A sociological analysis of Rhodes University students previously diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) and prescribed psychostimulant medications.

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ABSTRACT

Using the theoretical framework of symbolic interactionism, bringing into account the labelling theory, the stigmas attached upon mental health issues and the medicalization approach, this study sought to document and analyze the viewpoints that previously diagnosed Rhodes University students hold towards the ADHD label and the subsequent usage of psychostimulant medications. Seven respondents were involved in an in-depth interviewing process. Out of the seven respondents chosen, five of the respondents were diagnosed in their primary school years, whereas the other two respondents were diagnosed in their late teenage years or early adult years. These respondents were included to enlighten and support the narrative of the five respondents diagnosed in their youth. The findings varied, with some of the respondents feeling negatively affected by having the ADHD label attached to them, and others, positively affected by it. The findings were also diverse in terms of how the respondents experienced stimulant usage, with some believing that the benefits of usage outweigh the costs, and others, the opposite. At a general level, it was discovered that the respondents were not affected by the ADHD label in terms of their interactions with others in primary school. It was only as they got older did some become fearful of the stigma attached to the ADHD label, and that of medication.

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Chapter 1: Introduction

1.1. Brief Introduction to ADHD and Psychostimulant Medications

Attention-Deficit/Hyperactivity Disorder (ADHD) is a "neurobiological condition" associated with impaired abilities on several levels of functioning (Muthukrishna, 2013: 145). It appears to affect up to "3%-7%" of school-aged children, making it the most highly diagnosed child psychiatric illness in the world (Bruchmüller, Margraf, & Schneider, 2012: 128; Ghanizadeh, Bahredar & Moeini, 2005: 84). While ADHD is commonly associated with children, studies indicate that its symptoms continue into both adolescence and adulthood for up to "10% to 60% of those affected" (Scheffler, Hinshaw, Modrek & Levine, 2007: 450; Shaw-Zirt, Popali-Lehane, Chaplin & Bergman, 2005: 109). The symptoms associated with it primarily include "inattention, hyperactivity and impulsivity", which often exist along with other illnesses, such as "anxiety and depression" (Wilder, Koro-Ljungenberg & Bussing, 2009: 61; Shaw-Zirt, *et al.,* 2005: 109).

The most common therapy used to treat the symptoms associated with ADHD includes "Methylphenidate Hydrochloride" or "Ritalin": a psychostimulant drug known to improve "academic performance" and aid in the management of ADHD symptoms (Berger, Talia, Yoram & Goldzweig, 2008: 1036; Muthukrishna, 2013: 147; Venter, 2006: 143). In addition to Ritalin, other psychostimulant drugs have entered the pharmaceutical market and have gained increased popularity in recent years. These include Concerta, Adderall, DexoStrat and Dexedrine (Jacobs, 2014: 48). As most children diagnosed as ADHD are prescribed psychostimulant medications, the sales of stimulants are often used as an indicator of its prevalence in society (LeFever, Dawson, & Morrow, 1999: 1359). In the Western context, the numbers of children diagnosed with ADHD and subsequently prescribed stimulant medications appear to be significantly high (Conrad & Bergey, 2014: 32). In the South African context, however, the number of South African children diagnosed as ADHD and subsequently prescribed psychostimulant medications remains uncertain (Muthukrishna, 2013: 145). This is largely because the majority of studies surrounding the ADHD topic and the subsequent usage of stimulant medication predominate in the Western context, such as Europe and the United States, in contrast to the few studies that have been conducted in South Africa (Jacobs, 2014: 3). This is justified by Muthukrishna (2013: 145), who claims that there are few studies available portraying the extent to which South African children suffer from ADHD and by extension, the degree to which they engage in

psychostimulant therapy (Muthukrishna, 2013: 145). Thus, in using South Africa as the contextual framework, this research sought to analyze the experiences and views that previously diagnosed Rhodes University students hold towards the ADHD diagnosis and the usage of psychostimulant medications. This study was conducted within the context of Grahamstown, South Africa. A sociological analysis of this kind had not previously been undertaken in South Africa, which motivated the rationale underlying this study.

1.2. Aims of the Research

The primary aim of this research was to document and analyze the experiences of Rhodes University students previously diagnosed with ADHD and subsequently prescribed psychostimulant medications. The majority of respondents included in this study were diagnosed with ADHD in primary school, and were thus asked to reflect upon their schooling experiences as an ADHD pupil or child. In doing so, I aimed to determine whether or not the ADHD label had an effect upon them in their youth, and whether or not these effects were influenced by their interactions with others. Thus, I aimed to determine whether or not their experience of the ADHD label was affected by their interpersonal relationships with others, and whether or not they felt stigmatized for having the ADHD diagnosis attached to them in their youth. In addition, I also aimed to determine how they experienced the usage of stimulant medication, and whether or not the usage had any positive or negative effect upon them.

Two additional respondents were included in this study, both of whom were only diagnosed with ADHD in their late teenage or early adult years. This was done in order to enlighten and strengthen the account of the respondents diagnosed with ADHD during their primary school years. Their involvement furthermore provided insight as to how it felt to only have the ADHD label attached to them at a later stage in their lives, despite the fact that they both exhibited many ADHD-related symptoms in their youth. Their input furthermore provided a deeper understanding into how one may experience the usage of stimulant medications, and what positive and/or negative effects it may induce.

1.3. Theoretical Underpinnings

This study was guided by a variety of sociological approaches, beginning with what is referred to as the medicalization approach. To give brief mention, medicalization is considered as "the

process by which non-medical problems become defined and treated as medical problems" (Conrad, 1992: 207). Considering that that there are no "cognitive, metabolic and neurobiological tests" that can prove there is something physically or mentally wrong with the child/person who appears to have ADHD, some have argued that ADHD is, in fact, a medicalized condition (Timimi & Taylor, 2004: 8). To elaborate, social scientists have argued that ADHD is merely a "social construction", whereby the medical model defines it in terms of certain symptoms, yet fails to consider the context in which these symptoms occur (Levine, 1999: 199). Thus, what results is a society in which any action that goes against the normal expectations of good behavior become medicalized as an illness or disorder, with a possible negative impact upon the child or person in question (Malacrida, 2004: 63). In cases involving children, it is usually the teacher who initially medicalizes the child as having ADHD after noticing the child's continuous misbehavior in the classroom (Snider, Busch & Arrowood, 2003: 47). As a result, some scholars have argued that by referring the child for psychological assessment and ensuring that the child be placed on stimulant medication thereafter, teachers are able to exert control over the pupils they consider as 'unruly' or 'deviant' (Perold, Louw & Kleynhans, 2010: 458-9; Malacrida, 2004: 63). Thus, it is essential to take into account the social context influencing the viewpoints held towards ADHD, which interrelates with the meta-theoretical framework used in this study, namely: symbolic interactionism.

According to Babbie and Mouton (2001: 31), symbolic interactionism consists of three premises. Firstly, people react towards situations or actions based on the meaning they attach to it. Secondly, that the meanings they attach towards these actions derive from the interactions they have with others. Lastly, the meanings people attach towards certain actions are based on interpretation (Babbie & Mouton, 2001: 31-2). Thus, in their interactions with the ADHD individual, a person will react to the situation according to the meaning attached upon the ADHD diagnosis which, in turn, may have a negative effect on the ADHD individual him/herself. This interrelates with the labelling theory, which forms part of symbolic interactionism, and is applicable to the views that the previously diagnosed Rhodes University students may hold towards the ADHD label, as well as the impact this label may have had upon them at different stages of their lives.

The labelling theory refers to the idea that when a person is labelled as mentally ill, s/he internalizes this idea and become mentally ill (Pasman, 2011: 123). Thus, once a person has been diagnosed or labelled as mentally ill, this label begins to dominate his/her self-concept or "social self", most likely in a negative way (Pasman, 2011: 123). This has the potential to lead to feelings of shame, and the adoption of "self-stigma" (Pasman, 2011: 123). With self-stigma, a person begins to internalize their "new degraded identity" as being definitive of the person that s/he is (Mueller, Fuermaier, Koerts, & Tucha, 2012: 102). This leads to what is referred to as "self-esteem decrement" in which one's self-esteem decreases due to these internalized negative beliefs (Pasman, 2011: 124).

1.4. Research Design

In order to gather an in-depth understanding of the respondents' experiences and viewpoints towards ADHD and the usage of psychostimulant medication, a qualitative research design was best suited. The research method employed included semi-structured, in-depth interviews that were conducted with 7 Rhodes University students, all of whom are over the age of 18 years old, and came from different schooling backgrounds. Five of the respondents were diagnosed with ADHD in their early primary school years, whereas the other two respondents were diagnosed in their late teenage/early adult years. Their inclusion helped to strengthen the account of those diagnosed in their youth. Furthermore, five of the respondents were female and two of the respondents were male. All 7 of the respondents were Caucasian.

The in-depth, semi-structured interviews were conducted either at the participants' respective households, or on Rhodes University's campus in Grahamstown. The interviews only took place on one occasion, and took no longer than 30 minutes to an hour to complete. Gaining access to these participants occurred through informal social media networks, such as the Rhodes SRC page and the Rhodes University Community Forum page on Facebook. I furthermore ensured that I abided by the ethical standards permitted by Rhodes University at all times, prior to and during the research process.

1.5. Conclusion

In conclusion, this chapter sought to introduce the phenomenon of Attention-Deficit/Hyperactivity Disorder and the usage of psychostimulant medication, bringing into

account what the primary aims of this research entailed as well as the theoretical frameworks employed. Thereafter, I briefly outlined what research methods were used in the research process, and the kind of respondents that were chosen to participate. Having established this, the focus now turns to a more in-depth analysis of ADHD and the usage of psychostimulant medication, specifically from a biomedical perspective.

Chapter 2: Introducing Attention-Deficit/Hyperactivity Disorder (ADHD) and Psychostimulant medications: A Medical Perspective

2.1. Introduction

As the primary aim of this research was to sociologically analyze the phenomenon of Attention-Deficit/Hyperactivity Disorder (ADHD) and the usage of psychostimulant medications, it is thus imperative to first understand what ADHD and the usage of psychostimulant medications comprises. This will be achieved in this chapter by focusing on the biomedical understandings of ADHD, and the treatment of choice used to alleviate its symptoms, namely: psychostimulant/pharmacological therapy. This chapter will mainly focus on the medical understandings of ADHD, and the following chapter will seek to deconstruct the medical underpinnings of ADHD by using sociological theory.

This chapter will be divided up into several sections. In the initial part of this review, a historical account of the events that have led up to what is today known as ADHD in contemporary society will be discussed. Thereafter, I will discuss what ADHD is as well as the symptoms that are believed to be associated with it. After doing so, I will move onto the prevalence of ADHD worldwide, with a specific focus on South Africa. I will also give mention to how ADHD is believed to continue into both adolescence and adulthood for many of those affected, as this partly interlinks with the purpose of this research. Having established this, I will then discuss the therapies used to alleviate the symptoms associated with ADHD, where the main focus will be on pharmacological therapy. With that said, I will also be bringing into account other treatment methods that are sometimes used as an alternative to stimulant therapy, or in conjunction with it.

2.2. Historical overview of ADHD

In order to fully grasp the contemporary medical understanding of Attention-Deficit/Hyperactivity Disorder (ADHD), the history of how ADHD has evolved over the last century needs to be analyzed (Kleynhans, 2005: 11). In the last 100 years, several "biomedical and psychosocial" explanations and terms have been used to describe the behavioral characteristics with what is today known as ADHD (Kleynhans, 2005: 11). George Still (1902), a prominent British physician of his time, is typically known as the first author to have described the behavioral characteristics believed to be associated with it (Barkley & Peters, 2012: 1;

Kleynhans, 2005: 11). At a meeting of the "Royal College of Physicians", Still (1902) defined a disease that he believed resulted from a "defect in moral character" (Wolraich, 2006: 86). Still (1902) noted that children who had experienced brain damage at birth were unable to internalize and thus, conform, to the "rules and limits" within society (Wolraich, 2006: 86). Thus, Still (1902) suggested that unnatural behaviors in children had a biologically rooted cause, claiming that it was as a result of "pre-natal or post-natal brain injury" (Neophytou, 2004: 16). The children affected were furthermore seen as restless, inattentive, aggressive and overly-emotional (Wolraich, 2006: 86; Barkley & Peters, 2012: 1).

The belief that mischievous behaviors were associated with brain damage increased in the 1920s when the "*Encephalitis Lethargica"* epidemic came into being (Wolraich, 2006: 86; Rafalovich, 2001: 107). *Encephalitis Lethargica*, which was also known as "sleepy sickness", arose towards the end of World War 1 and was characterized by "tremendous sluggishness, hallucinations and fever" (Rafalovich, 2001: 107). It was a disease thought to inflict "irreversible damage" upon those affected, resulting in several "mental and physical impairments" (Rafalovich, 2001:107). Drawing on the works of Jane Kessler (1980), Rafalovich (2001: 108), claims that *Encephalitis Lethargica* caused up to 27 different symptoms, including: "sleep reversals, emotional instability, irritability, lying, thieving, impaired memory and attention, depression, poor motor control, and general hyperactivity" (see Kessler, 1980: 18). However, when other cases arose whereby similar symptoms occurred, yet there was little evidence of neurobiological damage, the name was changed to "minimal cerebral/brain damage" (Wolraich, 2006: 86; Kendall, 2008: 15). Minimal brain damage was considered as a condition inflicted by an unknown source of brain injury, thus causing the name to change to "minimal brain dysfunction" thereafter (Kendall, 2008: 15).

As the association with brain damage became increasingly unclear, the name continued to change in a manner that focused more on hyperactive behavioral characteristics, rather than specifically on neurobiological causes (Wolraich, 2006: 86-87; Kleynhans, 2005: 11). By the 1960s, the name had changed to "hyperkinetic reaction of childhood disorder", otherwise known as, "hyperactive child syndrome", where hyperactivity served as the core behavioral characteristic used to identify the condition (Kleynhans, 2005: 11). These children were then diagnosed with hyperactive child syndrome in accordance with the psychiatric classification

system known as the *"Diagnostic and Statistical Manual of Mental Disorders (DSM-II)"* (Wolraich, 2006: 87). In the 1970s, the diagnosis was broadened to include symptoms of "inattention and impulsivity", and the name was changed to Attention-Deficit Disorder (with or without hyperactivity) (Kleynhans, 2005: 11). In realizing that hyperactivity and impulsiveness in ADD children (with hyperactivity) was caused by "poor inhibitory control", the psychiatric classification of the disorder was changed to "Attention-Deficit/Hyperactivity Disorder (ADHD)" and is the name most commonly used today (Wolraich, 2006: 87). Having established the historical background underlying Attention-Deficit/Hyperactivity Disorder (ADHD), the focus now turns to the medical understandings of ADHD in contemporary society.

2.3. Understanding ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is considered a "complex, developmental, neurobiological condition" associated with impaired abilities on several levels of functioning (Muthukrishna, 2013: 145). It is commonly understood as a childhood condition characterized by age-inappropriate behaviors of "impulsivity, hyperactivity and inattention" (Wilder, *et al.*, 2009: 61; DuPaul, 2007: 183). It is also believed that children with ADHD have more difficulties in "family, school and psychosocial functioning", in comparison to children without ADHD (Sciberras, Efron & Iser, 2011: 321). The ability to determine whether a child has ADHD is based on the *"Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)"*; a list based on "scientific research evidence" that focuses on the child's symptoms to determine whether they have a neurobiological or psychiatric illness (Neophytou, 2004: 31; American Psychiatric Association, 2000). In order to be diagnosed as ADHD, it is necessary that the child exhibits "at least 6 inattention or at least 6 hyperactive-impulsive symptoms before age 7, with concomitant academic and/or social impairment" (DuPaul, 2007: 183). The abovementioned diagnostic criteria interlinks with the three medical sub-types of ADHD, as expressed by DuPaul (2007: 183).

The three sub-types of ADHD include: 1) the "predominantly inattentive type", 2) the "predominantly hyperactive-impulsive type" and 3) the "combined type" (DuPaul, 2007: 183). The predominantly inattentive type is whereby the child exhibits significant levels of inattentiveness, but is neither hyperactive nor impulsive (DuPaul, 2007: 183). The predominantly hyperactive-impulsive type is whereby the child has the ability to pay attention, yet is

significantly hyperactive and impulsive (DuPaul, 2007: 183). Lastly, the combined type is whereby the child is both hyperactive-impulsive as well as inattentive. In order to be diagnosed as ADHD, furthermore, the abovementioned symptoms must affect the child in two or more environments (such as the home and the school), and the symptoms must also be present for over six months before a diagnosis can occur (Singh, 2002: 361).

In addition to the varying sub-types of ADHD, the intensity of the symptoms is also thought to differ between individuals (Perold, *et al.*, 2010: 458; Kendall, 2008: 18). The severity of the symptoms is believed to vary between mild, moderate and severe (Kendall, 2008: 18). Individuals who exhibit mild ADHD symptoms have few problems in their "school and social relationships", but meet the necessary diagnostic criteria (Kendall, 2008: 18). Those who exhibit moderate ADHD symptoms usually engage in inappropriate behaviors and have lower esteem levels (Kendall, 2008: 18). These individuals are also more likely to have problems in their peer and familial relationships, and may have "coexisting problems such as learning disabilities and oppositional defiant disorder" (Kendall, 2008: 18). Those who severely suffer from ADHD symptoms have immense problems in their schooling and familial relationships (Kendall, 2008: 18). These individuals generally also suffer from "learning disabilities and oppositional defiant disorder (ODD) involving persistent patterns of disobedient and disrespectful behaviour towards adults or closely related authority figures in the child's life (Kendall, 2008: 18; Fraser & Wray, 2008: 402).

Thus, as is evident, the symptoms associated with ADHD manifest differently in each individual according to both the varying sub-types of the disorder and the severity of the individual's symptoms (Jacobs, 2014: 25). As a result, some social scientists have questioned the validity of the *DSM-IV* criteria and ADHD, debating whether it is an accurate and unified medical diagnosis (Kritjansson, 2009: 114). Venter (2006: 144), for example, argues that ADHD-like symptoms may not be caused by ADHD itself, but rather, the symptoms may be secondary to other problems such as "learning disabilities, below average cognitive potential or limited sensory abilities". In other words, there are concerns that the child who appears to have ADHD may, in fact, have other problems or conditions "masquerading as ADHD" (Newcorn, *et al.*, 2001: 137). There have also been concerns that because ADHD is often diagnosed alongside other conditions, such as oppositional defiant disorder, that ADHD, as its own condition, may not exist

as a specific and singular diagnosis (Kritjansson, 2009: 114; Timimi & Taylor, 2004: 8). These concerns have led some to question what the true medical definition or understanding of ADHD is which, in turn, has had an impact on the accuracy of its prevalence rates on a cross-national basis (Timimi & Taylor, 2004: 8). The changes in the diagnostic criteria over time, furthermore, have also negatively impacted upon one's ability to give an accurate account of the prevalence of ADHD (Jacobs, 2014: 25; Wolraich, 2006: 87). With this in mind, the focus now turns to the apparent prevalence of ADHD worldwide, turning the focus to its prevalence in South Africa thereafter.

2.4. Prevalence of ADHD

According to Bruchmüller, *et al.* (2012: 128), ADHD appears to affect a broad spectrum of children, with prevalence rates lying anywhere between "2% and 7%". In the United States, for example, Faraone, Sergeant, Gillberg and Biederman (2003: 104), claim that ADHD affects an estimated 1 in every 20 children. In the Netherlands, the number of children diagnosed with ADHD doubled between the period of 2003 to 2007 (Thomas, 2003: 19). Due to these high statistics, some have argued that ADHD is the most common or most highly diagnosed child psychiatric illness in the world; which lends itself to the question of over-diagnosis or misdiagnosis (Ghanizadeh, *et al.*, 2005: 84; Kendall & Shelton, 2003: 258; Thomas, 2003: 19).

Although some have questioned the over-diagnosis of ADHD, it is still typically believed that ADHD affects more boys than it does girls, with some believing that this is the result of the "gender stereotypes" commonly held in society (Faraone, *et al.*, 2003: 105; Thomas, 2003: 19). According to Purdie, Hattie and Carroll (2002: 63), boys are 5 to 9 times more likely to be diagnosed with ADHD than what girls are, with "school-based samples" reflecting a 2:1 ratio of boys affected to girls affected (DuPaul, 2007: 183). Quinn (2005: 580) argues that girls are less likely to be diagnosed as ADHD because their symptoms of "forgetfulness, disorganization, low self-esteem and demoralization" are more covert than the hyperactive behaviors frequently seen in boys. In addition, girls are less likely to engage in disruptive behaviors, and rather express their symptoms through being over-emotional or inattentive (Purdie, *et al.*, 2002: 63). Thus, it has been argued, that most girls exhibit the symptoms associated with the predominantly-inattentive type of ADHD, and are therefore, less likely to be recognized as ADHD and subsequently treated for it (Stallar & Faraone, 2006: 108). According to Stallar and Faraone

(2006: 108), it does not appear that ADHD is a sex-specific condition; however, girls are less likely to be diagnosed as a result of teacher and parental bias that commonly associates ADHD with the hyperactive behaviors seen in boys.

With that said, most of the studies surrounding the ADHD topic and the prevalence thereof have been conducted in the Western context, such as Europe and the United States, whereas few studies have been conducted in South Africa. Of the few studies that have been conducted in South Africa, the focus has typically been on the views held by others (teachers, general practitioners and education specialists, for example), rather than on the views of those diagnosed (Jacobs, 2014: 26; see Brasher, 2015). The abovementioned intertwines with the lack of data indicating the prevalence of ADHD amongst South African children (Muthukrishna, 2013: 145). Muthukrishna (2013: 146) claims that ADHD appears to affect up to 4-5% of South African primary school-aged children. It has also been suggested that up to 10% of South African primary school children suffer from ADHD–like symptoms (Perold, *et al.*, 2010: 458). In addition, a survey conducted by the Western Cape Department of Health (2013), showed that up to 5% of children and adolescents in the Western Cape were diagnosed with ADHD during this time.

While there is uncertainty surrounding the exact prevalence of ADHD amongst South African children, it must be mentioned that ADHD is generally considered as a condition that children will outgrow (Jacobs, 2014: 1). Recent research has shown, however, that ADHD can continue to affect adolescents and adults which will be discussed in greater detail in the following section.

2.5. ADHD and Adulthood

Although this study is not directly concerned with ADHD amongst adults, it is significant to note that it can continue to affect adults, and thus, childhood experiences of ADHD can have an impact on one's adult experiences of ADHD (McGough & Barkley, 2004: 1948). Some scholars have argued that 10% to 60% of children diagnosed with ADHD continue to display symptoms in both their adolescent and adult years (DuPaul, 2007: 183-184; Scheffler, *et al.*, 2007: 450; Shaw-Zirt, *et al.*, 2005: 109). Although the symptoms will vary in severity according to one's age, some medical professionals have claimed that there are nevertheless certain ADHD symptoms that persist into adulthood (Jacobs, 2014: 33). According to Jacobs (2014: 33),

individuals with ADHD remain incapable of dealing with frustration, leading to several temper tantrums and mood swings which ultimately affect their relationships with others. This, in turn, leads to social anxiety and lowered self-esteem levels amongst the affected individuals (Jacobs, 2014: 33; Shaw-Zirt, *et al.*, 2005: 109). In a study conducted by Weiss and Hechtman (1986), for example, it was discovered that formerly diagnosed children reported feelings of "sadness, loneliness and had fewer friends" in their adult lives in comparison to the respondents without ADHD (Shaw-Zirt, *et al.,* 2005: 109; see Weiss & Hechtman, 1986). It has also been argued that adults who were diagnosed with ADHD in their youth have higher rates of separation and divorce in their marital lives than those who were not diagnosed with ADHD (Toner, 2009: 52). In addition, it has also been found that adults with ADHD find it more difficult to concentrate, complete their daily activities, and often find themselves getting bored or easily distracted (Toner, 2009: 52). In order to treat the negative symptoms associated with ADHD, many affected individuals engage in a variety of treatment methods to be established in the following.

