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The Experience of Women University Students Diagnosed with Attention Deficit

Disorder

by

Sonya Lee Corbin Dwyer

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ABSTRACT

Hermeneutic phenomenological methodology was chosen to explore the experience of women university students diagnosed with Attention Deficit Disorder. Most research on Attention Deficit Disorder has been conducted with male children, resulting in limited knowledge of the disorder in females and adults. The purpose of the study was to describe and interpret women's experience. The study will contribute to others' understanding of this experience by presenting it from the women's perspective. Eight participants were interviewed at least twice. Four metathemes emerged from the data, describing the essence of these women's experience: Robbed of Time, Thoughts Like a Rubber Ball, Is ADD Real or Manufactured, and Janus-Faced. Possible implications for educators and mental health professionals, limitations of the study, and directions for future research are considered.

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TABLE OF CONTENTS

APPROVAL PAGE	ii
ABSTRACT	iii
ACKNOWLEDGEMENTS	iv
TABLE OF CONTENTS	vi
LIST OF FIGURES	ix
 CHAPTER ONE: INTRODUCTION	 1
Definition of Terms	4
 CHAPTER TWO: LITERATURE REVIEW	 6
Diagnostic Issues for Females	7
Definition and Prevalence of the Disorder	7
Theories of AD/HD Etiology	9
Neurology	9
Diet	12
Genetics	12
Diagnostic Problems	14
Comorbidity and Differential Diagnosis	16
The Role of the DSM-IV in Recognizing AD/HD in Females	23
Gender Issues in the Diagnosis of Childhood AD/HD	25
Women Diagnosed with AD/HD	29
Summary	30
Educational Issues for Women Diagnosed with AD/HD	32
Summary	37
The Experience of Women University Students	37
Summary	43
Conclusion	44
 CHAPTER THREE: THE METHOD OF INQUIRY	 45
Rationale for Employing Hermeneutic Phenomenology	45
Hermeneutic Phenomenology Methodology	47
Hermeneutic Phenomenology Approach	47
Hermeneutic Phenomenology and Feminist Compatibility	48
Summary	51
The Process of Inquiry	51
Selection of Participants	52
Data Collection	54
The Interview Process	54
Data Analysis and Interpretation	57
Journal Writing	57
Thematic Analysis	60
Accountability	62

Ethical Standards	65
Consent	65
Confidentiality	66
Risks	66
CHAPTER FOUR: HERMENEUTIC PHENOMENOLOGICAL REFLECTION	67
Portraits	67
The Writer/Researcher	67
The Participants	69
Robin	70
Dagny	71
LJ	72
Michelle	73
Christine	75
Suzie	76
Dawn	78
Sue	79
Researcher's Reflections	80
Essential Meaning of the Lived Experience of Women University Students	
Diagnosed with ADD	82
Robbed of Time	82
Consenting or Created Victims?	85
Taking Back Time	87
Thoughts Like a Rubber Ball	89
Catching a Rubber Ball	92
Positive Qualities of a Rubber Ball	94
A Rubber Ball Versus "Tuning Out"	96
Is ADD Real or Manufactured?	97
Is My Diagnosis Real or Manufactured?	98
Is the Assessment Process Real or Manufactured?	102
Am I Real or Not Real?	105
Janus-Faced	108
The God of Gates, Doorways, and Entrances	112
The God of Transitions	114
Summary	116
CHAPTER FIVE: DISCUSSION	117
Robbed of Time	117
Normality	117
The Effects of Labelling	118
Summary	121
Is ADD Real or Manufactured?	121
Etiology	121

Janus-Faced	124
The Role of Language in Women's Experience	124
Delayed Responding and Language	125
Summary	127
Thoughts Like a Rubber Ball	128
Web or Conveyor Belt?	128
Implications	130
Limitations	133
Future Directions	135
Study Summary	138
REFERENCES	141
APPENDICES	
Appendix A. Invitation to Participate	164
Appendix B. Cover Letter for Consent Form	166
Appendix C. Consent for Research Participation	168
Appendix D. Summary Characteristics of Participants	170

LIST OF FIGURES

Figure 1 Illustration of Janus	171
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CHAPTER ONE: INTRODUCTION

What is the experience of women diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD)? This research focuses on women diagnosed with AD/HD enrolled in university. AD/HD in adults is still a relatively new area because for decades clinicians believed that the symptoms disappeared in adolescence. While there is still debate over its prevalence in adulthood (Fischer, 1997), it is now generally accepted that AD/HD can be a lifelong condition (Weiss, 1992; Kaplan & Shacter, 1991). Adult women were chosen for this study because the number of females being diagnosed with AD/HD is rising and most research on AD/HD has been conducted on male children. This has resulted in limited knowledge of the disorder in other populations, particularly females and adults (Schaughency, McGee, Raja, Feehan, & Silva, 1994). While some practitioners are recognizing that women with AD/HD have different experiences than men with the disorder because of the socio-political context in which they live (e.g., Solden, 1995; Nadeau, 1996), current information about women who are diagnosed with AD/HD is primarily anecdotal, based on clinical observation.

One reason for choosing women university students is that adult women constitute the most rapidly growing section of the student population in higher education. Yet, there is little work on women's learning in higher education. This is due in part to much of the research having been conducted on the learning of girls and adolescent females and then extrapolated to adult women (Hayes & Flannery, 1995). These authors noted that the characteristics of adult women students are changing along with societal norms and expectations that may affect their education. So, before research on women's learning

can occur, researchers need to know what kind of information is relevant to this understanding. One place to start is with an awareness of the social contexts in which women's experiences occur and the personal or emotional meanings women give to their experiences (Laidlaw & Malmo, 1990).

Current research indicates that women perceive the academic climate to be chillier than men do, which includes finding university to be an inhospitable environment and reporting general dissatisfaction with the quality of their educational experience (Seagram, Gould, & Pyke, in press as cited in Pyke, 1997). In addition, college and university students with disabilities often encounter barriers to their education, including a lack of understanding and cooperation from administration, faculty, staff and other students, and a lack of adaptive aids and other resources (e.g., West, Kregel, Getzel, Zhu, Ipsen, & Martin, 1993). Attention-Deficit/Hyperactivity Disorder in the college population is a vastly understudied area (Weyandt, 1995) even though increasing numbers of students with the disorder are entering colleges and universities (Richard, 1994). Women university students with AD/HD may be experiencing even more obstacles in getting an education because they are female *and* have AD/HD.

This research will add to our understanding of women university students diagnosed with AD/HD by presenting their experience from their perspective. Understandings generated from this study may be useful to psychologists, counsellors, professors, and other professionals interested in improving services for students at post-secondary institutions. As well, research is needed to develop a better understanding of clinical indicators of AD/HD in females (Beiderman, Faraone, Spencer, Wilen, Mick, &

Lapey, 1994). Under-identification and under-treatment of females with AD/HD may have substantial mental health and educational implications (Beiderman et al., 1994).

This study evolved out of my experience as a facilitator of a supportive and educational group for women with attentional and organizational difficulties. This was part of a practicum placement position with the Student Resource Centre at the University of Calgary during the winter of 1996. I was particularly impressed with the diversity, as well as the similarities, of the women who participated in the group. While many of the women presented with the same characteristics, these varied in their degree and pervasiveness. Intrigue about this situation led to my research question.

To explore the way we experience the world, I used, as van Manen (1990) suggested, my own personal experiences as a starting point. From my practicum experience, I developed the question “What is the meaning of the lived experience of women university students diagnosed with AD/HD?” Hermeneutic phenomenology was chosen as the most appropriate methodology for this study. The purpose of hermeneutics is to try to ‘grasp’ the essential meaning of the phenomenon by questioning what something is ‘really’ like (van Manen, 1990).

According to phenomenology, reality is understood only in the form in which it is perceived and meaning comes from the interpretation given to it by a person (Stainback & Stainback, 1988). This approach can permit the research process to be an exchange of perception and interpretation that allows the women to participate actively in the description and interpretation of their experience. What people say and do is a product of how they define their world and the phenomenologist’s task is to capture this process of

interpretation (Taylor & Bogdan, 1984).

This chapter has provided rationale for this study. Chapter Two provides a more detailed review of the literature for its contribution to understanding further these issues as they are related to the experience of women university students diagnosed with AD/HD: (a) diagnostic issues for women with AD/HD (b) educational issues for adult women diagnosed with AD/HD and (c) the school experience of women university students. Chapter Three outlines the methodology and process of inquiry. Chapter Four presents the emergent themes and in Chapter Five, the implications of the results of the analysis, limitations of the study and directions for future research are discussed.

Definition of Terms

Before proceeding, it is necessary to clarify the terms ADD and AD/HD as both are currently used by clinicians.

Brown (1995) noted that most of the early diagnostic descriptions of the disorder focused on the hyperactive behaviour of 'disruptive children' (p. 93). He explained that this was the case until research indicated that most of these children had impulsive and inattentive characteristics in addition to hyperactivity. For many years, these three characteristics were considered to define the disorder; today some educators, doctors, and parents still consider a diagnosis of AD/HD only if all three symptoms are obvious (Brown, 1995).

It was not until the publication of the DSM-III in 1980 and the inclusion of the term Attention Deficit Disorder that this disorder or the label "ADD" could be used to label children with or without hyperactivity. However, when the DSM-III-R was

published in 1987, there was still a lack of research to support the notion that the disorder may occur without hyperactivity and hence, the diagnosis was renamed Attention-Deficit Hyperactivity Disorder. The previous diagnosis of ADD W/O that was used to designate 'without hyperactivity' was replaced by Undifferentiated ADD. This new label had no diagnostic criteria, thus questioning the validity of this diagnosis. However, since that time, many research studies have documented AD/HD with and without hyperactivity and, as a result, subtypes of AD/HD in the DSM-IV (APA, 1994) include Predominantly Inattentive Type (Brown, 1995).

CHAPTER TWO: LITERATURE REVIEW

This review is organized into three sections to provide a background for the phenomenon of concern (Swenson, 1996), the experience of women university students diagnosed with AD/HD. Osborne (n.d.) promoted critically reviewing existing research which may relate to the research question, grouping this research into meaningful clusters and summarizing these findings. The first section reviews diagnostic issues related to adult females, including definition and prevalence of the disorder in adulthood. Section two highlights the importance of focusing on the experience of this population by examining educational issues for women diagnosed with AD/HD. The third section explores the experience of women university students.

Rifken (1995) suggested that all information, including a literature review, should be bracketed or suspended until, or completed after, the research is completed in an attempt to elicit the participants' voices and the details of their experiences, rather than anticipate specific responses or validate the researcher's expectations. However, this information can become a source of knowledge for the researcher to develop phenomenological interpretation (Ray, 1990). Ray (1990) emphasized that select literature lets the researcher reflect more deeply on the experience. This literature review is not intended to be exhaustive (Swenson, 1996) as many of the references to the literature will occur during the data collection, analysis and discussion. Additional literature is referred to in the analysis in an attempt to compare and contrast the data with other known realities, which is an interpretive activity implemented to sort and classify the data thematically (Boyd, 1993). The different phases of the phenomenological

method were observed in this study as the literature was revisited several times throughout the data analysis process. The findings of these searches are presented in the following chapters.

Diagnostic Issues for Females

“Not since the establishment of learning disability as a special education category has a condition so captivated both the professional community and general public as has Attention-Deficit/Hyperactivity Disorder” (Reid, Maag, & Vasa, 1993, p. 198). Reid et al. (1993) also pointed out that like the term ‘learning disability’, Attention-Deficit/Hyperactivity Disorder is troubled by definitional and diagnostic problems.

Definition and Prevalence of the Disorder

The DSM-IV states “The essential feature of Attention-Deficit/Hyperactivity Disorder is 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” (American Psychiatric Association, 1994, p. 78). This current edition of the DSM indicates that there are three subtypes of this disorder, based upon whether individuals have a predominant pattern of inattention and/or hyperactivity (based on symptom pattern for the last six months): Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type; Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type; and Attention-Deficit/Hyperactivity Disorder, Combined Type. The authors suggest most children and adolescents with AD/HD have the Combined Type but it is not known whether the same is true of adults with the disorder.

A variety of adult AD/HD prevalence rates are reported throughout the literature.

Shaffer (1994) wrote “There have been no epidemiological studies to indicate how prevalent...AD/HD is in the adult population” (p. 635). Some writers have claimed that AD/HD is a “common” adult disorder, although they have not indicated their criteria for “common” (e.g., Milberger, Biederman, Faraone, Murphy, & Tsuang, 1995; Fargason & Ford, 1994). Without citing his source, Wender (1995) suggested that AD/HD “probably affects between 2 and 6 percent of the adult population” (p. 134). Other writers have based their prevalence rates on those of children with the disorder. For example, Milberger et al. (1995) indicated that AD/HD is estimated to affect 6%-9% of school-age children, of which 10%-60% persist into adulthood; Fargason & Ford (1994) suggested that AD/HD persists into adulthood in 11%-50% of childhood cases; Shekim, Asarnow, Hess, Zaucha, and Wheeler (1990), citing one study, stated that “several follow-up studies demonstrated that 70%-75% of patients observed continued to have difficulty concentrating and were overactive and impulsive into adulthood” (p. 416). However, in the same article, Shekim et al. (1990) claimed prevalence estimates of the disorder in children are between 3% to 5% of all children and so “it follows” (p. 416) that 1% to 2% of all adults may have the disorder. The DSM-IV indicated the prevalence rate to be 3%-5% in school-age children but it does not provide a rate for adults, noting “data on prevalence in adolescence and adulthood are limited” (APA, 1994, p. 82). So, while it is clear that there is no agreement on the prevalence rate, either in children or adults, there is a consensus that the disorder can continue into adulthood. Before exploring some of the problems with the diagnostic procedure, I will review the literature on the etiology of AD/HD. This is also an area that lacks consensus. However, it does help to provide

some background for the disorder.

Theories of AD/HD Etiology

The precise causes of AD/HD are unknown at present (Barkley, 1996). Barkley (1990) pointed out that research in this area continues to be methodologically difficult, with inconsistent and conflicting results, with most investigators suggesting multiple etiologies that may lead to AD/HD. In their review of the literature, Goodman and Poillion (1992) found five domains of causes of AD/HD: (a) environmental, (b) intellectual/developmental, (c) organic, (d) psychological/ behavioural, and (e) birth complications. While it is beyond the scope of this paper to examine the thirty-eight factors found by Goodman and Poillion (1992), I will highlight some of the more common causes cited. It is important to note that much of the research in this area has been conducted with hyperactive children, which may not be applicable to children who are diagnosed with the Predominately Inattentive Type. Wender (1995) suggested that, until recently, the only data concerning etiology dealt with children with AD/HD, leaving the question of the relationship between the etiology of AD/HD in childhood and AD/HD in adulthood unanswered. However, since the disorder requires a childhood onset, he decided the question is probably irrelevant as the cause presumably plays the same role in childhood and adulthood.

Neurology

Despite extensive efforts, researchers have been unable to demonstrate consistent neurobiologic differences between hyperactive children and controls (Zametkin et al., 1990). The authors stated that as a result, the validity of hyperactivity as a syndrome

remains controversial. Barkley (1990) asserted that because much of the research on etiology is neurological in nature which does not allow for direct evidence of causality, care needs to be taken in interpreting results of this research.

Chelune, Ferguson, Koon, and Dickey (1986) compared the neuropsychological performances of children with AD/HD and matched controls. The findings revealed a relatively circumscribed pattern of deficits on tests presumed to measure frontal lobe inhibitory control. Disorders of the prefrontal regions often result in inattention, distraction, and an inability to inhibit inappropriate responses (Zametkin et al., 1990). Chelune et al. (1986) also reported that lesions in this area result in a breakdown of the regulation of goal-directed activity and impulsive responding, creating difficulty in suppressing ongoing activities despite environmental feedback that they are no longer appropriate. The authors did observe that deficient frontal lobe functioning may not account for all forms of AD/HD or hyperactivity but may explain many of the findings associated with AD/HD.

Studies on cerebral blood flow indicated patterns of underactivity in the prefrontal areas and their rich connections to the limbic system via the striatum (Lou, Henriksen, & Bruhn, 1984). Lou, Henriksen, Bruhn, Borner, and Nielsen (1989) stated that low striatal activity appears to be a cardinal feature in AD/HD. The authors found striatal regions to be hypoperfused and by inference, hypofunctional, which was partially reversible with methylphenidate.

Additional evidence of a biological basis for the disorder is abnormalities in neurotransmitter function. Raskin et al. (1984) found that a comparison of the

cerbrospinal fluid of AD/HD and control children indicated decreased brain dopamine in AD/HD children. Shaywitz, Shaywitz, Byrne, Cohen and Rothman (1983) found evidence that deficiencies in dopamine, norepinephrine, or both, may contribute to brain underactivity because neurotransmitter underactivity occurs in areas of the brain where dopamine and norepinephrine are most involved.

Barkley (1990) explained that some children may acquire AD/HD secondary to a significant neurologically compromising event such as head trauma, infection, or hypoxic injury. These children may present with more severe symptoms during the immediate post-traumatic recovery period and a lessening of symptoms over time. As well, they may also show a poorer response to stimulant medication treatment.

Zametkin et al. (1990) found that global cerebral glucose metabolism was 8.1% lower in the adults with hyperactivity than in controls without hyperactivity. In these hyperactive adults, glucose metabolism was significantly reduced in thirty of sixty specific regions of the brain, including the premotor cortex and the superior prefrontal cortex, which are areas that have been shown to be involved in the control of attention and motor control. These findings support the role of the frontal lobes in the pathophysiological processes of hyperactivity.

Richardson (1998) has worked with many AD/HD adults who are addicted to sugar, especially chocolate (which also contains caffeine). Based on her clinical observations, she reported that they find that eating sugar helps them stay alert, calm and focused. She concluded that if the AD/HD brain is in need of more glucose, it would make sense that the body would find a way to increase the supply of glucose to the brain

as quickly as possible. However, she did state that it is impossible to sort out what is pure sugar craving when it is mixed with the stimulating effects of caffeine for people with AD/HD.

Diet

Lindgren (1994) noted that despite the lack of consistent evidence from controlled studies of the behavioural effects of sugar, subjective reports of its adverse effects of producing hyperactivity in children are widespread. He explained that diet is often disrupted in situations that also disrupt usual patterns of supervision and behaviour management, such as holidays, parties, and family visits. Therefore, some parents may attribute the increased activity levels seen in these situations to the food consumed rather than the other factors present, namely the excitement of the situation.

Other dietary considerations in AD/HD have focused on the Feingold K-P diet which eliminates all foods containing artificial colourings and additives and naturally occurring salicylates (found in such foods as almonds, apples, berries, peaches, tomatoes, and oranges) (Casey, 1993). Research evidence does not support this diet as an effective treatment for hyperactive children, with a very small subset of young children demonstrating only mild improvements (Casey, 1993).

Genetics

Twin studies have demonstrated support for the heritability of AD/HD symptoms. Goodman and Stevenson (1989) found that monozygotic pairs were more alike than same-sex dizygotic pairs on objective measures of attentiveness and parent and teacher ratings of hyperactivity. The authors found the link between adverse family factors (such

as parental malaise, marital discord, and parental criticism and coldness toward the child) and hyperactivity was weak, suggesting that family pathology may be a consequence rather than a cause of hyperactivity. As well, they found that perinatal adversity (including low birth weight and second born twins) was not related to later hyperactivity.

Zametkin's (1996) review of the genetics literature on AD/HD suggests that much of the early research in this area looked at siblings, not at parents. This focus may have contributed to a delay in the identification of AD/HD in adults. It is now recognized that AD/HD is commonly inherited as indicated by the findings that first-degree relatives of people with AD/HD were at five times greater risk for AD/HD (Biederman, Faraone, Keenan, et al., 1992).

Hauser et al. (1994) found a strong and specific association between AD/HD and generalized resistance to thyroid hormone (GRTH), offering GRTH as "a well-defined genetic disease that can serve as one genetic model of ADHD" while noting that "it is likely that ADHD is a heterogeneous illness caused by various genetic and other factors" (p. 757). Alessi, Hottois and Coates (1993) maintained that a direct causal relationship has not been demonstrated in this area and that the AD/HD may have simply been a manifestation of the elevated thyroid state of the patients. Bhatara, Kumer, McMillin, and Bandettini (1994) noted that while definitive answers regarding the relationship between AD/HD and thyroid disease are elusive, clinically the relationship may be significant.

While far from exhaustive, this section has presented a sample of the variety of conditions that have been attributed to the cause of AD/HD. Lorys-Vernon, Hynd,

Lyytinen, and Hern (1993) explained that since AD/HD is a behavioural diagnosis, further research is needed to more specifically differentiate the behavioural manifestations of the disorder before an accurate account of etiology can be presented. Next, diagnostic problems as they relate to females and adults are discussed.

Diagnostic Problems

Shaffer (1994) offered three major diagnostic problems with adult AD/HD. One is the requirement of a history of AD/HD in childhood. He discussed the problem of incorrect recollection on the part of the client who may forget or exaggerate difficulties experienced as a child. The second is that a diagnosis of AD/HD frequently occurs with other diagnoses. It is unclear, he stated, whether comorbidity is a direct consequence of AD/HD or a manifestation of continuously associated conduct and learning disorders. Third, some of the clinical features of AD/HD mimic those of other disorders, most notably, mood and borderline personality disorders. I will continue to explore the DSM system focusing on comorbidity and differential diagnosis and the role these processes may have played in the delayed recognition of AD/HD in adults in the next section.

The notion that children outgrow AD/HD by puberty or in adolescence was challenged in the 1980s when long-term follow-up studies demonstrated that the core symptoms persisted into adulthood (Fargason & Ford, 1994; Schaugency et al., 1994). In their follow-up studies of *hyperactive* children, Weiss and Hechtman (1993) found that, for many children with AD/HD, “the core symptoms diminished in intensity by adolescence” (p. 386). They noted that many adults became indistinguishable from normal controls, appearing to grow out of their childhood disorder. However, at least one

“disabling” symptom of the disorder continued to cause impairment in functioning in 66% of the adults. The importance of follow-up studies in the research of this disorder was acknowledged by Biederman, Faraone, Mick et al. (1995) who pointed out that child clinicians, such as pediatricians, do not usually follow clients into adulthood. These follow-up studies were a significant contributor to the recognition that AD/HD continues into adulthood.

Fargason and Ford (1994) suggested that a lack of awareness of the presence of this disorder in adults is one of the reasons it is under-diagnosed and therefore, inappropriately treated. Lomas (1995) echoed this observation when he stated “most psychiatrists rarely consider, detect, or treat adults for attention deficit hyperactivity disorder” (p. 961). He cited himself as an example, saying throughout his career which included 12 years as chief of psychiatry in a medical centre, “I cannot think of a single instance in which attention deficit hyperactivity disorder was even considered as a possible diagnosis for an adult patient” (p. 961). Fargason and Ford (1994) suggested that adults with AD/HD are usually self-sufficient although they tend to have poorer academic and job performance, and lower socioeconomic status than their siblings. A variety of coping strategies, combined with the lack of awareness among some clinicians, may have contributed to the delay in recognizing AD/HD in adults.

Brown (1995) pointed out that the more overt and often disruptive behaviour characterizing the Predominantly Hyperactive/Impulsive Type make it much easier to recognize and diagnose. Further, the lack of these “noisy” behaviours in those with Predominantly Inattentive Type can cause individuals with this “silent” subtype to be

overlooked throughout childhood, adolescence, and even adulthood (Brown, 1995, p. 98; Tzelepis, Schubiner, & Warbasse, 1995). Although hyperactivity is no longer considered the hallmark of the disorder, Greenblatt (1994) concluded from the results of her study that many professionals continue to believe otherwise. She noted that females may be misdiagnosed or under-recognized because typical hyperactive behaviour is less common in females. This may be another factor contributing to the recent recognition of the presence of the disorder in adults. This topic will be revisited in the discussion of gender issues in the diagnosis of girls and women with AD/HD.

Comorbidity and Differential Diagnosis

Brown (1995) reported that one factor that reduces recognition of AD/HD and may contribute to the lack of awareness of the disorder among adults, especially without hyperactivity, is the problem of comorbidity. He recounted that more than 50% of those diagnosed with AD/HD also meet diagnostic criteria for at least one other psychiatric diagnosis. He suggested that since these other disorders, especially in adults, are more familiar to most clinicians, it is likely that the person with AD/HD and a co-existing disorder may be diagnosed and treated for the comorbid disorder and not for AD/HD.

