers who do not have these problems, including a comparison group of women who claim also to have low self-esteem, but not the negative attributes of AD/HD, such as problems with inattention/concentration and motor- restlessness, could shed light on whether low self-esteem is cause or effect of AD/HD deficits.

Another area of investigation leading from the present research might be to examine the impact supportive versus non-supportive teachers have on AD/HD children. A number of women in this study reported negative experiences from their teachers, such as being locked in a cupboard, being beaten frequently, and being treated dismissively and critically. Weiss and Hechtman (1993) reported that when the AD/HD adults in their 15 year long-term study were asked what factors had been most beneficial to them when they were growing up, they had nominated a person, including a teacher, as being the most significant. It could be helpful to the development of self-esteem in AD/HD sufferers, especially females, to ascertain the impact of the teacher/pupil interaction. Perhaps, social skills training could be included in the curriculum for all children (not just AD/HD children), as well as cognitive areas of weakness noted and addressed instead of the child being made to feel that they are "stupid" or "dumb". Also, it would be advantageous for the teacher to be made cognizant of the fact that AD/HD children are at greater risk of peer rejection. Thus, positive discrimination techniques may be an advantage for such children.

Family was important to all the participants in this study, and further research into the family dynamics would be valuable. Faraone et al. (1991, p.112) report that "the relatives of the girls with attention deficit disorder had higher risks of attention deficit disorder, antisocial behaviour, major depression, and anxiety disorders". This also has implications for the treatment for AD/HD within the family and may save the distress of low self-esteem in both parent and child. An AD/HD child will grow up to be an AD/HD adult and, as seen in the cases of the participants in the present study, low self-esteem is a comorbid condition of undiagnosed AD/HD. There is also a need for further research on self-esteem between AD/HD women who were undiagnosed in childhood and AD/HD women who were identified and received treatment in childhood. Such a

study would provide further clarification of the impact of AD/HD symptoms on self-esteem.

The foregoing all have implications for the successful treatment of the distressing effects of AD/HD. This research, as well as that by many other researchers (Barkley, 1998; Nadeau, 1995; Schaedler, 1999; Weiss & Hechtman, 1993), point to the fact that the negative outcomes of undiagnosed AD/HD sufferers are not only the result of the biological factors of inattention, lack of concentration, impulsivity and/or hyperactivity/motor restlessness, but also the psychosocial factors of poor academic achievement, difficult family and peer relationships, and vocational failure, which lead to feelings of helplessness to change the life course. As Abramson, Seligman and Teasdale, (1978, p.55), report "convincing a subject that his helplessness is universal rather than personal will remove self-esteem deficits". Therefore, the treatment of AD/HD ideally should include the whole biopsychosocial-enviro-skills sphere.

Self-esteem issues are a major concern for AD/HD sufferers, especially for females. Krueger and Kendall (2001, p.65) reported that, among the participants in their study, "girls appeared to be more sensitive to others' responses to them, and adjusted their self-perceptions according to the feedback. The identity of AD/HD adolescent girls centered on a failing or inadequate self". Murphy (1995, p.136) stated that "approximately 80% of (his AD/HD) clinic's adult population have admitted to having low self-esteem". This researcher further stated that "helping to build self-esteem and self-confidence is therefore critical in the treatment of adults with AD/HD" (p.137).

In light of the findings from this present study, as well as comments from various authors and the results from other research (Barkley, 1998; Hallowell & Ratey, 1994; Lufi & Parish-Plass, 1995; Nadeau, 1995; Rucklidge, 1997; Schaedler, 1999; Weiss &

Hechtman, 1993), it appears that the emotional outcome of AD/HD does not have to be negative. The women interviewed for this study stated that they felt relieved when they were finally diagnosed, as did those reported by Hallowell (1995). By explaining that low self-esteem is not necessarily caused by AD/HD itself would allow people with the condition to focus on utilising or circumventing the core symptoms of hyperactivity/restlessness, impulsivity, distractibility, concentration/attentional difficulties and to use their strengths for their own advantage. For example, Antoinette remarked that her hyperactivity allowed her to undertake four different jobs at the same time. Likewise, Tina's restlessness was ideally suited for her employment as an air stewardess in that she coped very well with the rigours of international travel for quite a number of years. The other core symptoms of AD/HD could be overcome by familiarity with the pattern of behaviour, so that strategies could be developed in order to compensate. Therefore, the treatment of AD/HD women who were not diagnosed in childhood should, ideally, commence with an education of the nature of the condition. This would enable an AD/HD mother to be more understanding of the difficulties faced by their child(ren). Lufi and Parish-Plass (1995, p.98) comment that "an AD/HD child will face rapid despair and have a negative conception of what others may think about his/her actions", if attention is not given to the personality of the child. An AD/HD mother is in a better position to understand her AD/HD child if she, also, has first-hand knowledge of the adverse attributes experienced by her child. Through education, the mother could assist the child in overcoming the negative sequelae of AD/HD deficits.