2.6. Treatment Methods

According to Venter (2006: 144), a "multi-modal approach" is necessary for the management of ADHD as a single approach is "rarely effective". These approaches include: 1) the medical approach, 2) the behavioral approach, 3) the educational approach and 4) diet manipulation and lifestyle adaptations approach (Venter, 2006: 144). While I will give brief mention to the last three approaches, the primary focus will be on the medical approach as pharmacological/psychostimulant therapy is the most common strategy used to manage the symptoms associated with ADHD.

2.6.1. The Medical Approach: Psychostimulant Medications

Between the periods of 1937 to 1941, medication therapy became the treatment of choice to alleviate the symptoms with what today is called ADHD (Neophytou, 2004: 17). In a series of papers, it was reported that amphetamine usage reduced disruptive behaviors and improved academic capabilities in many of the children hospitalized at the "Emma Pendleton Bradley Home in Providence, Rhode Island" (Neophytou, 2004: 17). Charles Bradly (1937) is typically known as the first person to have introduced these psychostimulant medications (Singh, 2006: 440). Bradly (1937) conducted an experiment on 30 children between the ages of 5 to 14 who

expressed a variety of behavioral problems, "ranging from educational disabilities to epilepsy" (Singh, 2006: 440). Bradly (1937) found that the ingestion of the stimulant medication known as "Benzedrine", had remarkable effects on the children involved in the study, particularly with reference to their school performance (Singh, 2006: 440). The consumption of Benzedrine elicited within the children an "unusual motivation to work and an enhanced ability to read, comprehend and do arithmetic" (Singh, 2006: 440). It also had an effect on their emotional responses, causing them to become more docile and even-tempered (Singh, 2006: 440). This set the pathway for psychostimulant drugs to be the treatment of choice for ADHD in contemporary society.

In the last 50 years, "Methylphenidate Hydrochloride" or "Ritalin" has become the most popular psychostimulant drug used to treat the symptoms associated with ADHD (Berger, *et al.*, 2008: 1036; Muthukrishna, 2013: 147; Venter, 2006: 143). In addition to Ritalin, other psychostimulant drugs have entered the pharmaceutical market and have gained increased popularity. These include Concerta, Adderall, DexoStrat and Dexedrine (Jacobs, 2014: 48). These stimulant drugs are known to target the specific region of the brain responsible for "neurotransmitter dopamine" release, which ultimately allows an individual to focus and pay attention for longer periods of time (Jacobs, 2014: 48). In recent years, a non-stimulant drug known as "Strattera" has been introduced to help with the management of ADHD symptoms and was only made available in South Africa in 2005 (Jacobs, 2014: 48). Strattera targets the production of "noradrenalin" in the brain which is responsible for reducing "impulsivity and inattention", and lengthening one's attention span (Jacobs, 2014: 48-49).

In focusing on the positive effects of stimulant usage, Venter (2006: 145) explains that ADHD children who engage in pharmacological therapy are more capable of focusing in the classroom, and are also better-behaved. They are seen as less disruptive, more alert and able to complete their required tasks on time (Neophytou, 2004: 22). Additionally, Venter (2006: 145) argues that while it was not previously clear whether or not stimulant usage resulted in improved academic performance, it has now been shown that its usage results in enhanced "cognition, vigilance, reaction time, short term memory, learning of verbal and non-verbal material, school-based productivity and accuracy in children with ADHD". Thus, the usage of psychostimulant medication has been known to lead to marked improvements in academic performance

(Neophytou, 2004: 22). At a general level, there are many medical and psychiatric professionals who advocate for the usage of stimulant medications claiming that, in many instances, it serves to benefit the quality of a child's life as well as their interpersonal relationships with others (Neophytou, 2004: 21).

2.6.2. Side Effects of Psychostimulant Medications

Despite the benefits of stimulant usage, studies have also shown that it can result in several side effects. The most common side effects include: "loss of appetite, headaches, stomach ache, growth suppression and sleeping difficulties" (Jacobs, 2014: 49). Additional side effects which have been reported during prolonged usage include: "skin rashes, fevers, dizziness, changes in blood pressure and heart palpitations" (Kendall, 2008: 28). A large problem with Ritalin usage, in particular, is that it may lead to drug abuse in the child's future as it elicits feelings of elation and reduces fatigue (Jacobs, 2014: 49). It has also been shown that if the child discontinues the medication, he or she would suffer from withdrawal effects, thus indicating that it has an addictive aspect (Neophytou, 2004: 23). Although this will be elaborated upon in Chapter 3, it is also important to give brief mention of the psychological effects that stimulant usage may have upon a child. Neophytou (2004: 24) claims that by needing to take medication to act 'appropriately', the child may begin to feel as if he or she lacks the ability to manage his or her own behavior. This, in turn, may lead the child to feel inadequate or helpless in comparison to others, thus contributing to a lowered self-esteem (Neophytou, 2004: 24).

2.6.3. Prevalence of the Usage of Psychostimulant Medications

Considering that ADHD is the most highly diagnosed child psychiatric illness in the world, and psychostimulant medication is the most common therapy used to alleviate the symptoms associated with it, it seems to be inevitable that there will be large proportions of ADHD children/individuals who engage in pharmacological therapy (LeFever, *et al.*, 1999: 1359). Indeed, Lakhan and Kirchgessner (2012: 662) claim that "two-thirds of children diagnosed as ADHD receive pharmacological treatment, and the majority of medications used are stimulants". In the United States, the prescription of stimulants used to treat ADHD amongst individuals 18 years and younger increased from 2.4% in 1996 to 3.5% in 2008 (Lakhan & Kirchgessner, 2012: 662). In the 13 to 18 year old age group of U.S citizens, there was a marked increase in stimulant

prescriptions, ranging from 2.3% in 1996 to 4% in 2008 (Lakhan & Kirchgessner, 2012: 662). On a global basis, a study conducted by Scheffler, *et al.* (2007), indicates that there was a massive increase in the usage of psychostimulant medications between the period of 1993 to 2003 (Conrad & Bergey, 2014: 32). Analyzing data gathered from 70 different countries, primarily countries in "North America, Europe and South East Asia", Scheffler, *et al.* (2007), found that there was a 274% increase in the sales of stimulant medications during the 10 year period (Conrad & Bergey, 2014: 32).

According to Lakhan and Kirchgessner (2012: 662), however, the usage of stimulant medications appears to be lower in Western racial and ethnic minorities which, in my opinion, also resembles the South African case. As argued by Muthukrishna (2003: 146), in South Africa, it is more likely that children from wealthier families will engage in pharmacological therapy, rather than children from poorer communities and/or backgrounds. This partly interlinks with Truter's (2009: 413) argument that factors such as "economic situations, geographical location, and racial backgrounds" have an impact on whether or not a child will make use of psychostimulant medications. Keeping this in mind, it is still imperative to mention that studies indicating the exact extent to which South African children engage in psychostimulant therapy have been limited (Snyman & Truter, 2012: 2995). A study conducted by Truter (2009: 413) attempted to tackle this problem through gathering data from the nine South African provinces, and numerically comparing how many children had been prescribed methylphenidate medications during this time. Truter's (2009: 413) target group were ADHD individuals 18 years and younger, with the ability to afford private health care. It was found that in 2009, an estimated 34 733 South African patients in the nine provinces overall were using methylphenidate medications, with 16 989 of these patients being from Gauteng (Truter, 2009: 416). The main limitation of Truter's (2009) study, however, was that she only focused on children in the private health care system, and thus, the children prescribed methylphenidate medication in the public health care system was not considered. In my opinion, if Truter (2009) had extended her study to do a comparative analysis between the numbers of children prescribed methylphenidate medication in the private and public health care system, it may have provided valuable insight into whether or not "economic situations, geographical location, ethnicity and racial backgrounds" do, in fact, have an impact on whether or not a child will engage in pharmacological therapy.

2.7. Behavioral Management Therapy

During the last decade, several medical and health professionals have developed treatment interventions that can be used in conjunction with stimulant therapy, or as an alternative to it (Kendall, 2008: 30). One prominent alternative treatment includes "behavioral management therapy", which is a parental strategy often recommended by a clinician or family psychiatrist (Kendall, 2008: 30; Neophytou, 2004: 26). In essence, behavioral therapy involves rewarding the child when he or she behaves appropriately, and removing these privileges when he or she behaves badly (Kendall, 2008: 30; see Diller, 1999). The aim of behavioral therapy is to discourage inappropriate behaviors, and encourage desirable behaviors through a system of rewards which, in turn, increases the child's desire to please his or her parents (Kendall, 2008: 30). On a sociological level, however, Neophytou (2008: 26) criticizes this approach by claiming that by engaging in behavioral therapy, it is the child that is considered as the central problem in the family. The focus therefore is placed on changing the child's behavior, thus ignoring the social, cultural and personal factors influencing the child to behave negatively in the first place (Neophytou, 2008: 26). These factors may include alcohol abuse amongst parents, parental depression and stress or even problems in peer-associated relationships (Purdie, *et al.,* 2002: 68).

2.8. Educational Support

As ADHD is thought to severely impair one's daily functioning, it has similarly been argued that children diagnosed with ADHD will struggle in their academic performance (Jacobs, 2014: 50-51). As a result, it is believed that educational support, most likely in conjunction with pharmacological therapy, is necessary. At the primary school level, educational support generally includes providing the child with additional teaching outside of the classroom, while structuring the actual classroom setting in a more manageable format for the teacher (Jacobs, 2014: 51). This includes structuring the classroom setting in a formal, rather than informal manner, by allocating ADHD children seating in the front of the class (Purdie, *et al.,* 2002: 68). It furthermore involves making a conscious effort to reduce the noise levels in the classroom, and giving the ADHD children longer breaks between periods (Purdie, *et al.,* 2002: 68). This approach, in my opinion, may in fact be negative for the ADHD child, causing him or her to believe that he or she is 'different', and thus in need of additional support. This, however, will be elaborated upon in the

following chapter when deconstructing the medical framework underlying ADHD in accordance with sociological theory.

2.9. Diet Manipulation and Lifestyle Changes

In recent years, more naturalistic approaches towards the treatment and management of ADHD symptoms have come about (Jacobs, 2014: 52). These approaches primarily include changing one's diet to include vital minerals and vitamins (Jacobs, 2014: 52). As research has shown, by including "zinc, magnesium, omega 3, lecithin and vitamin B" into one's diet, the symptoms known to be associated with ADHD can potentially be reduced (Jacobs, 2014: 52). The two most common diets used to reduce the symptoms associated with ADHD, however, include the "Feingold diet and the low sugar/sugar elimination diet" (Chan, 2002: 41). The Feingold diet was founded by Dr. Feingold who observed that the rise in hyperactive behaviors correlated with the introduction of artificial food colorants and additives in food sources (Chan, 2002: 41). Thus, Feingold proposed that in order to reduce hyperactivity, parents must eliminate any foods containing unnatural food substances in their child's diet (Chan, 2002: 41). A similar argument has been made for the sugar elimination diet, as it is generally agreed that high sugar intake has the ability to elicit hyperactivity in children (Chan, 2002: 41). Beyond diet manipulation, however, those who advocate for the more naturalistic approach towards the management of ADHD, also stress the importance of exercise (Chan, 2002: 41). It is sometimes believed that children who engage in various sports, such as gymnastics, martial arts, and athletics, will eventually 'tire out', thus reducing their need to engage in disruptive, hyperactive behaviors (Chan, 2002: 41). However, most medical advocates in favor of ADHD would argue that diet manipulation and lifestyle changes is insufficient to 'cure' ADHD, and should therefore be used in conjunction with pharmacological therapy (Chan, 2002: 41).

2.10. Conclusion

To conclude, this chapter aimed to introduce the medical underpinnings underlying ADHD and the usage of psychostimulant therapy. This was achieved by initially bringing into account a historical overview of ADHD, thereafter discussing what it is believed to comprise of in contemporary society. Thereafter, I discussed the apparent prevalence rates of ADHD, both on a worldwide scale and in South Africa. I furthermore discussed how ADHD is sometimes believed

to continue into adulthood, thus indicating that it is no longer merely considered a childhood disorder. Having established this, I discussed what treatment methods are used to alleviate the symptoms associated with ADHD, where the primary focus was on psychostimulant therapy. To provide a more holistic picture on the methods used to manage ADHD, however, I furthermore briefly discussed three additional treatment methods that have arisen in the last decade, all of which are generally used in conjunction with pharmacological therapy.

Chapter 3: Theoretical approaches to ADHD

3.1. Introduction

In the previous chapter, I provided an account of the biomedical underpinnings of ADHD, showing that it is largely understood within a medical framework. As a result, the pharmacological treatment of choice used to alleviate the symptoms associated with it was also discussed, namely: psychostimulant medications. In this chapter, I will be using sociological theory to deconstruct the medical framework of ADHD, whilst further bringing into account what theoretical framework I will be adopting for the purpose of this research. As will become evident, one cannot merely understand the ADHD phenomenon from a medical/disease perspective, as the social and cultural factors contributing to diagnosis need to be taken into consideration as well.

This chapter will be divided into several sections. In the initial part of this discussion, I will provide a brief outline of the biomedical model of ADHD. Thereafter, I will begin to critique and deconstruct the medical model of ADHD by drawing on the concept of medicalization. In doing so, I will show that teachers and health care professionals are most likely the first individuals to medicalize ADHD in children. In the subsequent section, I will be drawing on the symbolic interactionist approach, the labelling theory and the stigma attached upon illnesses as these are the theoretical frameworks to be used for the purpose of this study. After explaining the abovementioned theories, I will be drawing on past research to illustrate what effects the ADHD label and stigmatization is thought to have upon ADHD children and the manner in which parents and peers are believed to reinforce this stigmatization. Thereafter, I will be using this research in relation to the experiences and views that previously diagnosed university students hold towards the ADHD label, and the usage of psychostimulant medication. This will be achieved by drawing on two studies, in particular, and is vital because it directly interlinks with the purpose of the current research. In the concluding section of this analysis, I will be discussing a study which focused on the diagnosis of ADHD in adulthood. This will be included as two additional respondents were involved in this study, both of whom were only diagnosed in their late teenage or early adult years. These respondents were included to enlighten the narrative of the other respondents who were diagnosed with ADHD in their childhood.

3.2. Critiquing the Medical Model of ADHD

According to Visser and Jehan (2009: 129-131), the biomedical paradigm remains dominant in the ADHD debate to the extent that ADHD has become considered as the "number one biologically based disease". In framing ADHD as a biologically rooted disorder, pharmacological therapy has remained the primary form of treatment to alleviate the symptoms associated with it (Visser & Jehan, 2009: 130). Thus it can be argued that the ADHD diagnosis and the usage of psychostimulant medications are inseparable from one another, as the diagnosis is generally used as justification for stimulant usage (Cohen, 2006: 14). However, it is important to mention that although the biomedical explanations of ADHD continue to dominate academic publications and media accounts, the uncertainty around the exact cause (or aetiology) of ADHD has elicited major controversies and speculations worldwide (Wright, 2012: 2; Visser & Jehan, 2009: 131). This is reiterated by Visser and Jehan (2009: 131) who claim that the "apparent empirical truth behind the biomedical discourse that positions the aetiology and intervention of ADHD within the realm of the biological paradigm is accompanied by a considerable amount of skepticism, which has sought to challenge the apparent firm ground of the biomedical explanation of ADHD".

The primary ground on which the biomedical framework of ADHD has been challenged is embedded in the fact that there are no tests that can prove the existence of any biological abnormality in the person that appears to have ADHD (Visser & Jehan, 2009: 131). In other words, there are no "specific cognitive, metabolic or neurobiological markers for ADHD" and there are no accurate medical tests that can be used to show any kind of legitimate biological abnormality (Timimi & Taylor, 2004: 8). As there are no medical tests, such as "blood tests, x-rays and brain scans" that can show that there is something physically or mentally wrong with the apparent ADHD individual, health care professionals, teachers, general practitioners and others make use of the *DSM-IV* criteria to determine whether a child or person has the condition (Cohen, 2006: 13). The *DSM-IV* criteria, it can be argued, essentially constitute a "behavioral checklist" grounded within subjective opinion (Cohen, 2006: 13). If an individual, most likely a child, is to exhibit a certain number of the behaviors listed in the *DSM-IV* checklist, it is more likely than not that s/he will be diagnosed as ADHD (Neophytou, 2004: 29). It has even been claimed that some doctors will prescribe Ritalin or other amphetamine medications after a mere

15 minute evaluation, using the *DSM-IV* criteria as the basis (Finley, 2007: 369). However, in Neophytou's (2004: 29) view, and in my own, the behavioral symptoms listed in the *DSM-IV* are somewhat arbitrary, as most individuals exhibit forms of hyperactivity or impulsivity at some point in their lives. This is reiterated by neurologist, Richard Saul (2014), who after years of experience with apparent ADHD children has come to believe that it is not a 'real' diagnosis. In his view, ADHD is simply an umbrella term for symptoms associated with otherwise normal childhood behaviors, and it is used for the profit-making incentive of pharmaceutical corporations and that of general practitioners. In addition, it has also been argued that by framing ADHD in a purely medical light, the social, psychological and environmental factors contributing to negative behaviors are not taken into consideration (Neophytou, 2004: 29). This has led some social scientists to argue that ADHD is merely a "social construction", whereby the medical model defines it in terms of certain symptoms, yet fails to consider the context in which these symptoms occur (Levine, 1999: 199). This intertwines with a sociological critique provided by Visser and Jehan (2009: 128-9), who claim that ADHD is merely a social and cultural fabrication, whereby the 'disorders' which exist in society have created apparent 'disorders' in children. The abovementioned views furthermore interlink with what is referred to as medicalization which will be considered in the following discussion.

3.3. Medicalization

The concept of medicalization was developed in Peter Conrad's, '*Identifying Hyperactive Children: The Medicalization of Deviant Behavior*' (1976), where his essential focus was on the "modern medical discovery of hyperkinesis" (Bowden, 2014: 425; Cohen, 2006: 15). In this paper, Conrad (1976) began to wonder why deviant behaviors were being placed within a medical framework, ultimately claiming that the pharmaceutical discovery of "behavioral controlling drugs" occurred prior to the onset of hyperkinesis or hyperactivity as a diagnosable condition (Cohen, 2006: 15; Davis-Berman & Pestello, 2010: 483). Thus, he suggested that hyperkinesis was simply a way to promote the profit-making incentive of pharmaceutical companies, which interrelates with Saul's (2014) views on ADHD (Davis-Berman & Pestello, 2010: 483). The concept of medicalization itself, however, was elaborated upon in a publication by Conrad and Schneider (1980), where it was stressed that behaviors that were previously considered as sins or crimes, were increasingly becoming considered as medical problems in

society (Cohen, 2006: 15). Thus, it was argued, that socially problematic or deviant behaviors, such as "excessive drinking, homosexuality and suicide", were undergoing the process of medicalization (Cohen, 2006: 15). In this vein, medicalization is understood as the "process by which non-medical problems become defined and treated as medical problems" (Conrad, 1976: 207). In simple terms, medicalization involves taking a socially deviant act, attributing a medical cause to it and using medical treatments in order to 'cure' it (Cohen, 2006: 15).

In a follow-up paper focusing on "medicalization and social control", Conrad (1992) extends the concept of medicalization in a manner which further portrays the dominance of the medical realm (Malacrida, 2004: 61-62). Drawing on Conrad's (1992) work, Malacrida (2004: 62) claims that the medicalization of otherwise normal behaviors, rests on the "ability of modern medicine to name and define the problem in medical language, to construct the individuals who present the problem in medical terms like 'patient' and 'sufferer', and to organize the ideal response to the problem along the lines of medical treatment and intervention". Thus, by using the dominance of the medical realm as the basis, individuals are able to place a medical label upon behaviors which are considered 'deviant' or 'abnormal' according to societal standards. Thus, what results is the "psychiatrization of difference" in which behaviors which fit outside the statistical norm of appropriate or good behavior become medicalized as an illness or disorder, with a possible negative impact upon the child or person in question (Malacrida, 2004: 63). This appears to be the case with ADHD because although there are no neurological markers that indicate biological abnormality, children or ADHD adults are continuously being medicalized as 'different' or 'deviant' in comparison to their non-ADHD counterparts.

In cases involving children, some scholars have argued that it is usually the teacher who initially medicalizes the child as having ADHD after noticing the child's continuous misbehavior in the classroom (Cohen, 2006: 14; Snider, *et al.*, 2003: 47). According to Searight and McLaren (1998: 485), it is the large amounts of information provided on the Internet about ADHD that makes teachers more aware of the symptoms which, in turn, prompts them to request that the child be psychologically assessed for ADHD if they notice the behavioral characteristics associated with it. As a result, some critics have argued that by referring the child for psychological assessment and ensuring that the child be placed on stimulant medication thereafter, teachers are able to exert control over the pupils they consider to be 'unruly' or

'deviant' (Perold, *et al.*, 2010: 458-9; Malacrida, 2004: 63). In this regard, some scholars, such as Cohen (2006) consider ADHD, and the subsequent usage of stimulant medications, as the "psychiatric colonization of childhood", where teachers and other educational professionals are able to exert dominance over children who they consider as 'abnormal' (Wright, 2012: 5; see Cohen, 2006). In the United States, for example, it has been argued that educators promote the phenomenon of ADHD and the usage of stimulant medication, primarily because of "decreased access to the use of traditional social controls of physical discipline and student expulsion or suspension" (Malarcida, 2004: 63). In an article published by Finley (2007: 367), it was discovered that U.S. teachers encourage the distribution of stimulant medications at school, whereas marijuana usage results in severe disciplinary action. Most children are administered their prescription drugs during school hours, indicating that the use and abuse of stimulant medications are not at the forefront of 'anti-drug efforts' in the United States (Finley, 2006: 366). In contrast, it can be argued that the children are administered the stimulant drugs at school in order to ensure that the teachers have some form of 'control' over the 'unruly' pupils in their classroom.

With that said, there still appears to be largely differing prevalence rates of ADHD and the subsequent usage of stimulant medications worldwide, which may be a reflection of culturally different viewpoints on what is considered as acceptable behavior in society (Kritjansson, 2009: 114). The countries which have most commonly accepted the ADHD construct include: the 'United States, Australia, Denmark, Switzerland, Germany, Holland, Israel, Spain and Taiwan' (Cohen, 2006: 14). Interestingly, countries such as France and Italy, which are known for adult psychiatric drug use, appear to have been resistant to stimulant usage amongst children during this time (Cohen, 2006: 14). Furthermore, the United Kingdom is also known to have lower prevalence rates of ADHD in comparison to the United States (Singh, 2008: 354). Singh (2008: 354) explains this through an analysis of how cultural understandings influence the manner in which ADHD is perceived in both the home and school. Singh (2008: 354-55) explains that in the U.K., there is limited public knowledge about the nature of ADHD, and there are still vast amounts of stigma placed upon the label. Thus, in the U.K., it is generally parents who turn to friends or relevant websites to consult whether their child has the symptomatic behaviors associated with ADHD (Singh, 2008: 355). Schools are furthermore under-resourced in the United Kingdom, and teachers are less knowledgeable about ADHD which makes it less likely

that they will be involved in the initial diagnosis (Singh, 2008: 355). In contrast to the United Kingdom, it is teachers, rather than parents per se, that are more likely to refer the child for psychological assessment in the United States (Singh, 2008: 355). Singh (2008: 355) argues that teachers are more knowledgeable than parents about ADHD in the U.S., and have an opportunity to financially benefit from the diagnosis through providing extra lessons to those diagnosed.

In general, it appears that the ADHD construct has been widely accepted in the United States. However, it must be mentioned that there are still cultural variations amongst white, wealthy Americans and African-Americans in their views towards ADHD (Bussing, Schoenberg & Perwien, 1998: 926). In their study, Bussing *et al.* (1998) sought to determine the differences in understandings of ADHD amongst white American parents and African-American parents. They found that African-Americans knew less about ADHD than their white counterparts, and most of the African-American respondents knew very few children who had been diagnosed with ADHD in their community (Bussing, *et al.,* 1998: 925-6). Bussing *et al.* (1998: 926) suggest that the reason African-American parents were less aware of ADHD was because they viewed the symptomatic behaviors commonly associated with it not as a medical condition, but as normal behaviors that their child will outgrow. This reflects the cultural variations in what is considered as acceptable or, in contrast, 'abnormal', behaviors amongst children in society, with Bussing, *et al.* (1998: 926) arguing that the unawareness of ADHD amongst African-American parents has the potential to undermine the accuracy of the ADHD medical label.