Murphy (1993) suggested that

perhaps the most difficult and challenging clinical problem in assessing and treating adults with attention deficits is differential diagnosis. Accurate diagnosis of adult AD/HD is far from an exact science—for instance, the symptoms of AD/HD are common to many other psychiatric conditions as well. (p. 5)

Fargason and Ford (1994) stated that symptoms of AD/HD overlap with those of several personality disorders, particularly borderline. Barkley and Murphy (1993)

emphasized that a diagnosis of adult AD/HD should be *excluded* if psychotic disorders, bipolar disorders or borderline personality disorders are present. Kane, Mikalac, Benjamin, and Barkley (1990) also suggested that the presence of a bipolar disorder precludes a diagnosis of AD/HD because of the associated attention and organizational deficits with bipolar disorders. It is often indicated that the concurrent psychiatric disorders be treated first before assessing the remaining attentional symptoms for the presence of adult AD/HD. Further, Barkley and Murphy (1993) suggested that “AD/HD and bipolar disorder are not related in any significant way developmentally, etiologically, conceptually, or otherwise, and so each should be considered as exclusive of the other at this stage of our understanding of both disorders” (p. 3).

Barkley and Murphy (1993) suggested that adult diagnoses of anti-social personality disorder, substance abuse disorder, major depressive disorder, intermittent explosive personality disorder, and narcissistic personality disorder should not preclude giving the additional diagnosis of AD/HD to an adult. They presented four reasons why a diagnosis of AD/HD is warranted in these cases:

1. AD/HD has a far earlier onset than any of these adult disorders, and the disorder which develops first should take precedence.
2. Follow-up studies of AD/HD children into adulthood indicate that small but significant minorities of clinic-referred children with AD/HD are likely to meet criteria for a variety of adult disorders.
3. Adding the diagnosis of adult AD/HD may significantly affect treatment planning.

4. Considering the diagnosis of adult AD/HD may cause the clinician to look more closely for its appearance in biological relatives that may have been overlooked.

As well, Barkley and Murphy (1993) suggested that the presence of immediate social or marital problems with the adult client should also not exclude a diagnosis of AD/HD as studies demonstrate that most AD/HD children (over 75%) continue to have significant social adjustment problems in adulthood (the authors' sources were not cited). In their analysis of AD/HD and comorbid psychiatric conditions, which corrected for overlapping symptoms, Milberger et al. (1995) demonstrated that AD/HD was not an artifact of symptoms shared with other psychiatric disorders and the comorbid conditions themselves were not an artifact of symptoms overlapping with those of AD/HD.

Contrary to Kane et al. (1990), Kohlberg (1994) reported "since the 1970s, it has been possible to identify patients who seem to have an overlap between the signs and symptoms of AD/HD and depressed and/or manic mood disorders" (p. 12), including bipolar, or manic/depressive, disorder. The author proceeded to discuss treatment of such an individual and pointed out that "the overlap in symptoms between these various combinations could be difficult to recognize unless one were familiar with these different syndromes" (p. 14). Shekim et al. (1990) found more dysthymic disorder diagnoses among adults with AD/HD who were not diagnosed with childhood AD/HD than those who were diagnosed and treated as children. Hallowell and Ratey (1994) reported that sometimes the first symptom that brings a person with AD/HD to consult a psychiatrist is some form of a mood disorder, particularly depression (the authors did not distinguish between despondency, dysthymia or clinical depression). The overlap in the symptoms of

depression and AD/HD can be significant so differentiating between these two disorders is sometimes difficult (Tzelepis et al., 1995). On this point, Tzelepis et al. (1995) suggested “clinicians who are not aware of AD/HD usually ascribe the symptoms of inattention, susceptibility to frustration, and irritability to depression” (p. 37).

Schubiner et al. (1995) reported that it is becoming apparent that there is a subgroup of individuals with a dual diagnosis of AD/HD and substance use disorders. They stated that being diagnosed with conduct disorder as an adolescent increases the risk of substance abuse. They concluded that since 40%-50% of children and adolescents diagnosed with AD/HD are also diagnosed with conduct disorder, it is not surprising that a number of studies found an increased incidence of AD/HD in populations of alcoholics and other drug abusers. This is consistent with the data of Biederman, Wilens et al. (1995) who found in their population of AD/HD adults without another co-existing condition, 40% had a diagnosis of substance use disorders. From this, the authors concluded that AD/HD by itself significantly increases the risk for psychoactive substance use disorders.

In a study by Shekim et al. (1990), the majority of dually diagnosed adults with AD/HD had a diagnosis of generalized anxiety disorder. The authors reported that this diagnosis was based on symptoms such as difficulty concentrating, restlessness, nervousness, muscular tension, and difficulty sleeping which, they noted, are common complaints among adult AD/HD patients. Shekim et al. (1990) suggested that the overlap between these two disorders needs to be clarified, especially because there may be a subgroup of patients with anxiety disorders who are AD/HD and may respond better to

stimulants.

Brown, Madan-Swain, and Baldwin (1991) noted that an important consideration in diagnosing adult AD/HD is the possibility of gender differences in the comorbidity of internalizing (e.g., depression, anxiety, and withdrawal) and externalizing (e.g., aggression, inattention, and overactivity) psychopathology. Several studies have suggested that AD/HD symptomology in both genders is characterized by external behaviour (e.g., Breen & Barkley, 1988), while other studies have indicated that women diagnosed with AD/HD are more likely to exhibit differences in comorbid patterns, including internalizing symptoms such as anxiety and low self-esteem (e.g., deHass & Young, 1984).

While the previously discussed writers suggested that AD/HD can be comorbid with a host of other DSM disorders, Popper (1991) cautioned that individuals who fulfill the diagnostic criteria for AD/HD may actually have a completely different disorder. He suggested some of the AD/HD “look-alikes” (p. 16) included depression, biologically-based anxiety disorders, schizophrenia, bipolar disorders, stress-induced anxiety states and child abuse or neglect.

Appropriate diagnosis is an important aspect of comprehensive health care. Health care reflects cultural models of health and of care. Health care for women highlights a gender perspective of these cultural models, and therefore, these models define health, define care and define women (Gadow, 1993). Ratey, Miller and Nadeau (1995) suggest that women diagnosed with AD/HD are likely to exhibit symptoms of depression and anxiety which mislead clinicians away from an underlying attention

deficit. This reflects clinicians' view of women's behaviour through social models that impact on their interpretation of symptoms. Women's anxiety and depression may be comorbid with a diagnosis of AD/HD or a consequence of the disorder because AD/HD symptoms interfere with women's ability to live up to social norms and role expectations (Ratey et al., 1995).

Penfold and Walker (1983) suggested that the effect of a woman's daily experience, while living out her expected role, is seldom considered by mental health professionals when diagnosing depression. They pointed out that depression is viewed as a cause rather than a consequence and is the most frequently overlooked symptom. Most women diagnosed with AD/HD have suffered years of failure and frustration in school, work, and social arenas. Many have repeatedly heard negative messages highlighting their weaknesses from parents, teachers, spouses, friends or employers. An effect is internalization of these negative messages (Murphy, 1995). "Symptoms" of depression may be normal reactions to such difficulties and feelings of inadequacy. Mental health professionals working with women need to be aware of the role that the structure of society plays in women's health so that women may receive accurate diagnoses.

Kaplan (1991) noted four elements key to the traditional definition of depression: (a) the experience of loss, (b) the inhibition of anger and aggression, (c) inhibition of action or assertiveness, and (d) low self-esteem. She suggested that psychology needs to make fundamental changes in its thinking about depression in women. Kaplan stated current research indicates that the capacities to act in the world, the expression of anger, and a person's sense of being validated by societal norms and expectations, are all

gender-based, influenced by socialization. Women usually inhibit anger and action to preserve relational ties (Kaplan, 1991) since their sense of self-worth relies heavily on their sense of their ability to make and build relationships (Gilligan, Lyons, & Hanmer, 1990). Is it any wonder that women outnumber men by about two to one for the diagnosis of depression (Worell & Remer, 1992)?

Murphy (1993) emphasized that a thorough assessment to rule out the presence of other conditions is crucial to an accurate diagnosis. He said this is also true even if the adult was diagnosed with AD/HD as a child because an earlier clinician may have been wrong, if, for example, the child was in the early phases of developing manic-depression.

Organic disorders that can mimic AD/HD include petit mal and partial complex seizures, traumatic brain injury, sensory deficits (particularly hearing impairment), medication toxicity, lead toxicity, renal disease, hepatic disease, thyroid disease, and substance abuse or withdrawal (Fargason & Ford, 1994). Other conditions that need to be ruled out are Post-Traumatic Stress Disorder, chronic abuse since infancy, or 'symptoms' induced in adulthood by a frantic lifestyle, juggling multiple roles or even too much coffee (DeMuth, 1996).

It appears that the problems of overlapping symptoms of AD/HD with other DSM and organic disorders and the prevalence of comorbidity of psychiatric conditions with AD/HD are major factors that contributed to the delay in the recognition that AD/HD can exist in adults. It should be noted that when the 'misdiagnosed' or comorbid condition was treated and not AD/HD, clients did not respond to the typical treatment (Weiss, 1992; Ratey, Miller, & Nadeau, 1995), emphasizing the need for an appropriate diagnosis. For

the majority of psychiatric disorders, there appears to be a consensus regarding the comorbidity with AD/HD. However, there seems to be mixed results concerning bipolar disorders.

The Role of the DSM-IV in Recognizing AD/HD in Females

Power and DuPaul (1996) claimed that the most significant modification made in the DSM-IV is its reaffirmation of the distinction between AD/HD with and without hyperactivity. As noted in the introduction, this distinction was vague in the DSM-III-R because committee members were not convinced sufficient evidence existed to validate this distinction (Power & DuPaul, 1996). DSM-IV field trials for AD/HD in children and adolescents conducted by Lahey et al. (1994) supported the decision to subdivide AD/HD into three subtypes. Their results also indicated that the three subtypes were found to differ in terms of types of impairment, age, and sex ratio. For example, more females tended to meet the criteria for the Predominantly Inattentive Type while more males met the criteria for the Combined Type. As well, they found that the DSM-IV definition appeared to be less biased than the DSM-III-R toward the symptom pattern typical of elementary school boys, because more girls and preschool children were identified with the DSM-IV criteria (Spenciner & Cohen, 1994-95).

As Power and DuPaul (1996) noted, DSM-IV criteria do not account for the developmental changes in the expression of the disorder across the life span. They suggested that the content of the criteria and the diagnostic thresholds are largely relevant to children between the ages of six and eleven years, and noted that the “overriding emphasis of the hyperactivity-impulsivity symptoms is on overt motor activity” (p. 291).

They did point out that many of the symptoms in the inattentive domain could be considered relevant for adults. However, the single threshold of six out of nine symptoms in each domain provided by the DSM-IV does not appear to take into account research which suggests a lower threshold for adults (Power & DuPaul, 1996).

Murphy and Barkley (1996) reported that the published DSM-IV guidelines were developed exclusively on children. Their preliminary data, consistent with that of Power and DuPaul (1996), suggested that the current DSM-IV thresholds for the diagnosis of AD/HD are too high for the adult population, and cannot be applied to the diagnosis of AD/HD in adults.

Wylie (1995) claimed that “some argue that the prevalence of certain diagnoses reflects the changing tides of political, economic and social trends at least as much as the discovery of new diagnostic populations that objectively meet improved criteria” (p. 29). She pointed out that Genova (n.d., as cited in Wylie, 1995), a psychiatrist in the United States, suggested that managed care influenced changes in diagnostic categories in the DSM-IV. These changes represent a shift away from diagnoses which are identified as requiring long-term, intensive and expensive therapy. Genova predicted that AD/HD will become the fad diagnosis of the late 1990s because it is a very well-defined condition which lends itself to a short-term, biological treatment that managed care prefers. This role suggests a misuse of the DSM-IV.

While the DSM-IV’s distinction between AD/HD with and without hyperactivity appears sound and an improvement over the DSM-III-R, its focus on children is of debateable relevance to adults. Research on adults is critically needed (e.g., prevalence

rates, types of symptoms demonstrated by adults as compared to children, and the number of symptoms that should be required for an adult diagnosis).

Gender Issues in the Diagnosis of Childhood AD/HD

Why are so few females diagnosed with the disorder compared to males? I will begin with a look at the gender differences in the diagnosis of childhood AD/HD.

Before proceeding, I would like to note that the samples used in many of these studies have important implications for interpreting their results. First, Barkley (1995) pointed out that studies often used very small sample sizes when evaluating gender effects. For example, in their study, Silverthorn, Frick, Kuper, and Ott (1996) had a sample size of eighty children who were diagnosed with AD/HD: thirteen girls and sixty-seven boys. Silverthorn et al. (1996) noted that difficulty in obtaining large samples of girls diagnosed with AD/HD has hindered past research efforts. Second, Epstein, Shaywitz, Shaywitz, and Woolston (1991) emphasized that the source of a sample can significantly influence the outcome of a study. Barkley (1995) appears to agree and reported that whether or not gender differences were found on ratings or lab measures (such as continuous performance tests) of AD/HD symptoms had a lot to do with whether the samples came from community populations screened for the disorder or from samples drawn from clinic referrals. He offered the possible explanation that females sent to clinics may need to show more severe symptoms, relative to other females, before triggering such a referral. Third, Silverthorn et al. (1996) reported that the focus of past research has been on sex differences in the primary symptoms of AD/HD, ignoring possible differences in the pervasiveness of the symptoms and the degree of functional

impairment associated with the symptoms. And fourth, Silverthorn et al. (1996) claimed “inconsistent and often inadequate definitions of AD/HD hurt interpretations of results” (p. 52) (e.g., only using hyperactive children in their samples). The noted characteristics of the samples suggest any resulting conclusions be viewed with some caution.

One intriguing aspect of attention deficit hyperactivity disorder...is the strong male predominance of the disorder. The male: female ratio generally ranges from 6:1 to 9:1 in community samples of prepubertal children...Unfortunately, research has yet to explain the reason for this male predominance (Silverthorn et al., 1996, p. 52)

Silverthorn et al. (1996) reported that in general, the research on sex and AD/HD suggests that boys and girls with AD/HD show more similarities than differences in the number and types of symptoms and problems in adjustment. These authors found that, contrary to a popular assumption, girls with AD/HD did not exhibit a more severe form of the disorder.

Biederman, Faraone, Spencer et al. (1994) claimed that because conduct disorder is associated with severely disruptive behaviour, it is likely to lead to a parent- or teacher-initiated referral of the child. Since conduct disorder is perceived to occur less frequently among AD/HD girls than AD/HD boys (deHass & Young, 1984; Barkley, 1995), this may explain why girls are less likely be referred (Biederman, Faraone, Spencer et al., 1994) or on the other hand, as Barkley (1990) suggested, this may explain the frequent referral, and therefore, the higher rate of males in clinic populations.

Nadeau (1996) claimed research has shown that parents and teachers focus more on boys who are experiencing academic difficulties than girls. She proposed traits that are typical of Predominantly Inattentive Type girls: shy, introverted, hypersensitive to

criticism, nonassertive, inefficient, daydreamy, try hard to conform to teacher and parent expectations, easily embarrassed, and very reactive to stress. She suggested that compliant girls who sit quietly at their desk unable to complete their work may be considered immature, passive, or as having less academic potential, characteristics which may not be likely to initiate a referral. As well, Nadeau (1996) suggested that while girls diagnosed as Predominantly Hyperactive-Impulsive Type may share some characteristics with boys diagnosed with the same subtype (such as argumentativeness and defiance), the girls also have different traits including being hyper-talkative, hyper-social, and having intense emotional reactions. The characteristics in girls may present as contradictory and lead a teacher away from considering the possibility of the presence of AD/HD, and, as a result, these girls may not be referred for assessment.

Barkley (1995; 1996) has proposed that gender referenced criteria should be developed for the diagnosis of AD/HD. He suggested that “a cutoff score should be gender-based with girls being defined as deviant relative to their own gender-based population norms and boys defined similarly relative to their own gender-based norms” (1995, p. 2). Gordon (1996) took exception to this recommendation, and stated “While controversy and uncertainty abound in the field of AD/HD, one thing is clear: This is a disorder that prefers males.” (p.1) Gordon (1996) did not clarify whether he was referring to all three subtypes of AD/HD. Nevertheless, this seems to contradict Lahey et al.’s (1994) findings previously discussed in this chapter, that more females tend to meet the criteria for the Predominantly Inattentive Type while more males tend to meet the criteria for the Combined Type (youths diagnosed with the Combined Type did not differ

significantly on sex ratio from those who met criteria for the Predominantly Hyperactive-Impulsive Type). It is also interesting to note that Lahey et al.'s (1994) findings indicated that the clinicians who provided validation for the new criteria before it was published in the DSM-IV “essentially *ignored* inattention symptoms in making the clinical diagnosis of attention deficit disorder with hyperactivity” (p. 1679). As well, McGee, Williams, and Silva (1987) pointed out that as a result of the emphasis in the research on AD/HD in boys, AD/HD has acquired a connotation of being a predominantly boys’ disorder. Berry, Shaywitz, and Shaywitz (1985) believed that due to this situation, professionals often fail to consider the possibility of AD/HD in girls and so only the most severely affected girls are referred and diagnosed. Perhaps these conclusions contributed to Gordon’s (1996) claim “that AD/HD is more of a “guy thing”” (p. 2).

There is also lack of agreement in the literature regarding sex and the timing of referrals. For example, Brown et al. (1991) found that girls with AD/HD had been retained in school more frequently than the boys with the disorder, which may indicate that the girls were referred later. However, Silverthorn et al. (1996) found that in their sample, girls were referred significantly earlier by their parents (at age 7.42 years vs. 8.77 for the boys). These authors suggested that given the later age of onset of first AD/HD symptoms in girls (3.49 years for girls and 2.82 years for boys), it appears parents have a lower tolerance for AD/HD symptoms in girls and so refer them at an earlier age.

deHass and Young (1984) indicated that unlike hyperactive boys, hyperactive girls did not demonstrate an impulsive response style and presented few discipline problems for their teachers. Greenblatt (1994) suggested that differences in

symptomatology may be a contributing factor to why hyperactive girls are overlooked or not identified until later by their teachers: they often do not present management problems in the classroom and so their inattention may go unnoticed.

In her study, Greenblatt (1994) explored whether identical behavioural characteristics would be viewed differently by diagnosing clinicians depending on the sex of the child. Her findings indicated that the sex of a child affects the likelihood of an accurate assessment of AD/HD with hyperactivity as only 28% of girls were accurately assessed compared with 72% of the boys. Furthermore, she found only 26% of the girls and 38% of the boys received a correct assessment for the Predominately Inattentive Type demonstrating that neither sex received a significantly higher level of correct assessments than the other sex. These findings, as well as those of Lahey et al.'s (1994) that more females tend to meet the criteria for the Predominantly Inattentive Type, suggest that girls in particular may be underdiagnosed.

Research findings suggested that parents tend to refer girls at an earlier age than boys (Silverthorn et al., 1996) while teachers refer girls later than boys, or not at all (Greenblatt, 1994). With regard to assessment, girls appeared much less likely than boys to be accurately assessed for AD/HD with hyperactivity while both sexes were under diagnosed for AD/HD without hyperactivity (Greenblatt, 1994). Since more girls tend to meet the criteria for Predominantly Inattentive Type (Lahey et al., 1994), they are more at risk than boys for being overlooked.

Women Diagnosed with AD/HD

Biederman, Faraone, Spencer et al. (1994) presented the results their research as

providing some support for the validity of AD/HD in adults because they found that AD/HD adults have a pattern of demographic, psychosocial, psychiatric, and cognitive features that reflect similar findings among AD/HD children. However, they reported they did not expect to find that among adults with the disorder, males and females had an equal representation. The authors suggested the unexpected finding of the “*overrepresentation* [italics added] of females in adult samples” (p. 13) raises additional questions regarding the validity of the disorder in adults. However, I question whether this concern may be misdirected. More specifically, since AD/HD is a disorder that requires childhood onset and they found an equal representation of males and females in adulthood, their results may be used to question the accuracy of the reported prevalence of the disorder in *childhood*, not adulthood, given the preponderance of boys diagnosed with AD/HD. Their findings may be used to question whether females are *under-diagnosed as children*.

Nadeau (1996) pointed out that early studies of adults diagnosed with the disorder demonstrated that AD/HD adults were predominantly male. However, she added, these retrospective studies only focused on adults who had been diagnosed with the disorder in childhood: Predominantly Hyperactive boys. She claimed that as statistics are collected on children who are hyperactive and non-hyperactive, some writers speculate that the demographics of AD/HD will change to a more even representation of males and females.

Summary

Schaughency et al. (1994) noted that little is known about AD/HD in adults and what we do know comes primarily from follow-up studies of childhood hyperactivity.

Heath, Wright, and Batey (1990) pointed out that because AD/HD is a continuation of AD/HD from childhood, it would be logical to suspect the symptoms to be similar. However, they noted, because of the normal developmental processes and personality integration, the symptoms in adults may be somewhat different. These possible differences in symptomology may have contributed to it not being recognized as an adult disorder until relatively recently. In addition, the issue of different symptomology for adults also questions the appropriateness of DSM criteria for adults.

Methodological problems in the literature on AD/HD in adults (e.g., follow-up studies only involving hyperactive children) suggest one proceed with caution, or we may contribute to further confusion in the field. Healthy skepticism can be the catalyst for further research by motivating researchers to further investigate issues about which they have questions. However, problems with diagnosis can also create problems with research. For example, if participants have not been given an accurate diagnosis, the research may not really be investigating issues related to AD/HD.

This section has examined some of the important research on issues in gender differences in diagnosing AD/HD. These include: difficulties with definition of the disorder and previous controversy over whether diagnosis of the disorder required the presence of hyperactivity; lack of agreement regarding prevalence rates and the appropriateness of the DSM-IV diagnostic criteria for females and adults; and lack of follow-up by clinicians from childhood into adulthood.

Few girls, in comparison to boys, are diagnosed with AD/HD. However, difficulties with sample size, source of samples, and inconsistent and inadequate

definitions of AD/HD suggest that findings of studies evaluating AD/HD gender effects be interpreted with some caution. It appears that more girls tend to meet the criteria for the Predominantly Inattentive Type which has been called the silent subtype. More boys meet the criteria for the Combined Type and have co-existing conduct disorder, both of which are characterized by disruptive behaviour, and are likely to result in parent- or teacher-initiated referrals. Girls with AD/HD with hyperactivity are much less likely than boys with the same disorder to receive an accurate assessment and both sexes are not likely to receive a correct assessment for the Predominantly Inattentive Type. More women than girls appear to be diagnosed with AD/HD. This may be a result of increased awareness about the disorder or a result of the changing roles for women which prompt self-referral. Girls that may have the disorder have to rely on teachers and parents to refer them and I have noted some of the difficulties regarding this issue. Therefore, AD/HD in adulthood may be a fairer representation of prevalence rates. Also, according to Nadeau (1996), as statistics are collected on children diagnosed with AD/HD with and without hyperactivity, some speculate the demographics of AD/HD will change to a more even representation of males and females.

These issues illustrate how and why the diagnostic process of AD/HD may be different for females and males and the consequences of these differences. These studies suggest a variety of events and issues which may shape the lived experience of women with AD/HD.

Educational Issues for Women Diagnosed with AD/HD

As previously stated, much of the research on AD/HD has been conducted on

children. Initially, it may appear that the educational concerns of children with AD/HD are similar to those of adults diagnosed with the disorder. However, the expectations of post-secondary settings are very different from school.

Brinckerhoff, Shaw and McGuire (1992) compared and contrasted high school with post-secondary settings. They described six major differences. One is the amount of classroom instructional time. In college and university settings, instructional time is typically twelve-fifteen hours per week, in contrast to twenty-five to thirty hours in high school. This implies more emphasis in college and university on independent reading and studying time. The second difference is that professors expect a higher level of academic proficiency than was acceptable in high school. Third, scholastic performance determines student status in post-secondary settings. The fourth is that universities and colleges emphasize student responsibility for decision-making. A fifth difference is the amount of academic freedom and freedom of choice students face in university and college. And the sixth difference they described is that students are expected to function autonomously at college and university. Students must gather information from numerous sources, including class notes, texts and library reference material. They must work on semester assignments and projects and balance personal freedom with the need to set personal goals. The authors explain that these differences in demands imply the need to use a broader array of learning and study strategies to achieve success in post-secondary settings. Under-preparedness and limited awareness of post-secondary expectations may make the differences between high school and university/college even greater.