To sum up, this research did not support the contention that having the condition known as Attention-Deficit/Hyperactivity Disorder necessarily caused feelings of low self-esteem in the participants, although all of the women admitted to having negative feelings of themselves. The most likely cause of their adverse self-concept was the result of the difficulties they all had endured growing up with an undiagnosed disorder

which neither they, nor their parents, understood. These difficulties encompassed the entire biopsychosocial and skills environment of their lives, and their interactions with other people were important in shaping their experiences. It must be noted that the relationships among these factors is much more complex than is possible to discover in a single qualitative study, but future research will, no doubt, add further to the body of knowledge concerning the phenomenon currently known as Attention-Deficit/Hyperactivity Disorder.

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Appendix 1

Southern Psychological Services

PSYCHOLOGY & CLINICAL HYPNOTHERAPY
A.B.N. 80 087 604 055

LYN BARTLETT, B.A., Grad. Dip. Couns., Dip. Clin. Hyp., M.A.Ps.S., M.A.S.C.H.

Suite 9
80 Kitchener Pde.
Bankstown 2200
Telephone: 9709-3401
Fax: 9763-9624

Volunteers Wanted.

I am currently undertaking a Master of Counselling (Hons.) programme at the University of New England, and the subject of my Master's thesis is "Factors Influencing Self-Esteem in AD/HD Women". I would like to interview women of any age who are agreeable to being included in my study. I am a registered psychologist in N.S.W., and wish to assure all volunteers that their identity will not be divulged to anyone. If you are interested in assisting with my research, please ring me or my secretary on 9709-3401.
Thank you.

Lyn Bartlett

Appendix 2

UNE
The University of
NEW ENGLAND

School of Health
Armidale NSW 2351, Australia
Head of School: Associate Professor Victor Minichiello

PLAIN LANGUAGE STATEMENT

THE EXPERIENCE OF SELF ESTEEM IN WOMEN WITH AD/HD

This study aims to explore the experience of women with AD/HD. I am interested in investigating how this condition affects your quality of life. This research is being undertaken as part of my Master of Counselling with Honours degree from the University of New England.

If you agree to participate in this study, I will ask you to take part in an individual interview which will be tape recorded. Each interview is expected to last for approximately 60 to 90 minutes, and will take place at a venue suitable to you.

Participation in this project is entirely voluntary. You are completely at liberty to withdraw your consent at any time, and to request that any information provided by you be erased. There will be no penalty should you withdraw consent for any reason. You are not required to answer any questions with which you feel uncomfortable, or which may incriminate you in any way.

Should you become upset as a result of participation in this research, you may wish to contact your local Community Health Centre or use a telephone counselling service. Contact details for these services can be located in the front of your local telephone directory.

All information you provide will be identified by a number only. The real names of the participants will not be recorded with the tape recordings and transcripts. All data will be kept in a locked filing cabinet in my home and will be destroyed after a period of five (5) years.

If you have any questions about this research, please feel free to contact me on telephone number: 9709-3401, or fax number: 9793-9624. Further information may also be obtained from my research supervisor, Dr. Victor Minichiello, at the University of New England, School of Health, telephone number: 02 6773-3952.

It is expected that this research and a summary report will be completed towards the end of 2002, and will be available to all participants who are interested in receiving the information.

Should you have any complaints concerning the manner in which this research is conducted, please contact the Human Research Ethics Committee at the following address:

The Secretary - Human Research Ethics Committee
Research Services
University of New England
Armidale NSW 2351
Telephone: (02) 6773 2352 Facsimile: (02) 6773 3543
E-mail: Ethics@metz.une.edu.au

Thank you for your participation.

Lyn Bartlett (Master of Counselling (Hons.) student)

9/80 Kitchener Parade
Bankstown NSW 2200
Telephone: 9709 3401

Appendix 3

UNE
The University of
NEW ENGLAND

School of Health
Armidale NSW 2351, Australia
Head of School: Associate Professor Victor Minichiello

CONSENT FORM

AGREEMENT TO PARTICIPATE

I, ..., have read the information letter for the study on women's experiences of AD/HD, and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, realising that I may withdraw my consent at any time. I agree that research data gathered for the study may be published, provided my real name is not used.

Participant: ..... Date: .....

Investigator: ..... Date: .....

Thank you for your participation.

Lyn Bartlett
9/80 Kitchener Parade
Bankstown NSW 2200
Telephone: 9709 3401