Thus, as is evident, cultural variations in the opinions held towards ADHD widely exist, which is not only evident in the school and familial setting, but also across different racial communities. Therefore, the social and cultural contexts influencing diagnosis need to be taken into consideration when analyzing the ADHD phenomenon, which further interlinks with the theoretical approach to be used in this study, namely: symbolic interactionism and the labelling theory.

3.4. Symbolic Interactionism and the Labelling Theory: A Theoretical Approach to ADHD

3.4.1. Symbolic Interactionism

The symbolic interactionist perspective derived from the works of George Mead (1934) and Herbert Blumer (1969), as a response to the positivist, top-down approaches that dominated

mainstream perspectives during this time (Carter & Fuller, 2015: 1). In contrast to the positivist approaches that regarded society as a "constraining entity" that ultimately defines the individual, the symbolic interactionist approach focuses on the autonomous human-being and how individuals make sense of their world through their own subjective interpretation (Carter & Fuller, 2015: 1). In essence, the symbolic interactionist perspective is a bottom-up theoretical approach that focuses on how individuals use language and symbols in their interactions with others in order to create meaning (Carter & Fuller, 2015: 1). The approach is less concerned with "objective structure" than with "subjective meaning", ultimately stressing that prolonged, meaningful interactions with others comes to define the 'make-up' of society (Carter & Fuller, 2015: 1).

According to Blumer (1969), the symbolic interactionist perspective essentially consists of three premises (Babbie & Mouton, 2001: 31). Firstly, people react towards situations or actions based on the meaning they attach to them. Secondly, the meanings they attach towards these actions derive from the social interactions they have with others. Lastly, the meanings people attach towards certain actions are based on interpretation and are ever-changing (Babbie & Mouton, 2001: 31-2). The ability to generate meaning in one's interactions with others is made possible through language, as language enables one to assess the responses of others and act according to what is societally considered as appropriate (Bradby, 2012: 32). In socially interacting with others, the symbolic interactionist approach stresses that a person's "social self" or "self-concept" is produced (Bradby, 2012: 32). According to Stets and Burke (2003: 5), the social self or a person's self-concept is the "set of meanings we hold for ourselves when we look at ourselves". The self-concept is essentially how we see ourselves, what our wishes, desires and thoughts are, and it is based on how we believe others perceive us and how they act towards us (Stets & Burke, 2003: 5). This notion is further evident in Charles Cooley's (1964) theory of 'Looking Glass Self', whereby he argues that people see themselves in the same way they believe others see them (Bradby, 2012: 32). By seeing ourselves in the same way that we believe others see us; our responses come to reflect the responses of others, and thus, the "meaning of the self becomes a shared meaning" (Stets & Burke, 2003: 4). Therefore, due to the "social construction of the self", individuals will automatically select the response that they believe others will expect them to choose and, in doing so, they are able to manage the meaning behind their social interactions (Bradby, 2012: 32). Thus, in the case of ADHD, a person's social self is

produced according to how they believe others perceive them as an ADHD individual. This, in turn, may drive the ADHD individual to engage in psychostimulant therapy, possibly in order to satisfy what is societally expected of them. In medical sociology, Gerhardt (1989) differentiates between two models of symbolic interactionism: the "negotiation model" and the "crisis model", with the latter being associated with the "labelling theory" (Bradby, 2012: 32).

3.4.2. The Original Version of the Labelling Theory

The original version of the labelling theory derives from the works of T.J. Scheff (1966), in his book, *'Being Mentally Ill'*. According to Rosenfield (1997: 660), the labelling theory focuses on the manner in which mental illnesses are associated with deviancy, whereby the label, rather than the behavior itself, becomes the pivotal characteristic used to define the individual. In Scheff's (1966) original conception, he argued that when a 'deviant' person is labelled as mentally ill, they internalize this idea and become 'mentally ill' (Pasman, 2011: 123). Thus, the cultural stereotypes associated with mental illnesses come to dominate one's self-concept or social self after being labelled as a mentally ill person (Pasman, 2011: 123). By internalizing the mentally ill label, Scheff (1966) further argues that the diagnosed individual feels that there is no other choice but to conform to the "role expectations" associated with their illness (Pasman, 2011: 123). In the case of ADHD, it can be argued that this would involve engaging in psychostimulant therapy, or the other therapeutical interventions discussed in Chapter 2. The original version of the labelling theory, however, was subject to severe criticism, arguing that Scheff's (1966) theory failed to provide concrete evidence that labelling had a negative effect on one's esteem levels and general well-being (Pasman, 2011: 123). This led to the formulation of the "modified version of the labelling theory", which was developed by Link, Cullen, Streuning, Shrout and Dohrenwend (1989).

3.4.3. The Modified Version of the Labelling Theory and Stigma

According to Pasman (2011: 123), the main difference between the original version of the labelling theory and the modified one is the focus on causation. In contrast to Scheff's (1966) version of the labelling theory, the modified version stresses that labelling does not perpetuate or cause mental illnesses, but it does have a negative effect on a person's general well-being and economic success if he or she internalizes the negative stereotypes or attributes associated with

his or her disorder (Rosenfield, 1997: 660; Moses, 2009: 57; Pasman, 2011: 123). This theory suggests that the label associated with mental illnesses instills a deep fear of rejection in those diagnosed, which results in certain coping strategies which are meant to prevent potentially negative outcomes (Moses, 2009: 571; Pasman, 2011: 123). These coping strategies include "secrecy, withdrawal", and abstaining from informing others about his or her mental illness (Moses, 2009: 571; Pasman, 2011: 123). While these coping strategies are meant to be self-protective, they are often self-defeating, resulting in the perpetuation of rejection, rather than the avoidance thereof (Moses, 2009: 571; Pasman, 2011: 123). By engaging in the abovementioned coping strategies, those diagnosed tend to isolate themselves from others which ultimately leads to a negative self-concept and a lowered self-esteem (Moses, 2009: 571). According to the modified version of the labelling theory, the formulation of a negative self-concept and a lowered self-esteem is largely as a result of the stigma placed upon mental illnesses (Pasman, 2011: 124).

According to Mueller, Fuermaier, Koerts, and Tucha (2012: 101), stigma, in general, "reflects the expression of a discrediting stereotype deriving from falsely assumed associations between a group of people and unfavorable characteristics, attributes, and/or behaviors". These scholars argue that there are three specific kinds of stigma which, in my opinion, interlink with one another and include: "1) public stigma, 2) self-stigma and 3) courtesy stigma" (Mueller, *et al.*, 2012: 101). Public stigma occurs when large segments of a population attach negative stereotypes upon "out-group members" who exhibit the behavioral and physical characteristics associated with mental illnesses (Mueller, *et al.*, 2012: 101). The out-group members or the mentally ill are labelled as a homogenous group who are 'different' in the eyes of the public (Mueller, *et al.*, 2012: 101-102; Pasman, 2011: 124). As society generally holds negative perceptions towards those with mental illnesses, it is most likely the case that the affected individual will begin to hold the same perception towards him or herself. This interlinks with the symbolic interactionist perspective as it is claimed that a person comes to see him or herself in the same light that others view him or her. Thus, once a person has been diagnosed or labelled as mentally ill, this label begins to dominate his or her self-concept or social self, most likely in a detrimental way (Pasman, 2011: 123). This has the potential to lead to feelings of shame, and the adoption of the second type of stigma, namely: self-stigma (Pasman, 2011: 123). With self-stigma, a person begins to internalize their "new degraded identity" as being definitive of the

person that they are (Mueller, *et al.*, 2012: 102). In self-stigma, one accepts the stereotypes associated with their disorder as their own, and acts in a way that is consistent with the stigmatization (Pasman, 2011: 123). This leads to what is referred to as "self-esteem decrement" in which one's self-esteem decreases due to these internalized negative beliefs (Pasman, 2011: 124). In developing a lowered self-esteem, the self-stigmatized individual is also known to develop a negative self-concept, often believing that the mental illness is a reflection of every aspect of one's self (Pasman, 2011: 124). This leads to the final type of stigma, namely: courtesy stigma.

According to Mueller, *et al.* (2012: 102), courtesy stigma refers to the notion that family members, such as parents, will be judged by others due to their mere association with the mentally ill individual. In the case of ADHD, courtesy stigma most likely arises through the public's negative perceptions of parents who appear incapable of disciplining their apparent ADHD child (Mueller, *et al.,* 2012: 109). This idea is illustrated in a study conducted by Wilder, *et al.* (2009: 61), whereby it is argued parents of ADHD children are subjected to the "blame-game" whereby in an attempt to understand why the child has ADHD, others begin to blame the parents for their child's misbehavior. As recent studies have shown, ADHD symptoms can be reduced through the correct dietary interventions, rather than through the use of medication (Wilder, *et al.,* 2009: 61). Consequently, parents, most likely mothers, are blamed for causing their child's symptoms through feeding their child unhealthy foods (Wilder, *et al.,* 2009: 61). As a result, society deems them "bad parents" in comparison to "good parents" who use all the correct interventions to help their ADHD child (Wilder, *et al.,* 2009: 61). Through being the subjects of courtesy stigma, scholars have argued that parents, most likely vulnerable mothers, may internalize feelings of shame and disappointment, believing that they are unable to nurture a well-behaved and respectable child (Mueller, *et al.,* 2012: 102). While this may be a valid argument, other scholars argue that parents and peers actually reinforce self-stigmatization and a lowered self-esteem in children and adolescents diagnosed with ADHD.

3.5. Labelling, Stigma and ADHD: The Case of Children and Adolescents

At a general level, labelling is associated with negative effects, such as a stigma which, in turn, leads to a lowered self-esteem and a negative self-concept (Pasman, 2011: 124). Some scholars, however, have claimed that there are positive effects associated with labelling, stressing that the

'mentally ill' diagnosis provides justification for inappropriate behaviors, as these behaviors can now be attributed to having an underlying medical cause (Young, Bramham, Gray & Rose, 2008: 494; see Murphy, 1995). However, one could argue that this is more applicable to the parents of ADHD children and adolescents, than to the diagnosed children and adolescents themselves. This is justified by Cohen (2006: 13), who claims that: "messages about ADHD destined for parents have a strong guilt-dissolving, 'natural-calamity'", which he elaborates upon by using a thought-provoking quote: "Learning that your child has ADHD can be distressing. But ADHD is nobody's fault. Nothing you have done has caused it". In Cohen's (2006: 13) view, the ADHD diagnosis relieves parents of their responsibility to raise well-behaved children, as negative behaviors can now be recognized as having an underlying medical cause. This idea is reiterated by Timimi & Taylor (2004: 8) who argue that by accepting the ADHD diagnosis, parents are not only neglecting their social responsibilities as mothers and fathers, but they are also "acting as agents of social control and stifling diversity in children". In Timimi & Taylor's (2004: 8-9) view, the ADHD label provides a sense of "tunnel vision", in that while it seems to provide a biological explanation for misbehavior, it limits the ability of parents to consider the social context and how interpersonal issues may be emotionally affecting their child. This further interlinks with Saul's (2014) argument that the ADHD diagnosis provides a 'crutch', but that we cannot truly know what is causing misbehavior, without looking at the core issues.

By accepting the ADHD label as a concrete, medical diagnosis, and reacting accordingly, it has also been argued that parents may induce the internalization of self-stigma in their ADHD child or adolescent him or herself (Moses, 2010: 783). Drawing on 'Weiner's attribution theory of stigmatization' (1988), Moses (201: 783) suggests that negative behaviors which would otherwise be controllable, are subjected to harsh and critical judgment by others when they cannot be controlled by the individual exhibiting them. To elaborate, Moses (2010: 783) claims that parents who blame their child's poor behavior on factors which 'naturally' exist within them, rather than on external or social factors, are more likely to be hostile, critical and tend to deliver harsher punishments. These ideas are reiterated in a paper published by Rogers, Wiener, Marton and Tannock (2009), who focus specifically on parental involvement in the diagnosis of ADHD. Drawing on previous research, Rogers, *et al.* (2009: 170-171), stress that several studies have indicated that parent-child relationships in families with ADHD children are problematic, claiming that the ADHD diagnosis often leads to more "stressful and conflicted family

environments, aggressive disciplinary practices, and dysfunctional interactions in comparison to families without ADHD" (See Woodward, *et al.,* 1998; and Johnston, *et al.,* 2002). This latter point (dysfunctional relationships) is somewhat evident in a response given by one the respondents who participated in my previous study (see Brasher, 2015). While the focus was on the views that teachers, general practitioners and education specialists hold towards the ADHD phenomenon, one of the respondents happened to be the mother of an ADHD child herself. She stated:

"It's very hard with a 20 year old, but when he walks in the door, I have a string of questions and I have to put ducks in a row for him all the time. I hate the humiliation that it means for him, but if I don't ask: 'do you have your cellphone?', 'did you speak to your lecturer about that?', 'when is your assignment for?', then he actually can't order it. I do become a bit problematic because sometimes I then take it for things he can order, and I become so anxious because he's been in trouble so much with deadlines that I start babying him for things he can do."

Apart from the issues of harsh discipline, stressful environments and *dysfunctional relationships*, it has also been argued that parents' tend to over-react towards their ADHD child's misbehavior, are less responsive to their child's needs and exhibit lower levels of parental support (Rogers, *et al.,* 2009: 170-171). A study conducted by Harpur, *et al.* (2008), furthermore, found that parents promote psychostimulant therapy, believing that it is necessary to control their child's misbehavior and that the benefits of usage outweigh the costs (Mueller, *et al.,* 2012: 103, see Harpur, *et al.,* 2008). The children involved in the study, however, reported that stimulant usage had a negative effect on both their level of pleasure and on their personality, indicating that the costs of usage outweighed the benefits (Mueller, *et al.,* 2012: 103, see Harpur, *et al.,* 2008). To some degree, it can be argued that the usage of stimulant medication in children indicates their need to satisfy their parents or other authority figures in their lives, with a study conducted by Davis-Berman and Pestello (2010: 486) showing that the main problem their respondents had with ADHD was that it made them feel incapable of living up to their parents expectations.

With this in mind, it can be argued that parents' negative illness perception of their ADHD child, and in turn, their promotion of stimulant usage, has the potential to lead to a lowered self-concept in the child him or herself and, in turn, self-stigmatization (Moses, 2010: 783). In other words, the child may begin to believe that the possible negative perceptions that his/her parents hold

towards him/her is an accurate reflection of who s/he is. Moses (2010: 783-4) further argues that the self-stigmatization in children or adolescents is potentially worsened in situations whereby the parents also engage in self-stigmatization. Due to the fear of courtesy stigma, as explained earlier, reports have shown that parents are often resistant to disclose their child's mental health problem to others (Moses, 2010: 783). In doing so, it is possible that the child will feel that his or her parent is ashamed or embarrassed of him or her, which may result in further self-stigmatization on the part of the child (Moses, 2010: 783). Thus, while the modified version of the labelling theory claims that it is the diagnosed individual who refrains from informing others about his or her mental illness, in the case of ADHD children, it may be the parents who are resistant and not the ADHD child, per se.

Apart from parental involvement in the perpetuation of labelling and self-stigmatization in their ADHD child, it has further been argued that non-ADHD peers may hold discrediting attitudes towards their classmates who they believe have ADHD (Mueller, *et al.,* 2012: 103). In a study conducted by Walker, Lee, Coleman, Squire and Friesen (2011), it was found that non-ADHD peers hold more stigmatizing and judgmental attitudes towards their ADHD classmates than they do to their classmates with asthma (Wiener, Malone, Varma, Markel, Biondic, Tannock & Humphries, 2012: 222; see Walker, *et al.,* 2008). The respondents considered their ADHD peers to be distracting and lazy, and found that they were often in trouble (Wiener, *et al.,* 2012: 222). It was also discovered that non-ADHD children preferred to maintain distance from the children with ADHD, and indicated that their parents felt the same way (Wiener, *et al.,* 2012: 222). This shows that children who have been assigned the ADHD label are highly subjected to what has been referred to as public stigma. Additional studies furthermore portray the extent to which ADHD children are rejected and stigmatized by their peers. A study conducted by Liffick (1999), as one example, sought to determine what attitudes pupils held towards other children with behavioral and physical impairments (Mueller, *et al.,* 2012: 104; see Liffick, 1999). In brief, Liffick (1999) assessed five dimensions of stigma (blame, sympathy, anger, help and acceptance) in relation to what views the groups of children held towards fictional characters in vignettes that displayed: "1) over-aggressiveness behaviors, 2) ADHD symptoms, 3) suffered from Down syndrome or 4) were in a wheelchair" (Mueller, *et al.,* 2012: 104). It was discovered that the children held considerably higher negative attitudes towards both the aggressive characters and the ADHD characters than they did to the other fictional characters (Mueller, *et al.,* 2012: 104).

This indicates that non-ADHD children may hold unfavorable attitudes towards their ADHD peers, which has the potential to result in peer rejection, and in turn, a lowered self-esteem and self-stigmatization on the part of the ADHD child.

3.6. Past and Present Perceptions of College Students/Young Adults on ADHD and Stimulant Usage

In the previous section, I provided an account of the potential experiences and viewpoints that ADHD children may hold towards the ADHD label, and the impact that parental involvement and peer rejection may have upon their self-esteem and self-concept. In this section, I draw on previous research that focused specifically on college students' experiences of childhood ADHD, as this directly interlinks with the purpose of this research. In doing so, I will be able to deduce whether the abovementioned literature is accurate, and what potential experiences and viewpoints the respondents involved in this study may hold towards the ADHD label and the usage of stimulant medication. Considering that research focusing on this specific idea is limited, I will only be focusing on two directly relevant studies, in particular.

In the one study, conducted by Shattell, Bartlett & Rowe (2008: 49), their aim was to determine the experiences of college students that were diagnosed with ADHD in their childhood years. The study included 16 participants, 3 of whom were male and 13 of whom were female (Shattel, *et al.,* 2008: 50). This, in my opinion, is interesting considering that ADHD is a diagnosis most commonly associated with boys (Purdie, *et al.,* 2002: 63). After conducting "non-directive interviews" with the 16 respondents, several themes emerged when analyzing the data, and included: problems in the respondents' familial relationships, schooling environments and in their peer relationships (Shattel, *et al.,* 2008: 51).

In their home lives, the respondents reported that the biggest impact ADHD had upon them was their inability to maintain a healthy relationship with their direct family (Shattel, *et al.,* 2008: 51). The respondents reported that their ADHD had resulted in massive arguments with their parents and siblings, mainly because they failed to complete their household chores in the required time-frame (Shattel, *et al.,* 2008: 51). This indicates the idea provided by Rogers, *et al.* (2009: 170-171), that ADHD may lead to conflict and stress within the family relationships. Other respondents reported that their parents lacked in patience and understanding, which

indicates that in some instances, parents of ADHD children may be less supportive and less responsive towards their ADHD child (Shattel, *et al.,* 2008: 51-2; Rogers, *et al.,* 2009: 170-171). In addition, while it has been suggested that parental involvement may lead to a lowered self-esteem in their ADHD child, the findings of this particular study revealed different results (Moses, 2010: 783; Shattel, *et al.,* 2008: 52). It was discovered that, for some respondents, their parents were incredibly supportive of them and stated that this helped with their self-confidence (Shattel, *et al.,* 2008: 52). One of the respondents reported that her father made her feel like the "most beautiful girl in the world" which was positive for her self-concept, considering that she was not succeeding in school (Shattel, *et al.,* 2008: 52). It was also found that the respondents' parents helped them with their homework, using "strategies such as flash cards, colored film through which to read, books on tape, cognitive games, and motivational tools" to facilitate an improvement in their academic performance, and stated that this helped with their confidence levels (Shattel, *et al.,* 2008: 52).

In elaborating upon the findings of Shattel, *et al.,* (2008: 51), it was previously stated that the ADHD label had a negative effect upon the respondents' schooling life and on their friendships. The respondents reported that they felt different to their peers and that the ADHD label had a stigmatizing effect upon them (Shattel, *et al.,* 2008: 52). To avoid stigma and being ostracized by others, the respondents were often reluctant to share their ADHD label with their peers (Shattel, *et al.,* 2008: 52-3). As one of the participants reported, "kids are mean", and thus felt that if she disclosed her 'condition' to her peers, she would be subjected to bullying and name-calling (Shattel, *et al.,* 2008: 53). This interrelates with the modified version of the labelling theory which stresses that those diagnosed with mental illnesses, often refrain from informing others about their mental illness which likely results in the perpetuation of rejection, rather than the avoidance thereof (Moses, 2009: 571; Pasman, 2011: 123). This, in turn, leads to isolation and a potentially lowered self-esteem (Moses, 2009: 571). Apart from peer relationships, the respondents also reported that they found it difficult to make friends, or maintain friendships (Shattel, *et al.,* 2008: 53). They stated that they felt different to others, and their inability to make friends led to a lowered self-esteem (Shattel, *et al.,* 2008: 53). One of the respondents dropped out of school for over a year, because she thought people saw her as 'stupid and retarded', indicating that it had embedded a negative self-concept within her (Shattel, *et al.,* 2008: 53). Another respondent claimed that most of her peers would maintain a distance from her, which

made her feel that there was something inherently problematic within her (Shattel, *et al.,* 2008: 52-3). Not only does this support the conclusion that peers prefer to detach themselves from their apparent ADHD classmates, but it also indicates that, in this instance, the 'public stigma' that the respondent faced led to self-stigmatization (Wiener, *et al.,* 2012: 222).

In the other study, conducted by Davis-Berman and Pestello (2008: 482), the aim was to explore the 'social and personal factors' associated with the usage of stimulant medication amongst previously diagnosed ADHD college students. They achieved this by interviewing 20 university students on their past and present experiences of the usage of stimulant medication (Davis-Berman & Pestello, 2008: 482)., Several themes emerged from their data, including: "1) recruitment of the young, 2) freedom from personal stigma, 3) social issues surrounding stimulants, and 4) side effects and abuse" (Davis-Berman & Pestello, 2008: 485).

Their first theme, 'recruitment of the young', essentially supports the idea mentioned earlier that teachers are usually the first individuals to medicalize a child as having ADHD (Cohen, 2006: 14; Snider, *et al.*, 2003: 47). Davis-Berman & Pestello, (2008: 485) found that even when parents initiated referral, it was usually due to the feedback given by the school that their child is inattentive and misbehaved. Davis-Berman & Pestello (2008: 485) claim that this shows that the children were not satisfying their teachers' expectations, that they were not being compliant nor well-behaved which, in my opinion, may be indicative of the idea that the ADHD label is a way to control 'unruly' pupils. The second theme, however, is one that I find particularly interesting. Davis-Berman & Pestello (2008: 486) found that the usage of stimulant medication in childhood resulted in "little personal stigma", with the respondents claiming that it had little effect on their sense of self or self-concept. Even those that there were administered prescription drugs during school hours, associated little personal stigma with it and claimed that they knew other children on the same medication, and felt accepted for having to take it (Davis-Berman & Pestello, 2008: 486). While a few of the respondents did feel a sense of embarrassment for taking their medication at school, it was generally agreed that the experience was non-problematic (Davis-Berman & Pestello, 2008: 486). In looking at the third theme derived from Davis-Berman & Pestello's (2008: 487) findings, it was discovered that although the respondents felt little personal stigma with regards to their experiences of stimulant usage, there were several other problems that arose in their interactions with others. The respondents reported that the ADHD

label made them feel that they were negatively stigmatized by others, especially by the parents of other children, and sometimes even by their peers (Davis-Berman & Pestello, 2008: 48). One of the respondents stated that there are negative social perceptions surrounding ADHD, claiming that if you are labelled as ADHD, you are considered to be "dumb". Thus, while the respondents did not feel stigmatized for taking ADHD medications, they did feel stigmatized for having the ADHD label attached to them (Davis-Berman & Pestello, 2008: 487). The final theme that emerged in Davis-Berman & Pestello's (2008: 488) findings was the respondents' experiences of the side-effects of stimulant usage. Most of the respondents reported that it negatively affected their personality, stating that while they could now concentrate better, they were not as outgoing as they were previously and that they lacked in social skills (Davis-Berman & Pestello, 2008: 488). They also reported that weight loss and sleeping problems were an issue, and that medication usage elicited irritability within them (Davis-Berman & Pestello, 2008: 488).