Unfortunately, the characteristics of people diagnosed with AD/HD do not match

the demands of the post-secondary setting. The cardinal symptoms of AD/HD--inattention, hyperactivity, and impulsivity--often result in very poor organizational skills. These poor organizational skills are often coupled with specific deficits in visual and/or auditory processing and sequencing, all of which impede academic achievement (Weiss & Hechtman, 1993). Based on her clinical observations, Solden (1995) reported that disorganization is the subject that women with AD/HD talk about the most in counselling. The author believes the reason for their difficulties with disorganization is the core of what AD/HD is--problems with attention, impulsivity, activity levels and cognitive processing. Many women with the disorder have difficulty focusing on routine tasks that have little external stimulation or structure and are hindered by distractions, the author noted. The disorder causes excessive impulsive shifting of attention or excessive shifting of activities and, according to Solden (1995), as a result, many women diagnosed with the disorder have difficulty figuring out the sequence of events needed to complete a task. Based on her clinical observations, Solden (1995) reported that women diagnosed with AD/HD, Predominantly Inattentive Type often have severe difficulty starting a task and then sustaining the energy to complete it. She described women with AD/HD as possibly having subtle information processing problems, including internal organization, especially of ideas which may include: shifting mental images; sequencing, prioritizing and planning, and categorizing; synthesizing ideas; mismatched input and output (processing incoming information slowly). She noted that all of these symptoms have the secondary effect of underachievement.

Based on their clinical experience, Hallowell and Ratey (1994) set forth criteria

for making the diagnosis of AD/HD in adults. A number of these symptoms can present as difficulties in meeting the expectations of university that have been previously discussed. These symptoms include: a sense of underachievement; difficulty getting organized; chronic procrastination; many projects going simultaneously and/or trouble with follow through; easy distractibility; trouble in going through established channels, following “proper” procedure; impulsivity, either verbally or in action (e.g., changing plans, enacting new career plans); a tendency to worry needlessly, endlessly; physical or cognitive restlessness; chronic problems with self-esteem.

Once a person is diagnosed, they need to receive treatment. There are a number of treatment issues that impact on learning. One of the “myths” concerning treatment of AD/HD is that medication eradicates all the symptoms. While medications that are used in the treatment of AD/HD can dramatically improve the quality of an individual’s life, it does not work for everyone diagnosed with the disorder and for those it does help, it improves but does not cure some symptoms (Hallowell & Ratey, 1994). Weiss and Hechtman (1993) note that some people with AD/HD also have specific learning disabilities which will not improve with medication. And medication does not eliminate academic difficulties, or years of academic failure or underachievement. Particularly if a diagnosis was not obtained until adulthood, many women with the disorder will have repeatedly heard negative messages highlighting their weaknesses from parents, teachers, friends, spouses, or employers. An effect is internalization of these negative messages and the belief that their problems are the result of low intelligence, lack of effort, or a moral or character defect (Murphy, 1995). Murphy points out that some adults with

AD/HD need vocational counselling aimed at identifying strengths and limitations and matching them to jobs that fit.

According to United States law (P.L. 94-142 and P.L. 98-199 (Torgesen, 1991)), appropriate academic adjustments must be provided to individuals with disabilities to allow for access to higher education institutions although the issue of accommodations for students with AD/HD is a complex one, as self-awareness is the key to accessing services at this level (Quinn, 1997). Appropriate modifications might include extending time for completion of exams and/or assignments, evaluating in ways that assess achievement rather than the disability, and allowing tape recorders in the classroom (Scott, 1994). Quinn (1997) suggested that post-secondary students take an active role, notifying the appropriate service provider of their disability and the accommodations necessary to meet their needs. The author also noted that in addition to accommodations, students with AD/HD may need assistance in prioritizing, organizing and time-management skills.

Stolowitz (1995), a student who was diagnosed with AD/HD and specific learning disabilities in later adulthood, described her university experiences and wrote that the academic system “is very destructive to those people who do not fit into little premade boxes”, calling the system “established and outdated” (p. 6). She stated that students with non-visible disabilities will remember their past academic experiences as being “emotionally painful, frustrating, and negative” (Stolowitz, 1997, p. 10).

Armstrong (1996) stated that most AD/HD researchers and practitioners see children with AD/HD (and perhaps adults as well) in terms of their “deficits” (i.e., their

diagnosis). Most studies point out what individuals diagnosed with AD/HD cannot do but few explore what they can do and who they really are. He suggested the need for studies on what individuals with AD/HD are interested in; what kinds of positive learning styles or combinations of intelligences they use successfully in the classroom; and what sorts of artistic, mechanical, scientific, dramatic, or personal contributions they can make to their schools and communities.

Summary

Literature on educational issues for women diagnosed with AD/HD provides an awareness of the variables that may affect their experience, which is shaped by having characteristics known as AD/HD. It suggests that post-secondary institutions' inherent expectations are quite different from high school. The symptoms known as AD/HD do not appear to match the demands of post-secondary settings, implying the need to provide these students with emotional and academic support and vocational counselling.

The Experience of Women University Students

As Hayes and Flannery (1995) noted, previous reviews on women in higher education have typically focused on research that characterize women as "reentry women". However, the characteristics of women students are changing. Belenky, Clinchy, Goldberger and Tarule (1986) point out that in spite of the increase in the number of women students in higher education, faculties resist open debate on whether women's educational needs are different from men's. Research is available on changes in women's participation in higher education such as enrollment, degree attainment, levels of achievement (Bellamy & Guppy, 1991; Heyns & Bird, 1982); women's

intellectual/cognitive development and ethical development (Hayes & Flannery, 1995; Belenky et. al., 1986; Gilligan, 1982; Clinchy & Zimmerman, 1982); and women's career plans (Brown, 1982). However, Erkut (1982) notes that the experiences of undergraduate women have not been researched by social psychologists and contributes this omission to the lack of theoretical perspective for studying women in higher educational settings and the limitations of social psychology's methodological tools. While social psychologists have conducted many studies in which college women have been subjects, their focus has not been on the college experiences of women students. The author called for work to begin on generating theories about the experiences of today's college women. Pyke (1997) pointed out that evidence for the operation and negative impact of some components of the chilly academic climate for women was not found in archival studies or in official academic performance records of students of both genders. It was not until the examination of the lived experience of graduate students that this understanding was generated.

The experience of women university students is beginning to be explored (Pyke, 1997). Specific topics related to their experience have previously been investigated including research on the omission of women in curriculum and academic discourse (Hall & Sandler, 1982; Smith, 1991; Lewis & Simon, 1986, Martin, 1985; Dagg & Thompson, 1988); sexual harassment and sexual discrimination in higher educational settings (Dagg & Thompson, 1988); and fields of study among women and men students and possible reasons for the differences (Women's Research Collective, 1974; Heyns & Bird, 1982; Hall & Sandler, 1982). However, studies specially related to the inner lived experience of

women university students with disabilities, including those with AD/HD, are absent, clearly suggesting the need for such research in this field.

Rowe (1974) developed categories of sexism in post-secondary settings including: (a) invisibility and other unconscious slights, and (b) conscious sexism, including harassment, exploitation, and provision of poor service to women. While “sexual harassment and violence against women are the most obvious manifestations of the sexist attitude present in Canadian universities (Dagg & Thompson, 1988, p. 94), Hall and Sandler (1982) suggested that even “unconscious” differential treatment may leave women students feeling less confident than their male classmates about their abilities and their place in the university setting.

An aspect of this invisibility is the lack of recognition of the many roles of a woman university student. The roles which a woman student may assume include those of student, colleague, professional, community member/citizen, and one-half of a primary relationship(s) with a significant other such as husband, child, parent, or friend (Hartsock, 1974). Hartsock identified subtle influences which structure the woman university student’s behaviour (that is, vary the nature and degree of her responsibility) in these roles. They include an informal reward system, labour market, familial responsibilities/expectations, academic tradition, the women’s movement, and role-models/mentors. The author pointed out that for the male university student, family responsibility is generally seen as an indication of stability and responsibility. However, it is seen as a disability or demonstration of a lack of commitment for the female university student.

A number of recommendations made by various authors address women students' roles, such as making child care facilities available on campus and including contraceptive pills in the university students' health care plan (Dagg & Thompson, 1988). An early progressive example of policy setting that takes into account a female student's multiple roles is the Dean's Committee policy of 1965 of the University of Michigan that stated that women with family responsibilities need not take a course load beyond their capacity to perform successfully, regardless of other policies on enrollment and admissions (Campbell, 1970). As enrollment pressures grow, such a policy is crucial to equality of educational opportunity, primarily benefitting returning women (Campbell, 1970). As well, it encourages the availability of financial assistance to part-time students, addressing the misconception that part-time students are not as committed as those able to devote themselves to full-time study (Hall & Sandler, 1982). Another way to promote the accessibility of higher education to women was provided by the Carnegie Commission (1973) which recommended the development of external degree and other nontraditional study programs to make higher education more accessible to women.

A larger issue that has been posed in the literature is the adequacy of the university organization as it exists. Universities promote the generation of knowledge through research and scholarship, both of which provide people with a very limited view of what knowledge is and how it is created (Schick, 1994). The author proposed that instead of learning about critical self-awareness, collaborative and nurturing education, or even the social construction of knowledge, women learn about the structures of the university to which they must conform in order to be acknowledged as educated people.

Schick (1994) suggested that work about and by women and other marginalized groups, work that is grounded in both theory and personal experiences, is excluded from this narrow view. If women's ways of knowing, their epistemologies and approaches to scholarship, are different from men's, an education system designed by men for men would be expected to be an awkward fit for women (Pyke, 1991). Throughout the literature on this topic, recommendations call for university women's centres and women's studies programs which are beginnings to including women's knowledge (e.g., Dagg & Thompson, 1988). Pyke (1991) calls for a restructuring of the education enterprise which will incorporate attention to and respect for alternative modes of "learning and teaching, researching and knowing" (p. 25).

The above noted themes of women university students' experiences are highlighted in two studies by Saul (1992) and Rifken (1995). Saul (1992) explored women's own accounts of their learning in higher education and identified four themes:

1. Professors' attitudes and actions set a climate for learning. The interaction between the professor and learner does affect learning in positive and negative ways.

2. Student actions were important in creating a positive learning experience. For example, the women's comments suggest that learning and motivation were enhanced when students were given a choice within the assignment and thoughtful advice from professors.

3. Women had a rich background of experiences that influenced the quality of the learning encounter. The women in the study validated adult education theory which places a high value on the impact of prior experience on current learning encounters.

4. Information about women's lives and achievements was vital to learning.

There was an expressed need for the inclusion of accurate information about the contributions of women to knowledge and about the impact that knowledge has made on women's lives.

Interviewing members in her support group for reentry women, Rifken (1995) categorized the themes that emerged according to motivational factors, perceptions and concerns, rewards of returning to school, support systems, and conclusions of support group members:

1. The women were strongly motivated to succeed because of their unique scholarship status and previous practical experience. They mentioned feelings of "a sense of achievement" and "completing a long-range goal" as primary sources of motivation (p. 4).

2. These reentry women felt the impact of conflicting role demands, alluding to a sense of time constraints and time pressures. They also wondered if they would succeed in what appeared to them as predominately a young person's domain. This perception was offset by being accepted by the younger students.

3. For the majority, the rewards of increased confidence, self-fulfilment, and self-worth outweighed the difficulties and helped them maintain high levels of motivation. They could also serve as successful role models for their children.

4. Familial support seemed essential to their inner feelings of worth and ability. Family encouragement was a primary source of motivation for the initial and subsequent pursuit of their goals.

5. The support group provided a tangible and practical group support system in which they could swap advice on how to manage academic activities.

This study suggested that, despite differences in age, ethnic background and marital status, the women spoke in similar ways, having similar reactions to their university experiences. The author concluded that gender and life experiences have been of greater significance than their ethnic differences.

There is a limited amount of current research available on the experience of women university students. However, the important themes that have been identified in the above two qualitative studies (Saul 1992; Rifken, 1995) echo in women's literature as far back as twenty-five years ago. While we might have come a long way, "we still have a very long way to go" (Pyke, 1991, p. 25).

Summary

Literature on the experience of women university students reveals that the characteristics of women students are changing as are their many roles besides that of student. While recommendations aimed at promoting access to higher education have been provided in the late 1960s and early 1970s, and continue to be made, few of these suggestions appear to have been widely implemented. Work about and by women, grounded in theory and personal experience, is mainly excluded from the traditional view of knowledge currently promoted in post-secondary settings, with the exception of women's studies courses. This issue is beginning to be addressed in research and this study hopes to contribute to this growing area.

Conclusion

This section has provided a rationale for this study of the experience of women university students diagnosed with AD/HD. The delay in the recognition of the existence of AD/HD in adults, the diagnosis of the disorder occurring more frequently in adulthood rather than childhood for females and the gender differences in the diagnosis of the various subtypes are all issues in this field in which there is a dearth of information. The experience of undergraduate women, in particular, has not been researched and as a result, there is a lack of theoretical perspective for studying women in higher education settings. Although it is illegal to discriminate against persons with disabilities in higher education institutions, equal access does not ensure equal results (Bireley, 1995) because the characteristics known as AD/HD do not appear to match the demands of post-secondary settings. Although appropriate academic adjustments must be provided, providing accommodations for students diagnosed with AD/HD is a complex issue.

The initial literature review provides the researcher with background for the phenomenon of concern. The hermeneutic phenomenological method suggests revisiting the literature several times throughout the data analysis process as topics are raised by my participants. The next chapter describes the research methodology of hermeneutic phenomenology and why it was deemed an appropriate method of inquiry for this research.

CHAPTER THREE: THE METHOD OF INQUIRY

Rationale for Employing Hermeneutic Phenomenology

“Women will starve in silence until new stories are created which confer on them the power of naming themselves”. (Gilbert & Gubar, n.d. as cited in Heilbrun, 1988, p. 33).

The research question for investigating the meaning of the lived experience of women university students diagnosed with AD/HD grew out of my personal experience, as described in Chapter One. The research question then dictated the appropriate method of inquiry. As well, our interests and assumptions shape which methodology we choose (Taylor & Bogden, 1984). As a feminist, I wanted to keep the women central to the study. I wanted the study to focus on women and to be for women. Therefore, feminist research methods were explored. Stanley (1990) described feminist research as exploring women’s conditions and circumstances of being in the world. She indicated women know certain things and understand particular experiences because we live them, that women have a particular epistemology because we have a particular ontology. She suggested that all women do not share the same state of being. Nevertheless, there are some experiences we share simply because we are women (Stanley & Wise, 1990).

Most of the research on AD/HD and adults with AD/HD, to date, has been considered representative of males and females. However, our understanding of the phenomenon of AD/HD has been shaped by one dimension—one sex (that of male)—rather than by two (Eichler, 1991). This is a result, in large measure, of the perception that hyperactivity is required for a diagnosis of AD/HD. Since males, more than females,

exhibit the Predominately Hyperactive-Impulsive Type, research in the area has historically concentrated on boys. Other diagnostic issues that this widely held belief presents for females were explored in Chapter Two. This study challenges the androcentricity of AD/HD. It is not my intention to look for sex differences in the experience of AD/HD but to explore the experience of *women* diagnosed with AD/HD. Their experiences may indeed be similar to men's experience or they may be different. It is, therefore, my intention to set out what that experience is and to work out the silence because as Spender (1989) puts it, in this field, "such a silence can be deafening" (p. 117).

Du Bois (1983) asserted that science is not value-free because it is shaped by our culture. She explained that our own values and assumptions influence the question we pose, our conception of how to approach the question, and the interpretations we generate from our data. She also maintained that methods of inquiry are reflections of our beliefs about the nature of reality and these beliefs influence how we organize and make meaning out of experience—our ways of knowing. Reinharz (1983) pointed out that feminism has confirmed the experience of women which had previously been denied as real or important and revalues experience as part of social science methodology. A hermeneutic phenomenological approach was chosen for this study as it too, values experience as part of methodology.

In the following two sections, Hermeneutic Phenomenology Methodology and The Process of Inquiry, I will describe the hermeneutic approach and the process I used, which is based primarily on guidelines proposed by van Manen (1990), to gather and

analyse the women's experiences. It is not the intention of this study to prove something but rather to invite women with AD/HD to describe their experiences.

Hermeneutic Phenomenology Methodology

'Methodology' refers to the philosophic framework, the assumptions and characteristics, of a research perspective--the theory behind the method (van Manen, 1990). How do phenomenology and hermeneutic phenomenology differ? "Stated in a simple way, phenomenology has to do with description of experience, and hermeneutics with interpretation of experience" (Bergum, 1991, p. 56). Hermeneutic phenomenology is concerned with description and with interpretation. I will briefly describe the methodology of the hermeneutic phenomenological approach in the next section.

Hermeneutic Phenomenological Approach

Hermeneutics as a research method is a way of systematically dealing with interpretation (Bolton, 1987). van Manen (1990) explained hermeneutic phenomenological research as the study of lived experience; the explication of phenomena as they present themselves to consciousness; the study of essences; the description of the experiential meanings we live as we live them; the human scientific study of phenomena; the attentive practice of thoughtfulness; a search for what it means to be human; and a poetizing activity. The goal is to obtain fundamental knowledge of phenomena and the meaning of Being since understanding and possibilities are the consequence of interpretations (Cohen & Omery, 1994).

Hermeneutic phenomenology is "the study of essence--what makes something what it is" (Ray, 1990, p. 173). As Bergum (1991) explained, the hermeneutic

phenomenological approach is concerned with the description of the experience and with the act of interpretation as a way of pointing to the nature, or essence, of the phenomenon. To more deeply understand the experience, the researcher must be involved in a dialogue between her inner passion and outer activities (Bergum, 1991).

In hermeneutics, Kvale (1996) explains, “The understanding of a text takes place through a process in which the meaning of the separate parts is determined by the global meaning of the text, as it is anticipated” (p. 47). The discovery of the meaning of the separate parts may lead to changing the anticipated global meaning, which in turn influences the meaning of the separate parts, and so on. This can be an infinite process so it ends when the researcher has reached “a sensible meaning, a valid unitary meaning, free of inner contradictions” (Kvale, p. 47). Guba and Lincoln (1989) asserted that hermeneutic philosophy maintains there are multiple, socially constructed realities and ‘truth’ is a consensus constructed from the amount and quality of information and the degree with which the information is understood and used. Hermeneutic methodology involves a continuing dialogue of iteration, analysis, critique, reiteration, reanalysis, and so on until a joint construction of meaning emerges among the researcher and participants (usually via their transcribed conversations) (Guba & Lincoln, 1989).

This section attempted to identify the essential qualities of hermeneutic phenomenology inquiry. This is continued in the next section by comparing it to feminist research methods.

Hermeneutic Phenomenology and Feminist Compatibility

A central problem for feminists is to integrate experiences that are specifically

located and structured into a social and research community that tends to make too sharp a distinction between anecdote and evidence and hence relegates first-person experiential data to an area that falls outside the realm of serious scholarly...debate. (Burt & Code, 1995, p. 10)

Methodological issues are of special concern to feminists who recognize the impossibility of maintaining a distinction between process and practice (Burt & Code, 1995). "Without practice there's no knowledge...practice in itself is not its theory. It creates knowledge but it is not its own theory" (Horton & Freire, 1990, p. 98). Wolf (1992) expressed that because feminists examine process and the use of power, it is more common to find them questioning methodology and developing a creative involvement of the researchers and the researched.

Reinharz's (1983) description of a feminist research model for contemporary sociology included the following features: topic of study is socially significant; data type is feelings, behaviour, thoughts, insights and actions as experienced; the method is determined by unique characteristics of the field setting; and data analysis is done during the study, relying on inductive logic (p. 171). This characterization is similar to that of hermeneutic phenomenology. Reinharz (1983) pointed out that methods which are communal and grounded in people's experience of the world as well as in our own partially existed but have been so undervalued that they constantly need rediscovering. Phenomenological psychology attempts to describe the essences of experiences with its guiding theory initially being an a priori, descriptive, intuitive inquiry into the necessary structures of intentional phenomena (Klein & Westcott, 1994). Klein and Westcott (1994) described phenomenological psychology as evolving over approximately the past

eighty years, receiving several interpretations and extending in a number of different ways. They illustrated that contemporary phenomenological psychology utilizes hermeneutic rather than descriptive methods.

Engaging in research from a feminist perspective also means not intentionally drawing boundaries between those doing the research and those being researched, although each person has a different relationship to the work being done (Lloyd, Ennis, & Alkinson, 1994). Kirby and McKenna (1989) asserted that research methodology should empower participants by enabling “people to create knowledge that will describe, explain and help change the world in which they live” (p. 17). By participating in the process of producing new knowledge, participants may know better what they already know (Horton & Freire, 1990).

Schick (1994) explained that in feminist research, women claim power to define themselves, to speak themselves into the world. Women need “to share our experiences, to struggle for understanding, to create new meaning” (Berry & Traeder, 1995). Hermeneutic phenomenology can be used to get beyond a surface understanding of a phenomenon, allowing for critical consciousness-raising (Kvale, 1983).

With respect to AD/HD characteristics, women are still defined by a standard derived from men.

when we look to men as reference points, we lose sight of who we are as women. It is like trying to define an apple by comparing it to an orange. The apple, described in terms of the orange, will never have its own identity...and value...The act of putting our experiences into words and presenting full, true descriptions of our worlds helps to make us three-dimensional beings; we describe ourselves as apples instead of not oranges. (Berry & Traeder, 1995, p. 7)

Joy (1993) regards hermeneutics as an exemplar of a contextual way of knowing, as a way of knowing that is distinguished by constant interaction of lived experience with the given characteristics of knowledge. She suggested that this implies the involvement of the reformation of boundaries, of both self-knowledge and the structures of knowing. This type of study provides women with the confirmation that they can be trusted to know because it begins with the participants' knowledge, not the researcher's (Belenky et al., 1986). Hermeneutics is not research as set apart. "It is very much about a way of life" because in hermeneutics "we enact what we value" (Ely et al., 1991, p. 232).

summary.

Hermeneutics is a philosophical method which is used to try to uncover hidden meanings. This philosophy asserts that there are multiple realities which are socially constructed. This section illustrated the compatibility of hermeneutic phenomenology and feminist research methods, further explaining the choice for this method of inquiry with the research question "what is the experience of women university students diagnosed with Attention-Deficit Disorder?" Now I will describe this study's hermeneutic phenomenological process.

The Process of Inquiry

"The new definition of experience is that it is interesting (not arbitrary), effective (in the sense that our ideas shape our world and are not simply shaped by it), uniquely human, and contextual" (Reinharz, 1983, p. 167).

In human science research, hermeneutics is considered the interpretation of experience via some text or symbolic form (van Manen, 1990). The researcher strives to

“interpret and understand rather than to observe and explain (Bergum, 1991) by questioning the “whatness” of a phenomenon or experience (Ray, 1990).

I have selected a hermeneutic phenomenological approach for my study of the lived experience of women university students diagnosed with AD/HD because of the issues highlighted by Gadow (1993): “women’s access to *their* [italics added] experience, access to meaning that establish the woman at the center” (p.1) of her own experience. Penfold and Walker (1983) stated that the voices of women are not considered relevant or authoritative in this society and men have the power to define women’s lives. Feminists maintain that women are experts on their own lives and experiences. This approach will provide an opportunity for the women and the data to “speak for themselves” (Osborne, 1990). I will address the issue of researcher bias under the heading ‘Accountability’. Other procedures addressed in this chapter include Selection of Participants, Data Collection, Data Analysis and Interpretation, and Ethical Standards.

Selection of Participants

The number of participants selected for a hermeneutic phenomenological study varies considerably (Polkinghorne, 1989) and depends on saturation. Saturation is the collection of data until no new information is obtained (Morse, 1995). Morse (1995) noted that there are no published guidelines in qualitative research for estimating the number of participants required to reach saturation nor tests of adequacy equivalent to formulas in quantitative research. Saturation is evaluated by the researcher on the adequacy and comprehensiveness of the data.

One of the principles of saturation in qualitative research is to select a cohesive

sample (Morse, 1995). Volunteers were selected based on the following criteria: they must be twenty years of age or older, presently enrolled in university, diagnosed with ADD or AD/HD by a psychologist or psychiatrist either in childhood or adulthood, currently experiencing difficulties with attention, impulsiveness, and/or hyperactivity, and able to articulate their experience (Osborne, 1990; 1994).

Volunteers were recruited in several ways. Posters were placed around the University of Calgary campus, including the University Counselling Centre, inviting women to participate. The Student Resource Centre and University Health Services distributed a letter, which I provided, to women who presented with difficulties with attention, impulsiveness, and/or attention (see Appendix A). This letter explained my research and invited interested potential participants to contact me. As well, an advertisement for volunteers was placed in the Gauntlet, the student newspaper.

All the women initially contacted me by telephone. I introduced myself and reiterated the purpose of the research, the methods I was employing and what participation in the study would involve. As well, I was able to ask them a few questions to determine if they met the eligibility requirements. If they did meet the criteria and were still interested in participating, the women were provided with a cover letter either in person or through the mail that explained the study in more depth (see Appendix B). With this additional information, if the women still wished to participate, they were required to sign an Informed Consent form (see Appendix C).

As each participant was identified, the initial interview was scheduled shortly after. Initial interviews were conducted over a four month period. This allowed me to

evaluate the comprehensiveness of the data as it was being generated. I determined that saturation was reached after interviewing the eighth participant. Appendix D presents a summary of their characteristics that pertain to the eligibility requirements, as well as some demographic information. This is not in keeping with phenomenological philosophy as it suggests that knowledge gained by this study is generalizable. However, it is offered for readers who are interested in an overview of the characteristics of the women who volunteered to participate. Each of these eight participants will be introduced individually in the next chapter, which will demonstrate their uniqueness.

Data Collection

While there are various ways of obtaining experiential descriptions from participants, I have chosen to use the dominant technique of interviewing (Ray, 1990). The two purposes of the interview in hermeneutic phenomenology are to explore and generate experiential narratives which may be used to develop a richer and deeper understanding of a human phenomenon and to develop a “conversational relation” with a participant about the meaning of an experience (van Manen, 1990). The interview attempts to understand the world from the participant’s point of view, to unfold the meaning of the participant’s experience, and to uncover their lived world prior to scientific explanations (Kvale, 1996).

The Interview Process

Interviews were conducted in a setting chosen by the participants. These included offices at the University of Calgary and an office at one of the participants’ place of employment. The university was the most convenient for the women as they spent

considerable time on campus attending classes.

To assist my participants in reflecting on their experience and to determine deeper meaning, three interviews were arranged to allow for reflection on previous interviews (van Manen, 1990). Each participant, with the exception of one, was interviewed individually on two separate occasions. The purpose of the second interview was to provide the women with an opportunity to read the draft description of the phenomenological themes so they may be starting points for further sharing about the nature of the lived experience (van Manen, 1990). At the beginning of this interview, I presented each woman with a summary of the topics she had discussed in the first interview. In addition, I surveyed the recurring topics from all of the conversations and shared this information with them. Then the women were asked to speak to whatever topics they wished to explore further. This reflection was an opportunity for the women to generate deeper meanings of their experience. Each interview was approximately seventy-five minutes in length. The interview sessions were audio-taped for later transcription. Participants were offered the option of participating in a third interview. This interview was a means to account for the quality of the study. It is described further in the section 'accountability.'

One participant, Robin, left the country after the first interview and could not be located by telephone, postal service, or electronic mail. When she returned to university, the second interviews had been completed, transcribed, and the thematic analysis was partially completed. It was decided that a 'second' individual interview would not be conducted with Robin but that the data from her first interview would be included in the

research. Robin's first conversation complemented those of the other women and made a valuable contribution to the collaborative hermeneutic conversation. As well, Robin did participate in the 'third' interview in which I presented my metaphorical analysis. This interview also allowed her to reflect on her experience, for more interpretive insight.

An interview is an exchange or sharing of views between two people discussing a topic of mutual interest (Kvale, 1996). For the most part, the initial interview was minimally structured and open-ended. I began with the question "what is your experience as a woman university student diagnosed with Attention-Deficit/Hyperactivity Disorder?" Participants were encouraged to discuss their experience from a point where they wanted to begin.

So that the material gathered using this approach does not become unmanageable, it was important that I be oriented to my question so the interview did not "go everywhere and nowhere" (van Manen, 1990). One way of staying close to the participant's lived experience was to be very concrete and to ask the women for specific examples.

As researcher, I asked clarifying questions as they arose and used active listening skills such as paraphrasing and reflecting. When I had no further clarifying questions, the participant was asked if there was anything further she wanted to discuss or ask about (Kvale, 1996). When the participant had nothing further to say, I concluded the interview by mentioning some the main points I learned from our conversation (Kvale, 1996). Then she was thanked for her time and for sharing her experience with me. If the conversation continued after the audio-tape was turned off, notes were taken. All tapes were coded with a number and the transcripts were identified using the participant's pseudonym.

In order to stay close to the data, I transcribed the first interviews, with the exception of two that were of poor audio quality. These two, and all of the taped second interviews, were transcribed by a professional who had no information which could identify the participant. I reviewed all transcripts for accuracy.

The transcripts were kept in file folders; the first interviews in one folder and the second in another. The transcripts, audiotapes, and computer disks were kept in a locked filing cabinet.

Data Analysis and Interpretation

The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others--to indwell--and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand. (Maykut & Morehouse, 1994, p. 123)

Analysis is the way I went about teasing out what I considered to be the essential meaning of the data (Ely et al., 1991). Giorgi (1970) stressed the importance of psychologists learning to understand the values that meanings already have rather than trying to superimpose values on top of them. Hermeneutic phenomenology's purpose is to seek a fuller understanding of a lived experience through description, reflection, and direct awareness of the phenomenon (Ray, 1990). Data collection is virtually simultaneous with data analysis so the initial analysis may also be the basis for formulating questions for subsequent interviews (Swenson, 1996).

Journal Writing

"There is no neutrality. There is only greater or less awareness of one's bias. And if you do not appreciate the force of what you're leaving out, you are not fully in

command of what you're doing" (Rose, 1985, p. 77).

I wanted to avoid prejudging the data by acknowledging, and attempting to suspend, preconceived notions about the phenomenon, especially during the generation and early analysis of themes. I attempted to make explicit and explore my presuppositions in the form of a journal because as Ray (1990) pointed out, "one must know and understand the self first before entering into the lifeworld of another" (p. 175). By identifying my presuppositions, I was able to try to bracket my presuppositions (Ray, 1990) and set them aside in order to see the phenomenon as it is (Osborne, 1994).

The initial step of qualitative data analysis is discovery. This involves identifying potentially important ideas, concepts, and themes by writing down recurring ideas, questions, and thoughts in the form of a journal (Maykut & Morehouse, 1994) during the entire research process. Another purpose of journal writing is that it was a systematic way for me to reflect on and critically question my own practices during the research (Lloyd, Ennis, & Alkinson, 1994), to account for my decision-making process.

Journal notes were started during the writing of the research proposal and continued until the study was completed. Initially, journalling can be a way of focussing on the topic. An example of becoming aware of, distancing myself from and then critically evaluating my assumptions is part of the following entry:

May 12, 1997

After completing five interviews, I realize I have been looking for, perhaps even probing for, something specific that I expected to find. I anticipated that the impact of the diagnosis would cause the women to see life as "before and after the diagnosis". The first participant seemed to suggest this but not the others. I certainly don't mind being wrong because this is one trap I can now avoid as a

practitioner. Now, as a researcher, I have to ask the data ‘what is the impact of the diagnosis, of the label?’ ‘Is the impact a process versus one reaction?’ I look forward to this exploration....

An example of discovery of interesting links can be seen in the following entry:

August 16, 1997

I was listening to some music today, thinking about my conversations with my participants. The metaphor “double-edged sword” kept popping into my mind but I’m unsure of its meaning. A few of the women spoke about their initial reaction to the diagnosis as being negative (because of the public’s beliefs around AD/HD) which became a positive ‘acceptance’ (is that more of a clinical term, I wonder?). So to me, the diagnosis can be a double-edged sword—both good and bad, positive and negative. But is that what the metaphor means?

My journal writing also contained reflections on my research procedure, as the next example illustrates.

September 14, 1997

There are so many options for the second interview and presenting information from our first conversation back to the participants. I could send them the entire transcript in the mail, with the significant statements highlighted. However, for some of the women that would be 75%-80% of their transcripts! I think that would be too overwhelming for them (it would be for me—how could I say more about an hour long conversation which wasn’t already said?) Okay, I’ll give them my summary, my margin notes (condensations of my interpretations). Now, should I send it in the mail prior to our meeting? I would like to capture their immediate reactions so we could discuss what the summaries bring up for them—after all, that’s the purpose of this second interview—to go ‘deeper’.

As illustrated, these reflections can keep me focussed, keep numerous bits of information organized and even keep my creativity vibrant (Kirby & McKenna, 1989).

Kirby and McKenna (1989) pointed out that the journal also includes both intellectual thinking and emotional comments, the researcher and the research woven together.

“Being cognizant of the relationship between the thinking and the emotional part is

important because you will likely find yourself “going on instinct” in this research” (Kirby & McKenna, 1989, p. 51). I will discuss the role of creativity and instinct in more detail in the following section.

Thematic analysis

As noted in the previous section, the beginning of analysis starts with journal writing because analysis is interwoven with data collection. The concept of ‘self-as-instrument’ implies personal control, personal responsibility and personal creativity (Ely et al., 1991). Because analysis is the product of an inductive and emergent process, a description of the process does not entirely capture what goes on (Lofland & Lofland, 1995).

In qualitative research, themes are usually expressed as statements. These statements highlight explicit or implied meaning that runs through most of the collected data or that involves deep and profound emotional or factual impact (Ely et al., 1991). Freire (1970) recognized that “themes are never isolated, independent, disconnected, or static” (p. 91) because they are “the expression of reality” (p. 92). He emphasized the use of a dialogical methodology to generate themes and to stimulate people’s awareness of these themes.

After the conversation, the audiotapes were transcribed into text. Next, I engaged in reflective analysis. As the lived experience was disclosed or opened up to me, the researcher, I recorded these occurrences so that I could synthesize the insights, letting “the capacity of knowing surface” (Ray, 1990, p. 177). These disclosures formed the basis of the themes which describe the essence of the lived experience (Ray, 1990).

van Manen (1990) described phenomenological themes as “knots in the webs, around which certain lived experiences are spun” (p. 90). I practiced one of his approaches to isolating themes in text, the selective or highlighting approach, to assist with my reflective analysis. I listened to and read the text several times, asking myself “What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience?” (p. 93). I then highlighted these statements.

The working themes were arranged on a large sheet of paper to visualize the relation among them (Lofland & Lofland, 1995) and posted in a room where most of the data analysis took place. Extracting themes from the data invited me to go back and ask more questions of the data. This is partially what it meant by the analysis process not being a linear one. Tesch (1987) describes it as more of a “cycling and spiralling”, the reason why researchers have to be immersed in their data.

Intuition is important in the process of reflecting on the data and in grasping the essence of the phenomenon (Ray, 1990; van Manen, 1990). The goal is to arrive at an understanding of lived experience that is both rigorous—based on systematic observation—and imaginative—based on expressive insight (Ellis & Flaherty, 1992). By possessing the character of intuition, knowledge can be reached and the essence of the experience understood because “an act of intuition is an act of reason” (Ray, 1985, p. 90). As van Manen (1990) asserted, thematic understanding is not a rule-bound process but a process of insightful discovery, “a free act of “seeing” meaning” (p. 79).

Once the themes and data were revisited several times, and I felt I had a consensus on the essence of the experience, I turned to the data again to find examples of this

'truth'. I extracted some features of the phenomenon that helped make its essence visible (van Manen, 1990) by asking the following questions of the data: Of what aspect is this an instance? What questions about an aspect does this item of data suggest? What sort of answer to a question about an aspect does this item of data suggest? (Lofland & Lofland, 1995). Sometimes, the examples were used to show how the phenomenon differs from other phenomenon as well as demonstrating the appropriateness of the themes that I have identified (van Manen, 1990).

During this phase of analysis, I listened closely to the women's voices and what they had to say about their lives and their experiences. Examples of the types of questions I asked of the data were: What are the recurring words, phrases, and topics? What are the concepts participants use to capture their experience? (Maykut & Morehouse, 1994). Many of the women used metaphors in our conversations. Schön (1979) suggested that the process of making metaphors involves seeing things in new ways and generating new frames of reference. Ely et al. (1991) pointed out that participants' use of metaphors indicates that they are actively growing into new knowledge. Working with metaphor is a cognitive act, which also involves imagination and feeling (Ricoeur, 1979). My interpretation of their experience often pointed to the women's own words, their metaphors. Metaphors provide "ordinary access to extraordinary thinking that we may not yet have tried" (Miller, 1991, p. xvii). Results of my analysis are presented in Chapter Four. The themes are expressed as metaphors.

Accountability

We are now aware that there is no value-free science. This realization does

not mean that we give up standards of scientific rigor and of objectivity, but it does mean that we should question traditional ways of conducting research (Eichler & Lapointe, 1985, p. 5).

The lack of standard techniques of qualitative analysis may be due to the richness and the complexity of the subject matter (Kvale, 1996). There are many criteria by which research may be evaluated and even more terms used to describe these criteria: reliability, validity, verifiability, internal consistency, falsifiability, credibility, dependability, and so on. Attention to accountability is continuously repeated throughout the entire research process, from beginning to completion, to make the study credible and produce results that can be trusted (Ely et al., 1991). In this section, I will explore strategies that I used to account for the quality of this study. The topic of generalizability will be discussed in Chapter Five.

Using the terms “validity” and “reliability”, Dreher (1994) points out that the quantitative paradigm is sometimes misapplied by attempting to reduce or eliminate investigator bias rather than to account for it. She noted that validity and reliability are enhanced by the manageability/smallness of the number of participants. Working with a smaller number of participants for a longer period of time allows for validity and reliability to be achieved through extended, trusting, and confidential relationships between the researcher and participants. Trust is also needed to acquire informed data, and accurate, rich descriptions (Stainback & Stainback, 1988). This study involved working with eight participants. The telephone introduction assisted me in establishing rapport with my participants even before meeting them in person. There was a lapse of

two to five months between the first and second interviews. The direction of the second interviews illustrated how some of the participants felt more comfortable with me and with the process by exploring more personal stories in depth.

The interview data was collected over a six month period and additional analysis and writing extended over another five months. This prolonged engagement (Ely et al., 1991) provided me with sufficient time to become immersed in the data. Further, journal writing acted as a technique to bracket my presuppositions and provided accountability for procedural decisions.

Another way to account for the quality or the soundness of ideas put forward in this study is through discussion with others (Bergum, 1991). Once metaphorical themes were identified from the transcripts, I presented them back to my participants in a third interview so that we could interpret their significance. As well, these themes were points for further sharing about the nature of their lived experience (van Manen, 1990). After presenting the metaphors, I asked “Is this what the experience is really like?” (van Manen, 1990, p. 99). As this question surely generated deeper insights and understanding, it was presented to see if my thematic analysis resonated with the women’s experience.

Participants were offered a choice of meeting with me as a group or individually, or discussing the analysis individually over the telephone. All eight participants volunteered to take part in a third interview. Time constraints appeared to be the determining factor in their choice of setting. Five women asked for a telephone interview, one woman met with me individually and two women, Suzie and Robin, met

with me as a small group. More women were interested in meeting as a group but a convenient time could not be found that fit with their schedules. Given the number of telephone interviews, these conversations were not audio-taped and instead, I chose to use field notes (Kirby & McKenna, 1989). The results of this third interview are discussed in Chapter Five.

Osborne (1990) suggested that the study is considered valid if it convinces the reader that the findings are believable, reasonable, and accurate. As Bergum (1991) pointed out, in hermeneutic phenomenology “conversations are not finished; publishing the work opens the conversations to a wider group” (p. 67). “A good phenomenological description...is validated by lived experience and it validates lived experience” (van Manen, 1990, p. 27).

Ethical Standards

Ethical standards were ensured by employing the following measures.

Consent

As identified in the section “Selection of Participants”, participation in the study was voluntary and the participants were able to withdraw at any time. Before participating, each woman was required to sign an Informed Consent form. The cover letter accompanying the consent form detailed the purpose and methods of the research and the participants’ involvement in the study. This information was reviewed with each participant in the introduction letter, during the telephone introduction, and at the beginning of the first interview.

Confidentiality

While the confidentiality of participants was maintained, the limits of confidentiality were explained and included on the Informed Consent form. To ensure anonymity, pseudonyms were used in all written material and transcripts, including the coding of audiotapes. The pseudonyms/coding information identifying the participants was stored in a separate locked file cabinet with the signed consent forms. Only first names were used during the interview. Once the audiotapes were transcribed, they were stored in a locked file cabinet along with the computer disks. These tapes were accessible only to myself and my supervisor. Participants were able to listen to their own audiotape and see the corresponding transcript if they wished. Two years after the publication of the analysis, all audiotapes and transcripts will be destroyed.

Risks

Although no risks were anticipated, it was possible that discussion of their experience may have raised issues and been stressful for the women. Participants were informed that they did not have to elaborate on anything that made them uncomfortable and that they could stop the interview at any time. Following the completion of interviews, if they decided they did not want part or all of their interview to be used, I would have removed their data from the research. Participants were able to contact me if they needed to discuss any concerns that may have arose from our conversations and I would have referred them to an appropriate professional.

No participants reported stress either during or after the interviews. All of the interviews, in their entirety, were used in this study.

CHAPTER FOUR: HERMENEUTIC PHENOMENOLOGICAL REFLECTION

when I began to consider the subject...I soon saw that it had one fatal drawback. I should never be able to come to a conclusion. I should never be able to fulfil what is, I understand, the first duty of a [researcher]--to hand you...a nugget of pure truth to wrap up between the pages of your notebooks and keep on the mantelpiece forever. All I could do was to offer you an opinion...But in order to make some amends I am going to do what I can to show you how I arrived at this opinion...I am going to develop in your presence as fully and freely as I can the train of thought which led me to think this. Perhaps if I lay bare the ideas, the prejudices, that lie behind this statement you will find that they have some bearing upon women and some upon [AD/HD] (Woolf, 1959, p. 6).

Portraits

This section is intended to allow the reader to meet those involved in the study, namely the writer/researcher and the participants. Who I am as writer/researcher affects my interpretation, the style of my written expression and how I will narrate the women's experience. Then I will introduce each of the women so that you, the reader, may get a sense of each of their lived lives. This description preceeds the data analysis as its purpose is to help place the women's comments in context.

The Writer/Researcher

What brought me to study the experience of women university students diagnosed with AD/HD? I reflected upon my experience with AD/HD to locate myself in the research. In this section, I will explore how I was drawn to this topic and to this population.

Why adult AD/HD? I first became interested in finding out more about adults who exhibit characteristics known as AD/HD while working as a psychologist in private practice in Newfoundland. I vividly remember the first woman who presented with issues

regarding inattention, disorganization, and the incompleteness of tasks. She felt her work performance was being compromised. Having previously worked as a school psychologist, I was much more familiar with children with AD/HD symptoms, almost all of whom were hyperactive. Hyperactivity did not appear to be present in this woman. When I began to research adults and AD/HD, I found there was a paucity of information on this population. A seed was planted.

Why university students? As an educational psychologist and a graduate student in the School and Community Psychology program, I am interested in factors that affect learning. I am interested in identifying the needs of students and strategies to effectively address those needs. Part of this involves working with educators to enhance skills relative to specific student needs. In order to effectively assist these students, we must be mindful of their experience, from their perspective. From a personal point of view, I have been a full-time university student for ten years. I am cognizant of my journey through academia, which has been quite positive. I wanted to know about the experience of other students.

Why women? I consider myself a feminist. I define a feminist as someone who believes all persons are equal. I also consider myself a feminist therapist. This is a little more difficult to define. While it is beyond the scope of this section to discuss feminist therapy theory and principles, for me the basic premise of being a feminist therapist is recognizing the social context in which people's experiences occur and the role of certain social structures in creating and maintaining the issues brought into therapy (Feminist Therapy Institute, 1995). My feminist philosophy has drawn me to do qualitative

research with women. I assent to a continued development of a psychology that includes women's experiences and women's perspectives (Kaschak, 1992).

As previously noted in Chapter One, the idea for this study crystallized during a practicum placement with the Student Resource Centre at the University of Calgary. My practicum supervisor, Dr. Marilyn Samuels, also has an interest in adult AD/HD. Together we developed the idea for a supportive and educational group for women with attentional and organizational difficulties. The emergence of this group incorporated my interests in women's psychology and counselling women, and research conducted on support groups. Since gender issues and the different ages and life stages of group members are factors that can impinge on the functioning of a support group (Kelly, 1995), we decided the group would be for women university students only. What really drew me to study AD/HD and the lives of women university students who live this experience were my observations during the group sessions that the women were the same and different at the same time. The "different" aspect was certainly not highlighted in the literature that I found on the topic. This diversity intrigued me and made the seed take root.

The Participants

Each woman's story presented here is reconstituted from our conversations about their experience. Some demographic details as well as the themes that pertain to each woman's individual experience are described. The women are presented in no particular order.

Robin

Robin is a twenty-five year old, third year undergraduate student. In the year prior to the first interview, she was diagnosed with dyslexia and ADD, the characteristics of which she views as one and the same. As a child, Robin was hyperactive but she has since grown out of the hyperactivity. Thinking of her diagnoses as more of a learning style, she is concerned about the accuracy of the term “Attention-Deficit/Hyperactivity Disorder.” She dislikes the label because of the negative connotations of having a ‘disorder’, preferring to explore a person’s strengths and weaknesses rather than simply use a label.

Robin also expressed concern about bias in the assessment process, feeling that the examiner was ‘looking’ for ADD symptoms. She does not perceive her symptoms as being as severe as those of other people she has met. However, she has not met any other women diagnosed with ADD, although she would like to.

Robin does not consider medication an option for her, relying instead on behavioural coping strategies she has gleaned through personal observation. For example, she has chosen to live alone because it is quieter and helps her to focus. She also exercises a lot and tries to maintain a healthy diet. She has learned that eating a lot of sugar or not getting enough sleep can make her impulsive. When she attends university, Robin does not get involved in outside activities, preferring to concentrate only on school. She has learned a number of strategies that she uses with regard to academic work, including the accommodation of writing exams in a private room and choosing professors that suit her learning needs. Interested in alternative treatments,

Robin reads many books on the topic.

Robin thinks that people with ADD characteristics should be seen as “different” and not as “wrong.” Recognizing the emphasis in our society to conform, she asserts that people should not all be the same because she believes that all individuals have gifts.

Dagny

Dagny, age twenty-one, is in her fourth year of an undergraduate degree. She was diagnosed with ADD at age six although she did not personally become aware of it until about age eighteen. Growing up she came to the conclusion she was stupid because it would take her twice as long as her peers to complete her work and her work would not be as “good” as her peers. She became very discouraged and passive, which, she noted, she grew out of. She describes herself as a private person and commented that her mother did not know how much she struggled in high school because she retreated to her room rather than talk to her mother.

Dagny’s current support system includes a psychologist and her mother. She feels her psychologist is very supportive and understands her. The psychologist put a positive slant on the diagnosis by focusing on Dagny’s strengths and not just the diagnosis. Dagny stopped seeing her over the summer due to a lack of time. Dagny now feels her mother has undiagnosed ADD. They relate well.

Dagny tries not to take her medication regularly. The reasons for this include wanting to be “normal” and hoping she can perform well without it. As well, the prescriptions her doctor writes for her are only sufficient for three days at a time so she takes it when she finds it absolutely necessary. For example, she was worried about

interacting with her co-workers at her summer job, especially conversations, so she would take her medication before meeting with her supervisor. She has asked her professors for help in the past but she did not receive what she needed mostly because she felt they do not understand ADD. She prefers to work things out on her own now. She sets goals for herself which she is determined to achieve. She sees ADD as something to “fight” because it could take her rewards away from her.