3.7. ADHD and Diagnosis in Adulthood

As two of the respondents included in this research were only diagnosed in their early adult years, I will be drawing on a study conducted by Young, *et al.* (2008: 495), which focused on how the adult respondents included in their study felt about themselves prior to receiving a diagnosis, and how it affected them once they were officially diagnosed. All of the respondents included in the study reported that they exhibited the symptoms associated with ADHD in their childhood years, yet a diagnosis was only made when they were older (Young, *et al.,* 2008: 495). From the findings of Young, *et al.* (2008: 495-7), several themes emerged, including: "1) review of the past – feeling different from others, 2) the emotional impact of diagnosis and 3) consideration for the future."

With reference to their first theme, 'feeling different from others', the respondents reported that they often felt inadequate in comparison to their peers and family members, and often felt judged and criticized by their parents for their misbehaviors (Young, *et al.,* 2008: 495). The respondents reported that their parents would refer to them as "stupid and lazy", often comparing them to their successful siblings (Young, *et al.,* 2008: 496). Young, *et al.* (2008: 496) found that in most cases, the respondents accepted the judgments of others as being definitive of who they are, often believing that truth lay behind it: "They tried their hardest by saying you're stupid, pull yourself together, and they convinced me that was true and in the end I felt I'd been sent to this place

down at the bottom of the scrap heap". Thus, while in this instance, the participants had not yet been diagnosed as ADHD, it is evident that their academic failures and disruptive behaviors led to much criticism by their parents, and in turn, the internalization of what has been referred to as, self-stigma.

In line with the second theme, the 'emotional impact of diagnosis', the respondents reported that a deep sense of relief overcame them once they were officially diagnosed (Young, *et al.,* 2008: 496). This is because they could now attribute their long years of negative behaviors as having a justifiable and underlying medical cause: "In one part of me, I felt elated. It was almost like, 'Oh, there's an actual reason why I acted like that" (Young, *et al.,* 2008: 496). Their sense of relief, however, was soon met with frustration and confusion, with some of the respondents feeling disheartened that an early diagnosis had not been made (Young, *et al.,* 2008: 497). Many of the respondents believed that the outcome of their lives would have been more successful and fulfilling, had they been diagnosed in their childhood years (Young, *et al.,* 2008: 497). However, Young, *et al.* (2008: 497) found that the respondents soon accepted their newfound diagnosis, and had begun to accept themselves, despite the fact that they were only diagnosed when they were older. As one of the respondents stressed: "Acceptance of myself. I accept myself now. I don't have this, so much of this frustration inside me. There's a reason why I do these stupid little things" (Young, *et al.,* 2008: 497). Thus, it can be argued, that the ADHD diagnosis provided the respondents with a sense of relief, it allowed for them to accept themselves which seemed to be lacking in their childhood years.

In drawing on Young, *et al.* (2008: 497-8) final theme, 'consideration for the future', it was found that the usage of medication amongst the respondents had positively affected their lives. The respondents emphasized that the usage of medication aided in their ability to stay focused, and that they could now achieve the goals which they previously felt were impossible (Young, *et al.,* 2008: 497-8). However, since many of the respondents felt that there was a sense of stigma attached to ADHD, many of them refrained from disclosing their diagnosis to individuals outside of their friendship group or immediate family (Young, *et al.,* 2008: 498). Thus, they hoped that the future result of the ADHD diagnosis would be one where there is a lack of stigma placed upon the ADHD label, and the subsequent usage of psychostimulant medications (Young, *et al.,* 2008: 498-9).

3.8. Conclusion:

In conclusion, the above aimed to provide a sociological account of ADHD and the subsequent usage of stimulant medication. This was achieved by giving brief mention to the biomedical model of ADHD, bringing into account a sociological critique using the concept of medicalization, thereafter. As was evident, many scholars have questioned the accuracy of the ADHD medical label, stressing that it is simply a way to control 'unruly' children and that it absolves parents of their responsibilities to raise well-behaved children. Thereafter, I discussed the theoretical frameworks to be used for the purpose of this research, namely: symbolic interactionism, the labelling theory and the stigmatization of mental illnesses. After providing a description of these theories, I related and applied them to the possible experiences ADHD children may hold towards the ADHD label. I then used this literature and theory in relation to the previous experiences of college students with childhood ADHD. By doing so, I was able to draw on what possible experiences and viewpoints the respondents involved in this study may hold towards the ADHD label, what impact it had upon them in their youth, and in what ways the usage of psychostimulant medication affected them. In order to contextualize the topic further, an additional study was discussed which focused on individuals who were only diagnosed with ADHD in their adult years, yet exhibited the symptoms in their youth. This was included because two of the respondents involved in this study were only diagnosed in their adult years, due to the failure of their parents and/or teachers to notice their symptoms when they were young. Thus, by using the study conducted by Young *et al.* (2008), I hoped to deduce what potential experiences the adult ADHD individuals involved in this study hold towards the ADHD label, which will further serve to enlighten the narrative of the respondents diagnosed during their childhood years.

Chapter 4: Research Methods

4.1. Introduction

In the previous chapter I provided an account of the theoretical frameworks underlying this study. In this chapter, I discuss the research methods employed during the research process. As this research aimed to gather an in-depth understanding of the respondents' experiences and viewpoints towards the ADHD label, and the subsequent usage of stimulant medication, a qualitative research design was best suited to meet the study's objectives. In the following, I therefore discuss what qualitative research entails, what research paradigm guided this investigation, bringing into account how the research paradigm interlinks with the theoretical framework that was used. In addition, I will be discussing why quantitative research methods were inapplicable for the purpose of this investigation, thereafter turning the focus to what qualitative research methods were employed instead, namely: in-depth, semi-structured interviews. Having established this, I will then discuss what participants were involved in the study, and how I gained access to them, concluding with the ethical considerations that needed to be taken into account when conducting the research process.

4.2. Types of Research

4.2.1. Qualitative Research: Research Paradigm and Symbolic Interactionism

Qualitative research is considered a "naturalistic approach" that explores the meanings people attach to their experiences within their natural contexts or social worlds (Denzin & Lincoln, 2000: 3). The essential aim of qualitative research is to produce a "detailed description and analysis of the quality, or the substance, of the human experience" (Marvasti, 2004: 7). This is achieved by focusing on the "meanings, metaphors, symbols, and descriptions" that individuals attach to their experiences within their surrounding world or within their interactions with others (Berg, 2001: 3). Using qualitative research methods, the researcher attempts to understand the human experience from the perspectives of the "social actor" themselves (insider or 'emic' perspective) (Babbie & Mouton, 2001: 270). To elaborate, the purpose of qualitative research techniques is to understand and describe human behaviors and the meanings that individuals attach to their experiences, rather than to explain human behavior through statistical analyses and quantification (Babbie & Mouton, 2001: 270; Fossey, Harvey, McDermott & Davidson, 2002:

717). In order to do so, the researcher positions him/herself in the 'shoes' of the people she/he is investigating, which enables him/her to examine the behaviors and experiences from the respondent's own perspective (Babbie & Mouton, 2001: 270). This, in turn, allows for the researcher to share in the experiences of his or her respondents and explore how the respondents "structure and give meaning to their daily lives" (Berg, 2001: 7).

In using a qualitative approach, this study was guided by the interpretivist research paradigm. Drawing on the philosophical underpinnings of this paradigm, it is assumed that reality does not exist "out there" or independently from the human experience, but rather, it is constructed through the "interpretations and experiences" of the individual (Vanderstoep & Johnston, 2009: 166). In essence, interpretivists stress that knowledge is "constructed or created by people", and that this knowledge is produced in the interactions one has with others (Vanderstoep & Johnston, 2009: 166). These tenets of the interpretivist paradigm, it has been argued, are directly relatable to the symbolic interactionist theoretical framework (Neuman, 2007: 76). The primary way in which the interpretivist research paradigm interlinks with the symbolic interactionist approach is that both place an emphasis on social interaction in the construction of reality and/or meaning-making (Vrasidas, 2001: 88). To elaborate, the symbolic interactionist perspective holds that individuals act according to the meaning they attach to particular things and that this meaning arises out of, or is derived from, the interactions one has with others (Blumer, 1986: 4). This meaning, however, is based on interpretation and also has the ability to change (Blumer, 1986: 4).

Thus, in using the interpretivist research paradigm and the interactionist approach as a guide, the aim of this research was to document and analyze the experiences and viewpoints the respondents hold towards ADHD and the usage of stimulant medication, focusing specifically on the meanings attached to it. In doing so, it became clear whether their experiences of the ADHD label and the usage of stimulant medication were influenced by their interactions with others, and if the meanings they attached to it changed over time. This was achieved following an "inductive approach" to research whereby the dominant concepts and themes emerged when analyzing the data acquired during the research process (Merriam, 2002: 5; Thomas, 2006: 238). In doing so, the data itself generated the relevant themes and concepts, which cannot be achieved using "structured methodologies" (Thomas, 2006: 238). This latter point interlinks with why

quantitative research methods were inapplicable for the purpose of this investigation, which will be discussed in greater detail in the following section.

4.2.2. Quantitative Research Paradigm and Inapplicability

According to Fossey, *et al* (2002: 718), quantitative research is rooted in the positivist paradigm and is commonly understood as a scientific method of inquiry. Drawing on the philosophical underpinnings of the positivist approach, knowledge exists apart from the researcher, and thus, in order to objectively acquire this knowledge, the researcher and that which is being researched need to exist independently from one another (de Villiers & Fouche, 2015: 127). The approach used to acquire this knowledge is that of empiricism, which necessitates that "observation and measurement" be at the core of the scientific investigation (de Villiers & Fouche, 2015: 127). In doing so, quantitative researchers apply "deductive logic" to their research question, whereby they begin with a general statement or hypothesis, predict future outcomes and then use these findings to produce generalizations about the nature of a phenomena (Fossey, *et al.*, 2002: 718; Marshall, 1996: 522). This is achieved by, for example, issuing surveys to a large representative sampling population, transforming the findings into numerical or quantitative data thereafter which, in turn, allows the quantitative researcher to generalize his/her findings (Fossey, *et al.*, 2002: 718; Marvasti, 2004: 9).

Thus, as is evident in the above, the quantitative research approach aims to produce findings that can be quantifiably generalizable, and furthermore requires that the researcher remain detached from that which is being researched in order to gather this data (de Villiers & Fouche, 2015:127; Fossey, *et al.*, 2002: 718). As the purpose of this investigation was to gather an in-depth understanding of the respondents' experiences of ADHD and the usage of psychostimulant medication, a quantitative research design was inapplicable. This is because the sheer nature of this research required close interaction with the participants, which can only occur through direct contact and not through quantitative research techniques, such as surveys. Furthermore, while quantitative research aims to produce generalizable findings, the purpose of this research was to provide a general overview of the respondents' experiences, and not to produce findings which can be generalized to the whole. To elaborate upon this, Vanderstoep and Johnston (2009: 167) claim that the "different research participants are going to have different interpretations of their own experience and the social systems within which they interact". In addition, it is most likely

that the researcher will also impose his or her own "cultural, social or personal" understandings when attempting to analyze the research participants' experiences (Vanderstoep & Johnston, 2009: 167). Therefore, most qualitative research, including the one that was conducted, does not aim to produce findings that are 'generalizable', but rather, it aims to represent the experiences or understandings purely of those involved in the study (Vanderstoep & Johnston, 2009: 167). Having explained the inapplicability of the quantitative research methods and approach for the purpose of this study, the focus now turns to what qualitative research methods were employed instead, namely: semi-structured, in-depth interviews.

4.3. Research Methods

4.3.1. Semi-structured interviews

According to Fossey, *et al.* (2002: 727), qualitative research interviews aim to generate the information that portrays how the respondents view their own lives, which in turn, allows for the researcher to gain access to the respondents' experiences and views towards reality. For the purpose of this investigation, semi-structured, in-depth interviews were employed which involves conducting "intensive individual interviews with a small number of individual respondents to explore their perspectives on a particular idea, program, or situation" (Boyce & Neale, 2006: 3). Semi-structured interviews are characterized by a combination of flexibility and structure in the interview process, meaning that while an interview guide was used to ensure that the conversation remained on topic, there was some flexibility in the path that the conversation took (Legard, Keegan & Ward, 2003: 141; Fossey, *et al.*, 2002: 272; see Appendix A). Semi-structured, in-depth interviews are furthermore characterized by a high level of interaction between the researcher and research participant, and the ability of the researcher to probe the research participant so as to gather the necessary information needed to fulfil the research purposes (Legard, *et al.*, 2003: 141). In order to achieve this, it was imperative that I established "rapport" with the participants when the interviews were conducted (DiCocco-Bloom & Crabtree, 2006: 315). Rapport, in essence, refers to a researcher's ability to build a trusting and respectful relationship with his or her respondents (DiCocco-Bloom & Crabtree, 2006: 316). It also involves establishing a safe and comfortable environment in which the respondents feel at ease to share personal information about their lives (DiCocco-Bloom & Crabtree, 2006: 316). By establishing rapport with the participants, I enhanced my ability to delve deeply into their

experiences of ADHD and the usage of psychostimulant medication, as the respondents felt more relaxed during the research encounter. Finally, while other interview methods, such as unstructured interviews, are used in conjunction with various research methods, semi-structured interviews are usually used as the main source of data collection when conducting particular kinds of qualitative research projects (DiCocco-Bloom & Crabtree, 2006: 315). For the purpose of this research, in-depth, semi-structured interviews were the primary research technique used to collect the data.

4.3.2. Research Participants and Gaining Access

Using convenience and snowball sampling, the semi-structured, in-depth interviews were conducted with seven Rhodes University students, all of whom are over the age of 18 years old. Although previous studies have shown that ADHD predominates amongst boys, the respondents who came forward in this study included five females and two males (Stallar & Faraone, 2006: 108). In addition, all seven of the respondents were Caucasian, which, to an extent, supports the idea that "economic situations, geographical location, and racial backgrounds" will have an impact on whether or not a person is diagnosed as ADHD and subsequently prescribed stimulant medications (Truter, 2009: 413). The seven respondents came from varying schooling backgrounds which allowed for a cross-section of their schooling experiences to be established. Their years of study also ranged from undergraduate level to postgraduate level which enabled a broader account of the respondents' experiences to be analyzed.

While the purpose of this investigation was to document and analyze the experiences that previously diagnosed Rhodes University students hold towards the ADHD diagnosis and the usage of stimulant medication, two of the respondents were only diagnosed at a later stage in their lives. The one respondent was female, and the other was male. The female respondent was diagnosed officially when she was 17, and the male respondent was diagnosed when he was 22. However, late diagnosis occurred because the authoritative figures in the respondents' lives had failed to notice the symptoms associated with ADHD when they were young. Their participation, however, was relevant as it helped to enlighten and strengthen the narrative of the respondents who were diagnosed in their youth. It furthermore provided insight as to how it felt to only have the ADHD label attached to them when they were older.

For the research process, semi-structured, in-depth interviews were employed. Each interview took anywhere between 20 minutes to an hour long to complete, and only took place on one occasion. Thus, I did not impose on the respondents' personal lives to a great degree, as I only required their assistance on one occasion. In some instances, the interviews were conducted on Rhodes University's campus and in other instances; the interviews were conducted at the respondents' respective households. This was dependent upon where the respondents felt most comfortable to be interviewed, or where was the most appropriate place for them at that time. By conducting the interviews in a relaxed environment, I managed to establish rapport with the participants. This, however, occurred without developing a 'relationship' with them (Duncombe & Jessop, 2001: 6). Gaining access to these participants took place through informal networks, whereby I posted the topic on social network sites in order to find relevant respondents. These social network sites included: the 'Rhodes SRC' page and the 'Rhodes University Community Forum' on Facebook, and were chosen because many Rhodes University students have access to and are part of these Facebook groups. While the majority of the respondents were found using these two platforms, there were instances that I gained participants through referral from other individuals well-acquainted with the diagnosed individual. In this way, both convenience and snowball sampling were used.

4.4. Ethical Considerations

According to Aguinis and Henle (2002: 34), ethics assesses "right or wrong" actions according to specific "principles or guidelines". In qualitative research, "research ethics" essentially refers to the ethical guidelines that must be followed in the encounter between the researcher and the research participant (Flick, Kardoff & Steinke, 2004: 334). For the purpose of this research, there were a variety of guidelines that needed to be adhered to. Prior to conducting the research, the proposed study was approved by the Higher Degrees Committee of Rhodes University and the Sociology Department's Ethics Committee. It then became necessary to find relevant research participants, following the ethical guideline of "voluntary participation". Voluntary participation includes allowing your participants to come forward if they wish to participate, rather than forcing them through "physical or psychological" coercion (Marvasti, 2004: 135). In order to achieve this, and in turn, gain access to the research participants, the topic was posted on the 'Rhodes University SRC' page and the 'Rhodes Community Forum' on Facebook. I informed

the participants that if they wished to participate, they needed to send me a private message on Facebook. In doing so, I allowed for the respondents to come forward anonymously if they wished to partake, and thus, the ethical guideline of voluntary participation was met. In other instances, however, acquaintances of the potential respondents informed them of the purpose of the research upon becoming aware of the study. In instances whereby the respondents appeared willing and interested to participate, the respondent's acquaintance provided me with their contact details. I then messaged these respondents stating the purpose of the research, and that they had the right to say no if they did not wish to partake. In all instances, the respondents were willing to participate, thereafter consenting to participation. Thus, the ethical guideline of voluntary participation was once again met.

When conducting the research, I ensured that "informed consent" was received from the participants prior to conducting the interviews (RUSEC, 2014: 24-5). Informed consent essentially involves providing the research participants with the necessary information regarding the purpose of the study, how the data generated will be used, what participating in the study will require of them and how much time will be needed (Lewis, 2003: 66-67). It furthermore involves informing the participants that they have the right to withdraw at any stage during the interview or research process, and that no harm, whether emotional or physical, will be imposed upon them (Vanderstoep & Johnston, 2009: 13-15). In the remote instance that it triggered any form of emotional distress, the participants were informed that I requested the counselling centre be available to provide psychological support.

In addition, it is necessary that the participants were aware that the data gathered remains confidential. Confidentiality entails that those taking part in the study will not be named and their personal information will not be disclosed to anyone external to the research team (Marvasti, 2004: 138). In maintaining confidentiality, the respondents were informed that their names and/or the school and location of the school they went to would not be listed on any report or presentation. I informed the participants that a pseudonym or 'false name' would be used in place of their real names. As the interviews were tape-recorded, the participants were also notified that nobody external to the research team would hear these tape-recordings. These recordings were then transcribed, and deleted thereafter, in the interest of maintaining anonymity and confidentiality.

The abovementioned information was listed on a consent form, signed by both my supervisor and myself, and given to the research participants who gave written consent (through signature) if they were willing to participate in this study (see Appendix B). In doing so, the ethical principle of "autonomy" was achieved as the participants remained autonomous agents who had the choice of deciding whether or not they consent to participating in the study (Orb, Eisenhauer & Wynaden, 2001: 93). Where consent was given, I also provided the participants with my own contact details in case they wish to see the final draft upon completion of the study, or their own transcribed piece (RUSEC, 2014: 24-5).

4.5. Conclusion

In conclusion, the above aimed to portray why a qualitative research design was best suited to meet this study's objectives, bringing into account what research paradigm has been used and how it interlinks with the theoretical framework. Thereafter, I justified why a quantitative research design was inapplicable for the purpose of this investigation, turning the focus to what research methods were employed instead, namely: in-depth, semi-structured interviews. In addition, I discussed what participants were involved in the study, how I gained access to them, paying particular attention to what ethical guidelines needed to be adhered too when the interview process was conducted.

Chapter 5: Data Analysis and Processing

After conducting the interviews with the seven respondents, it became clear that each participant held both similar and differing experiences of the ADHD diagnosis and the subsequent usage of stimulant medication. In the initial part of this chapter, I will be analyzing the experiences of the five respondents diagnosed in their youth according to the following themes which emerged during the research process: symptoms experienced (5.1), teachers' involvement, age at diagnosis and the effect of the ADHD label (5.2), ADHD and familial interactions (5.3), ADHD, peer relations and stigma (5.4), stimulant medications and side effects experienced (5.5), ADHD alongside other conditions, social contributory factors and alternative coping mechanisms (5.6) and the benefits of a healthy diet and exercise (5.7). These themes will be discussed in relation to the theoretical frameworks chosen, as well as the literature on ADHD as discussed in the previous chapters.

Thereafter, I will be analyzing the experiences of the two respondents diagnosed in their late teenage/early adult years. This will be done in order to strengthen the account of those diagnosed in their youth, whilst furthermore discussing how it felt for the respondents to only have the label attached to them when they were older. The dominant themes which emerged when conducting the interviews with the two respondents diagnosed when they were older, included: symptoms experienced (5.8), ADHD, the failure of realization and the ultimate relief provider (5.9), ADHD, peer relations and the failure of stigma (5.10), side-effects of stimulant medications: benefits outweigh costs (5.11), and earlier diagnosis and coping mechanisms (5.12). For the purpose of this investigation, it was furthermore necessary that I abided by ethical guidelines explained in Chapter 4. As part of meeting these requirements, a pseudonym has been used in place of the respondents real names, illustrated using an asterisk (*) on the first occasion of each pseudonym being used.

5.1. Symptoms Experienced

As discussed previously, ADHD is commonly associated with age-inappropriate behaviors of "impulsivity, hyperactivity and inattention" (Wilder, *et al.*, 2009: 61; DuPaul, 2007: 183). With that said, there appear to be three sub-types of ADHD, including: 1) the "predominantly inattentive type, 2) the predominantly hyperactive-impulsive type and 3) the combined type"

(DuPaul, 2007: 183). As literature suggests, girls are more likely to have the predominantly-inattentive sub-type of ADHD, which was similarly discovered in this study (Stallar & Faraone, 2006: 108). Out of the five respondents diagnosed when they were young, three of the girls seemed to have fallen within the predominantly-inattentive sub-type of ADHD, whereas the other two displayed symptoms typically associated with the combined type. Of the respondents with the combined type of ADHD, the one is a female, and the other, a male.

Sarah* seemed to exhibit the symptoms associated with the predominantly-inattentive type:

> "From my experience, there's the ADHD where you're lacking concentration, and then there's obviously, the ADHD with hyperactivity. So, growing up, my first exposure was that if you had ADHD, you were hyperactive, you always, you know, caused disruptions and you couldn't concentrate. So, when I first was diagnosed with that, it didn't make sense to me because I never had the hyperactive things, I just couldn't concentrate in class, I got distracted very easily by things, sort of like in a more dreamy kind of way you know?. So, it never quite linked up that I had that because my association was always with hyperactivity. So, my symptoms were more distractive [and] lack of concentration."

Similarly, Emma* answered:

> "My understanding is that it's supposed to be hyperactive and sort of everywhere, which way, bouncing up and down, but as a child I was mainly quite distracted by different sounds and noises at school."

Kayleigh* had a limited understanding of ADHD. However, her experience of the symptoms led me to believe that she fell within the predominantly inattentive sub-type:

> "Uh, well, I don't think I have a very good understanding of it (laughs). What I understand is that, for myself, I battled to concentrate for extended periods of time, especially throughout a lesson. I also battle to concentrate in a conversation for the duration of it, I battle to eat without standing up, and walking around, and doing something else."

The other two respondents, one female and one male, seemed to have exhibited the symptoms associated with the combined sub-type of ADHD. Hannah*, the female respondent with the

combined type of ADHD, felt that it is a highly complex condition and explained that she battled to control it:

> "It's kind of subconscious, almost, now as I experience it, but if I went back to like, the classroom, jho, I don't know, it's almost something I feel you don't have control of. It really is this kind of, drifting away, not staying focused. I think it was not always concentrating in class, hyperactivity, I mean, I've always been very hyper, I've always had to move around and stuff. So ya, not concentrating, getting easily distracted, hyperactivity, I guess those are the symptoms I experienced."

Later in the interview, Hannah also stated that: "I am someone, even to this day, that doesn't filter out what I say all the time", which led me to believe that she does, in fact, suffer from the combined type of ADHD as this show she has the tendency to be impulsive.

With that said, the male respondent, Jeffrey*, who also suffered from the combined type of ADHD, stressed 'impulsivity' as one his core symptoms more so than Hannah. In a study conducted by Abikoff, *et al.,* (2002: 356), it was similarly found that girls with the combined type of ADHD are less aggressive, impulsive and disruptive than boys with the combined sub-type of ADHD, which indicates that impulsivity predominates more amongst boys with the combined type of ADHD than it does girls.