Dagny has found the information available on the Internet on ADD as both comforting and useful. On the Internet there are an abundance of personal stories written by people with ADD that provide Dagny with much strength as she does not feel as alone when she reads them. She also gives these stories and other information to her boyfriend to read so he can better understand her.

LJ

LJ is in her mid-thirties. At the time of the first interview, she had been diagnosed with ADD for about a year and was a university student taking some graduate courses as an unclassified student. She has already earned two undergraduate degrees, one of which is a professional degree. After completing the second degree, LJ was employed in her field. In retrospect, she says she chose to quit this job because of the ADD symptoms, although she was unaware she had the disorder at that time.

During the course of the present research, LJ became enrolled in a diploma program at a technical institute that she planned to use in conjunction with her second degree. The road to the diploma program was not an easy one for LJ and she sought a vocational assessment to help her with choosing a career. Some of the results of this

assessment were contradictory to information other professionals had given her and with the literature she has read on the ADD. She has come to the realization that she does not want a job that keeps her in an office five days a week but would prefer to be out in the field, with a more hands-on approach. Another psychologist she consulted about ADD is a significant part of her support system and is helping LJ resolve the contradictory information other professionals have presented to her. LJ feels she relies on others' opinions because she often does not know what she thinks or how to listen to what she thinks.

LJ was having difficulty accepting her diagnosis of ADD because she felt her assessment was incomplete, based on her reading in the area. As well, her mother does not agree with the diagnosis and feels LJ's actions of fidgeting, for example, when she was a child were done on purpose to bother her. Also, LJ does not consider herself to be a typical person with ADD. She does not feel she has done poorly academically, although her performance has been very uneven and inconsistent. Her advisors for both of her degrees indicated to her that she was not putting any effort into her work. LJ is currently trying medication as part of her treatment and finds that it is helping.

Michelle

Michelle is thirty-seven years old and was diagnosed with ADD within the a few months prior to the first interview. She describes herself as having a "sporadic, interrupted university career." Michelle went to university after high school but did not achieve the high marks she expected based on her secondary school training. This caused her to question her ability and generate possible explanations. Michelle thought that

since she is a woman of color, perhaps her high school teachers had pushed her through, not wanting to be perceived as discriminatory, a type of reverse discrimination. She dropped out of university after one and a half years and worked in a variety of jobs that she did not enjoy, for approximately two years. She then went back to university and completed an undergraduate degree. After applying to one graduate program and not getting accepted, Michelle obtained a summer job and returned to university to improve her marks to get into a professional faculty. She did not get into this faculty and went to work full-time. She decided she really did not enjoy that work and returned to university again to upgrade her marks. After a couple of years, she found that she had almost enough credits for a second degree. She proceeded to then add up the courses she had in each faculty to see which area she needed the least number of courses in for a major. She was completing this second degree when we initially talked.

Michelle described her academic performance as “hit and miss” because her achievement was so unpredictable. If she gets along with a professor or finds the professor stimulating and is interested in the subject, she does well. If professors say something sexist, for example, she loses any respect for what they have to say and stops listening, not learning any more from them. As well, she has been battling depression “ever since [she] can remember.” Michelle feels a good support network of friends with similar interests to her own has really helped her be successful in university.

Michelle’s described her relationship with her mother as somewhat problematic. She is unsure whether a childhood diagnosis of ADD would have improved the situation or not. Some of the things Michelle did as a child were interpreted by her mother as

being done on purpose, just to annoy her.

Michelle has a lot of questions about ADD being a deficit and whether it is a real or manufactured deficit. Having read a book on the topic before her assessment, she wonders about its accuracy, concerned that she may have been influenced by the book and as a result, presented herself in a certain way.

Christine

Christine is a forty-one year old, divorced single-mother of two children, both of whom are diagnosed with ADD. She is in her fifth year of an undergraduate degree. She was diagnosed with ADD about three years prior to the initial interview, as a result of her children being diagnosed. She described her initial reaction to her diagnosis as feeling overwhelmed and devastated, as well as feeling guilty that her children inherited the disorder from her. She did research on ADD for a course she took in university and this research helped put things into perspective for her. She has come to terms with the diagnosis and tries to focus on the positive.

While she focuses on the positive, Christine knows there are negative aspects to ADD symptoms. However, she says it is sometimes easier to blame things on the ADD than it is to take responsibility for them. As well, Christine is adamant about not lumping all people with ADD together. For example, she was interested in attending an adult support group until the group leader, who has ADD, asked her out. She was very angry with his inappropriate behaviour and expressed it to a friend who said promiscuity was an issue for people with ADD. Christine does not want others thinking that about her.

Christine enrolled in university for the first time after working in one particular

field for many years because she was not being recognized in her job. She found the two faculties she has taken the most courses in to be very supportive. Her experience with professors has also been positive as she finds them nonjudgemental and accepting. She describes herself as having many, many interests and finds it difficult to make up her mind, changing her mind about faculties a few times, sometimes questioning whether her last change was impulsive. She sets high goals for herself and sometimes questions whether they are achievable or realistic. Christine feels that she needs to work in a positive environment because she would find it difficult to not bring the negative issues home with her, to dissociate herself from that aspect of a job.

Christine found the decision to put her children on medication for ADD a very difficult one to make. She stresses the importance of not using medication in isolation but in combination with other strategies such as behaviour modification. She personally finds medication tremendously helpful, and described the first time she tried it as her “whole world” coming into focus. However, a side effect of too much medication is aggression, intolerance and impatience. When Christine started university, she did not have any study skills. She has since developed many of her own, modifying or changing them as required.

Suzie

Suzie is twenty years old, in her second year of university. She was diagnosed with ADD when she was sixteen. The diagnosis facilitated a deeper self-understanding of her actions and motivations and also helped Suzie to change her behaviour. The diagnosis has also provided Suzie with a reason to ask for help which she now does as a

last resort.

Initially, Suzie was not aware that ADD affected areas of her life other than learning. She has always had and continues to have social difficulties, particularly with relationships and making friends. Having a quick temper, she reacts quickly to others but sometimes her interpretation of their actions is inaccurate. She realizes she reacts impulsively to others. Her parents, who are her main support system, are helping her become more aware of these situations. As well, she feels she has very high expectations of friends so she is always disappointed because they cannot live up to them.

Suzie feels that she learns faster than most. However, once she has mastered a topic she then finds herself easily distracted. She was always in trouble for not listening in grade school. She now looks ahead at what her professors will be discussing to help her stay interested. She feels as if she sees things from a different perspective than most people and this enables her to make connections that other people do not see. She believes she is smart but academically her performance has always been lower than what she feels she is capable of achieving. She has a lot of difficulty with test-taking and had to take the Effective Writing exam three times before she passed it. She learns from doing, applying what she is taught. She has received a lot of tutoring in learning strategies from her psychologist.

Suzie enjoys the freedom of university because she can make choices. She feels her faculty is very suitable for her ADD characteristics. However, she perceives that she has to achieve things by 'sneaking in the back door', such as getting into university and her faculty because her marks do not reflect her ability. She questions whether she is

good enough to walk in the front door. Even though she met entrance requirements when she was admitted by the 'normal route', it often does not feel 'normal' to her.

Dawn

Dawn is in her mid-twenties and her second year of university. She was diagnosed with ADD a year before we met. Initially Dawn did not think she was smart enough for university but she went to prove to herself that she was. She found that she studied all of the time and had no social life. Although Dawn worked really hard and got 'B's, she felt she was not living up to her potential and could do better. She went for an assessment of her reading difficulties and to her surprise was instead diagnosed with ADD. She is not satisfied with the assessment process as she perceived that too much weight was put on 'one bad' day of a two day assessment. As a result, she is not really convinced of her diagnosis. Part of her does not believe it and part of her wants to believe it because it would explain her difficulties with school. Therefore, the diagnosis did provide a little relief as the cause is not a lack of ability. She does not feel she has a severe form of the disorder.

A lot had changed for Dawn by the second interview. Her medical doctor became angry with her for missing appointments so she found another doctor. She finds the new doctor much more understanding of her difficulties. He prescribed Ritalin instead of the Dexedrine she was taking before because she did not find that Dexedrine really helped. The Ritalin has helped her make many positive improvements. As well, he increased the dosage of the medication she is taking for depression and recommended exercise and taking fewer courses. She was working part-time and reduced the number of hours she

worked. She feels the results of implementing these changes include using her time more efficiently and effectively, taking time for herself by reading for pleasure, and enjoying a social life which did not exist before. Recently, she became engaged to be married.

Dawn believes there is a social stigma about having ADD. She wishes there was some conclusive way to test for ADD, such as a blood test. She knows people with similar difficulties and wonders if and how the assessment process accurately distinguishes between those with ADD and those who exhibit similar characteristics.

Sue

Sue is in her late forties and is a divorced single mother of two children. She was diagnosed with ADD a couple of years ago after her oldest child was diagnosed with the disorder. Sue completed an undergraduate degree in the mid-1970s and has just returned to university where she is now enrolled in a diploma program. She is really enjoying university this time as she understands herself and her needs better because of the diagnosis. For example, she finds that her hands do not move quick enough to keep up with her thoughts and now she has strategies to deal with this issue. As well, during her first degree, Sue spent all of her time studying, having to work ten times harder than her peers but back then she did not know why.

Medication for ADD is not an option for Sue. She tried it once but she has sensitivities to medication and did not respond well to it. As a result she looks for other ways to help her focus. For example, she finds she works well with a coach, someone who will help her complete a task by telling her when she is becoming distracted. Sue has difficulty changing modes and feels that once she is out of the house, she may as well

keep on moving since she finds she cannot go back to the house and resume the activity that she has left. The diagnosis helped her put her need to be busy into perspective. She always seemed busier than most people in all facets of her life. She recently sold her car to help her reduce the number of errands and appointments she made for herself.

Sue has never had time for friends. When she was in university the first time, she did not have a social life because she did not have time, she was always studying. Later, she became a single mother and worked full-time. She has always felt alone and lonely. She has felt like a 'square peg in a round hole' her whole life and she does not feel understood by her family. A relative once commented that it was like Sue and her brother were from different planets, not the same family. After she became diagnosed, she joined a group with other adults diagnosed with ADD. The group really helped increase Sue's self esteem because the other group members experienced the same "weird" things that she did so she no longer felt as alone. As well, she enjoys talking to people with ADD characteristics because she finds them so dynamic in their thinking. However, people without ADD qualities tend to keep her grounded.

When Sue was initially diagnosed with ADD, she was shocked and it took her about a year to get comfortable with it. Part of the reason for her reaction was the lack of positive literature on the topic. She now feels that the diagnosis and label are empowering because it explains a lot for her. She focuses on the positive, believing that people with ADD are in the majority but those who are diagnosed are in the minority.

Researcher's Reflections

Throughout the introductions of the participants, the term "ADD" was used to

honor and respect their use of that label. For the remainder of this paper, I will use the term “ADD” to reflect its use by my participants. As I explained in Chapter One, the common term was ADD prior to 1994. AD/HD has become more prevalent with the publication of the DSM-IV, however all of the participants in this study used the term ADD. It is interesting to note that most of these women were diagnosed with AD/HD, Predominately Inattentive Type. While ADD and AD/HD refer to the same disorder, they are perceived as being two different diagnoses by the participants. They see the distinction as ADD being the label when hyperactivity is not present and AD/HD being used when it is. When participants’ exemplars are presented, they are quoted verbatim, including their use of the term ADD.

I am looking at the experience of these women from many points of view: as a psychologist, a university student, a researcher and a woman. ADD has affected all the women I have spoken with for this study in different, yet similar, ways. Their paths have been a little different but the adventures have had some common features. I am struck by their strength to persevere in the academic world when other people may have decided on another route. After the interviews, I felt inspired and uplifted. These women have found, and continue to find, creative ways to deal with their difficulties. These women are resilient, finding support in different places such as parents, friends, faculty, psychologists, and medical doctors. Their experience of having symptoms known as ADD is apparent in school, work, home, and social life. So while the negative consequences are evident, the positive ways in which they deal with them are as well.

Essential Meaning of the Lived Experience of Women University Students Diagnosed with Attention-Deficit Disorder

“Themes are the stars that make up the universes of meaning we live through” (van Manen, 1990, p. 90). Now I will present ‘the stars’ that make up the meaning of the lived experience of women university students diagnosed with Attention-Deficit/Hyperactivity Disorder. The data, taped conversations with my participants, yielded these stars to me, the researcher. The words of the participants are used to describe and expound the essence and meaning of their experience.

Up to this point, I have chosen to use the word “theme” to describe my analysis. However, it is necessary to now introduce the term “metatheme”. The metatheme speaks for the group and is a major dimension of the phenomenon being studied (Tesch, 1987). Tesch (1987) pointed out that they are also known as core themes, central themes, final themes, major themes or essential themes. In this section, a “theme” is considered as occurring across some, but not all, conversations and are more specific to pieces of data rather than the data as a whole (Tesch, 1987). Each metatheme is introduced by a heading and the themes relating to each metatheme are identified by sub-headings (Hagedorn, 1993). Although the metathemes are presented as discrete, they were in actuality intertwined throughout the women’s stories of their experience (McEvoy & Daniluk, 1995).

Robbed of Time

One of the women, Sue, spoke about being “robbed of time”: “...due to having ADD and being a single parent of children with problems...I’ve been robbed of time,

never having enough time to deal with my stuff.”

What is ‘time’ to these women, what have they been robbed of? They have been robbed of the ability to study as much as they need to or want to, to complete tasks, to organize. Dagny described her experience with studying: “for the longest time...I’ve just been persistent with my habits, saying ‘well, maybe if I just put in a little more time, it might be better’ and in my first year...because my courses weren’t that difficult, I could put in the extra time to compensate for the ADD. But then in second year, my GPA dropped down because the courses increased in difficulty so I didn’t have as much time to cover the information.” LJ explained the “noticeable impact [ADD] has is definitely on your study skills and your ability to organize and kind of put yourself on a time table for things like papers...I end up studying the night before the exam...and ...doing my paper the night before it’s due.” “I used to get really ticked off at people who used ...read the book three days before going in and they’d get As and I’m thinking...‘how did you do that?’ ...I used to spend a lot of time doing this...I know I work harder than they do and that’s very frustrating to me,” expressed Christine. Michelle said “I’d just been putting in my first draft...I didn’t realize that people actually continued to work on their papers after the second and third and fourth drafts...part of the reason that I hadn’t been doing it was just because I never had enough time because time always gets away from me.”

Something else that represents the time that these women are robbed of is a social life. Dawn explained: “I took four courses...getting ‘B’s and ‘B-’s but that’s because I worked my butt off and didn’t have a social life, didn’t go out at all, *at all*, except for going to work (part-time) and home, that was it.” Sue said about her first degree “it was

very, very difficult getting educated...It seemed to me that other people were able to fit in their academics and social life to have a balanced life but not I. I seemed to be spending 90% of my time studying and barely 10% having a social life.” And about her life in general, Sue commented “I’ve never had enough time for friends...I was pretty much on my own. I’ve always felt alone, I’ve always felt lonely.”

The Merriam-Webster’s Collegiate Dictionary (Merriam-Webster, 1993) defines ‘rob’ as “to deprive of something expected or desired.” These women expected to be like other people in terms of the length of time required to complete tasks. Dagny presumed that she should only have to put in the same amount of time as her classmates: “I shouldn’t have to study six hours every night, none of my peers do it and they still get good grades and I’ve just got sick of it...I can no longer go through taking twice as long to do things...because I have twenty-four hours in my day, like they do...so that’s when I finally went and started seeking help...though already in my first week of work...I’ve already put in about an hour and a half overtime each night...because I’m taking longer...It doesn’t just affect your studies.” This caused her to rethink her career decision: “Do I want to go on always having to take twice as long as other people?” Dawn said “I rush through to make myself be done.” The time factor is also a consideration in planning her education: “Should I take three or four [courses]?--like this is a big decision for me.”

How does it feel when you do not possess something that everyone else seems to have? It is discouraging and exhausting. Dagny said “I wasn’t aware I had this [growing up] and it was always just very discouraging and you’d sit there and think ‘why should I even bother? It’s going to take me twice as long as my peers and it will not be

comparable to them in terms of quality of the final paper, it wouldn't be good enough.'

...so I got very discouraged." Now that she is aware of her diagnosis, Dagny explained "I

won't ever be normal, I will never be able to do four hours work in four hours time."

Dawn: "People just don't know...I don't really want to sit down and try to explain to them, I don't have the energy for that...you're *so exhausted* from studying and working."

Consenting or Created Victims?

In order for there to be a crime, there has to be a victim. The term 'victim', according to Fattah (1991), implies that a person has been subjected to "loss, inconvenience, discomfort, pain, and suffering of one sort or another" (p. 4). When a person has been robbed of time, they experience all of these. LJ explained "It probably has kept me from what I wanted to do which was science because...you can't cram, you can't leave things, you have to do things as you go along...I've tried the science thing four times without success." "I took a Spring and Summer [course] in the evening...it was difficult, just not enough time, not enough time for anything. As a result, I know my marks were probably compensated...and just being tired. You get tired of being tired...I didn't have a social life, I didn't have any time." said Dagny. From Dawn: "It seems to me just too much time at a desk [studying]--it burned me out, it really has."

Too often, victims are blamed. This is usually done in an attempt to figure out how the crime could have been prevented, and to understand the causes behind the crime being committed. The same is true for these women, especially before they were diagnosed with ADD. They were blamed for their difficulties. LJ described her experience: "People say... 'you're not trying, try harder...you basically don't put any effort into what you do...you need to put more effort into it' ...What you do is not good enough

because people perceive the effort's not there...so you feel guilty because you don't understand what it is and you just accept what is fed to you." Suzie said "I was tired of people telling me I wasn't trying hard enough." Without a label that explains their difficulties, other people searched and supposedly found the causes to be these women's effort, or lack thereof.

Even *with* a diagnosis, some of the women were still personally blamed for their difficulties. In trying to explain their disorder to professors, they do not always feel understood. Dagny: "I don't share [the diagnosis] with professors because in general...a lot of them don't know much about it, they don't understand it, and again would be 'you just need to work harder. It's an excuse.' That's how they see it." In his book Blaming the Victim, Ryan (1971) discusses how norms (time limits in this case) in our society are taken for granted without any efforts to examine their purpose and usefulness. As well, no thought is given to the ways in which the norms (time limits) might themselves contribute to the development of the problems experienced by people who have been diagnosed with ADD.

These women have been aware that the 'crime' of stolen time has been happening for quite a while: Michelle said "I was always fighting deadlines--always struggling to meet a deadline....I know that all my life, I've had this problem with procrastination and so I'm thinking 'well, if I can't get anything better then it's because I'm lazy.' And it never dawned on me that the procrastination actually was because I didn't know where to start and so you don't start. You don't have to worry about where to start because you're not starting." Now instead of blaming it on her lack of effort, Michelle understands that

her difficulties are more complicated. Without the knowledge of specific learning strategies, problems can become compounded.

Taking Back Time

What do you do when you realise you have been robbed? You often seek help to try to prevent the crime from occurring again. Dagny explained “when you do look for help...you’re looking for a way to, to not necessarily work less, but a way to do it more efficiently.” Michelle has a friend who acts like a coach and helps her with paper writing by telling her “Ok, enough research, time to start organizing.” Sue said, “In all my years of being busy...I have accumulated a lot of paper...I never have personal time to do my own sorting and filing at home.” She enlisted the use of a coach. “I find I work extremely well when I’ve got somebody without ADD helping me and we got a lot accomplished... someone bringing the focus back for me.” Help from other individuals, not all of them professionals in this area, can make a big difference is their ability to complete tasks.

With regard to their studying, the women use learning strategies, often discovered on their own, to remedy the time they do not have. Christine said “By reading [the text] out loud, that sort of brings me up equal with [my peers].” Sue described her strategy for getting started on a paper: “I have built into my school curriculum a time factor and when I know I have a project coming up, I make myself do studying for a test almost immediately. I make myself do the first page of an assignment immediately and then I can let it go for a few days. And that gives me a kick start and then I have no problem going back to it.” Specific strategies that address their own problem areas can help them

feel and be successful.

Accommodations for the classroom are another way to help them deal with 'robbed time'. Christine explained: "that what I find I need, a little bit of extra time for exams because when you ask me a question, there's no magical solutions to me...I'd say I have so many things that come up with me at the same time that it takes me *double* that time [than it takes someone without ADD]." The issue of accommodations are a little more complex as it takes the cooperation of other individuals. However, by changing their environment, sometimes in a very minor way, these women are able to achieve to their expectations.

Sue decided on a lifestyle change to help her recover some of the lost time: "I've gotten rid of my car...It's wonderful...not being able to hop in the car at a moment's whim and go and do an errand or make up an errand to keep busy...I've got to be in motion all the time, and I have been in motion for 47 years...I have to unlearn that and it is so difficult...I have to be still and I never have been still." Michelle has a strategy she uses at home to help keep track of her time: "I find that if I do this list thing...it keeps me focused on what to do and so then I start to see there is actually movement happening...it's more rewarding to do things when you can see that things are actually happening." As these examples demonstrate, ADD affects other areas besides university and social skills. In Michelle's situation, learning strategies used for university can also be generalized to the home.

Another option some of the women have used to help with their time issue is medication, Ritalin or Dexedrine. Michelle described the effects it has had for her so far:

“I’ve only been taking [the medication] for about a week and interestingly enough, probably for the very first time in my life, I started and completed a project in one day...normally I wouldn’t have done that. I might have left it for another day and that other day may never have come along because I’ve got this box full of projects that I have started.” Dawn: “This Ritalin seems to be controlling a lot of my symptoms so I don’t spend twenty minutes just organizing myself to start studying. I’m like ‘open book, let’s go’ so I’m actually doing more studying...I don’t think I work harder [than my peers], not anymore...I don’t study all of the time like I used to. I have a life.”

For Dagny, the formula of changing the individual rather than making structural changes in the environment (Ryan, 1971) is a difficult one by which to abide. Dagny explained it this way: “I do believe in responsibility. I want to be responsible for my success. I don’t want Ritalin to...knowing that without the Ritalin maybe I would have gotten a ‘B’ instead of an ‘A’, as an example, that ‘A’ doesn’t mean much anymore. I would rather not take the Ritalin and work harder, suffer more, and suffer more in terms of just frustration...to get that ‘A’.”

More than one change in their way of approaching tasks is often required for these women to see their results equal their effort. Some women sought professional assistance to help them develop a treatment plan that works for them. These women demonstrated that the approaches they may take are as individual as the women who need them.

Thoughts Like a Rubber Ball

Dagny uses the analogy of a bouncing rubber ball to explain the difficulties she encounters when she tries to study. The problem of her mind wandering, or rubber ball

thoughts, also extends to social settings. Dagny: “Holding a conversation is actually very difficult because you can’t stay focused on what the person is saying, and also because of the acceleration of the mind. Where they are moving...step by step forward and I’m kind of like a rubber ball in a room just bouncing left to right, very, very random. So it’s difficult to follow their conversation and of course they’re looking at you and thinking ‘where did *that* come from?’...I know my sense of humour is probably the most obvious of all this. No one ever understands my jokes I make. So now I make the joke, of course no one ever gets it, ‘I’m not as funny as I think I am’...they don’t see the relation and so they don’t see the humour.” These women’s thoughts do not fit what many other people would consider a linear pattern. ‘Linear’ refers to a line, which is usually straight, and involves a single dimension or relates to sequential development (Merriam-Webster, 1993). People with linear thought patterns may anticipate what will come next in a conversation or make certain assumptions about the appropriateness of a joke’s punch line and when these women who have diagnosed with ADD do not follow these unwritten rules, they are misunderstood.

Like these women’s thoughts, a rubber ball may change directions abruptly and without warning. Dagny: “Your mind just is at a very accelerated rate, kind of just zooming through life and just zooming through thoughts and ideas, usually which are not related to what you’re doing.” As a result of this thought pattern, organizing information for written assignments can be difficult for these women. Undergraduate students at this university are required to pass an Effective Writing Exam. Suzie: “with that English essay, reading it one time I didn’t pass it, I saw exactly where I had changed thoughts and

I literally just went ‘period, change thoughts’ on the page.” After she learned some writing strategies, Suzie was able to recognize this during the exam and she passed on her third attempt.

It is very difficult to keep track of the exact path of a bouncing rubber ball and even more difficult to remember the path that the ball took. The women’s non-linear thought pattern, so aptly described by this bouncing rubber ball analogy, has a profound effect on their academic performance. Suzie commented “the mandatory English exam...was extremely difficult for me...when I went in to talk about it, they just kept saying that I was unclear or I babbled.” Remarked Sue, “In doing assignments, my mind races along at an incredible speed and I can’t get my handwriting to work as quickly...because my mind is racing, my hands don’t move quick enough to write.” Michelle reported “the thought would be out of my head so fast that I wouldn’t remember that I thought it.” Said Dawn, “I can’t focus long enough to retain things...if the sentence is really long, I’ve lost the concept by the end of the sentence...studying... takes me so much time, I get side-tracked by anything.” The difficulty of following the paths of others’ thoughts has negative repercussions on some of the women’s listening skills. Dagny: “You hear everything but you don’t really hear everything...You don’t hear anything on a focus level but you’re very aware of everything going on around you...you’re not really following any thought. That’s probably one of the greatest problems with ADD, is to try and stay on one channel and to follow it on a continuance. That’s very much a struggle.” Dawn: “My mind used to wander a lot...at the lectures I found it difficult to keep up with the prof. I was always on his last words. He was

moving on to something else and I was still stuck back there. I was constantly getting lost in lectures.” Each of these women described different ways in which her thought pattern affects her ability to perform tasks necessary to be successful in university. This emphasizes the individualism of the expression of the symptoms called “Attention-Deficit/Hyperactivity Disorder.”

The effect of having thoughts like a rubber ball on the women’s learning styles is not the same for each one. One woman has difficulty seeing the whole path of the rubber ball but can see each time it has landed, comprehending the points presented in a lecture but not understanding the big picture. LJ said “One of the problems I have is an inability to fit the different single elements I get into the big picture...when I study...I need to sit down and I need to piece the stuff together...sort of in a picture for me so I could see how it interrelates.” Robin, on the other hand, can see the path as a whole but not the individual places in which the ball touches down: “I can put everything, the whole concept, I can sort of see it and I don’t get tied up with all the little details. So I can really see if there’s a problem with the whole concept and work from there.” It is important to understand the styles of each individual, and not assume that ADD affects each person in the same manner.

Catching a Rubber Ball

As anyone who plays handball knows, trying to keep up with where a rubber ball is going, or trying to control its path, is physically draining work. The women in this study expend a tremendous amount of energy trying to keep up with and control their thoughts. LJ: “I need to come home and turn off my brain for four hours...I’m so tired

physically from being forced to maintain my concentration and alertness for that period of time.” Interestingly, physical exercise can provide them with respite from trying to control their thoughts. Dagny: “While working out...I can let my thoughts go.” Robin: “When I’m at the gym, you can have that time to let your mind rest.”

The women cannot control or direct a rubber ball when they are blindfolded. Michelle: “I think the diagnosis has actually helped me...I can just say ‘This is the way I think’ and ‘This is how I think best’ and ‘This is how I work best’ and to be able to just do that...Recognizing my pattern...causes me to slow down...I find myself actually *thinking* before I speak.”

Newton’s First Law of Motion states that an object in motion tends to continue in motion at constant speed (Gonick & Huffman, 1990). Likewise, the energy required to stop these rubber ball thoughts is significant. Dawn reported “I tend to watch T.V. for an hour before I go to bed to get my mind off studying so I don’t fall asleep with accounting on the brain and figures in the head. That really makes my sleep very, very disturbed; I wake up and think I’m in accounting class.” Dagny explained, “You just kind of want to take out your brain and put it on the shelf so you can sleep...It’s almost like being two different people because you sit there and you get annoyed with yourself, and it’s like ‘shut up already.’ But then your mind says ‘oh but, but remember?’ ‘Yeah, like I know, I was there, shut up’ ...It’s just like an eternal conflict because you’re aware of ...what you’re doing, you’re aware that your mind is kind of rambling on and going through all of these different notions of things completely irrelevant and unrelated and you have other things that you could be doing, like sleeping.” The only other strategy that was offered as

a way of helping to improve sleep patterns, in addition to watching television or reading a book for pleasure before going to bed, was diet considerations. Dagny described protein, found in such foods as eggs and turkey, as being a soothing element and consuming these products before going to bed would help her sleep better.

The women developed some academic strategies that help them cope with having thoughts like a rubber ball. Michelle: "I learned that in organizing my thoughts, I do it much better talking to people than I do trying to write it down myself. When I write it down myself, I just don't know what to write because my thoughts are always going all over the place. So when I talk to people about it, if they don't understand where my thoughts are going, they stop and ask me a question and then I can clarify it." LJ: "If I need to go through a kind of step by step process and I need to think it, sometimes it helps to say it out loud." Sue: "I find that if I have a dictaphone, things move much easier for me...my thoughts are like lightening and if I have to write them, it's too much for me...However, if I can say it, it's better for me." These learning strategies reduce the frustration they feel completing tasks required for university.

Positive Qualities of a Rubber Ball

Can having thoughts like a rubber ball be an advantage and a disadvantage at the same time? Some of these women say 'Yes'. Christine: "When you ask me a question, there's no magical solutions to me...it could be this because of this and I really have that divergent thinking thing going on and that might be all nice and sound great...but then there's trade-offs with that too in that it takes me forever to answer multiple-choice questions...I'd say I have so many things come up with me at the same time that it takes

me *double* that time [as] somebody else [without ADD].” Dagny: “Because your mind is always just kind of moving around and bouncing just from so many areas...it’s easier to move into another area because your mind just naturally bounces to and from. On the other hand, when you do move [physically] to that area, your mind still isn’t there because again, it’s bouncing to and from.” Since they are able to process information rapidly, these women may require more time to answer exam questions. As well, they may be unable to adjust quickly to changes in their physical environment. For example, when they are in biology class, they may be thinking about their psychology class. Then, when they actually get to their psychology class, they are still thinking about biology class. Difficulty in adjusting to these physical changes may be perceived as inattention by other people.

Some of these women need a rubber ball’s bouncing qualities in their environment and enjoy non-linear thought patterns of other people. In discussing her program at a post-secondary institution, LJ said “the speed with which we’re going is helping me to stay with it and to focus because it is very quick.” Sue: “I also find it difficult to take notes in class because as the prof is talking, I have already assimilated what he or she has said and I’m miles ahead in my thinking.” Sue also explained “I find that the people that I communicate best with are those that have [ADD]... because they’re so dynamic in their thinking and...our conversation is just so powerful, just so dynamic.” Dagny found this out when she was talking to her psychologist: “I made a strange association and I stopped because you get used to talking to people who don’t have ADD so you’re very aware that ‘Oh, they’re not going to follow that’ ...[you have to be aware] in order to *fit* socially...She

said ‘Don’t worry, I have it, I understand. I have ADD too.’ and it was like ‘This is so good, someone who could follow...my thought pattern.’

Thoughts like a rubber ball is not always a liability. Some of these women consider their thought pattern to be an advantage or positive attribute. Sue: “Because of the ADD, I’m able to process information very quickly and I’m able to handle about twenty things at the same time.” Dagny: “In terms of the positive points...look at computers and multi-tasking...our worlds and our lifestyles are becoming very dynamic and...our minds are already in that pattern of just randomly bouncing around. In that sense, we are tuned to making those adjustments and those adaptations because we’ve already been there and come back...you can do many things at one time because your mind is never focused on one thing.”

A Rubber Ball Versus “Tuning Out”

Hallowell and Ratey (1994) called “tuning out” the hallmark symptom of ADD. To “tune out” is defined as dissociating oneself from what is happening or from one’s surroundings (Merriam Webster, 1993). Some of what these women have portrayed is not tuning out or dissociating themselves. They are only too aware of their surroundings—their thoughts are making connections based on what they are being presented with or hearing. These connections may not be linear but they are related to what has happened in their environment. Their environment has stimulated their thoughts—has reminded them of something else they know, has helped them formulate new questions and ponder new possibilities.

However, while they are busy thinking, if new information is being generated in

or conveyed from their surroundings, these women will miss it. This may be the reason for the perceived “tuning out.” Depending on where the original thought takes them, they may indeed end up “tuning out.” The term “tuning out” nevertheless implies intentionality and does not accurately reflect these women’s depiction of their difficulty with controlling their thought patterns. The analogy of their ‘thoughts being like a rubber ball’ reveals a different image. Once the thought, like a ball, is in motion, the women seldom can predict where it will go or how long it will travel, making it hard to catch. The thought moves so quickly that the women often find it difficult to remember how they arrived at the present location. On the other hand, watching a rubber ball can uncover new and exciting discoveries. However, while playing with a thought, or rubber ball, may be an asset in certain situations, it may be a detriment in others. The structure of our present educational system does not readily embrace deviation from norms (in this case, linear thought patterns), which is then defined as failure to learn the rules (Ryan, 1971).

Is ADD Real or Manufactured?

In discussing her decision whether or not to tell people that she has been diagnosed with ADD, Michelle talked about the reactions of the people whom she tells. “I’m finding that there is sort of like a stage of...typical reactions. The first reaction tends to be denial...When I describe that I’m easily distracted and have a hard time completing tasks, people will say ‘Well, that’s just because you’re busy. We are all really busy and how is that any different?’...Then it moves from there into sort of a political kind of analysis, whether or not Attention Deficit Disorder is a *manufactured* disorder or whether

it is a real phenomenon.” This question posed by Michelle is two-fold. Firstly, are the symptoms that constitute the disorder named Attention Deficit Disorder truly a disorder? And secondly, if the disorder is manufactured, what purposes does it serve? Neither of these questions are answered here, if indeed they can be answered. However, these women addressed this dilemma by questioning the label, the assessment process, and their concepts of themselves.

Is My Diagnosis Real or Manufactured?

Hartmann (1993) asserted that “ADD is neither a deficit nor a disorder. It is, instead, an inherited set of skills, abilities, and personality tendencies” (p. 25). While this is not a widely held belief, some of these women also questioned the label. Robin: “As far as the label ‘Attention Deficit Disorder’, I’m not convinced that it’s a disorder or that it’s a deficit...I don’t really like the label that comes with it...I think it’s important to look at the strengths and weaknesses and ask yourself whether it’s a disorder or not. I think there can be an intent to give something a label and that can be really damaging...I think they’re just going about it the wrong way. The way they’re perceiving it is as a disorder and they’re not going to find the answer because I don’t think it is.” The term ‘disorder’ is defined as “an abnormal mental condition” (Merriam-Webster, 1993). While deviating from the norm or from the average does not mean that something is unfavourable, the connotations of “an abnormal mental condition” are quite negative. As well, the issue of whether all of the characteristics that come under the term ‘ADD’ are a deficiency or impairment was raised by some of these women. Michelle: “The kinds of reactions...caused me to reflect on whether or not it’s a deficit. We think of these kinds

of things as drawbacks or disabilities or deficits and I guess I kind of question whether or not that's a valid way to look at it or not...I mean, is this a manufactured deficit or is it really a...deficit?" Scholten (1997) coined the term 'Attention Deluxe Dimension' because she describes the symptoms as an abundance of attention rather than a deficit of attention. She did point out that in certain situations, people diagnosed with ADD may 'look' as though they are inattentive when they were actually attending to a number of different things at the same time. She believes in matching people's natural abilities to environments which allow them to develop their potential.

This diagnosis means different things to these women, in different situations and for different purposes. Sue: "I fill out the loan papers and I see there's a space there and it says 'Do you have a disability?' and I pondered at first whether I should tick off 'yes' ...If you do know you have it and you put it down as a disability, my question is 'Do I really need help?' I don't know...I haven't quite worked out yet in what manner it does affect the learning process although I know it does in some sense." While Sue considers it a disability for student loan purposes, she has embraced the label because it has helped her to understand herself. Sue: "What a shot in the arm of self-esteem basically, that I no longer feel so much a square peg in a round hole--that there's other people out there." Barkley (1990) notes that people with ADD are a heterogeneous population. He stated there is great variation in the degree of symptoms and their expression across situations. This further adds to the confusion for some women. Dawn: "I still don't know about my diagnosis...the scale is just so wide. I've seen some women with really severe ADD...I definitely have some signs of ADD but I don't think I have the severe ones." LJ: "I see it

as an impairment but I'm not sure how much of an impairment it is...I have two experts saying 'little impairment', 'big impairment', and I don't know."

Society's concept of what ADD may or may not be has contributed to the women's doubt in their own abilities and in their diagnosis. For most of these women, the diagnosis has come later in life (that is, not in childhood) and they have heard negative messages regarding their effort for many years. These women internalized these messages that they were to blame for their problems and difficulties. LJ: "People say... 'you're not trying...you basically don't put any effort into what you do'...so you feel guilty because you don't understand what it is and you just accept what is fed to you...[a diagnosis] definitely would have made a difference in terms of emotional mental health because I think there'd be less guilt...you'd understand what was going on rather than blaming yourself or having others blame you for not being typical and normal." Dawn: "I certainly display some of the symptoms, I don't think I display *all* of them but I do some...The fact that if this is what I do have gives me a little relief in that I'm not an idiot...that I can do it but this is the reason why I'm having such a hard time doing it." However, the diagnosis of a disorder may simply be another form of blaming the individual for not fitting in. The person is given a label instead of looking at the environment and how it may contribute to the problems the person is experiencing. Michelle: "Almost like blaming of the individual when they don't fit into the norm that is expected...We tend to be one of the societies that looks at *individual* accomplishments and *individual* responsibility...The person who functions best with the communal kind of support that I think is necessary in order to live with Attention Deficit Disorder becomes

this special need.”

The structure of our school systems may be playing a big part in perpetuating the existence of the disorder by making it difficult for people with these characteristics to ‘fit in’ and succeed. Robin: “Because I really think the way that schools are set up is really damaging to someone with so-called ADD...because they tend to process things differently and they do want to have things more hands on...It’s sort of like the other way around--if [people without the diagnosis of ADD] were to learn in an atmosphere that was set up for someone with ADD...all of a sudden they would have the disorder and they probably wouldn’t pay attention either.” This echoes Hartmann (1993) who questioned the label in part because he believed that schools are set up so that people with these skills fail and the next step becomes finding out what is wrong with these people as opposed investigating what is wrong with the education system.

While Quinn (1997) claimed that the increased attention given to the problems associated with ADD is the result of “the general overall awareness by the public of the symptoms of the disorder” (p. ix), these women’s experiences suggest that there is still a great need for public awareness. Public support is important because other people’s reactions play a big role in these women’s responses to their diagnosis. Dagny: “How many people want to admit that they are learning disabled? How many people want to admit they’re different? I think even the ones that do aren’t very vocal with it. In terms of society, on a personal level, do you tell it to people because unless you know someone else has it, you’re going to get the same idea--‘you don’t have it, you’re just lazy.” Dawn: “There’s still a stigma about ADD and I’d just rather not go through that...I don’t really

tell a lot of people...I pretty much keep it to myself and to my family.” Christine: “I don’t know...why people are so negative about this.” Sue: “Who wants to know that they have ADD? There’s too much negative literature out there.”

Is the Assessment Process Real or Manufactured?

One would think that the assessment process used to diagnose this disorder should be able to provide us with some proof of its existence. Apparently not in this case. According to the women who went through the process, rather than provide any tangible evidence, the assessment procedure actually contributed to some of the doubt surrounding the label’s validity. LJ: “The problem with adult stuff is it’s all retrospective, right?...I asked my mother...and she’s like ‘no, you don’t have ADD...I was always told...all these things that are ADD-like things and yet she says ‘no, that didn’t happen.’ So that causes you to doubt what you think.” Robin: “The actual survey...I found it more unscientific...I thought it really strange too, when they were diagnosing me, they asked me all these questions, just sort of general. I know they just don’t know enough about what goes on but it seemed to be really ridiculous...I felt they were really making links to things that weren’t necessarily related at all.”

Hallowell and Ratey (1994) began their book by stating that once you learn about this syndrome, you will see it everywhere because many of the symptoms are so common. This is true for some of these women. Dawn: “Everybody probably has problems getting it sometimes or they have attention problems at sometime, I mean it’s so generalized...I’ve talked to a lot of people and they say ‘Yeah, I have problems with this too’...so how do you know? How do you pull out those with real ADD from those that

don't?...I'm still not really sure." LJ: "If you've got the symptoms, it's 'do they become an impairment?' So what becomes an impairment?...How do you know what the gap is when you're getting 'A's but you know you're under-performing by a mile?...Maybe what my expectations are or what I think my potential is is...not realistic."

Some of the women were dissatisfied with the particular examiner and assessment that they had. LJ: "Having read...Wender, Hallowell, Barkley and one Nadeau edited...I know what the assessment procedure is supposed to look like and it did not resemble what occurred. That's one of the reasons that I had the doubt." In the second interview, LJ had dealt with this issue: "I have come to terms with it...The first assessment...where he diagnosed me as ADD...the result may have been correct but he was totally out to lunch in terms of the assessment procedure." Robin: "It was almost as if she was looking for it." Dawn: "A lady who just quickly assessed me...That's why I was extremely surprised...'You've already diagnosed me on four or five visits, two of which were...for a reading assessment.' That's why I was a little disappointed in that whole system. So I don't necessarily believe it because I didn't think it was thorough enough." If clients are unsatisfied with the thoroughness of the assessment and the competence of the examiner, the diagnosis will have much less credence, leaving them with questions about its appropriateness and accuracy.

To further complicate this issue, LJ received contradictory information from different professionals she consulted. LJ: "(The psychologist's) last question was 'Are you certain about this ADD thing?' and I said 'No, I'm not' and she said 'I'm not either'...That's one of the reasons that I had the doubt...There's all the people 'yes', 'no',

‘yes’, ‘no’, ‘maybe’...and I don’t know how to listen to what I think.” By the second interview, LJ had clarified this for herself: “The vocational assessment...had elements in there that were correct but there were things that just seemed incorrect to me...Probably the most helpful part about that was (her psychologist) said...‘Both of the conflicting bits of information are correct...and it’s just how you fit it together.’...That was really very helpful.” This information helped LJ feel comfortable in keeping what she felt was correct and dismissing what she felt was not accurate.

Emphasizing the women’s strengths can help to put a positive outlook on the assessment process and diagnosis. Dagny: “[The psychologist said] ‘Okay, yes, you have ADD, but despite that, you still have strengths and just because you have this one set back, you do have other strengths. So let’s see if we can find those strengths and also find out what other factors are affecting you. And work within these strengths, work within your parameters.’” Robin: “I think you need to recognize the negative aspects of all things but emphasize the strengths because that’s really important—for someone to believe that they are capable of doing things and that they do have a lot of potential and how they can build on that strength because so much of it goes unrecognized.” The label itself, *Attention Deficit Disorder*, accentuates the negative indicia and there is no mention of anything remotely positive about having the disorder or about any of its features in the DSM-IV.

These women expressed that they would feel better having an objective test to determine whether or not they have ADD. This desire was influenced by their view of what they considered to be ‘scientific’. As well, they do not feel that the current

assessment process is definitive due to its perceived subjectivity. Dawn: "If they can somehow prove by taking samples from people's blood...say 'yeah, you have ADD because there is this problem with your gene', would be kind of a relief because it would be scientific now instead of just...observation." Sue: "I'm a very black and white person, my background is research...and having a diagnosis of ADD without a blood test that says 'you have ADD' or 'you don't have ADD', not having a brain scan...it kind of bothers me that I have a diagnosis and so does my daughter, of having a serious thing--society claims that it's serious...there is no conclusive test...I don't doubt that I have it. I don't doubt that my daughter has it."

Am I Real or Not Real?

After receiving the diagnostic label of Attention Deficit Disorder, some of these women began to wonder about how they presented themselves to the examiners. They speculated that they may have somehow contributed to getting a label that may not be accurate or appropriate for their circumstances. This situation was created for one woman in part by reading a book on ADD before the assessment and for another by feeling she was not at her best on one of the days she was assessed. Michelle: "Did I present myself as having Attention Deficit Disorder because I read the book; was I influenced by it? So there are those kinds of questions that I have about the whole diagnosis procedure...Perhaps I have over analysed it, I don't know. But I wonder would the psychologist or psychiatrist have come to those conclusions if I presented myself differently. So then it comes back to the struggle that I have of whether or not I present myself accurately or not. Am I real or not real? But at the same time, I think that I know

that I do a lot of those things.” Many people decide to pursue an assessment based on information they have read. In fact, Weiss (1994) states that the first step in determining whether a person has ADD is to screen themselves for it with a checklist or self-assessment. The second step is to consult a professional who’s duty it is to confirm the diagnosis if it is present. However, Michelle’s specific concerns are not addressed, leaving the responsibility up to the professional. Another issue is being assessed under conditions that will help present the individual in their best light. Dawn: “One day I came in and I was having a bad day and they assess me on my bad day...I was tired and I was a little agitated and I just didn’t want to be there. So I read [in the report]...‘her eyes were all over’. Of course I wasn’t there, I didn’t want to be there...The next time I was there I was fine, I was...calm...I had a good night’s sleep...it was fine and they assessed me on that too...I could have walked in and acted. I could have acted any which way and they would have assessed me on that.” Should clients be given the option of cancelling if they are having a bad day? This opens up many complications for the professional (such as cancelled appointments on short notice) as well as requiring self awareness on the part of the client. This may or may not be a viable option. Regardless, this issue and its implications for the diagnosis may need to be discussed with the client.

After receiving the diagnosis, some of the women went through a process of redefining who they are in light of this new ‘information’ about themselves. Michelle: “I didn’t get as high marks as I was used to in that first year of university. I think I kind of thought that there was something wrong with me, that I wasn’t as smart as I thought I was...The diagnosis has actually helped me in some ways because it makes me stop

thinking that there's some internal character moral flaw that I have." Christine: "This is really overwhelming...it didn't happen overnight. It took me a long time to get where I'm at, to think the way I think, and to feel good about being me and feel okay about having faults and having ADD, and it's not the end of the world...It's taken me a long, long time to get here...I'm not an expert on this, I don't know everything. I know about me and about my sons and that's about it." Sue: "I did a presentation paper on ADD...I stood at the front of the class and said 'I was diagnosed with ADD. It was traumatic at first but now the news is really empowering.' And it is that way because now I understand why I do the things I do and why I have done the things I've done and it's really putting things into perspective for me."

Rather than the diagnosis itself helping to put things into perspective, some of the women changed their perception of what labels mean to them. Dagny: "You've got low self esteem because you're not normal. I mean, I hate to say 'normal', and unusual or weird or different, because I see them as differences--it should be different, it shouldn't be a wrong or a right...I've learned over time that just changes in the perception of it and *that's* helped a lot with self esteem--*a lot*--just be aware that I'm different and that I'm not slow." Robin: "I guess that's how I perceive it, more as a learning style, and I try not to emphasize so much having a disorder because how would you have any confidence to do anything? I don't think I would get through university if I was so worried about having a disorder...whether I have a disorder or not, it doesn't matter--it's more how I perceive it and how I can deal with it."

Janus-Faced

“There is no natural phenomenon and no phenomenon of human life that is not capable of a mythical interpretation, and which does not call for such an interpretation” (Cassirer, n.d. as cited in Falkner, 1997).

Most of the contents of Roman myths were copied from the Greeks and merged with gods of their own. In Greek mythology, Hermes (who the Romans renamed Mercury) is considered the messenger for the other gods (Perowne, 1983). In hermeneutics, the researcher is the messenger for the reader, describing and interpreting the data and conveying the essence of the experience as themes. In this study, Hermes is carrying a message from Janus as Janus is expressed in the experience of the women university students diagnosed with Attention-Deficit/Hyperactivity Disorder.

The lived experience of women university students diagnosed with ADD is Janus-faced. Janus is the Roman god of gates and doorways, depicted with two faces looking in opposite directions (see Figure 1). Janus was an original Roman god that remained unchanged (Perowne, 1983).