When asked how he experienced the ADHD diagnosis, Jeffrey responded:

> "When I was younger I had huge difficulty controlling *impulses*. I remember, I was never one to really hit people or anything like that, but I remember my mom friend's son, when he would come through [to visit], there were times where we'd be doing something and I'd just like, hit him, because he'd be irritating or I just felt like hitting him or something. In terms of talking, I often jump the gun when people are busy talking, thinking like, they're asking a question: 'oh, oh', they're asking a question, meanwhile they haven't even said like two words into the sentence."

Jeffrey also reported that he severely struggled with his ability to pay attention and that he was hyperactive:

> "In terms of symptoms, I've obviously got attention difficulties, often. When we were at the neurologist, [he noticed that] my brain waves are very erratic and my brain's always on a high speed, especially if I'm concentrating or if I'm concentrating too much. Sometimes, what my brain will do, or will often do, is it will 'short circuit'. The easiest way to describe it is something like an 'absence seizure'; I just literally shut down. I don't spaz out or anything, I just run out of energy for a couple of seconds. I won't know I'm actually doing it, and then I will come back, like I go into a dream world and then I just snap out of it. Hyperactivity (laughs), yeah, it's not always all the time but also, lots of fidgeting. There are lots of times when I have energy; I can keep going, like on Matric vac, after a week all of my mates are dying, and I'm like, 'alright chaps, come on, let's keep on going!'."

Thus, in all instances, the respondents reported to have exhibited the symptoms associated with ADHD, with some emphasizing the symptoms associated with the predominantly-inattentive type, and others exhibiting symptoms more commonly associated with the combined type. In all cases, the respondents reported that their teachers had been involved in their diagnosis of ADHD. This arguably supports literature which stresses that teachers are usually the first individuals to 'medicalize' ADHD amongst the pupils in their classroom, using the dominance of the medical profession as the basis in which to do so (Cohen, 2006: 14; Snider, *et al.*, 2003: 47). While all five of the respondents had initially been diagnosed by their teacher, they seemed to hold both similar and varying viewpoints towards their teacher's involvement, and the subsequent attachment of the ADHD label upon them. This theme will be discussed in the following, bringing into account some of the findings of my previous study which focused on the views that General Practitioners, Education Specialists and Teachers hold towards the ADHD diagnosis and the usage of Methylphenidate Hydrochloride (Ritalin) (see Brasher, 2015).

5.2. Teachers' Involvement, Age at Diagnosis and the Effect of the ADHD Label

All five of the respondents reported that their teacher had been involved in their initial diagnosis of ADHD, with some feeling that their teacher's involvement provided a sense of relief and that

they were grateful for it, whereas others felt somewhat negatively affected by having the ADHD diagnosis or label attached to them. When asked at what age she was diagnosed and who the first person was to diagnose her, Sarah responded:

> "I was first diagnosed in Grade 4 or Grade 5 because I remember I had a teacher that recommended I at least go get tested, or go speak to a doctor about that."

Sarah felt that while her Grade 5 teacher showed more concern, she also believed that her Grade 4 teacher and her sports teachers used the ADHD diagnosis to 'manage' her because she was a 'distraction' and was unable to keep up with the rest of the class:

> "From my experience, in Grade 4, it probably was the teacher who couldn't manage from me not being able to keep up. In Grade 5, though, because I had a teacher that was a family friend, she did show more concern. Also, my sports teachers, I'll never forget the one day, I was swimming, and I got distracted and I was always behind. So, I think it was a distraction for some of the sports teachers. So, I do think it's a way to try and manage."

Sarah's experience supports the idea that teachers' involvement in the initial diagnosis of ADHD and their subsequent promotion of stimulant usage, is a way to exert control over or 'manage' the pupils that they consider to be 'unruly', 'deviant' or 'misbehaved'. The ability to do so, it is argued, rests on the dominance of the medical profession that is able to medicalize or place a medical label upon behaviors which are considered as 'different' or 'abnormal' according to societal standards (Malacrida, 2004: 62-63). To elaborate upon this idea, in my previous study which focused on the views that teachers, general practitioners and education specialists hold towards the ADHD diagnosis and the usage of stimulant medication, General Practitioner 2 confirmed the notion that doctors have the ability to medicalize otherwise normal behaviors or conditions (Brasher, 2015: 26):

> "As doctors, we *medicalize* everything. It's beneficial for the drug company to sell drugs, so we will all medicalize birth and death and we could even medicalize religion if you like (laughs). We can medicalize shyness, social awareness disorder or whatever you call it, we will you give you a name for any disorder you want and give you a pill for it".

As literature suggests, the medicalization of otherwise normal behaviors, has the potential to negatively impact upon the affected individual who is considered as 'different' in comparison to others (Malacrida, 2004: 63). In Sarah's experience, having the ADHD label attached to her by her teacher, and subsequently confirmed by her doctor, not only came as a surprise, but it negatively affected her in that it had been a 'scary' experience:

> "It came as a surprise. You know, I think like, then what you were like 12, and then if someone says you have this thing, and it sounded *scary*. You have this thing now, but if you take this medicine, it will make you a better person, a better student. So, it was kind of a bit of a scary thing then, and then you have to try and kind of figure it out."

Sarah's experience is applicable to the symbolic interactionist perspective as discussed in Chapter 3. According to this perspective, people act according to the meaning they attach to particular things and that this meaning arises out of, or is derived from, the interactions one has with others (Blumer, 1986: 4). In Sarah's experience, her interaction with others and the subsequent attachment of the ADHD diagnosis upon her was a 'scary' experience, and thus, she reacted by engaging in psychostimulant therapy in order to satisfy what was societally expected of her; 'to make her a better person, a better student'. Thus, drawing on the labelling theory, she felt that there was no choice but to conform to the role expectations associated with her condition (Pasman, 2011: 123). Using her cousin's experience of ADHD in a manner which resembled her own, Sarah also implied that the ADHD diagnosis had an impact on her self-esteem levels:

> "My cousin has ADHD, the hyperactive one, and I can see a big difference in him, as well. I do see how it affects his self-esteem, because the one day, he came home from school and he said to us: 'No, I'm stupid because I'm not doing well'. So ya, it's sad to see an 11 year old think they're stupid and that made me feel, like, you know, it brought back bad memories."

In both Sarah's and in her cousin's experience, they had come to believe they were 'stupid' as a result of their ADHD diagnosis, which had the ultimate effect of decreasing their self-esteem levels. Their experiences interrelate with the labelling theory, as it is argued that once a person is 'labelled' as mentally ill, his/her self-esteem or self-concept will come to be affected if he/she internalizes the negative attributes or stereotypes associated with his/her 'disorder' (Rosenfield,

1997: 660; Moses, 2009: 57; Pasman, 2011: 123). In their experiences, 'stupidity' lay at the core of the ADHD label, which subsequently led to a lowered self-esteem. At a general level, it appeared that Sarah held a negative connotation towards the ADHD label and also felt that the ADHD diagnosis was a way for her teachers to 'manage' her as she was unable to keep up with the rest of the class.

The latter idea was reinforced by Kayleigh who was initially diagnosed by her "teacher in Grade 6 or 7" and believed that, at a general level, 'behavioral drugs' are promoted by teachers because it makes their classroom easier to manage. This was evident in her statement:

> "From what I've experienced, I think a lot of teachers want kids to be on behavioral drugs like Ritalin because it kind of makes your class more docile and easier to teach, really."

However, in Kayleigh's experience, it was a relief that her teacher had been involved in her diagnosis, arguably because her previous interaction with her O.T. teacher had made her internalize the idea that she was not good enough and that she would never succeed. When asked how she experienced her interactions with her teacher/s, she responded:

> "I was told in Grade 3, that I would never finish school. Well, they told my mom and I was standing right next to her and that has some serious psychological effects on a child (laughs). My O.T teacher, she was like, she's never going to be able to read because I also have dyslexia. She was like, she's never going to be able to read, and she's never going to finish Grade 7. Okay great! So it came as quite a relief when I got diagnosed as ADHD and prescribed behavioral drugs, because it meant that I was able to focus and concentrate to the best of my ability, rather than spending my time, thinking that I'm *stupid* and not worth being in school."

Drawing on the symbolic interactionist perspective, it is argued that through the interactions one has with others, one will come to see him/herself in the same way that he/she believes others see him/her (Bradby, 2012: 32). This occurs largely through language; as language enables one to assess the responses of others and act according to what is societally considered as appropriate thereafter (Bradby, 2012: 32). Thus, in Kayleigh's experience, it can be argued that while the ADHD diagnosis and the subsequent usage of stimulant medication provided a sense of relief,

she felt that it was necessary due to her prior interaction with her O.T. teacher who had made her see herself as 'stupid' and unworthy of being in school. Thus, it can be argued that the ADHD diagnosis and the subsequent usage of stimulant medication, helped relieve her of these feelings of inadequacy and stupidity as her problems could now be attributed to having an underlying medical cause. Kayleigh's experience supports the idea that the ADHD diagnosis or 'label' may be positive for those diagnosed as it can be used to provide justification for behaviors which are considered 'inappropriate' according to societal standards (Young, *et al*, 2008: 494; see Murphy, 1995).

Similarly, Emma, who also suffers from dyslexia and had been diagnosed by her "English teacher in Grade 4" reported that prior to her ADHD diagnosis, she felt as if she was 'stupid':

> "Before they noticed, I thought I was stupid, legitimately, I thought, 'Why? What's wrong with me? Why am I not getting good grades?' And then ya, they noticed, and it was more like, oh ya, I didn't know what was wrong, so thank you, that's nice."

In her experience, having the ADHD label attached upon her came as both a relief and a surprise as she could now understand why she was exhibiting these behaviors and why she was not succeeding in school:

> "It was a relief and a surprise, because now I knew what was wrong. Before you don't know what the problem is, or what's happening, and you don't know why you're acting this way, and you don't understand basically."

Thus, similarly to Kayleigh's experience, Emma felt relieved that she had been diagnosed or 'labelled' as ADHD as she could now explain her behaviors as having an underlying medical cause. With that said, she also reported that her prior interactions with her teachers were not always positive, and that many of them failed to care. When asked how she experienced the ADHD diagnosis overall, Emma seemed to have been most negatively affected by her interactions with her primary school teachers:

> "I think the school could have handled it a bit better. Before, they were like, she's failing, let's just push her through. They shouldn't have done that. They should have asked: 'Why is she failing?' the first year that I failed, not in Grade 4 when you've got most of

your schooling grounding. Also, I didn't like the fact that they didn't really care, it was like: 'Oh well, it's your problem, sort out extra lessons.' It was only in Grade 11 and Matric that my teachers said: 'Emma, let's get your marks up so you get into university and pass.' Then they were keen to help me but before that, they didn't really care. It was like, your parents problem, to sort you out."

Emma's experience reflects Prosser's (2006: 3) idea that parents will often seek out the ADHD diagnosis due to the lack of support given by the child's school. Thus, they are not seeking the ADHD diagnosis as a 'cop out for poor parenting', as literature suggests, but because they feel they have no other choice but to do so (Prosser, 2006: 3). This is largely because the schooling structure fails to provide adequate support for ADHD children, and teachers often have limited "knowledge, resources and training" to deal with the behavioral symptoms associated with ADHD (Prosser, 2006: 3). This is potentially the reason why Emma's teachers simply 'pushed her through', instead of helping her improve her marks. It can be argued that the teachers were not knowledgeable enough about ADHD, and were unaware of the correct strategies in which to help Emma.

Jeffrey similarly reported to have had somewhat negative interactions with his primary school teachers, who were involved in his initial diagnosis in Grade 2. Like Emma, Jeffrey felt that only in High School were the teachers more understanding and supportive of him:

"Only really in High School when I went to a different school, did the teachers actually notice. *I mean, I'd be left handed in primary school, trying to cut with the scissors and the teachers would be like: 'no, you must cut with this hand.'* So, in High School, when the teachers are a little bit more logical, and actually realize that it's ADHD [that it got better]. I think it was only some teachers that I got really close with that I'd tell: 'Listen, I'm really struggling with this'. Usually, I'd be struggling with a class, and I'd be like, 'I've got ADHD', and they'd be like: 'Okay cool'. Then, they were rather supportive; they had a little bit more understanding. So, then they would say, if you need to come back after school, or during break to finish writing something down, then that's fine, that sort of thing".

In his experience, however, having the ADHD label attached to him, initially by teachers, came as neither a relief nor a surprise, mainly because he felt that he was too young to truly understand it and that his parents had not fully explained it to him:

> "Pfft, I don't even know if my parents told me when I was five. When I was seven, I was like 'okay, well what's that?' You know, it's just like okay, and they say, 'well, we're going to prescribe you this, and it will make things easy', and you're like, 'okay'."

Similarly, Hannah also reported that her ADHD diagnosis failed to have any positive or negative effect upon her, precisely because she was diagnosed from a very young age and has a mother that is protective of her:

> "I think I was too young to really understand, you know, I guess I was just told, you battle to concentrate and you need to take this medication to help you focus more, be calmer, I guess. I don't think it was a problem. I've always been very protected by my mom, she's never really always told me the exact reason why things are the way they are. It's kind of just like, do this, and this will help (laughs). There's never really been a full explanation, but it's something I've just had to live with."

Like the other respondents, Hannah also reported that one of her teachers had been involved in her initial diagnosis of ADHD. Despite her limited understanding of it, Hannah did report that she felt somewhat grateful for her teacher's involvement, and the subsequent attachment of the ADHD label to her. However, while she was grateful she had been diagnosed, she also felt that it was not the best decision to have given her psychostimulant drugs at such a young age because it created a sense of dependency which still affects her today:

> "There's a very good educator in [location omitted], she's my Grade 2 teacher and she's one of the best foundation phase teachers I know. She diagnosed it with me and ya, like, I'm grateful that I was diagnosed with it from a young age, but I don't know if it was completely the right thing to do to give me Ritalin from a young age, because it created this dependence, reliance, on it, that I needed in order to concentrate."

In both Jeffrey and Hannah's experience, it can be argued that while neither of them felt directly affected by the ADHD label when they were young, their interactions with their teachers and

subsequently, their parents, had made them feel that drug therapy was necessary in order to satisfy what was societally expected of them; to make them 'calmer', 'focus more' or 'make things easy'. This arguably shows that stimulant therapy is a way for the authoritative figures in a child's life to control his/her 'misbehaviors', and that it is the teacher that often makes parents feel that it is necessary (Perold, *et al.*, 2010: 458-9; Malacrida, 2004: 63; Searight & McLaren, 1998: 485).

This interlinks with the viewpoint given by General Practitioner 2 in my previous study (Brasher, 2015: 31) whereby he stated:

> "You know, if the teacher says: 'your child is misbehaving, I think you should consider getting them assessed by a psychologist who then might put them on Ritalin', parents are often too willing to comply because they don't want to have to deal with constant calls from the teacher. They probably also don't want to have to deal with behavioral issues at home, and they also want their kid to get better marks. So, often they'll agree to putting their child on Ritalin."

As is evident in Hannah's experience, she wished she had not been given stimulant drugs from a young age because it created a sense of dependency, which still affects her today. This, however, will be elaborated upon in section 5.6.

As is evident, then, all five of the respondents reported that their teachers had been involved in their initial diagnosis of ADHD. This supports literature which claims that, in most instances, it is the teacher that will refer a child for psychological assessment if he/she notices the symptoms typically associated with ADHD in the affected child (Searight & McLaren, 1998: 485). From the experiences of the respondents in this study, some felt grateful for it, and others, negatively affected by it. In Sarah's experience, having the ADHD label attached upon her was a 'scary' experience, and implied that it affected her esteem levels. In contrast, both Jeffrey and Hannah stressed that the ADHD label came as neither a relief nor a surprise, mainly because they were too young to understand. However, like Sarah, both Jeffrey and Hannah engaged in stimulant therapy, possibly to satisfy what was societally expected of them. Kayleigh and Emma's experiences also seem to resemble one another, as both suffer from dyslexia and believed that they were 'stupid' prior to their diagnosis. Thus, they both seemed relieved for their teacher's

involvement and subsequent attachment of the ADHD label to them, as they could now attribute their behaviors to having an underlying biological cause.

5.3. ADHD and Familial Interactions

In this section, I will be discussing how the respondents experienced the ADHD diagnosis in terms of their interactions with their family members. This will be discussed in relation to the literature and theoretical frameworks discussed in Chapter 2 and 3. As was evident in the interviews, most of the respondents were both positively and negatively affected by the ADHD label in terms of their interactions with their family members. At a general level, however, it appeared that their interactions were more positive than negative and four out of the five respondents reported that their siblings had also been diagnosed with ADHD, which I considered to be an interesting finding.

When asked how she experienced the ADHD diagnosis in terms of her relationship with her parents and/or siblings and if this experience had any effect upon her, Sarah responded:

> "Um, not so much with my parents, my mom is a psychologist so I don't think it changed my relationship with them. They were very careful to explain to me what the doctors told them, and why I should go on this. They were very careful about that. And then, a few years after that, my brother was also [diagnosed as ADHD] and put on ADHD medicine when he was also around that age, when he was in Grade 4. So, you know, it didn't change my relationship with them at all."

In Emma's experience, she felt that the ADHD diagnosis improved her relationship with her parents and reported that her mother was relieved when she was diagnosed:

> "It probably made [my relationship with them] better because I was annoying them and having fun, and ya. My mom was relieved, I think, when I was finally diagnosed. She was worried; she was very upset that I was upset [prior to my diagnosis]."

While her experience of the ADHD diagnosis in terms of her relationship with her parents appears to be positive, the relief her mother felt when she was diagnosed may be indicative of the idea that ADHD provides as a 'natural, guilt-dissolving calamity' for parents, as the their child's problems can now be explained as having a biologically rooted cause (Cohen, 2006: 13). In

Emma's experience, however, she too felt relieved as prior to her diagnosis she considered herself to be 'stupid', which as has been mentioned, may have been worsened due to the lack of support provided by her school.

In Kayleigh's experience, the ADHD diagnosis had a somewhat negative effect in relation to her interactions with her family. This relates to the literature outlined in Chapter 3 whereby it is argued that parent-child relationships in families with ADHD children are often problematic, as the diagnosis tends to lead to more "stressful and conflicted family environments and dysfunctional interactions in comparison to families without ADHD" (see Woodward, *et al.*, 1998; and Johnston, *et al.*, 2002). Kayleigh seemed to have spoken to this idea quite intensely, specifically in relation to her brother who had always been the 'problem child' in the family:

> "My experience with ADHD as a whole, I think, has been quite negative because my brother is such a problem kid. He has a whole range of behavioral difficulties, so I always kind of had a negative connotation with it, and a couple of my dad's ex-girlfriends have abused Ritalin as recreational drugs. So, when he heard that I was going on Ritalin, he was like: 'No, you can't take this stuff'."

Kayleigh similarly reported that her mother had been resistant to put her on stimulant medication upon learning of her ADHD diagnosis:

> "Before I went onto Ritalin, I got hypnotherapy. It had absolutely zero effect on my ability to concentrate (laughs). Um, my mom's a bit of a crazy hippie, so it was like, you had to try all the alternatives before you turn to mainstream drugs (laughs)."

Kayleigh furthermore reiterated the idea that although both she and her brother suffered from mental health issues, she felt that her brother's problems always appeared worse and that she had come to internalize it:

> "As the other sibling, you are forced to deal with your sibling's issues, as well as your own. So, like, for example, I've suffered from depression my whole life, but my brother's depression was always much worse than mine, so in my eyes, I wasn't depressed, because, in relation to this person who has become the keystone of mental illness, in my mind, mine wasn't nearly as bad."

Thus, in Kayleigh's experience, as a whole, the ADHD diagnosis had a somewhat negative effect in her interactions with her family, mainly because her brother suffered from several mental health issues that appeared far worse than her own. As a result, she and arguably her parents as well, seem to have attached a negative connotation to ADHD which may be the reason why they were initially resistant to engage in psychostimulant therapy. This corresponds with the symbolic interactionist perspective as it is argued that people act according to the meaning they attach to certain things, and that this meaning derives from the interactions one has with others (Babbie & Mouton, 2001: 31). Thus, Kayleigh may have attached a negative connotation to ADHD due to her interactions with her parents who similarly held the label in an adverse light. Due to the negative connotation they attached to it, her parents were initially unwilling for her to engage in stimulant therapy, and thus, Kayleigh reacted by trying alternative methods of treatment in order to satisfy what her parents expected of her. However, her parents soon came to accept her diagnosis, and gave her the freedom to choose whether she wanted to take psychostimulant medication:

> "In the end, it was left to me to decide if I wanted to take it, which I think is good, that my parents gave me that freedom to actually make that choice myself and decide to actively contribute to my education, rather than passively just sitting back."

This indicates that while there were some negative aspects in her relationship with her family as a result of her ADHD and her brother's mental health problems, she also felt that her parents had come to respond positively in the end by leaving her with the choice to decide what was best for her. This indicates that the meaning both her and her family attached to the ADHD label changed over time, which is the final analysis that fits within the symbolic interactionist perspective (Babbie & Mouton, 2001: 31-2). As discussed previously, however, her desire to engage in stimulant therapy or to use 'behavioral controlling drugs', as she terms it, may have been induced by her previous interaction with her O.T. teacher who had made her feel 'stupid' and 'not worthy of being in school'.

Like Kayleigh, Jeffrey also stressed a somewhat conflicting experience of ADHD in relation to his interactions with his family members. While Jeffrey was considered as the misbehaving child, he stressed that his brother was considered as the 'better child'. He furthermore spoke of how his parents considered him a 'brat', how he was not allowed to 'vent' and how his parents

would ground him if he did not perform well academically. This arguably supports the idea mentioned in Chapter 3 that "parents of ADHD children often exhibit lower levels of parental support, that they tend to over-react towards their ADHD child's misbehavior, and are less responsive to their child's needs" (Rogers, *et al.*, 2009: 170-171). When asked how he experienced ADHD in terms of his interactions with his family, Jeffrey responded:

> "Uh, it definitely did cause some problems (laughs). Especially because my brother was like, the better child, and my parents, they would think that you're giving them 'shit', but you're not. They'll think that you're being a little brat or things like that, and as I said, you'll say something or do something, and then they'll (his parents will) be lecturing me or something like that, and then 10, 20 seconds into the lecture, or 5 minutes into a 2 hour lecture, my mind's already gone past this, I'm like: 'okay cool, what can I do now?'. Then they'll be like: 'Are you listening to me?!' Also, I didn't feel like I was allowed to vent, which caused a whole lot of other issues which came up. I think, obviously, moving out of the house and going to varsity helped. I think when I was doing well in school, my parents were a little less on my back, but then, a lot of the time I wasn't doing well, and then I'd be grounded or go for extra lessons, do this or that."

Thus, while this shows that Jeffrey had a negative experience of ADHD in terms of how his family reacted to his behaviors, he also reported that his interactions with his parents were: "Kind of a mixed bag. Now, my parents are like: 'You made it through Varsity! Yay!' that sort of thing". This indicates that was some sense of support in how they interacted with him, and are proud of what he has achieved today.

As is evident, then, the respondents seemed to have had both positive and negative experiences of ADHD in terms of how they interacted with their family members overall. In the above cases, the respondents did not appear to feel stigmatized or 'labelled' by their parents, and thus, they failed to engage in self-stigmatization as a result of it. This contradicts literature which suggests that parents of ADHD children often hold negative illness perceptions towards their ADHD child which ultimately induces a lowered concept in the child him or herself and, in turn, self-stigmatization (Moses, 2010: 783). While Jeffrey's parents sometimes responded negatively towards his actions, there was no indication that this severely impacted upon his esteem levels or self-concept as literature otherwise suggests (see Moses, 2010). In Kayleigh's experience, while

she and her parents initially held a negative connotation to ADHD and the usage of medication, she also felt that her parents responded positively by allowing her to choose whether she wanted to engage in psychostimulant therapy. Her experience goes against the idea that it is the parents who promote psychostimulant therapy, believing that it is necessary to control their child's misbehavior (Mueller, *et al.,* 2012: 103, See Harpur, *et al.,* 2008). Thus, while in these cases, there was generally positive interaction between the affected respondent and his/her parents, Hannah did report that, even to this day, she feels most *labelled* by her mother and that there are elements of their relationship that have come to negatively affect her:

> "[With my mom], it became like this label, which is very exhausting and it started to really make me see myself in a negative light. I feel like in some ways, it started to define me, which I don't think it should."