Like Janus, the women look in opposite directions. Christine: “I was trying to pinpoint something that was a reflection of my experience having ADD and I couldn’t think of *one* thing...there are so many words...so I asked one of my sons ‘If you had to do this, what do you think it would be, your perspective on this?’ and he said, ‘Well, the good or the bad?’ ...I thought it was interesting that he said immediately ‘the good or the bad’ too because that’s exactly what I said...I like to think of things positively [but] that’s not what it’s all about. There are some negative things that are significant too...it has the

negative but it also has the positive.”

As some of the previous themes have illustrated, the essence of these women’s experience is paradoxical. Seemingly contrasting aspects are pervasive across their stories. They discussed the positive and negative aspects of the characteristics known as ADD. For example, as the metatheme **thoughts like a rubber ball** demonstrated, this type of thought pattern can be advantageous while being a liability. The women also spoke about the positive and negative aspects of being given the label of Attention-Deficit/Hyperactivity Disorder, as was shown in the metatheme **is ADD real or manufactured**. As well, there are positive and negative aspects of taking medication as part of the treatment of ADD. Some benefits were described in the metatheme **robbed of time**. However, Christine told me about the side effects she experienced: “I’m supposed to take twenty milligrams of Ritalin twice a day...I took it and I got aggressive, like really angry...really, really intolerant and really impatient.”

It is particularly during difficult times that the women need to see the two sides of ADD. The negative aspects are usually the most obvious but reframing the perceived negatives or looking at these aspects with a new face can help the women to see the positives. In times of war, Janus’ temple was always left open so that he could go to the instant aid of the Romans. It was shut only when Rome was at peace (Perowne, 1983). For some women, this situation is analogous to their utilization of treatments, such as medication. For example, Dagny only takes Ritalin for the most important situations: “There are situations in which I realize I need to [take Ritalin] because to not would be destructive...because the consequences would be too rough...I’ll learn...without the Ritalin

[when] there are no consequences.”

The women also look in opposite directions, toward the ‘said’ and ‘unsaid’, when it comes to the issue of disclosing that they have been diagnosed with ADD. Dawn: “There’s still a stigma about ADD and I’d just rather not go through that....I don’t tell a lot of people that I have it, really...if it comes up in a conversation I might say it but I pretty much keep it to myself and to my family.” Michelle: “whether or not to disclose...I tend to be fairly open about myself, especially with people that I know well and family members...when I hear [the other women] wonder whether or not [they] should disclose...you know society is going to have a negative reaction to it...it becomes setting yourself apart from what’s acceptable, what’s normal.”

Dagny’s experience illustrated looking in opposite directions at ‘body’ and ‘self’: “What I find best represents me and what gives me the greatest support...is a book, Ayn Rand’s Atlas Shrugged...It does have a very strong female character...who is very determined and independent and accomplishes her goals and because I know how much I struggle to accomplish mine, it’s also in that sense a role model...to separate [ADD] from myself, I know it could destroy me and I have to overcome it. Everything I idolize...I know ADD could destroy that for me...so I realize that if I don’t fight it, I will be at the bottom but if I do fight it, I could be at the top. So in that sense, I do see it as something that could defeat me.” By separating ADD from her sense of self, Dagny can focus on fighting what she perceives as the negative effects of the disorder.

Our concept of Janus would be fragmentary if we considered only one of his faces. The same is true for women university students diagnosed with ADD. If we

looked at only one aspect of their experience, the picture would be incomplete. Suzie: “if you take me and you pull out my essay, it won’t make sense sometimes. But if you talk to me and you listen to what I’m trying to say, then it does.” When describing her experience of having ADD characteristics, Suzie used contrasting adjectives: “It’s extremely like very fast, very slow, very relaxed and that’s my life...that’s what my ADD is all about...it’s like a daydreamer and it’s very exciting, it’s very slow, someone who is very sensitive and that’s how I feel.” Her experience of ADD cannot be captured by one adjective or quality as it is the interplay between the ‘fast’ and the ‘slow’.

Like Janus, the women in this study do not look in only one direction at a time. As a result, they are able to see more possibilities. Again, while this can be an advantage, the same quality may also be a disadvantage. Christine: “everything’s a trade-off...I believe kids with ADD have a great imagination. That to me is the positive side. The negative side would be that they come into my bedroom every now and then because they’re scared...they think there’s ghosts in the house. Being impulsive, there’s a whole bunch of negative things that go with that but the positive side is that they can get a lot accomplished during the day. Being creative...good problem-solving skills—corporations pay big money to be able to solve problems for them. The down side of that would be that they’re pretty creative and they could probably end up in jail too”. Robin: “More and more I’m thinking vision is a strength and that their greatest strength could be their weakness too...you’ve got to look at the strengths too because that could be connected to the weakness, it could be causing them.” Robin feels that her learning style is different from ‘the norm’ and therefore may be perceived by others as a weakness. However, she

believes her awareness of her learning style is an important component in her ability to utilize her strengths.

The God of Gates, Doorways, and Entrances

The first month of the year is named for this Roman god. Appropriately, Janus' faces are set back to back, to see the year just ended and to face the year just ahead. For these women, reflecting on the past can help put the future into perspective. The assessment process should ask about childhood history to determine childhood onset of the characteristics known as ADD (Barkley, 1990). Once a diagnosis is made, negative messages about effort and ability can now be reframed. This new explanation for their behaviour can help to alleviate guilt over perceived lack of effort, internal character flaws, or feelings that their achievements are fortuitous. LJ: "I have a lot of guilt about not going [to class] because you don't know why you're not going or why you hate to sit...I assumed that the problem...was due to a lack of maturity or adjustments...now I understand why I did." Michelle: "the last couple of years have been so satisfying for me...producing really, really good work and not have to feel like a fluke." However, when the validity of the ADD diagnosis is questioned or not accepted by others, conflict is created within these women as to its validity, again impacting on their interpretation of the past and future as was demonstrated in **is ADD real or manufactured**.

Like Janus, the diagnosis can represent beginnings and endings because it can often be the door to new self-awareness, and new self-understanding, putting an end to old interpretations. The women in this study have looked for this doorway for many years and while they are initially shocked when they find it, this shock turns into relief and

empowerment. Suzie sees herself as two different people, the old self who then influences the new self: “that was like someone else and I’m learning from that person. There were emotions I had to get rid of and detach myself from that but now that I feel detached, there’s so many things I’m learning...I’m so different now.” Robin: “for the first time in my life, I’m realizing that I do things differently, like little different learning styles than the norm. It never occurred to me that not everyone could do that...so just to be aware of that.” Michelle: “it takes a lot of pressure off in terms of thinking of myself as a lazy person or not a lazy person. Now it’s in terms of this is how I work...it’s now knowing where to start and how to start.”

Another paradox can arise when a woman knows what she must do to achieve academically but dislikes it all the same. In the first interview LJ told me “You need to have a certain amount of structure in order to be successful. With ADD it has to be imposed somehow. It doesn’t just come internally...I know that I function better where there is some kind of structure.” Then in the second conversation she said “I hate [structure]...I’m just experiencing it and I don’t like it any better. I can see how it helps but I really hate it.”

The god of entrances reared his heads in Suzie’s story of how she came to be in university. “It wasn’t my grades at all. Complete back door into the university...I went into [one faculty] and now I’m in [another] through the back door...that’s flukey but it worked out.” When I brought it to her attention that this was the second time she had used the metaphor of the ‘back door’, she explained: “maybe that’s just an invert way of saying ‘I don’t think of myself as good enough to walk in through the front’...I always

think I have to weasel and push for something I need to get and so to me, I always associate things with sneaking in or getting in through the back door...I don't feel I'm good enough to walk in through the front...I don't feel I'm going in the normal route." LJ's diagnosis of ADD was an entrance for her into the program she is presently taking: "I went to see them because I said 'Will you let me in having withdrawn from chemistry four times or failed it, whatever, even though I know I can do this?' I sold them on the fact I've had the ADD diagnosis and I didn't know--it will make a difference." The ADD diagnosis helped them just as Janus aided the Romans in times of war.

The diagnosis is usually the gateway to treatment. Some of the women would have liked to have found this gate earlier in their lives. LJ: "I guess for me in some ways I think an earlier diagnosis would have been helpful...if I had intervention, I think I would have been more successful at some things". Dawn: "Even when I knew I had ADD I still wasn't doing well. It wasn't really until I got on the Ritalin that I started to do well."

The God of Transitions

The women's situations are rarely static. They are frequently in transition as they learn about themselves. Like the god of departures and returns, these women are constantly leaving issues only to come back to them in the future. It appears that for them, no door is closed forever. LJ: "An object that represents my experience of ADD is one of those kaleidoscopes...you see changing pictures and sometimes it's out of focus and then it changes into a design and then is out of focus...like understanding the picture you're seeing and then not understand the picture...and then understanding a different picture...things are constantly changing--the brightness, the diversity in terms of life and

your life experiences.”

Between the first and second interviews, Dawn had changed doctors, changed medication, cut down on the number of courses she was taking, and reduced the number of hours she was working part-time. She was learning how to balance school, work, and social life in a way that worked for her. Michelle was trying to come to terms with the label with which she was diagnosed: “It’s not that I have doubts about whether or not I exhibit these kinds of behaviours and characteristics so much as resisting the psychiatric categorization...being aware of the implications behind some of the questions that are asked...the implications of those questions are that it’s wrong to do that.” Christine was planning on taking a new career direction: “I don’t know if I’m doing the right thing or not, but that’s just sort of what I came up with what would be a good route for me to take.” Suzie postponed going to a new university for a year due to changes in her family’s circumstances: “I didn’t feel like that’s where I was supposed to be. I feel comfortable here. I feel that I’m supposed to be here.” Dagny was getting used to her work situation and how her medication fit into that picture: “Depending on the work situation, if deadlines and that were tight or if it was just stressful work, then yeah, just as a coping mechanism. But I tried not to. I think it’s kind of awkward if you’re taking it in front of your peers...so you try and avoid that.” Sue was going through a lifestyle change, having sold her vehicle because she could not stop herself from being busy: “So now I don’t have a car and I have to unlearn that, and it is difficult.” The same treatments and strategies do not work for all of the women. Each woman is unique, each with her own story to tell.

Summary

This study sought to describe and interpret the experience of women university students diagnosed with Attention Deficit Disorder. The weaving of the four metathemes into one cloth is the essence of these women's experience. In Chapter Five, I will revisit the literature with this new understanding.

CHAPTER FIVE: DISCUSSION

In this chapter, I will examine the literature as it pertains to the emergent metathemes. The metathemes are not revisited in the order in which they are presented in Chapter Four. In particular, I will first discuss those metathemes that received full validation from my participants and close with the metatheme that was not fully validated but from which other metaphors emerged. Then I will conclude with the implications and limitations of this study and recommendations for future directions.

Robbed of Time

The women in this study felt that they were robbed of time because they expected to be able to do tasks in the same amount of time as their peers; they expected to be normal. Questions they asked themselves included, What does it mean to be normal? Are there alternatives to this concept? Is the diagnostic label “Attention Deficit Disorder” contributing to these feelings of not being normal?

Normality

In Offer and Sabshin’s (1966) discussion of ‘normality’, they point out that this term is often used as an absolute concept, infrequently taking into consideration the individuality of each person. As well, the authors suggested that normality is culturally bound: symptoms that are ‘abnormal’ in one particular culture are not necessarily indicative of what is considered abnormal in another. Regardless, normality is still taken as a fact, and as a concrete thing (Penfold & Walker, 1983).

How is the concept of normality constructed and used? Rather than answer this question, many researchers look for better ways of ‘naming’ or ‘labelling’. Penfold and

Walker (1983) proposed an alternative by starting with the concept that human growth and development are shaped and given form by the experience of living in a particular location with the social structure. They maintained that this allows for the view that different experiences are not a result of personal fault, choice or misfortune but are the outcome of living in a society where resources and power are not equitably distributed. And this view has no place for the concept of normality.

While the term 'normal' is associated with mediocrity to some, for the majority it does not have a negative connotation (Offer & Sabshin, 1966). In therapy, 'reframing' is a technique in which the counsellor changes the frame of reference for looking at an individual's behaviour, helping to re-define 'normal'. Another technique in feminist therapy is 'relabelling' which is when the label applied to the client's behaviour or characteristics is changed, usually by shifting the focus from a negative to a positive interpretation (Worell & Remer, 1992). Sue's preference for Sholten's (1997) term "Attention Deluxe Dimension" demonstrated this shift. The women in this study questioned the terms "deficit" and "disorder" in the label Attention Deficit Disorder but they did not challenge the term "attention". "Attention" is not a pejorative. While the label is meant to be descriptive of the person's characteristics, the findings from this study question its accuracy. In the next section, we will further explore the effect of labels and labelling.

The Effects of Labelling

"The importance of language resides in the fact that it is through language that we both *name* experience and *act* as a result of how we interpret that experience" (Giroux &

McLaren, 1992, p. 15).

In his book, Schur (1984) demonstrates that when a person is perceived as deviant, differing from the group norm, reactions include a process of categorical 'typing', or labelling. When individuals are seen in terms of this label, other people's responses to them are heavily influenced by that identification. Sometimes the label becomes, in the view of others, the individual's essential character. When an individual is considered only in terms of her presumed membership in the category, she may be attributed various supplementary traits that people believe to be characteristic of anyone bearing the label.

Penfold and Walker (1983) described the relationship between symptoms and a diagnostic category. If a label, created to name and make comprehensible some activity or process, is detached from the context of that activity or process, the abstract becomes the concrete. Once the symptoms are formulated and detached from the person's account, they can be arranged to provide an explanation for what is observed, which is the diagnostic procedure. The symptoms become attached to the diagnosis and there is no further need to account for the original relationship in which they were generated. The symptoms within the diagnostic category allow them to become a distinct entity and so the person becomes a patient whose diagnosis determines her thoughts, feelings or behaviour. The women in this study fear that they will become defined by their label when they make their diagnosis public.

Worell and Remer (1992) explained that feminist approaches to diagnosis challenge most of the assumptions that underline traditional approaches by minimizing

the pathologizing of an individual. This is accomplished by including assessments of women's environments and the environmental/societal contexts of their lives, which includes reframing many of the client's 'symptoms' as strengths.

Labels do serve purposes in our society, one of which includes accessing services. Wylie's (1995) critique of the DSM suggests that clinicians only assign their clients labels for insurance purposes and then the label is forgotten. If this is the case, what prevents the clinician from thinking in terms of the diagnostic labels? Assigning a label only for economic reasons poses an ethical dilemma for clinicians. If there were no third-party reimbursement, the client would probably not be able to afford treatment; the clinician would not be able to earn a living if they did not get paid for their service.

Most authors agree that ADD is a heterogeneous disorder (Biederman, Newcorn, & Sprich, 1991; Barkley, 1990). However, this is not emphasized in the literature. Instead, the literature describes characteristics that are 'common' to people with the disorder. The women in this study consider many of these characteristics to be inaccurate. An example of this occurred in Christine's story when she described being distressed to hear that people with ADD were considered to have problems with promiscuity, which she felt did not apply to her. The characteristics of a group of people with the diagnosis are attributed to everyone with the diagnosis. This method of stereotyping is inappropriate and can be damaging to people diagnosed with ADD. If they are all considered to be alike, the treatment will also be assumed to be the same. The findings of this study have demonstrated that this may not be accurate or ethical. On the other hand, the perceived need for diagnoses will continue in educational institutions until

students are no longer required to have a 'label' in order to receive particular services. This presents a conflicting situation for the women in this study. They do not want to be defined by a label but if they want services, they are placed in a position of having to use the label. For example, Sue considered her diagnosis to be empowering. However, when she was faced with whether she defined it as a disability on her student loan application, she was unsure of what to do. She heard from a friend of hers that the diagnosis is considered a disability so that is what she indicated on her application.

Summary

Some authors feel that clinicians should eliminate the concept of normality by assessing the person's positive and negative attributes (Offer & Sabshin, 1966). Would that accomplish eradication of the concept? It is unlikely. However, it does reframe the client's characteristics and is useful for treatment by focusing on a person's strengths which she may use to help her improve other areas. By helping clients become more self-aware, they are able to put their personal characteristics into perspective, which may in turn help increase their self-esteem. However, labels serve many purposes, one of which includes gaining access to services.

Is ADD Real or Manufactured?

The women in this study questioned the origin of the disorder: did society invent it or does it really exist? Their questions prompted me to revisit the literature on the etiology of ADD.

Etiology

Many authors agree that the literature on etiology is contradictory and

inconsistent, and the multicontributory nature of all possible factors make it extremely difficult, if not impossible, for a definitive answer to be reached (Lorys-Vernon, Hynd, Lyytinen, & Hern, 1993). Chapter Two explored the causes of ADD that are offered in the literature which include neurological differences between those with and without ADD, diet sensitivities and the impact of genetics. Some of the women in this study believe that ADD is a result of a neurological cause. They also recognize that genetics plays a role, particularly the two women with children who were diagnosed after their children received a diagnosis.

Some environmental etiological factors of ADD have been proposed although none have received substantial empirical support (Cantwell, 1996). The child of one participant, Sue, was tested for lead toxicity which was confirmed. Sue has read that this is the leading cause of ADD. She reported that the treatment for lead toxicity, chelation, costs about two thousand dollars and is not covered by her medical insurance. My review of the medical research did not turn up any studies that linked lead with ADD although Cantwell (1996) noted it has been presented as a cause.

Psychosocial factors are not thought to play a primary etiological role (Cantwell, 1996). However, current conceptions of the etiology of ADD emphasize the role of parenting in relation to key impairments rather than core symptomatology (Hinshaw, 1997). The author suggests that salient predictors of antisocial behaviour include maternal overstimulation, maternal negativity, and maternal authoritativeness. However, he also questions the relationship between treatment approaches and the knowledge of causal factors, challenging the belief that treatment must be directed to underlying or

primary causes. This is qualified by an explanation that clinicians should not be pessimistic about the potential of treatments given the “undoubted genetic influences on dimensions of inattention and hyperactivity” (p. 9). Does this also apply to the relationship between the assessment procedure and knowledge of causal factors? Some of the women expressed their dissatisfaction with the assessment process, describing it as unscientific. They expressed their desire for a more definitive test, such as a blood test. However, since the precise causes of ADD are unknown, should that cast doubt on the method by which ADD is diagnosed?

As Lorys-Vernon, Hynd, Lyytinen, and Hern (1993) pointed out, ADD is a behavioural diagnosis, based on behavioural manifestations. All of the DSM-IV diagnostic features of the disorder are observable, perhaps since the criteria are used to diagnose children. Is the current assessment process the most effective? Should the process be different for adults who may have more self-awareness? Are observable behavioural criteria the only features that can be used in making a diagnosis? The women in this study described “thoughts like a rubber ball.” More research on adults’ experience of the disorder may be useful in determining more unobservable symptoms.

If, after reviewing the client’s history, the client has the symptoms of ADD, have had them since childhood, have the symptoms to a much greater degree than peers of the same mental age, and there is no other diagnosis that can explain the symptoms, then a diagnosis of ADD can be made (Hallowell & Ratey, 1994). Maybe a clearer understanding of this process would clarify some of the issues surrounding etiology and assessment for the participants in this study.

Janus-Faced

When I discussed the analysis with the participants, three women spoke about the issue of language. Two women described not having the language to express their thoughts and feelings. Another spoke about her tendency to interpret language very literally. Like Janus, language is a doorway--the doorway to communication. Language is a formal system of signs and symbols (Merriam-Webster, 1993), which may or may not be words. Our conversations during the third interview, as well as the theme of the 'said' and 'unsaid', caused me to explore the concept of language and the role it may play in the lives of women university students diagnosed with ADD.

The Role of Language in Women's Experience

"Language plays a crucial role in human existence. Its symbolic function allows us to structure our world and to form bridges of meaning" (McCannell & Herringer, 1990, p. 58).

In his discussion on 'thought and language', Harman (1973) claimed that language makes thought possible, allowing us to put our thoughts into words. He did, nevertheless, state that not all mental states involve the language we speak because babies have desires, beliefs and thoughts before they learn a language. What language does do for us is provide us with the ability to think aloud. Instead of forming a thought first and then putting it into words, we can express what we are thinking by putting in words what was originally not in words. Learning a second language, he suggested, is more than learning to translate between the first and second language because we have not fully learned a language until we can think in it so that translation is no longer necessary.

In Chatterjee's (1963) book, she pointed out that words do not mean anything unless we understand the conventions of the language to which they belong and that without this familiarity, they are nothing more than a sequence of meaningless sounds. Belenky et al. (1986) reported that studies on gender differences in the use of language indicate that it is divided into two domains, listening and speaking, with men doing the talking and women doing the listening. Could it be that the women in this study are not used to verbally expressing themselves aloud? Are women taught more listening skills than they are about articulating feelings and thoughts? Jordon, Kaplan, Miller, Stiver, and Surrey (1991) answered these questions affirmatively when they considered their own experience: "Many of our most difficult challenges have centered around the use of language and the attempt to find the words that best capture what we want to communicate" (p. 3). Their experience supports the view that this predicament is common to more women than only those diagnosed with ADD. Stanley and Wise (1993) also agree: "We need a woman's language, a language of experience. And this must necessarily come from our exploration of the personal, the everyday, and what we experience--women's lived experience" (p. 146). So does language play a unique part in the experience of women university students diagnosed with ADD? The next section will explore this issue by describing a new explanation of what ADD may be.

Delayed Responding and Language

In the third interview, three women described restrictions of language that they experience. In his new theory of ADD, Barkley (1993; 1994; 1997) suggests that indeed language plays a major role in the lives of individuals with characteristics known as

ADD. However, this role of language is quite different from that explored by the women in this study.

Barkley (1993; 1994; 1997) adapted and applied Jacob Bronowski's theory that the evolution of our ability to inhibit and postpone a response to an event is what makes human language and thinking unique from other species. This capacity arose primarily from the expansion of the frontal lobes (Barkley, 1993) and permitted the evolution of four important mental abilities: (a) separating our feelings from facts, (b) prolonging the event in our mind, (c) self-directed speech (our mind's voice and self-control), and (d) breaking apart and recombining events (Barkley, 1994). The author suggests that people with ADD have deficits in these abilities and are less able to use language in these ways. For example, it is not that they do not think before they act but that they act before taking time to think. This theory, he asserted, better explains findings in the literature that are not easily accounted for by existing theoretical models. According to this theory, ADD is not a disorder that is merely a deficit in behavioural inhibition or represents a loss of control, but rather it is a shift of the sources of control (Barkley, 1997). He recommends 'temporally tightening up' the consequences of a person's behaviour because problems lie in the delay in the accountability of their actions. Therefore, he concluded, it is time, not consequences, that is the problem for those with ADD and removing time, not outcomes, is the solution. It is not the consequence of the behaviour that affects the behaviour but the time delay that does. By reducing the time lapse between the behaviour and the consequence, the behaviour can be improved.

This theory has huge implications for post-secondary settings. Chapter Two

illustrated the differences between high school and post-secondary institutions. In university, there is a greater emphasis on independent reading and studying and an expectation to function autonomously. At the beginning of university courses, students are presented with the due dates of many assignments and exams. These deadlines are usually toward the end of the course, approximately twelve to fourteen weeks later. If students with ADD have deficits in language and are unable to prolong an event in their mind, would this account for the procrastination that some of the women in this study described? Barkley seems to suggest that these students would benefit from much shorter time lines.

Summary

Women writers have expressed the difficulty of finding a language to accurately describe women's lives and experiences (Heilbrun, 1988; Surrey, 1990). Therefore, the experience of the lack of language to express themselves described by participants in this study may be a result of their gender more than it is of their diagnosis.

Barkley (1993; 1994; 1997) presented a novel theory of ADD involving the role of language and showed the relationship between four executive mental functions, behavioural inhibition, and self-control. The four executive functions (separation of affect, prolongation, internalization, and reconstitution) are necessary for behavioural inhibition by providing self-control which is the means to manage our behaviour. His theory has important implications for the treatment of people with ADD by focusing on immediate consequences of their behaviour.

Thoughts Like a Rubber Ball

As I reported in Chapter Three, my interpretations were shared with my participants in an attempt to account for the quality of my analysis. I would like to describe what occurred in that third interview under the heading of this metatheme as this was the only interpretation that did not fully resonate with the experiences of all eight women.

Web or Conveyor Belt?

As expected, new meaning and deeper insights were generated during the third interview. With the exception of this metaphor, the women discussed how the interpretations resounded with their experience and then they added to the interpretations. Their responses spoke to the diversity of the experience of being a woman university student diagnosed with ADD as the exemplars in Chapter Four also demonstrated.

Six of the eight women felt that the rubber ball metaphor appropriately described their experience. For example, Sue stated that the non-linear thought pattern described by **thoughts like a rubber ball** is *the* difference between people who have the disorder and those who do not. Robin and Suzie, however, did not feel it fully validated their lived experience.

At this interview, Suzie portrayed her thoughts as linear and more akin to items on a conveyor belt. The conveyor belt is accelerated, forcing the items to come at such a speed that it makes it difficult to pick up each one. Robin, on the other hand, pictured her thoughts as forming a web as each thought creates a number of possibilities and those possibilities spawn more possibilities and so on.

Clarke (1990) described six aspects of thinking that he interpreted as existing in a circular process, similar to that of Robin's analogy of a web. Each aspect involves a management skill for thinking: (a) scanning and focusing to purposefully search for meaningful information, (b) creating categories and classes to use grouping techniques to increase mental efficiency and power, (c) inducing propositions from facts to use what the senses know to create new ideas, (d) activating conceptual knowledge to hypothesize relationships between concepts and events, (e) predicting and planning to use mental models to predict, plan, or decide on the future, and (f) developing procedures to create problem-solving steps appropriate to a specific decision or plan (p. 13). Metacognitive awareness involves monitoring activity in each of these six aspects and allows attention to be focused on one thing at a time. Other functions of metacognition include timing, sequencing, evaluating errors, choosing and adapting strategies and checking output against goals--which may be summed up as directing the mind toward purposes. Clarke (1990) asserted that students need to be aware of their own mental processes in order to learn to manage them.

As described in Chapter Four, the women in this study developed their own strategies to help them manage having thoughts like a rubber ball. They even considered this thought pattern to be advantageous in certain situations. By re-interpreting this metaphor, Suzie and Robin demonstrated their awareness of their own mental process and developed a deeper understanding of their own thought patterns. This is another purpose for discussing my analysis with my participants.

Implications

“Personal knowing is the opposite of generality. It cannot be expressed in general terms, but that is no impediment to its expression” (Gadow, 1990, p. 170).

This study’s findings are not intended to promote the needs and experiences of women as universal (Kaschak, 1992) but to make visible the varying experiences and perspectives not available in ADD research. Nor are the findings intended to serve as generalizations to all women diagnosed with ADD. The purpose is to complement the existing literature as well as to extend the knowledge of the lived experience of women university students diagnosed with ADD. This study may assist women who are diagnosed later in life or who have symptoms but are not yet diagnosed by helping to increase their understanding of their own experience.

Cantwell (1996) pointed out that the DSM-IV criteria has been based on the clinical picture of elementary-school age children. This study describes the lived experience of women university students diagnosed with the disorder. The core symptoms of ADD may change over time, however most of our knowledge is based on studies of elementary-school age boys with the disorder (Cantwell, 1996). There is a growing body of literature on adult ADD and this study contributes to that area by presenting these women’s description of their ‘symptoms’ and some of the consequences of these characteristics. Some of the women described characteristics similar to the Inattention criteria of the DSM-IV that included being easily distracted, difficulty with organization, sustaining attention, following through on instructions, and finishing tasks.

While these results are not generalizable to other populations, I can speculate on

how these women's stories may be put in a larger context, namely how they may be similar to those of women in academia and women with physical disabilities.

The women in this study explored stressful events in their lives, particularly how these events related to their education. They also shared academic experiences with me that they described as less than satisfactory. Pyke (1997) found similar support for the chilly climate construct. Results suggested that as many men as women reported barriers that hindered them from completing their degrees expeditiously. However, women tended to list more of the barriers than men. She pointed out that what is remarkable is that in spite of these situations, women did not withdraw in large numbers nor take longer than men to complete their degrees.

My participants had not withdrawn from post-secondary education by the completion of this study. One participant was taking the year off due to financial reasons. Pyke (1997) found that the largest male/female differential of declared hindrances to completion of doctoral degrees was insufficient financial support. In her study, 46% of women compared with 28% of men reported financial factors as hindrances, including the need to work full time, the need to do a Teaching Assistantship in order to earn money, the problem of unpaid internships, and no financial support from the university in the summer. Given the many other roles of a woman university student identified by Hartsock (1974), particularly family responsibilities, insufficient financial support can contribute to the perception that universities may be inhospitable environments for women.

Women with physical disabilities may present with similar experiences as the

women in the study that this study presents as themes, namely **Robbed of Time, Is [My Disability] Real or Not Real**, and **Janus-Faced**. Women with physical disabilities often take longer to complete tasks or activities than those without physical constraints.

Women with physical disabilities that do not have outward physical ‘evidence’ or an objective test to determine its presence, such as Chronic Fatigue Syndrome, are often met with skepticism by others over its existence, causing the women to also question the diagnosis’ validity. Once a disability has been diagnosed, the naming can be the ‘gate’ to treatment. While the details of their experience will be difference from those women diagnosed with ADD, these metaphors may also accurately reflect their experience.

It is the hope of this researcher that the findings of this study contribute toward the elimination of stereotypical attitudes toward women university students diagnosed with ADD. The danger of analyzing the data as a whole is the assumption of similarity (DeMarco, Campbell, & Wuest, 1993). However, the exemplars that are provided demonstrate the differences in the expression of the disorder and in the experience of these women. One of the purposes of this study was to provide a venue for their voices because it is from their voices that we can learn, if their voices are heard. As a psychologist, I heard the need for more explanation of the assessment process and of the diagnosis by the clinician to the client. I heard the need for more follow-up after the assessment process is completed if the result is a diagnosis of ADD. As a university student, I heard the need for more effective communication between faculty and students. I heard the need for more education, awareness and understanding of ADD on the part of faculty and students, including those diagnosed with the disorder. As a woman and a

feminist, I heard the need for a language that can more accurately represent these women's experiences, a language that goes beyond the label of "Attention Deficit Disorder." As a researcher, I heard the courage, persistence, ambition, and the strength of spirit from the voices of these women.

Other implications of this study are the future directions that the findings suggest. These are discussed later in this chapter.

Limitations

We must remember that there is no absolute interpretation of the data and that interpretation can produce contradictory as well as coherent meanings. The best the researcher can do is to argue a particular interpretation as persuasively as possible, supported by references to the data, and leave the final judgement to the reader (Osborne, 1990, p. 87).

The limitations of this study are in reference to issues of methodology of the selected approach. Morse (1994) discussed some of the limitations of qualitative research, including phenomenology: methodological ambiguities, disagreements over terminology, and difficulty documenting conclusions. I wish to address those of which I was particularly cognizant.

As previously noted in the Implications section, the metathemes presented in this study are based on an in-depth understanding of eight women university students diagnosed with ADD, situated in a particular time and place. Therefore, they cannot be generalized with confidence beyond these participants. Every human situation is novel and emergent, filled with multiple meanings and interpretations (Ellis & Flaherty, 1992).

Another possible limitation is the role of the researcher in interviewing participants and extrapolating themes. There are few prestructured or standardized

procedures for conducting these interviews and many methodological decisions have to be made during the interview (Kvale, 1996). I attempted to account for my decision-making process through journal writing as I discussed in Chapter Three. During data analysis, the text is re-created in an attempt to make sense out of what the researcher has learned. The interpretive practice is both artful and political because there is no single interpretive truth; it is “endlessly creative and interpretive” (Denzin & Lincoln, 1994, p. 14).

Producing good, reliable knowledge requires following a systematic approach (Code, 1995). By relying primarily on one author, that of van Manen, I hoped to achieve that. However, at the same time, I must acknowledge the limitations of following one methodology. Although I discussed the compatibility of hermeneutic phenomenology and feminism in Chapter Three, they are also incompatible. Hermeneutic phenomenological research may not directly contribute of the understanding of the manifestations of the gender-inflected power and privilege in our society (Code, 1995). As well, studies using this method do not necessarily contribute to the understanding, conceptualization or theorizing about women’s oppression or describe the actions necessary for women’s liberation. Nor do the results always explain the differing interpretations of the nature of the personal and its relationship to the political (Stanley & Wise, 1993). Research utilizing hermeneutic phenomenological methodology may address these feminist issues, depending on the research question being asked.

Another limitation of this study that I, as researcher, am responsible for may be the constraints indicated by the wording of the research question. The question “what is

your experience as a woman university student diagnosed with Attention Deficit Disorder?” may have unintentionally limited their responses to their ‘school’ experience. The participants may have explored other topics if the question was worded differently, such as “what is your experience as a woman diagnosed with ADD?”. This issue is raised again under Future Directions.

Future Directions

An important aspect of this study is not in the answers but also in the questions it generates (Kaschak, 1992). One question it raised for me was “Is this experience unique to women diagnosed with ADD?” Although a purpose of this study was to make visible the experience of these women rather than look for gender differences, this question can have important implications for women’s role in our society and how that role affects their education. Similar research on the experience of women homemakers, women in the workforce, and men university students diagnosed with ADD would be a step toward answering this question. Solden’s (1995) book, while based on clinical observation rather than research, suggests that problems with time management are more of an issue for women given the role expectations for women in our culture, especially with regard to child rearing. The women in this study spoke primarily of lack of time as it related to academic tasks and balancing these demands with work and social life. Therefore, it is difficult to compare their experience with that of the women Solden sees in her practice.

Psychiatric theories fail to explain or to provide solutions for many of the dilemmas women encounter in their daily lives (Penfold & Walker, 1989). For example, Why do these women feel robbed of time? Why does it take them longer to complete

academic tasks? Answers to these questions may yield important information to assist educational institutions in providing accommodations for students diagnosed with ADD. For instance, one of the questions concerning accommodations that educators ask include “how much extra time is adequate?” In addition, these students could be taught more effective learning strategies if more was known about what contributed to being robbed of time.

The topic of relationships is presented in much of the literature on ADD as a prominent issue (e.g., Hallowell & Ratey, 1994). From her observations, Solden (1995) suggested that women with ADD hide and separate from relationships to protect themselves from ‘bombarding’ stimuli and the vulnerable self-image they have developed as a result of their shame and guilt. She also indicated that misinterpretation is a big area that causes problems for women in relationships if they do not check out other people’s reactions. As well, she stated that women with ADD avoid people because of all the clutter and disorganization in their life, which may cause shame. Hallowell and Ratey (1994) described the most problematic manifestation of ADD for people is their inability to observe their own behaviour and to correctly gauge the responses of others. They suggested this is a result of the problem they have paying attention or noticing the subtle cues that social fluency and self-regulation depend upon. The women in this study briefly explored some of these difficulties. LJ described feelings of guilt, and Sue discussed not having time for friends. Suzie briefly talked about her quick reaction to other people’s actions which she does not always interpret accurately. Most of the what these women described could be classified as “social” difficulties. As previously

discussed, the lack of discussion on relationship issues may have been due to the wording of the question “What is your experience as a woman university student diagnosed with Attention-Deficit/Hyperactivity Disorder?” As well, none of the participants in this study were currently married which may also have influenced their topics of conversation.

After the third interview, I indicated to Sue that a future area of study in which I may be interested is relationships and women diagnosed with ADD. She responded that it is a *big* issue, especially before there is a diagnosis.

Through the understanding of the women’s experience, four metathemes were highlighted as ways that the women experience the world. Based on these findings, there is support for the need to develop further the deep meaning of each of these metathemes within the lives of women diagnosed with ADD. Separate studies could be conducted that describe the meaning of time, thought patterns, labels, and contrasting aspects of the experience of ADD for these women.

This research illuminated the experience of women university students diagnosed with ADD. Three women spoke of other health issues, including depression. More research is needed that seeks to reveal the women’s experience with other health and illness issues. Subsequently, this also raises the question of whether there are differences between the experience of women with mental health and those with physical health issues?

Some of the women in this study spoke about the desire to be normal. For example, Dagny did not take her medication regularly in an attempt to seek normalcy. As Penfold and Walker (1983) demonstrated, normality is not objective but simply agreed

upon, dependent upon an interaction between the definer, the context, and that being defined. More research is needed that describes how women university students diagnosed with ADD define normalcy.

Another important consideration for future directions is the accessibility of research findings (DeMarco, Campbell, & Wuest, 1993) for women who may have the symptoms, their family and friends, educators, and the general public. The women in this study described the paucity of positive information on the disorder and the need for increased public awareness. They feel misunderstood by people outside of, and sometimes within, the field. This may be a result of the skewed information presented to the general public. The media appears to focus on the perceived negative aspects of ADD (e.g., Marshall, 1998). Educating the public is an important direction for the future. However, this is a difficult task given the inconsistencies in research findings (on etiology, for example) and even lack of agreement among professionals over the existence of such as disorder (Moses, 1991; Schwartz, 1994).

Study Summary

The experience of women university students diagnosed with ADD is clearly an issue worthy of more study. Further study would benefit similar women, and professionals in mental health and educational fields who support and provide services to these individuals. These women's voices can inform professionals about the effect of the characteristics known as ADD and about the meaning of their lived experience. The only way to know the other as individual is by speaking with them, not about them (Gadow, 1990).

The participants expressed their positive regard for the research process. I found the process to be respectful by valuing others' experience and expertise. It is a process that allows creativity and innovation while being systematic. Hermeneutic phenomenology focuses on the meaning of lived experience, requiring self-awareness on the part of the researcher and participants.

These women describe and interpret their experience in terms of four metathemes: Robbed of Time, Thoughts Like a Rubber Ball, Is ADD Real or Manufactured, and Janus-Faced. The metaphors are analogies of what it is like to live the experience. These meanings may guide the understanding and actions of those working with women university students diagnosed with ADD.

Most of the existing literature on the topic of ADD, such as prevalence rates and etiology, raises many questions while attempting to answer them. The results of this study support the literature which suggests there are many diagnostic problems, including DSM-IV criteria, which contributes to doubts concerning the validity of this disorder. Research on gender issues suggests there are methodological problems with this type of quantitative research, including small sample sizes of females, sources of samples, and comparing participants diagnosed with different subtypes of the disorder. These issues clearly indicate the need for more research in the area.

This study is not intended to be the last word on the topic. While the study has described and interpreted these women's experiences, it also raised specific questions for future research. Findings suggested that the characteristics of ADD may change over time. Comparative research that examines differences between women within particular

age ranges (e.g., women aged twenty to twenty-nine, women aged thirty to thirty-nine, and so on) may elucidate this issue. Research on men university students, women homemakers, and women in the workforce who are diagnosed with ADD may help explain whether the findings of this study are unique to women university students.

I know that this research will have a profound effect upon my practice as a psychologist. This research revealed the many challenges these women face and the creativity in the strategies they use to meet these challenges. I have gained much knowledge on the issues they confront in school and in their personal lives. This process has been exciting, rewarding, and fulfilling. It is a privilege to be able to submit this dissertation as a small contribution to the knowledge of this field for women who have the diagnosis and for professionals working with them.

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Appendix A

Invitation to Participate

Dear Student:

This letter is an invitation for your participation in a study on *the experience of women university students diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD)*. As a Doctoral candidate in the Department of Educational Psychology at the University of Calgary, I am conducting a research project as part of the requirements for my degree which is being conducted under the supervision of Dr. Marilyn Samuels. This letter is to provide you with some information so you can decide whether you wish to participate.

I am interested in exploring with you your experience as a women university student diagnosed with AD/HD. For the purpose of this study, participants should be over the age of twenty, be presently enrolled in university, and have been diagnosed with AD/HD by a psychologist or psychiatrist.

If you have any questions, please feel free to contact me at 284-1611, Dr. Samuels at 220-5667, the Office of the Chair, Faculty of Joint Education Ethics Committee at 220-5626, or the Office of the Vice-President (Research) at 220-3381.

If you think you may like to participate, please call me at 284-1611 and we can arrange a time to meet and further discuss this study, with no obligations for you to participate.

Thank you for your time.

Sincerely,

Sonya Corbin Dwyer, M.Ed.

Graduate Student

Appendix B

Cover Letter for Consent Form

Dear Participant,

Thank you for your interest in my research. As a Doctoral candidate in the Department of Educational Psychology at the University of Calgary, I am conducting a study on *the experience of women university students diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD)* under the supervision of Dr. Marilyn Samuels. This letter is to provide you with additional information so that you can make an informed decision regarding your participation.

Your participation will involve being interviewed on two (2) occasions, with an opportunity for a third, follow-up interview. Each interview will be approximately one to two hours in length and will be conducted in a location selected by you (e.g., your home, or an office or classroom at the university). The information you share during the interviews will be kept confidential and viewed only by me and my supervisor, Dr. Samuels. During these interviews, you can refuse to answer specific questions or disclose certain information, and you may withdraw from the study at any time.

I will be audio-taping and transcribing these interviews. To protect your privacy, you will be asked to choose a pseudonym which will be used in the dissertation, reports, presentations on the study or publications in relevant journals. Short excerpts of the interview may also be used with any identifying information changed to insure anonymity. Audiotapes will be coded with a number and the coding information identifying the audiotapes will be stored in a separate locked file cabinet. The signed

consent forms will be stored separately. These will be accessible only to me and my supervisor. Two years after the successful completion and defence of my dissertation and publication of the data, the tapes and transcripts will be destroyed.

I will share my understanding of your experience with you during the second interview so that you may confirm or correct it. You will have the opportunity to meet with me a third time to go over the results of my analysis to ensure my understanding matches your experience.

Your participation in this study will not likely involve any risks greater than those ordinarily experienced in daily life. However, it is possible that discussion of your experience may raise issues and be stressful. If you need to discuss any concerns that may arise from our conversations, I will refer you to an appropriate professional.

If you have any questions at any time during the process, please feel free to contact me at 284-1611, Dr. Samuels at 220-5667, the Office of the Chair, Faculty of Joint Education Ethics Committee at 220-5626, or the Office of the Vice-President (Research) at 220-3381.

If you are still interested in becoming a participant, please sign the attached consent form (a copy is provided for your records).

Thank you for your interest and cooperation.

Sincerely,

Sonya Corbin Dwyer

Appendix C

Consent for Research Participation

I, _____ consent to participate in a research project entitled “The Experience of Women University Students Diagnosed with Attention-Deficit/Hyperactivity Disorder” being conducted by Sonya Corbin Dwyer under the supervision of Dr. Marilyn Samuels.

I acknowledge that:

1. I volunteer to be interviewed and share my experience as a university student diagnosed with AD/HD.
2. I am aware of the procedures of the research project and am willing to be interviewed and audio-taped for the purpose of the study. I understand that a follow-up meeting will be made available for me to verify the analysis of my information.
3. I understand that my participation in this study may be terminated at any time by my request, or the investigators. Participation in this project and/or withdrawal from this project will not affect my receipt of services from The University of Calgary.
4. I understand the possible risks and that reasonable safeguards have been established to minimize the risks.
5. I understand that the interview information will be kept confidential except under a few conditions. These limits have been explained to me. I will choose a pseudonym that will be used, along with short excerpts of the interviews, in the dissertation, reports, presentations or publications of the study. Identifying information will also be changed.

6. I understand that all raw data will be coded (no names), kept in a locked file cabinet, and destroyed two years after successful completion and defence of the dissertation and publication of the data.

7. I have received a copy of this consent form for my records.

8. I understand that if I have questions at any time, I can contact the researcher at 284-1611, her supervisor at 220-5667, the Office of the Chair, Faculty of Education Joint Ethics Committee at 220-5626, or the Office of the Vice-President (Research) at 220-3381.

LIMITS OF CONFIDENTIALITY

The information which I share can be considered confidential except under a few conditions.

If I tell you about the possibility of:

(A) danger to myself or someone else;

(B) sexual or physical abuse of a child

I understand that this must be reported to the appropriate authorities.

Signature of Participant

Date

Participant's Name Printed

Signature of Researcher

Date

Appendix D

Summary Characteristics of Participants

At the time of the initial interview, all of the women, with the exception of one, had been diagnosed within the four years prior to the initial interview. The two youngest participants were diagnosed in childhood (one when she was sixteen years of age and one when she was in grade one). Three of the women had already earned university degrees and one woman held a college diploma. At the time of the first interview, the participants were enrolled in a variety of faculties, including music, psychology, management, philosophy, education and women's studies. Six of the women are single and two are divorced, single-mothers. The single-mothers had at least one child diagnosed with ADHD, which subsequently led to their own diagnosis. Seven of the women are white and one is a woman of color.

By the second interviews, six of the eight women were using medication as part of their treatment of ADHD. Two women were taking time off from university and working full-time. Two other women had left the university setting, one taking university courses at Mount Royal College and another was enrolled in a full-time program at the Southern Alberta Institute of Technology. The remaining four participants were still enrolled at the University of Calgary.

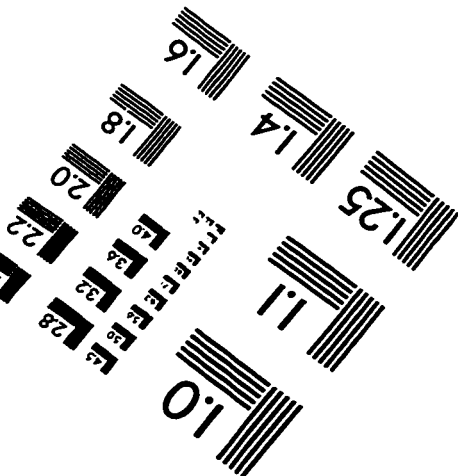
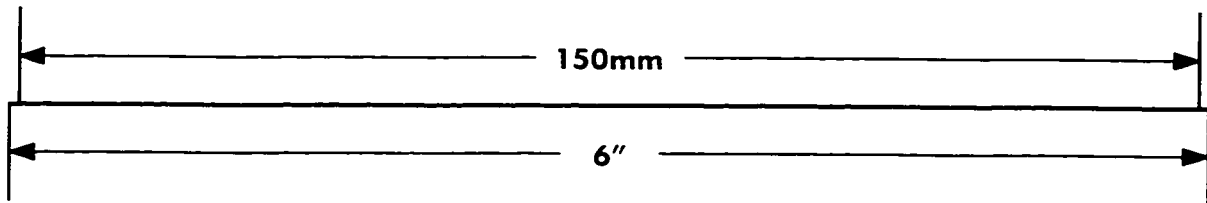
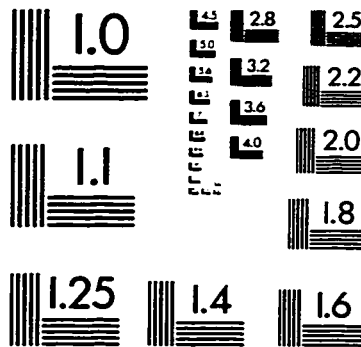
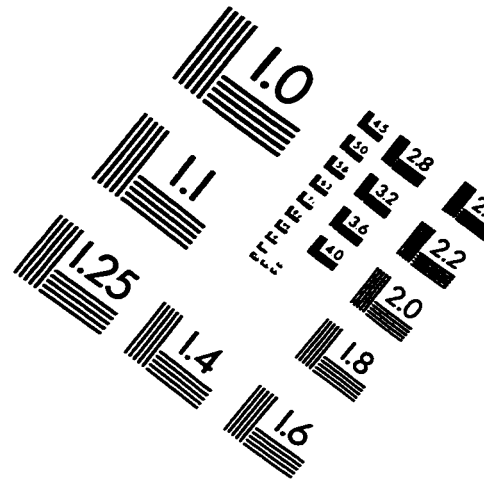
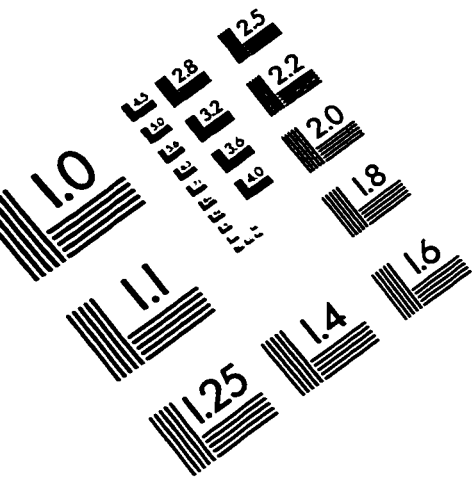
Figure 1

Illustration of Janus



by H. E. Thomson, 1998

IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc.
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

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