Hannah continued:

> "Even yesterday morning I was talking to my mom about the problems I'm experiencing and she's like AND you're ADHD, 'yes, I'm ADHD'. All the time. Obviously it's a bit hurtful because then once again, I'm getting associated, it's defining me, whereas I don't always believe it's completely who I am."

Hannah's experience interrelates with the modified version of the labelling theory, and the theory of self-stigmatization. The modified version of the labelling theory suggests that labelling has a negative effect on one's esteem levels if one internalizes the negative associations with one's disorder (Rosenfield, 1997: 660; Moses, 2009: 57; Pasman, 2011: 123). Through internalizing the negative stereotypes associated with one's disorder, the affected individual may engage in self-stigmatization. With self-stigma, a person begins to internalize their "new degraded identity" as being definitive of the person that they are (Mueller, *et al.*, 2012: 102). This leads to what is referred to as "self-esteem decrement" in which one's self-esteem decreases due to these internalized negative beliefs (Pasman, 2011: 124). In Hannah's case, the internalization of self-stigma appears to have been induced by her mother who seemingly held a negative illness perception towards her. This, in turn, led her to believe that this 'new degraded identity' as an ADHD individual was definitive of the person that she is, and caused her to see herself in what

she referred to as a 'negative light'. This potentially led to a decrease in her self-esteem levels, having internalized the idea that the ADHD label 'defines' her.

However, while she felt that her mother labelled her and that this induced a negative self-concept within her, Hannah also stressed that there were aspects of her mother that were both supportive and loving:

> "I've had, especially with my mom, amazing support and the fact that she did her research and knew what she was doing was just; I had a sense of security. I had a sense of this was not bad. My mom always reminded that it's not fair that if you're experiencing this. That's why we need to get you this help and I always have agreed with her, even though sometimes she takes it too far."

Hannah seemed to be grateful for her mother's involvement, possibly more so because she had failed to develop a close relationship with her father. Hannah believed that she had genetically acquired ADHD from her father, and considered this to have been an unfortunate outcome:

> "My father, for instance, suffers from serious ADHD. It cost him his job. At 9 o' clock in the morning, you're supposed to be at least focusing and working, but I'll find him on Facebook. I think with my parents, it's just a bit sad, because I feel like: 'wow, I don't really look up to my father that much', so it's pretty unfortunate that I had to develop this from him."

Having established how the respondents experienced the ADHD diagnosis in their interactions with their family members, the focus now turns to the respondents experiences of ADHD in their relationships with their peers and/or friends. The findings varied, with some of the respondents feeling stigmatized by their peers in their youth, others as they got older, and some not experiencing stigma or labelling at all.

5.4. ADHD, Peer Relations and Stigma

As discussed in Chapter 3, it is generally agreed that non-ADHD peers or friends hold stigmatizing and judgmental attitudes towards their ADHD classmates (Wiener, *et al.*, 2012: 222; see Walker, *et al.,* 2008). For the most part, this study revealed somewhat different findings as while the respondents were aware of the stigma attached to ADHD, they did not feel

stigmatized or judged by their peers in their primary school years. It was only as they got older that they became aware of their peers' reactions, and experienced a sense of judgement as a result of their ADHD diagnosis. In their primary school years, however, it was generally considered to have not been a problem. Sarah was the only respondent to have feared the stigma in her primary school years. When asked how she experienced ADHD in terms of her interactions with her peers and/or friends and if this had any impact upon her, Sarah responded:

> "If I think about it, at school, it wasn't really something you talked about. You didn't want to have any *association* with that. I didn't really tell people because I felt *weird*. When you're like 12 and you already have *self-esteem problems* and on top of it, you have to admit that you're not doing well. It's really not great."

Drawing on the labelling theory, it is suggested that the 'mentally ill label' instills a deep fear of rejection in those diagnosed, which results in certain coping strategies which are meant to prevent potentially negative outcomes (Moses, 2009: 571; Pasman, 2011: 123). These coping strategies include secrecy, withdrawal, and *abstaining* from informing others about his or her mental illness (Moses, 2009: 571; Pasman, 2011: 123). In Sarah's experience, she seems to have abstained from informing her peers about her ADHD diagnosis, possibly due to her fear of rejection. This may have been worsened by the 'public stigma' generally attached upon mental health problems.

In contrast, Kayleigh seemed to have not been affected by the ADHD diagnosis in terms of her interactions with her peers during primary school:

> "I don't think it really affected me, I like to think I'm quite a people's person, I get along with most people. I don't think it really affected my relationship with my peers".

When asked whether or not she abstained from informing her peers about her ADHD diagnosis, Kayleigh gave an interesting response:

> "Ya, personally, I don't really, I don't personally attach a *stigma* to it. So I don't mind if people know I'm ADHD, and I feel like, if people know that I am suffering from these things, people who are also suffering from these things are more likely to come to me for advice. So, I've never had a problem with letting people know".

This led me to believe that while Kayleigh is aware of the stigma attached to the ADHD label, this stigma had failed to affect her and believed that her diagnosis can be used to better the lives of others. Thus, she did not engage in self-stigmatization which would have occurred had she internalized any negative associations of ADHD.

Similarly, Emma reported that the ADHD diagnosis did not impact upon her direct friendships during her primary school years:

> "Not really. I'm a very sociable person so for me, with that aspect, no. Most of my friends were just chilled about it, they didn't mind. Like, they didn't judge me for it, if that makes sense".

However, Emma also reported:

> "Some people did know, and they were like: 'Oh shame, she's stupid'".

As theory suggests, 'public stigma' occurs when large segments of a population attach negative stereotypes upon 'out-group members' who exhibit the behavioral and physical characteristics associated with mental illnesses (Mueller, *et al.,* 2012: 101). In Emma's experience, the public stigma attached to her ADHD was that of 'stupidity'. However, it was only once she got older that she became fearful of the public stigma attached to ADHD, and has now found herself refraining from informing her peers about her ADHD diagnosis and the subsequent usage of medication at university level. As Emma explained it:

> "At varsity people look at it like, 'ugh, you're using Ritalin as a crutch or whatever', and I'm like: 'mm, actually.' So that *judgement* is not nice. Especially when you get to postgrad level, they are like: 'Why are you still using it?' It's not fair, we're just trying to pass, you know. So, university is probably when I started not telling people."

This indicates that while she failed to feel stigmatized in her youth, she is largely aware of the stigma attached to the ADHD label and the subsequent usage of medication as an adult, and has found herself refraining from informing others, possibly due to fear of rejection and judgement by others. In engaging in this coping strategy, the labelling theory suggests that a lowered self-concept will result in the affected individual (Moses, 2009: 571). While Emma did not speak directly to this, she did state that she needed to get her 'confidence up', which occurred prior to

her going off of medication. This, in part, may be due to the reactions of her peers who questioned why she is still using medication, even at postgraduate level, and thus she appears to have been negatively influenced by her interactions with her peers. In her experience, however, it can be argued that she is more fearful of the stigma attached to Ritalin usage, than to the ADHD label itself, which influenced her choice to stop using it. Her decision to discontinue using medication, however, will be elaborated upon at a later stage in this analysis, as there appeared to be further reasons for her decision.

Similarly, Hannah reported that that she did not feel judged or stigmatized for having ADHD in her primary school years and that her interactions with her peers were non-problematic. It was only in high school that she felt more affected by it:

> "In school, it wasn't too much of a problem, especially in primary school, because people don't really judge you. It was like, okay, I have a problem, and then we just move on with life. It was more in high school [that it became a problem]."

In contrast to the labelling which suggests that those diagnosed with mental illness refrain from informing others about their mental illness due to fear of rejection, Hannah seems to have informed her peers of her diagnosis more than usual in primary school, perhaps in order to justify her behaviors or make her classmates understand why she behaved a certain way:

> "I almost used to tell my peers, ya, I have ADHD. I was not ashamed of it, but I think some people could have been embarrassed, like, 'why are you telling me that? You don't need to tell me that kind of thing'. I kind of let it *define me*, like ya, I have ADHD; this is why I'm at the front of the classroom. I'd feel like I have to give these deep descriptions of why things are the way they are."

This shows that while she internalized the ADHD label as being definitive of the person that she is, she did not engage in secrecy or withdrawal when it came to informing others about her diagnosis. This contrasts to what the modified version of the labelling theory suggests. Hannah further reported that she informed people to a great degree, perhaps because:

> "My mom was so loud about this is what I have."

This experience also contrasts to what literature suggests whereby it is argued that due to the fear of 'courtesy stigma', parents are often resistant to disclosing their child's mental health problem to others (Moses, 2010: 783). In doing so, it is possible that the child will feel that his or her parent is ashamed or embarrassed of him or her, which may result in further self-stigmatization on the part of the child (Moses, 2010: 783). Thus, while Hannah did feel labelled by her mother, it did not appear that her mother herself was fearful of 'courtesy stigma', or that she was embarrassed or ashamed of her which otherwise would have resulted in secrecy, and further self-stigmatization on the part of Hannah.

Drawing on her high school experience, however, Hannah reported that her interactions with her peers were more negative than in primary school. With that said, she did not associate her negative interactions as being a result of her ADHD label itself and stressed that there were further reasons as to why she had an unhappy high school experience:

> "I don't want to kind of mix feeling labelled with ADHD, with just the unhappiness I experienced at school. I didn't have a great high school experience. I don't think it helped that I was not considered popular, I was considered a bit weird, and at the same time, I was that girl who was in a separate venue. It was clear I had these like, special privileges. I don't feel like I was labelled (because of the ADHD), I feel I was more labelled for being unpopular, weird, and the ADHD could have influenced that because I'm hyperactive and out there, sometimes a bit too out there (laughs) and that could have linked to why people saw me as a bit weird, but I don't know if they knew, like, okay, this is ADHD. I think they just thought it was who I was. I think people didn't realize the struggles I was going through; they just thought I should go in with the system."

Thus, while she felt that the ADHD label may have worsened her interactions with her peers, it was not solely because of the ADHD that others held her in a negative light. At a general level, she felt that she was labelled for being 'different', and that the ADHD diagnosis had made it worse. However, it can be argued, that her peers considered her 'weird' as a result of the symptoms commonly associated with ADHD which, in turn, had an impact on her popularity levels at school. This corresponds to literature which suggests that non-ADHD peers prefer to remain detached and distant from their classmates who they believe have ADHD, which may negatively impact upon the affected individual's self-esteem levels (Wiener, *et al.,* 2012: 222).

The decision of her peers to remain distant from her may also indicate that Hannah was subjected to 'public stigma' as she was considered as the 'out-group member' who was 'different' to her non-ADHD peers.

In general, Jeffrey seemed to have had negative interactions with his peers, and reported that he had been 'bullied' a lot during school. He also reported that he felt incompetent and stupid in comparison to his peers during his primary school years, and that this negatively affected his self-concept. In Jeffrey's words:

> "In Grade 7, I got 6 months behind in work. I was always the kid that the class had to wait for when it came to writing things down and I'd rarely actually get to finish. So, I remember halfway through Grade 7, the teacher was looking through my books and she was like, 'listen, you've got like barely half of these lessons' and so, I had to spend the last six months of my Grade 7 [year], pretty much catching up about six months' worth of work. That sort of gets to you because you're sort of like, 'Why can't I do this and they can?' You feel sort of like, stupid, you feel a little bit, incompetent."

This shows that while in primary school, Jeffrey's ADHD diagnosis led to feelings of 'stupidity' and 'inadequacy' in comparison with others, which indicates that the label had a negative effect upon his self-concept. However, Jeffrey also reported that he only began to internalize this as he got older, and how at university, he often feels rejected and judged by his peers. With that said, he also reported that he has learnt to deal with the criticism and rejection of others, perhaps because he has come to accept his ADHD diagnosis, and the associated negative reactions of others:

> "I think, as you grow older, that's where you really start to notice it. It's only started to affect me more lately because I've seen how detrimental it can actually be in, for example, a lab where you've actually got to pay attention to detail and stuff like that, because otherwise people give you 'shit' and call you a 'fucking idiot'. It's only recently, though. I've been very good with criticism and rejection, but then, on the side, it's like: 'guys, I'm not doing this intentionally'."

This shows that while his interactions with his peers are negative, he also tries to explain to his peers why he acts this way, with the hope that they will eventually come to understand that it is the ADHD, and not himself. As Jeffrey explained it:

> "They don't actually realize what it actually is, and I mean, a couple of people in my lab will actually tune me. It's like when people talk about something, and you don't know if you are part of the conversation or not because you're not in the area, you're not engaging, sort of thing. So, they'll say something, and you'll be like: 'oh ya', and you'll chip in a comment or something like that, and there's about two people who have been like: 'Listen dude, like, we're not talking to you. Why do you always do this? It's irritating.' Then I will be like, actually, go look at the *DSM-IV*[1]. If you don't believe me, go read it yourself and you'll see it's actually one of the things. I'll be like, 'I'm sorry guys, but there's nothing I can do'."

Jeffrey continued:

> "In the lab, I mean, I have days where because of the stuff I go through, sometimes I'll do something, or I won't put something back or something like that. It's almost like forgetfulness, and I try to *inform* people in my lab, but obviously people in my lab are like: 'ugh, no.' I want the guys in my lab to know, so that they have an idea, so like, if one of them asks me to do something, it would be nice of them to at least check-up if I've done it. I mean, it's a not a lot."

His lab mates' response in the form of what he referred to as 'ugh no', or their referral to him as a 'fucking idiot', arguably shows the extent to which the ADHD label subjects a person to 'public stigma' in that he is considered as the 'out group member', who is different in comparison to the rest of his lab mates. While this rings true, the labelling theory further suggests that those labelled with mental illnesses and subjected to stigmatizing by others, will begin to internalize the attitudes of others as being definitive of the person that they are (self-stigma) (Mueller, *et al.*, 2012: 102). In Jeffrey's experience, he indicated that he has become 'very good with criticism and rejection' which, in my opinion, implies that he has not fully

[1] DSM-IV: A list of criteria that focuses on a child's symptoms to determine whether he or she has a neurobiological or psychiatric illness (Neophytou, 2004: 31; American Psychiatric Association, 2000).

internalized the negative stereotypes associated with ADHD and, in a sense; he has come to accept it. However, in being aware of the stigma attached upon the ADHD label, and to avoid being further ostracized by others, he reacts by informing his lab mates of his condition, perhaps to justify why he acts or behaves a certain way, 'guys, I'm not doing this intentionally' or 'go look at the *DSM-IV* criteria'. This is contrary to how some theorists view the labelling theory whereby it is argued that the 'mentally ill' label results in secrecy, withdrawal or abstaining from informing others on the part of the affected individual in order to avoid rejection (Moses, 2009: 571; Pasman, 2011: 123). These theorists further argue that these coping strategies are often 'self-defeating', and ultimately lead to the perpetuation of rejection, rather than the avoidance thereof (Moses, 2009: 571; Pasman, 2011: 123). By engaging in the abovementioned coping strategies, those diagnosed tend to isolate themselves from others which may instill a negative self-concept and a lowered self-esteem in the affected individual (Moses, 2009: 571). Thus, in Jeffrey's experience, it can be argued that his ability to deal with 'criticism and rejection' made him more capable of informing others about his diagnosis, which limited the impact it has upon his self-esteem levels. This, in part, may be due to his desire to make others understand, which also appears to Hannah's reaction during her primary school years.

5.5. Stimulant Medications, the Side Effects Experienced and the Benefits and Costs of Usage

In this section, I will be discussing the respondents' experiences of stimulant usage and the side-effects thereof. While the previous themes have already indicated that the respondents engaged in pharmacological therapy, what they used and how it affected them, has not yet been discussed. As will become clear, the respondents experienced several negative side-effects. However, for some, the benefits of usage outweighed the costs, whereas for others, the opposite was experienced, which resulted in the discontinued use of medication.

5.5.1. Stimulant Medications: Positive and/or Negative Outcomes

As literature suggests, most individuals diagnosed as ADHD are treated with pharmacological therapy/psychostimulant medications (LeFever, *et al.*, 1999: 1359). The most common stimulant medication comprises of 'Ritalin', otherwise known as 'Methylphenidate Hydrochloride' (Berger, *et al.*, 2008: 1036; Muthukrishna, 2013: 147; Venter, 2006: 143). In addition to Ritalin,

other psychostimulant drugs have entered the pharmaceutical market and have gained increased popularity in recent years. These include Concerta, Adderall, DexoStrat and Dexedrine (Jacobs, 2014: 48). The five respondents reported to have been given stimulants, primarily Ritalin, and the majority reported that their doses were altered as they got older. When asked whether or not she was prescribed medication upon being diagnosed as ADHD, Sarah responded:

> "Yes, I took Ritalin. I'm not sure which dosage to be honest, but I took Ritalin for about 2 or 3 years."

Kayleigh was the only respondent to have reported starting with Concerta, and then decided to use Ritalin as she got older:

> "I started with Concerta, but it stopped me from sleeping [so then I went onto Ritalin]. I was put on the 36mg."

Emma responded that she had been put on Ritalin, and that they altered her dosage to determine what strength was best for her. This occurred after her interaction with a remedial teacher who informed her that she must speak to her General Practitioner about using medication:

> "I was referred to a remedial teacher at another school, and we did a lot of lessons there and then they suggested that I speak to my GP about using Ritalin and then the reason they said I need to speak to them is because obviously, you've got to find the right dose. You can't just, you know, you don't want one that's too strong or whatever."

In Hannah's experience, it has already been stated that she was put on Ritalin from a young age, and that this created a sense of dependency upon it. Hannah responded, however, that they tried other medications, apart from Ritalin, but that the Ritalin works best for her. She also spoke of how her dosage was altered throughout her primary school years:

> "I started, obviously, on a small dosage when I was younger and as I got older, that dosage increased and now I'm taking, I don't know if you've seen the box, but it's like that Ritalin. It's a long, plastic tablet and it's a white plastic tablet and it's quite a high dosage. Obviously, I was only starting to take that kind of Ritalin towards the end of my primary school career, in Grade 6 maybe. I was put on Ritalin, nothing else, [at this time]. Then we went onto Concerta. It wasn't strong enough, at least not for me. Then we also

did Strattera, which is a very expensive drug. I feel like Strattera, it didn't do the same effect, it didn't make me as, like, clicked and put on as what Ritalin did but I think they saw it as a positive alternative, but it didn't work."

Jeffrey, who was also put on Ritalin after his parents enquired with his psychiatrist, spoke of how his dosage altered over time:

> "We spoke to my psychiatrist and he's the one who put me on Ritalin and things like that. So, my psychiatrist came through and he did a couple of sessions with me, and he obviously started me on Ritalin, a low dose of about 5mg, and then after a while, he increased it."

When asked whether the usage of medication led to improvements in their lives, most of the respondents spoke of how it led to improved academic performance. In Sarah's experience, she did not feel that it necessarily improved her academic performance, but she did speak of how it enabled her to work faster than usual:

> "Yeah, that's the only thing. I did find I could do things faster. I don't remember it improving any of my academic work. When I did do my work, I was doing well. I just didn't do it as fast as everyone else. So I did find that year that I was improving, and I don't know if that did help with confidence, but I do remember finishing things faster because I stopped getting in so much trouble for not getting the tasks done in the time frame."

Sarah's experience supports the literature outlined in Chapter 2, whereby it is argued that children who engage in psychostimulant therapy are less disruptive, more alert and able to complete their required tasks on time (Neophytou, 2004: 22). In Kayleigh's experience, stimulant usage also led to improved academic performance and allowed her to complete her tasks in a timely manner, which was evident in her statement:

> "[By using Ritalin] I got my stuff done, and I got it done on time and to a pretty decent standard."

Similarly, Emma also reported that the usage of medication resulted in improvements in her academic performance, and that it positively affected other areas of her personality:

> "It made me more focused, a lot calmer. So, I think I became a lot more serious about my academic career at school. [In school, Ritalin usage resulted in] a 20% increase [in my marks]. Then at Varsity, it kind of just went to 10%."

Hannah's experience of Ritalin resembles Emma, and spoke of how it improved both her social skills and her academic capabilities. When asked whether or not Ritalin usage led to improvements in her academic performance and/or other areas of her life, Hannah responded:

> "Yes, academically, and I think socially, as well, how I behaved socially in school. I don't take it as consistently now but I am a very hyperactive person, at least with my friends, and I don't know if the Ritalin would make that any better. I'm not a hundred percent sure, it did help taking it".

The respondents' experiences supports Neophytou's (2004: 22) claim that the usage of psychostimulant medication leads to marked improvements in a child's academic performance. This is because, as literature suggests, stimulant drugs target the specific region of the brain responsible for "neurotransmitter dopamine" release, which ultimately allows an individual to focus and pay attention for longer periods of time (Jacobs, 2014: 48). In Hannah's experience, Ritalin usage helped her with both her academics and social skills. This supports the idea that stimulant medication has the ability to improve the relationships that one has with others (Neophytou, 2004: 21).

In stark contrast to the other four respondents, Jeffrey reported that Ritalin did not result in improved academic performance, and that instead it caused major diversity in his marks:

> "It was actually when I was on Ritalin that everything was (up and down). Grade 2 and Grade 3 were better, Grade 4 I was like getting 90s for some subjects, I got 97% for Maths and then 93% for Natural Sciences and then the next term, I was down to 50s, maybe, or 40s. This was while I was on Ritalin."

Thus, while most of the respondents felt positively affected by the usage of Ritalin, and stressed that it aided their academic capabilities, it was interesting to find that Jeffrey was negatively

affected by it and that it had a detrimental impact upon his marks. With that said, while most of the respondents did report the positive effects associated with its usage, there were also several negative side-effects that the respondents experienced. Two common themes seemed to have emerged when questioning the respondents on whether or not they experienced any side-effects associated with stimulant usage, which will be discussed in relation to one another and include: 5.5.1) The 'Zombie-like' Dilemma and 5.5.2) Anxiety and Stress Inducement.

5.5.2. The 'Zombie-like' Dilemma

As outlined in Chapter 2, the most common side-effects associated with stimulant usage, include: "loss of appetite, headaches, stomach ache, growth suppression and sleeping difficulties" (Jacobs, 2014: 49). Additional side-effects which have been reported during prolonged usage include: 'skin rashes, fevers, dizziness, changes in blood pressure and heart palpitations' (Kendall, 2008: 28). In Sarah's experience:

> "The first few weeks of taking it, I remember feeling very sick. I remember having, now that I think about it, I also had a very bad skin reaction to taking Ritalin. I can't remember exactly, but I remember when I was getting older, and you start to get self-conscious about your appearance and Ritalin was making me feel like my skin was breaking out and things like that."

While these side-effects are generally considered as common, Sarah also indicated Ritalin usage made her feel disorientated or 'out of it', and implied that its usage had a negative effect upon her memory. This is the side-effect which I refer to as the 'zombie-like' dilemma. As Sarah explained it:

> "I don't remember much else. To be honest, I don't remember much about that year because I *felt out* of it [because of the medicine]. But ya, it felt *weird to have* to take medicine, that's all I really remember."

While the initial part of her statement indicates that stimulant usage may have potentially impacted upon the memory of her primary school years, the latter part of her statement, 'feeling weird to have to take medicine', shows the emotional impact that stimulant medication may have upon a child. Her experience supports Neophytou's (2004: 24) claim that by needing to take

medication to act 'appropriately', the child may begin to feel as if he or she lacks the ability to manage his or her own behavior. This, in turn, may lead the child to feel inadequate or helpless in comparison to others, thus contributing to a lowered self-esteem (Neophytou, 2004: 24). This idea was perfectly exemplified by a response given by General Practitioner 2 in my previous study (Brasher, 2015: 34). In expressing his viewpoints on the effects of labelling and the expectations placed on the child, General Practitioner 2 stated:

> "It's not just the expectations, but it's the fact that he's now been labelled as abnormal. So, what they say is that they're giving him this medication to make him normal, but he was normal in the first place. So what you're doing is your taking away that confidence in himself that he's normal, which is devastating for a child."

Sarah seems to have spoken to this idea, as it made her feel 'weird' to have to take medicine in order to achieve or become the person that others expected her to be. As a result, Sarah made the decision to discontinue using medication in high school which will be elaborated upon in section 5.6.

Jeffrey spoke of how Ritalin usage exacerbated his mood swings, and like Sarah, implied that it affected his memory negatively. When asked what side-effects he experienced, Jeffrey responded:

> "The only thing I remember really is mood swings, you could be like: 'this is a green cup' and I'd be like, 'well, why is that green?' A little bit of bipolar kind of vibes there but ya, that's what I can remember. On top of that, no, I think I was quite young when I went on Ritalin so trying to remember any symptoms I had, is difficult. You see, what Ritalin actually did to me, well this is the reason I went off it, is it turned me into a *zombie*. So, I don't actually have much memory of my primary school years, from about Grade 2 until about Grade 7. I don't actually have much recollection of it; there may be bits and pieces, but not much."

Their experiences of its usage elicited an interesting finding, as I have not previously come across literature that portrayed this. Their decision to discontinue using Ritalin may be indicative of the idea that the costs of usage outweighed the benefits, which contrasts to both Kayleigh's and Hannah's experiences. Regarding the second theme: 5.5.2) Anxiety and Stress Inducement,

Kayleigh and Hannah spoke of how Ritalin usage exacerbated the symptoms associated with their other diagnoses, which will be discussed in the following. However, their experiences of their additional diagnoses, in relation to their ADHD diagnosis, in itself, will be discussed in-depth in the following section.

5.5.3. Anxiety and Stress Inducement

Both Kayleigh and Hannah spoke of how the Ritalin usage induced high levels of anxiety within them which, in part, was also due to their other conditions. Despite this, both seemed to have continued using it into their adult years. When asked what side-effects she experienced, Kayleigh responded:

> "I suffer from quite an anxious form of depression. I battle from anxiety and stress, and both Ritalin and Concerta tend to exacerbate that."

Similarly, Hannah reported that she severely suffers from anxiety, and that the Ritalin made it worse. This is the reason why she went off it in Grade 9, which was evident in her statement:

> "I was diagnosed and given Ritalin at the age of 9 and by Grade 9, I had to get off it because it was just giving me nervous attacks. It was too much. I think over-doing it for too long is actually really, really bad. What do I mean by attacks? Basically, I think it was linked to my anxiety, because in Grade 9, that's when I was diagnosed with bad anxiety. I just, started to get very nervous for unnecessary reasons, I was becoming rather irrational and they did take it down to the Ritalin. That's when I was like, 'no, I'm ready to get off this'. When I stopped, it did help, because you're taking this drug and it's supposed to make you awake for so long, and I think my body, just kind of rejected it but then after a break, I went back on it again."

Thus, while both Hannah and Kayleigh reported that stimulant medication exacerbates their anxiety, and that they considered it as a negative side-effect, it was evident that they are both still on it today, which contrasts with both Sarah and Jeffrey's experience. This is because, it can be argued that the positive effects it has on their academic performance outweighs the cost of usage, and in Hannah's experience, it may be as a result of her dependence upon it as mentioned previously.

Apart from the abovementioned side-effects that the respondents experienced, Emma did not seem to suffer from any severe side-effects, per se. The only side-effect that she experienced was that of appetite suppression, which was evident in her statement:

> "Mmm, they say you don't eat as much. Definitely, I've noticed, that when I've gone off it, I've gained a bit of weight so I think it does prevent you from gaining weight or ya, that's sort of thing. Otherwise, I didn't really notice any other side-effects."

Having shown that each participant engaged in psychostimulant therapy, what positive and negative effects they associated with it, and that three out of the five participants made the choice to discontinue using medication, the focus now turns to the respondents' experiences of ADHD alongside their other conditions, as in some cases, their other conditions further motivated their reasons for the discontinued use of stimulant medications. In doing so, I will also be discussing the respondents' ideas on the social factors and interpersonal issues which contribute to the ADHD diagnosis, and what alternative coping mechanisms were or were not employed when continuing or discontinuing the use of medication.

5.6. ADHD alongside other Conditions, Social Contributory Factors and Alternative Coping Mechanisms to Stimulant Medication

Most of the respondents reported being diagnosed with other conditions, alongside ADHD, in their primary school years. This supports literature which suggests that most children diagnosed with ADHD are also diagnosed with other conditions, such as: "Major Depressive Disorder, Generalized Anxiety Disorder and/or Oppositional Defiant Disorder" (Factor, Reyes, & Rosen, 2014: 531). As a result, there have been concerns that ADHD-like symptoms may not be caused by ADHD itself, but rather, the symptoms may be secondary to other problems such as "learning disabilities, below average cognitive potential or limited sensory abilities" (Venter, 2006: 144). In other words, as there are concerns that the child who appears to have ADHD may, in fact, have other problems or conditions "masquerading as ADHD" (Newcorn, *et al.,* 2001: 137). This concern has been compounded by the fact there are no tests that can be used to prove a "unique etiology for ADHD" (Furman, 2005: 994). In other words, there are no "specific cognitive, metabolic or neurobiological markers for ADHD" and there are no accurate medical tests that can be used to show any kind of legitimate biological abnormality (Timimi & Taylor, 2004: 8).

As there no medical tests that can show that there is something physically or mentally wrong with the apparent ADHD individual; health care professionals, teachers, general practitioners and others make use of the *DSM-IV* criteria to determine whether a child or person has the condition (Cohen, 2006: 13). If an individual, most likely a child, exhibits a certain number of the behaviors listed in the *DSM-IV* criteria, it is more likely than not that s/he will be diagnosed as ADHD (Neophytou, 2004: 29). Once diagnosed, these children are then prescribed stimulant medication, and if the child responds positively to its usage, it is believed that the ADHD diagnosis has been confirmed (Furman, 2005: 998). Therefore, in order to 'verify' whether a child has ADHD, parents, teachers and medical professionals often base it on the idea that if the stimulant medication causes an improvement in the child's behavior, then the diagnosis that the child has ADHD has been proven true (Snider, *et al.,* 2003: 47). However, this is incorrect, as all children will respond similarly and positively to small doses of stimulant medication (Snider, *et al.,* 2003: 47).

By using this limited biomedical approach towards ADHD and the alleviation of the symptoms associated with it, it has also been argued that the interpersonal issues and social factors which may be contributing, or even causing, a child's 'misbehaviors' are not taken into consideration (Timimi & Taylor, 2004: 8-9). Thus, the ADHD diagnosis provides a sense of 'tunnel vision' in that while it *appears* to provide a biological explanation for misbehaviors, it limits the ability of others to consider the additional contributing factors which may emotionally impact upon a child (Timimi & Taylor, 2004: 8-9). This idea is supported by Damico and Augustine (1995: 260) who stress that because of the 'medical model', we are often too willing to localize problems within the individual as being medically caused, and therefore fail to consider the larger social context contributing to a child's lived experience. While I do not intend to invalidate or deny the respondents' ADHD diagnoses, I will be discussing the respondents' experiences of the social context and how their interpersonal issues played a role in their experiences of the ADHD label. In doing so, I will also be discussing how the respondents experienced their additional diagnoses, as it seemed to have impacted upon their experiences of ADHD, and in some cases, the subsequent discontinuation of the usage of stimulant medications. In other cases, the respondents' decision to discontinue medication was as a result of their newly discovered studying techniques and approaches towards learning.

An interesting finding arose when interviewing Sarah. Reflecting back upon her experiences as an ADHD child, Sarah has come to believe that she never truly suffered from ADHD, and thus, she has rejected the ADHD label. While Sarah was not diagnosed with other conditions apart from ADHD, she did report that she had several other problems that were not taken into consideration, and that these problems were being overshadowed by her concentration issues. She also spoke of how the teaching methods employed at her school were not suitable for her personality. As she explained it:

> "To be honest, I don't even think I ever had ADHD, now that I think back about it. I just get distracted very easily, but I also felt that the teaching methods weren't adapted for my personality. I probably had like a lot of other problems, like anxiety and self-esteem issues, which I don't think the schools were taking into account. So, they were like, she has concentration issues so let's help her out with this. And then when, like I spoke to my mom, it was so bad and then it got better when I grew up and got more *confident*. That's why I stopped taking it in high school because I didn't need it; I discovered my own learning methods and things like that."

This speaks to the evolving nature of identities as indicated in the interactionist perspective. It can be argued that Sarah's self-concept no longer complies with that of an ADHD individual, which shows that the meaning she attached to herself changed over time.

Similarly, Emma reported that she has recently decided to discontinue using stimulant medication. While Emma does believe that she suffers from ADHD, she spoke of how her decision to go off medication occurred because she developed her own learning techniques and how she needed to build up her confidence prior to going off it:

> "In Honours, I noticed that we had to work a lot at night and stuff and the Ritalin is finished by then but I'd still do very well. So I know, that I think it was just more about me getting my *confidence up and learning to deal with the ADHD* and all these things, and dyslexia and working around them. With extra lessons and stuff, they teach you tricks, especially in the remedial schools, so they teach you how to cope, and what to do, and how to answer questions, because I have dyslexia, how to answer a certain way. So,

with all of that, I definitely think you don't always have to be on concentration medication".

Both Sarah and Emma spoke of how they had other problems affecting them, and how they needed to get their confidence levels up prior to taking themselves off medication. This highlights how a person's interpersonal issues can impact upon their experiences of mental health problems or, in Sarah's view, a lack thereof. In Sarah's experience, it was the teachers who were only focusing on her concentration issues, and not her self-esteem or anxiety issues, which led to her eventual rejection of the ADHD label. In Emma's experience, it was the ADHD, alongside her dyslexia, which negatively impacted upon her confidence levels. In university, this may have been exacerbated by her peer rejection of Ritalin usage, which may have influenced her decision to go off medication. While she did not reject the ADHD label, per se, she does believe that medication is not always necessary to alleviate the problems associated with it, and thus, like Sarah, has developed her own coping mechanisms or learning techniques to aid in her academic success.

When interviewing Jeffrey, it became apparent that he had been diagnosed with several conditions in his youth, specifically insomnia, anxiety and depression. This supports literature which suggests that those diagnosed with ADHD are usually also diagnosed with internalizing disorders, including: 'Major Depressive Disorder and Generalized Anxiety Disorder' (Factor, *et al.,* 2014: 531). Jeffrey reported that he had been prescribed several kinds of medications to treat these conditions, which he felt was too 'many drugs for a little boy':

"After a while, I was struggling to sleep, I was getting depressed and so they put me on anti-depressants, and then also some sleeping pills to help the insomnia. It's so many drugs for a little boy, especially because it wasn't working. They were throwing drugs at me because they were like, maybe this will help, you must use this to try and counteract this. It was just a whole cocktail [of medicines]. Whereas, with some people, Ritalin does help and that's all they need and they're fine. That's where my dad spoke to [my doctor] and he turned around and he was like, actually, we've been treating you wrong the whole time".

Although this cannot be generalized, Jeffrey's experience somewhat indicates the extent to which 'drug therapy' has become accepted in contemporary society, which, in Saul's (2014) view serves to benefit the profit-making incentive of pharmaceutical corporations and general practitioners alike. This idea was apparent in my previous study, whereby General Practitioner 2 and the Education Specialist believed that the sales of stimulant medications, in particular, are used to benefit the capitalistic interests of pharmaceutical corporations (Brasher, 2015: 43). As General Practitioner 2 explained it:

> "The pharmaceutical corporations are in charge of the world (laughs), they know exactly what's going on. You won't find a poor pharmaceutical company, they all do very well. You know, there's a very smooth process from the development of drugs to the profit of the company and it's not just got to do with research development and the benefit of mankind, health and disease, it's got to do with making money and they do it very well. So, basically, they're producing 99% more Ritalin than they need to, but they're also making 99% more profit. How can we argue with that?"

While Jeffrey participated in a variety of pharmacological treatment methods in his youth, his father soon came to reject the continued use of Ritalin upon realizing how it was it negatively affecting his son. Through his interactions with his father, Jeffrey similarly came to reject it, which supports the symbolic interactionist assertion that people act according to the meaning attached towards certain things, and that this meaning is derived from the interactions one has with others (Babbie & Mouton, 2001: 31). As Jeffrey explained it:

> "Eventually my dad was like: 'no, my son can play a game of soccer with his mates every morning, and that's how he can use his adrenalin.' So, pretty much from the end of Grade 7, I've been going without meds since, which wasn't easy (laughs) but I've actually gained a lot of control over it."

Thus, both Jeffrey and his father opted for the discontinued use of medication, and like Sarah and Emma, Jeffrey developed his own coping mechanisms to deal with the symptoms associated with ADHD.

Hannah who, as has been mentioned, suffered from a 'very bad anxiety disorder', spoke of how she wished she had not been given Ritalin from a young age, as it created a sense of dependency

and prevented her from developing her own alternative coping mechanisms. When asked how she experienced medication and the ADHD diagnosis overall, and if she agrees with the way it was handled, Hannah seems to have been most negatively affected by Ritalin usage:

> "I feel like, maybe, they could have given me a chance, found different methods, instead of just going straight onto the Ritalin because I think, because I went onto the Ritalin at such an early age, I immediately became dependent on it. There weren't any strategies used to help me strive through the situation without medication. It might have been nice to have been given more time to see if I could actually function without the medication."

Thus, while Sarah and Jeffrey were able to develop their own coping mechanisms to deal with the ADHD upon going off it in primary school, and Emma in university, Hannah wishes she had been given that opportunity, which she felt she was denied. This is possibly because 'drug therapy' is the most common or most suitable way for the authoritative figures in a child's life to control the child's 'misbehaviors', without taking into consideration the emotional impact it may have upon a child him/herself. This idea was further evident in Hannah's statement:

> "I think the teacher most probably thought she needs this because this is a very important time in her education and there's no time to waste by trying to figure it out. She just needs to take it so she can continue and progress."

Hannah continued:

> "[However], it's crazy to think that the solution to this was meds, ONLY meds, you know, I don't know, and I feel that's what a lot of teachers do, they label your kids, like immediately."

This interlinks with what was stated earlier in this analysis; that teachers use the ADHD diagnosis and promote stimulant medication in order to 'manage' the children they consider as 'abnormal' according to societal standards or according to their own subjective opinion. In doing so, these children become 'labelled' as different, and the social factors or interpersonal issues contributing to the child's behaviors' are not taken into consideration. While she did not directly speak to her own interpersonal issues contributing to diagnosis, and has not rejected the ADHD label, she did speak of what she would do in the same situation. As a prospective teacher,

Hannah believes that it is of utmost importance to understand the child's background before a diagnosis can be made. She also believes that just because a child is hyperactive, it does not necessarily mean that he/she is ADHD. This speaks to the idea that ADHD may be a misdiagnosed or even, 'medicalized', condition. As Hannah explained it:

> "I'd like to look at the child as an individual, like, 'Who is this child? How do they perform at school? Where are their strengths? Where are there weaknesses?' If I had the chance, if they would allow me too, I'd really be curious to know how the child behaves at home and stuff, and not just in the classroom. Also, just because a child's hyperactive, doesn't mean they need to be diagnosed. I mean, a lot of children are hyperactive and maybe you just need to give them something, a stimulant, but not necessarily medication, and that will help them."

Hannah also stated:

> "I've heard of this teacher in Cape Town, the principal, that won't let the ADHD kids take Ritalin, but what he does, is he examines this child and he suggests lifestyle changes and then the children enforce these lifestyle changes, and they've actually seen that these children have gotten better."

This shows that there are alternative methods available to treat the symptoms associated with ADHD, and that drug therapy is not always necessary. While Hannah wishes she had been given the chance to develop these coping mechanisms, she did stress that there are positive benefits associated with Ritalin, and this is perhaps the reason why she is still on it, unlike the other three respondents discussed previously:

> "I do wish I had more of my lifetime without it to see how I did but then I again, I do fear that if I hadn't taken it, I would have gone downhill. I do see the benefits of it, especially if I haven't taken my Ritalin and maybe I write a test and it doesn't go well, I'll know, okay, it' s because I didn't take my Ritalin. So I do see, feel, the benefits."

Lastly, Kayleigh who was diagnosed with depression and dyslexia seems to have accepted the ADHD label wholeheartedly. While there were some negative aspects of it in relation to her family, specifically her brother, she generally felt that the outcome was positive overall. She also

did not appear to have severely suffered from any other external interpersonal issues, which otherwise would have affected her views towards the ADHD label. In Kayleigh's words:

> "I think, there have been some negative aspects of my relationship with other people in terms of ADHD, but I think overall, it's been quite positive. If I had been given Ritalin earlier in primary school, I think that would have really helped me. Other than that, I think the circumstances, under which I was diagnosed and then treated, were as good as they could get."

This shows that in Kayleigh's experience, Ritalin usage served as her primary coping mechanism, and despite the fact that it exacerbates her depression and stress; it seems that, for her, the benefits of usage outweigh the costs, and similarly felt this way in primary school. This was an interesting finding, considering a study conducted by Harpur, *et al.,* (2008) showed that children prescribed stimulant medications reported that the costs of usage outweigh the benefits, whereas their parents reported the opposite. In Kayleigh's experience, it appeared that her parents were more resistant than she was to engage in pharmacological therapy. At a general level, Kayleigh felt positively affected by having the ADHD label attached to her as it helped relieve her feelings of 'stupidity', and like Hannah, believes that her experience may help her as a prospective teacher:

> "I feel it has helped me as a prospective teacher, because I want to get into lecturing and teaching, and it's helped me really understand the behavior of some people, and that your ability to learn is completely different across the board. That a lot of people learn in different ways, and you need to find ways to build on those tools that people are given, instead of just following a script as you are told to follow it and expecting everyone to learn in the same way."

Having discussed the respondents experiences of the ADHD diagnosis alongside their other conditions, their views on the social and interpersonal issues which contribute to diagnosis and, in some instances, their reasons for the discontinued use of medication, the focus now turns to the respondents' viewpoints on lifestyle adaptations (diet and exercise) as a means by which to alleviate the symptoms associated with ADHD. While three out of the five respondents seemed to have developed their own learning techniques to help them manage, it was commonly stressed

that exercise helped all five respondents to a major degree. This will be briefly discussed in the following section, as the primary focus of this investigation was on stimulant medication and thus, the alternative strategies employed only need to be discussed in brief.

5.7. The Benefits of a Healthy Diet and Exercise

As discussed in Chapter 2, a 'multi-modal approach' is necessary for the management of ADHD as a single approach is "rarely effective" (Venter, 2006: 144). As a result several medical and health professionals have developed treatment interventions that can be used in conjunction with stimulant therapy, or as an alternative to it, one of which is lifestyle adaptations in the form of exercise and diet manipulation (Kendall, 2008: 30). While most of the respondents did not see diet as being of great importance in reducing ADHD symptoms, they did stress that exercise had positively impacted upon them. In Sarah's experience:

> "I was very active, I did sports, I swam a lot, I did hockey, so I was very active and it did help."

Similarly, Kayleigh responded:

> "I do a lot of exercise, generally. I don't find it helps with my concentration. Ya that said, it would probably be worse if I didn't exercise as much."

In Emma's experience, diet had little impact upon her because she has always eaten very healthily. However, she did find that exercise helped to a great degree when she was younger:

> "Well, not really diet because at home, we eat very healthily. The sugar thing, when I eat sugar, it doesn't do anything to my personality or whatever. Ya, exercise seems to be a thing, every day, just letting some of that excess energy and excitement out into physical activity. So I think that helps."

In Hannah's experience, she also believed that exercised helped her to a great degree, and reported that a healthier diet would have benefited her. However, as a child, she did not engage in a healthy diet as this was not enforced by her mother:

> "Exercise, ya, I've always loved to be physically active so that helped, A LOT, because, you know, all your energy is put into this movement and I needed to do it, I was a little

> girl that needed to move (laughs). I didn't really change my diet, obviously I was encouraged not to eat a lot of sugar and stuff, but we didn't really. My mom was not a very disciplined mother when it came to that, she was just like, eat normal food. So no, I wasn't really that conscious about it. I do think, I believe that if a diet is right, it could really influence it. Even to this day, I feel my ADHD is worse because of the diet I had. If I changed it, like, I eat too much sugar and I don't think it necessarily helps, definitely."

Jeffrey reported to have engaged in many sports when he was younger, and spoke of how it had a positive effect upon him. He also stressed the importance of diet and how Vitamin B shots have helped him in recent years:

> "Exercise did help especially when I was younger, but I was doing a lot more exercise and activities when I was younger (in comparison to now). Diet, something like caffeine, a stimulant, I definitely think can exacerbate the symptoms, temporarily. Vitamin B, I remember, I don't know if I didn't sleep enough or if I just had a low thing of Vitamin B, but I was just like, down the whole time, and then when you get it, you're either more normal or more energized".

Thus, as is evident, exercise seemed to have a positive effect upon the respondents, and it helped relieve the symptoms associated with ADHD. While diet was less emphasized than exercise, there were instances where the respondents spoke of the benefits that a healthy diet can induce, and Hannah indicated that a healthier diet may have benefited her. For the most part, however, exercise was used in conjunction with pharmacological therapy.

Having discussed the dominant themes which emerged in the interviews with the respondents diagnosed in their youth, the focus now turns to the experiences of the two respondents who were diagnosed in their late teenage years or early adult years. Their experiences will be explained in relation to some of the themes discussed above. This will be done in order to strengthen the account of the five respondents diagnosed in their youth, whilst furthermore discussing how it felt to only have the label applied to them as they got older. The two respondents diagnosed in their late teenage years/early adult years included one male and one female. The female respondent was diagnosed in Grade 11 at the age of 17, and the male respondent was only diagnosed when in university at the age of 22.

5.8. Symptoms Experienced

Like the majority of the respondents diagnosed in their youth, the two respondents diagnosed when they were older appeared to suffer from the 'predominantly-inattentive' sub-type of ADHD. When asked what symptoms she experiences as an ADHD individual, Jasmine*, the female participant, responded:

> "From what I understand, it has a lot to do with concentration, and also not being able to finish things that you start. I think that was my biggest problem as a kid, and still now. You can't concentrate on things long enough to complete a task, you have a lot of things that are half started, half finished, and they never really get finished".

Aaron*, the male participant, also reported to have symptoms that typically correspond to the 'predominantly-inattentive type' of ADHD. This was interesting considering that boys are usually known to have the 'combined type' of ADHD or the 'hyperactive-impulsive type'. When asked what symptoms he experiences/d as an ADHD individual, Aaron spoke of the symptoms he experienced as a child, and still seems to have the same symptoms as an adult:

> "Oh, I get distracted, like, so easily. There's this one joke of like someone saying, 'oh look, a butterfly'. I know it's meant to be a humorous joke, but on one level I take a look at it like, oh yeah I was kind of like that. It's because I kept going off on tangents".

Thus, like most of the respondents diagnosed in their youth, both Jasmine and Aaron battled with their concentration and their ability to stay on topic. Thus, once the respondents were finally diagnosed, they appeared to be relieved, which will be discussed in greater detail in the following. This will be achieved by comparing their experiences of ADHD to the experiences of the respondents diagnosed in their primary school years.

5.9. ADHD, the Failure of Realization and the Ultimate Relief Provider

Jasmine seemed to have a very similar experience of ADHD to Kayleigh as both respondents had brothers diagnosed with several mental health problems that appeared far worse than their own. Like Kayleigh, Jasmine spoke of how her brother's problems overshadowed her own, and in her opinion, is the reason to why she was only diagnosed at a later stage in her life.

This was evident in Jasmine's statement:

> "My older brother was diagnosed as well, also when he was very young, Grade like 00, I think. In my experience, my brother presented much worse issues than I did. So, it was always like, that my brother's issues were these paramount things, and because I could cope better, it was kind of like, pushed aside. So, it was never really my issue, as much as it was my brother's issue because his was much more serious. And then, when I got older, and started taking Ritalin, everyone was like: 'whoa, you were ADHD this whole time'. But I had to manage it better because there wasn't room for it to be managed for me. When I thought, I'm really having problems concentrating, I'd also think, but it's not as bad as my brother's, he's doing okay so I must be fine".

Drawing on the symbolic interactionist perspective, it can be argued that through the interactions she had with her family, the ADHD label became associated with her brother, and not with her. Thus, she reacted by internalizing the idea that her problems were less severe than her brother's, and therefore had to develop her own coping mechanisms to deal with it instead. This resembles Kayleigh's experience as she too internalized the idea that her brother's problems were worse than her own. As a result, once Jasmine was finally diagnosed, she felt relieved as prior to diagnosis she felt that others had failed to focus on her. When asked whether the ADHD diagnosis came as a relief or as a surprise, Jasmine responded:

> "It came as a relief. Most definitely!"

The male respondent, Aaron, spoke of how while others were somewhat aware that he was ADHD in his youth, his diagnosis was not confirmed and that he had seen several specialists, where some confirmed his diagnosis and others, denied it. Aaron also spoke of how, like the respondents diagnosed in their youth, his teacher had informed his parents that they believed he was ADHD. However, unlike the other respondents, his parents were not as willing or quick to allow for such a diagnosis to occur:

> "I had primary school teachers saying: 'you're child definitely has ADHD', but we also had the conflicting psychologists saying yes or no. I know my parents were quite cautious about it, and they were like, no we're not going to jump on the bandwagon. What happened with me was I reached the end of my second year and was academically

excluded and went to see a psychologist to talk about ADHD. I took a variety of tests, scored rather high and was told they have no idea how I made it into varsity. So, I came back the following year with my appeal for academic exclusion on the exceptions on the ground of having ADHD and was prescribed Ritalin."

Thus, while Aaron's experience resembles the experiences of the five respondents diagnosed when they were young, in that it was his teachers that referred him for psychological assessment, his parents were not as willing to 'jump on the bandwagon' in the same way that the other parents were. This interlinks with what literature suggests, whereby it is argued that many parents do not use the ADHD diagnosis as a 'cop out for poor parenting' as most parents feel aggrieved by their child's ADHD diagnosis (Prosser, 2006: 3). Thus, in many instances, parents will engage in a process of 'doctor shopping', feeling that an initial diagnosis is inadequate and that a confirmatory diagnosis is necessary (Taylor, O'Donoghue, & Houghton, 2007: 117). This applies to Aaron's experience as his parents sought confirmation from many specialists upon being informed that he may have ADHD. However, in his experience, he was only diagnosed when he was older as his parents had rejected the ADHD label in his youth.

Like Jasmine, Aaron also indicated that the ADHD diagnosis provided a sense of relief. Similarly to Emma and Kayleigh, Aaron spoke of how his diagnosis was relieving in that now he could understand why he exhibited certain undesirable behaviors. This was evident in his statement:

"It was like okay, at least I know it's *normal* the way I'm thinking, the way I get distracted so easily."

This shows that the ADHD label provides a sense of relief for those diagnosed as they can now attribute their behaviors to an underlying medical cause (Young, *et al*, 2008: 494; see Murphy, 1995). Reflecting back upon his primary school years, Aaron also spoke of how he felt incompetent in comparison to his sister and believed he was not given the required level of attention that he felt he deserved:

"I do know at the time I had a sister that was doing incredibly well, like top 3 of the grade every year and then I came along, 'the slow kid', and it did make me feel like they were providing the required level of attention for everyone else and there was something up

with me because I couldn't, for lack of a better word, they would say something and I would be like: 'Okay', the next day people would remember it and I'd be like, you said that yesterday? Really? So, I know I felt for a long time that it was me, that everyone else conformed to this way of learning and it worked for everyone, except me, and there was therefore something wrong with me."

In contrast to literature which suggests that the 'mentally ill label' instils a negative self-concept and lowered self-esteem levels in those diagnosed, it can be argued that in Aaron's experience, it was the lack of the ADHD label that negatively affected him as he considered himself as the 'slow kid' who had something wrong with him. Thus, the ADHD diagnosis came as a relief as he could then understand why he was less academically capable than others, and could perhaps use it to understand why he was academically excluded in second year. Thus, prior to his diagnosis, he internalized the idea that there was something inherently problematic within him, and this is arguably why the ADHD label had a relieving effect upon him. His feelings of inadequacy appears to resemble Emma and Kayleigh's experiences as well, as both respondents reported to have thought they were 'stupid' before being diagnosed as ADHD.

5.10. ADHD, Peer Relations and Failure of Stigma

Like many of the other respondents, both Jasmine and Aaron are aware of the 'public stigma' generally attached upon ADHD. However, neither of them felt affected by it and both are very open about their diagnosis. When discussing how she experiences/d the ADHD diagnosis or label in terms of her interactions with her peers, and whether or not she was/is open about her diagnosis, Jasmine responded:

> "I was very open about it because I have a background in understanding behavioral diseases. I do think that often telling people is met with like a: 'ugh, okay', so you're lazy or you want to take the easy way out of something. I think the biggest problem is that a lot of people don't think it exists, that it's a completely made-up thing that you're just lazy or you want to drug yourself. And that's actually a very widespread thing, even in university, people are like: 'O, you take Ritalin. That must help.' Ya, there's a lot of stigma behind it, but I don't really care. It is what it is."

Thus, similarly to Kayleigh, Jasmine is well aware of the stigma attached upon ADHD. In her opinion, however, the stigma attached to it is that others do not believe it exists, and often judge her as a result of her diagnosis. Her response also shows that she is aware of the stigma attached to the usage of Ritalin, believing that others consider it as a 'crutch' to improve one's academic performance. However, although she is aware of it, she is not personally affected by it which would otherwise have affected her self-concept or self-esteem levels had she internalized any negative stereotypes associated with ADHD. Her viewpoint contrasts to Emma's experience in that Emma is fearful of the 'public stigma' attached to ADHD, and as a means to avoid judgement from others, Emma refrains from informing her peers at university level.

Similarly, Aaron reported that he is not personally affected by the ADHD label, and although he knew of other children diagnosed when he was young, he stressed that it had no impact upon his relationship or feelings towards those children. When asked whether or not he abstains from informing about his ADHD diagnosis, Aaron responded:

> "Well, the way I see it, is that I'm very open about it in the sense that if someone asks, 'hey, are you ADHD?' I'm like: 'ya, no, I am.' But it's not like I'm going to go around, broadcasting it. The thing is I kind of take a look at it, and ya, that's a part of who I am."

Thus, like most of the respondents, apart from Sarah and Emma, Aaron does not refrain from informing his peers about his diagnosis, which contrasts what the modified version of the labelling theory suggests. The latter part of his statement: 'part of who I am', also indicates that he has accepted himself as an ADHD individual, and has not internalized the negative stereotypes associated with it. However, Aaron did state that prior to being diagnosed, his peer relations were somewhat negative, and that his first girlfriend often felt annoyed by his actions:

> "Oh no, my first girlfriend, jeez, it irritated the living heck out of her because I couldn't properly hold a conversation. I would keep jumping from idea to idea to idea and ya, no, it irritated her massively. I know previously I would have a conversation with someone, and I'm pretty sure after five minutes, they'd like: 'Oh my God, can I get away from this person?'."

Aaron continued:

> "I will say after being diagnosed, after getting medication for it, my friends started inviting me out more which was pretty good. It definitely had a positive impact, the medication at least, but it also made my friends go: 'Ya, that kind of makes sense, why were you only diagnosed now?'."

Thus, it can be argued, that prior to his diagnosis, his peer relations were negative. However, upon being diagnosed and given medication, his peer relations improved which ultimately may have positively impacted upon his esteem levels or self-concept. Furthermore, Aaron spoke of how although he knew children diagnosed in his school, it had little effect on his attitude or how he felt about them:

> "There were at least 2 or 3 people in my grade who had been diagnosed with it, but I can't remember who they were, or how they acted. What I do remember is that there were kids diagnosed with it in my primary school years."

When asked whether it affected the way he saw them, Aaron responded:

> "No, not really. Most of the time and this is going to sound quite rash, but I quite frankly, don't care. So, you have ADHD? I don't care. So, you don't have ADHD? I don't care."

Aaron's attitude towards his ADHD classmate's contrasts to what literature suggests; that non-ADHD peers or friends hold stigmatizing and judgmental attitudes towards their ADHD classmates (Wiener, *et al.*, 2012: 222; see Walker, *et al.*, 2008). In his experience, the ADHD label had little impact in how he felt towards his peers. This strengthens the account of the respondents diagnosed in their youth who, with the exception of Sarah, stressed that their relations with their peers in primary school were non-problematic; essentially believing that when you are young, less judgment exists in your relationship with your peers. Thus, due to a lack of judgment, most of the respondents reported to have informed their peers of their diagnosis which, as has been mentioned, was possibly done in order to justify why they behaved a certain way.

5.11. Stimulant Usage: Benefits Outweigh Costs

Like the respondents diagnosed in their youth, both Jasmine and Aaron reported using psychostimulant medications as the main treatment method to alleviate their symptoms associated with ADHD. The main stimulant used was Ritalin, as the other respondents also reported. When asked whether or not she made use of medication upon being diagnosed as ADHD, Jasmine responded:

> "Yes, I started with Concerta, and I was put on the 36mg. It made me unable to eat, so now I'm on Ritalin."

Aaron, however, started on Ritalin and is now on Concerta. In contrast to the other respondents, Concerta works better for him:

> "Yes, my doctor first placed me on Ritalin; I want to say, 20mg. Then after about 6 months, that got bumped up to 30mg. Then after about two years, I was put on the 54mg Concerta, which I am currently still on and it works a heck of a lot better than the Ritalin."

Like the other respondents, apart from Jeffrey, both Jasmine and Aaron spoke of the positive benefits associated with usage, primarily improved academic performance. They furthermore spoke of the negative side-effects that came with it, but that the benefits of usage outweigh the costs. Their views correspond to that of Kayleigh and Hannah as both spoke of how Ritalin usage exacerbates the symptoms associated with their other conditions. However, in all instances, it was reported the advantages that come with usage outweigh the many disadvantages. When asked what effects stimulant usage has upon her and if these effects are positive or negative, Jasmine responded:

> "I get very bad side-effects. If I take Ritalin in the morning, I just don't eat for like, 7 hours, and then later, I'm like 'oh shit, I haven't put anything in my mouth today.' On top of that, I think it creates a whole dimension of like, social anxiety, and that's something I don't experience at all off Ritalin. I also struggle with depression, but not an anxiety form at all. It's like a much more depressed, on the scale of anxious and depressed. I do find that when I take Ritalin or Concerta, I just like don't want to deal with people. Like, if

> you look at not temper, but like a span of tolerance, I find that when I'm on those kinds of behavioral medications, it's completely shortened. I just don't have any patience to like, deal with anybody, which is so different from my normal personality. The pros do outweigh the cons, it's like, you have to get your stuff done and just deal with it."

Thus, as is evident in this statement, Jasmine like many of the other respondents had been diagnosed with other conditions, apart from ADHD. Specifically, this statement shows that she has both anxiety and depression, which corresponds with literature which claims that most diagnosed with ADHD suffer from 'Generalized Anxiety and Major Depressive Disorder' (Factor, *et al.*, 2014: 531). Like Kayleigh and Hannah, Jasmine feels that the benefits of medication usage outweigh the costs, despite the fact that it exacerbates the symptoms associated with her other conditions. In looking at the more common side-effects, however, it appears that she battles with 'appetite suppression' – a side-effect which is similarly experienced by Aaron. When asked how he experiences the usage of stimulant medication, and if he associates any negative side-effects with it, Aaron spoke in-depth about how it improved his academic performance, and how he is still learning to make sense of this newfound improvement in his marks. In Aaron's words:

> "I know, in primary school and high school; I would consistently get 50 or 60 percent. Varsity was the first time where I wouldn't consistently get 50 or 60% and now I'm consistently getting 70% or higher. I know, just from my perspective, I'm like: 'What the hell? This isn't right. No I should be getting lower, why am I doing well?' This doesn't sit well with me".

Aaron continued:

> "I know a number of times I've been working in the labs for like 8 hours, without going: 'Oh jeez, I needed lunch'. Also, it does keep you awake and I know I suffer from insomnia already, so I think it's quite a bad combination. There have been a number of days where I will take it in the morning, and want to go sleep and like: 'nope', three or four hours later than I finally go to sleep which does impact on the working schedule. I would say, now that I think about it, the anxiety is a little bit increased but I want to say

that the benefits make you go like, 'okay, I'm feeling a bit anxious about this but I know I can do it'".

In the initial part of his statement, it is evident that he battles with appetite suppression and sleeping problems, which are side-effects commonly associated with Ritalin usage. In the latter part of his statement, Aaron spoke of how it increases his anxiety. However, like Kayleigh, Hannah and Jasmine, Aaron feels that the benefits of usage outweigh the costs, arguably because its usage led to major improvements in his academics and social skills.

5.12. Earlier Diagnosis and Coping Mechanisms

As stated earlier, Sarah, Jeffrey and Emma developed their own coping mechanisms upon discontinuing the usage of stimulant medication. In contrast, Hannah has not developed alternative coping mechanisms, and wishes she had been given the opportunity to do so. This is because, it can be argued, she became dependent upon the positive effects that psychostimulant medication induced Both Jasmine and Aaron indicated that an earlier diagnosis may have been helpful. At the same time, however, both Jasmine and Aaron appeared somewhat grateful for their late diagnosis as it gave them the opportunity to develop alternative coping mechanisms in which to deal with the symptoms related to ADHD. When asked how she experienced the ADHD diagnosis and if she agrees with the way it was handled overall, Jasmine responded:

> "An earlier diagnosis may have been helpful, but I also think that the fact that it was diagnosed later, made me develop certain coping mechanisms that I wouldn't have developed had I been medicated earlier, which I think did have some value to it".

Being a Science graduate, Aaron was well aware of how stimulants can affect a person's brain chemistry if he/she only starts using it as an adult. This was evident in his statement:

> "The thing is, I know that, from Biochemistry perspective, the ages 22 to 27 is when the brain chemistry starts settling for the rest of your life. Umm, and going on medication at that point, it alters brain chemistry which probably isn't the smartest move".

This implies that an earlier diagnosis may have been helpful. However, Aaron also held the viewpoint:

> "At the same time, if I hadn't gone through life the way I had up until this point, I know I wouldn't be who I am, if I had gotten medication earlier, if I had gotten treatment earlier, maybe I would have fitted better into society, maybe I would have made friends better at a younger age. That's in the past, though. I also know that there are quite a few parents that are like: 'Oh my God, my kid is hyperactive, ADHD.' So, I think my parents took the right approach and it helped me develop different coping mechanisms. Plus, whenever I get higher than 60 percent, I'm like: Oh wow, that's me now, which is a great feeling. In comparison to, I want to say, if you're getting 70s and 80s, cool, and then you're getting low 60s. That feeling is quite different. All in all, I'd say, my life is the way I lived it and ya, I'm pretty much happy with the outcome".

This shows that while Aaron was relieved when a diagnosis finally occurred, he was also grateful that his parents were not as quick to 'jump on the bandwagon' as what several other parents are, which in a sense, shows that Aaron believes that ADHD has the potential to be misdiagnosed or even, over-diagnosed. He also spoke of how while he previously internalized the idea that he lacked in his academic capabilities, he now considers himself as academically successful which, in large part, is due to the positive effects he associates with stimulant usage. Thus, contrary to what the labelling theory suggests, the ADHD label had a positive effect on both respondents diagnosed in their early adult years, arguably because they failed to internalize the negative stereotypes associated with ADHD and the subsequent usage of medication.

5.13. Conclusion

In conclusion, this chapter sought to analyze the experiences of the respondents who were previously diagnosed as ADHD and subsequently prescribed stimulant medication. In the initial part of this analysis, I drew on the experiences of those diagnosed in their youth. The findings varied, with some of the respondents feeling negatively affected by having the ADHD label attached upon them, whereas others felt positively affected by it. As was evident, all five of the respondents reported that their teacher had been involved in their initial diagnosis, which supports the literature discussed in previous chapters. I then discussed how the respondents experienced the ADHD label in terms of their interactions with their family members, turning the focus to their peer interactions, thereafter. As was evident, the findings varied with some of the respondents having a negative experience of ADHD in terms of their interactions with others,

and others, a lack thereof. Thereafter, I discussed how the respondents experienced stimulant usage. It was generally felt that its usage led to improved academic performance. However, for some of the respondents, the costs of usage outweighed the benefits which led to the discontinued use of medication. Others, however, reported the opposite. After discussing this, I then analyzed the respondents' views on the social factors and interpersonal issues which may contribute to the diagnosis of ADHD, and what alternative coping mechanisms were employed upon discontinuing the usage of medication. In the concluding section, I briefly discussed the respondents' views on exercise in the alleviation of ADHD symptoms. All of the abovementioned was discussed in relation to literature and the theoretical frameworks explained in Chapter 2 and 3.

Having established this, I then analyzed the experiences of the two respondents diagnosed in their late teenage years or early adult years. Their experiences were discussed in relation to the viewpoints of those diagnosed in their youth. In doing so, I was able to deduce how it felt to only have the ADHD label attached upon them at a later stage in their lives. As was evident, the ADHD label provided a sense of relief for both respondents, as prior to this both respondents felt that an inadequate amount of attention was paid to them. Their experiences also sought to enlighten and support the narrative of the respondents diagnosed in their youth. I achieved this by drawing similarities and differences between their experiences and the experiences of those diagnosed when young.

Chapter 6: Conclusion

The overall aim of this research was to document and analyze the experiences and views that previously diagnosed Rhodes University students hold towards the ADHD label and the usage of stimulant medications. This study was contextualized within the theoretical framework of symbolic interactionism, involving the labelling theory, the stigma attached upon mental health issues and to a smaller degree, the process of medicalization. The research strategy took the form of a qualitative research design, in which seven different respondents were involved in an in-depth interviewing process. This included five female respondents and two male respondents. Five of the respondents were diagnosed with ADHD in their primary school years and subsequently prescribed stimulant medication, four of which were female and one of which was male. The other two respondents were diagnosed in their late teenage years or early adult years, one of which was male and the other, female.

In analyzing the overall findings of this study, it was discovered that the respondents held both similar and differing experiences of the ADHD label and the usage of medication. Sarah, the first female respondent, seemed most negatively affected by having the label attached to her, and believed that teachers use it in a way to manage the children they consider as 'unruly' or 'difficult to control'. While she engaged in pharmacological therapy, she soon discontinued the usage, implying that the costs of usage outweighed the benefits and that she felt 'weird' for having to take medication. This supports Neophytou's (2004: 24) claim on the emotional impact that stimulant usage may have upon a child, stressing that by needing to take medication to act 'appropriately', the child's self-esteem or confidence levels may be affected. Furthermore, while Sarah was not affected by the ADHD label in terms of interactions with her family, she was affected by it in her peer relationships, and thus abstained from informing her peers about her diagnosis, arguably due to the fear of stigma. Sarah also came to reject the ADHD label upon gaining confidence, which speaks to the evolving nature of identities and the ever-changing meaning attached upon the self as described by the symbolic interactionist perspective.

Emma, the second female respondent, also seemed to have a conflicting experience of the ADHD label. While she was grateful for her diagnosis, she also reported to have experienced negative interactions with her primary school teachers. Thus, it is possible that her parent's sought the ADHD diagnosis due to the inadequate support given by the school. She also reported

that she suffers from dyslexia, and that prior to her diagnosis, she considered herself to be 'stupid'. Thus, the label had a relieving effect upon her as she could now attribute her behaviors as having an underlying medical cause. She furthermore stated that the diagnosis had a positive impact upon her relationship with her family, and that it did not affect her relationship with her peers during primary school. It was only once she got to university that she became fearful of the 'stigma' attached to ADHD and stimulant medications, and has found herself refraining from informing her peers of her diagnosis. She also reported to have recently decided to discontinue using medication, which may have been influenced by her peers who seemingly hold a negative connotation towards Ritalin usage.

While Kayleigh, the third female respondent, seemed to have initially held a negative connotation to the ADHD label as a result of her brother, she reported that her diagnosis was a positive experience overall. She also spoke of how her O.T. teacher had instilled a negative self-concept within her, which partly may be the reason why she desired a diagnosis in the first place. Thus, the diagnosis helped relieve her of her feelings of 'inadequacy' as her problems could then be attributed to having an underlying medical cause. In addition, Kayleigh spoke of how the diagnosis had little impact on her peer relations, and that she does not refrain from informing her peers about her diagnosis. This is because, in her own view, she does not personally stigmatize the ADHD label, although she is aware of the general stigma attached to it. Thus, in having accepted the ADHD label as part of who she is, her self-esteem or self-concept has not been affected which otherwise would have occurred had she internalized any negative stereotypes associated with ADHD. Kayleigh also reported that she uses Ritalin, and that it exacerbates the symptoms associated with her other conditions. However, she also reported that the benefits of usage outweigh the costs. As a whole, it appeared that the ADHD label and the usage of medication benefited Kayleigh and that her experience had been positive overall.

Hannah's and Jeffrey's experiences of the ADHD label and the usage of medication somewhat appeared to resemble one another. Both Hannah and Jeffrey reported that their teacher had been involved in their initial diagnosis, but that the label had little impact upon them when they were young. This is because they believed they were too young to truly understand it, and have parents that did not fully explain it to them. Drawing on the symbolic interactionist perspective, however, both reported to have engaged in pharmacological therapy, possibly in order to satisfy

what both their parents and teachers expected of them. Hannah reported to have felt labelled by her mother, and that this induced a negative self-concept within her, which corresponds with what the labelling theory suggests. In contrast, while Jeffrey reported to have had negative interactions with his family members, there was no indication that this negatively impacted upon his self-concept, per se. In addition, while both respondents appeared to have had negative interactions with their peers as a result of their ADHD, it only began to affect them as they got older. However, neither respondent refrained from informing their peers about their diagnoses, which contrasts to what the labelling theory suggests. It can be argued, however, that they informed their peers to a great degree to justify why they act in a particular way or exhibit certain 'undesirable' behaviors. Finally, while Jeffrey discontinued using medication in Grade 7, Hannah reported that she still uses it. This is because, for Hannah, the benefits of usage outweigh the costs, whereas for Jeffrey, the opposite was experienced.

After discussing these findings in-depth, I then related the experiences of the respondents diagnosed in their youth to the two adult respondents' experiences of the ADHD label and the usage of medication. It was discovered that Jasmine's experience was similar to Kayleigh's experience, as both have brothers who were diagnosed with several mental health problems that always appeared far worse than their own. Thus, like Kayleigh and Emma, Jasmine was relieved once a diagnosis finally occurred. However, she was also grateful that she was only diagnosed at a later stage as it aided in her ability to develop alternative coping mechanisms which would not have arisen had she been diagnosed when she was young. Like Kayleigh, Jasmine is aware of the stigma attached upon ADHD and the usage of medication, and is not personally affected by the stigma attached upon it. This contrasts to Emma's experience. Finally, like Hannah and Kayleigh, Jasmine spoke of the negative side-effects associated with stimulant usage, and indicated that the benefits of usage outweigh the costs.

Aaron, the male adult respondent, had an interesting experience of ADHD. In contrast to the respondents diagnosed in their youth, Aaron's parents were unwilling to accept his ADHD diagnosis, and engaged in a process of 'doctor shopping' instead. This is the reason why he was only diagnosed at a later stage in his life, and like Emma and Kayleigh, considered himself as the 'slow kid' prior to his diagnosis. Thus, while it came as relief when he was finally diagnosed, he

also implied that a late diagnosis was beneficial and believed that his parents took the right approach.

6.1. Limitations and Improvements:

While this study elicited interesting and diverse findings, there are several areas that it could be improved upon in future studies. If I were to continue doing research in this area, it would be important to include the views of parents as well. By doing so, a case study technique could be employed whereby the views of the respondents' parents could be used to enlighten and strengthen the narrative of the respondents who suffered from ADHD in their youth, or still suffer from it in adulthood. Alternatively, a case study analysis focusing on the views of diagnosed ADHD children and their parents may be of interest if I were to do my Doctorate of Philosophy. It may have also been useful to include additional respondents diagnosed at an older age, as while two were involved, a greater number of respondents may have strengthened the respondents' accounts to an even greater degree. In addition, as this was a small scale study, the wider implications of the research are limited. Overall, however, this research has been significant in that it provided valuable insight into how one may experience the ADHD label and the subsequent use of medication, both in one's childhood years and as adults. It furthermore provided insight into how one may experience ADHD in terms of one's interactions with others, and what kind of positive or negative impact the views and attitudes of others may have upon the affected individual.

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APPENDICES

Appendix A: Interview Guide Example

Attention-Deficit/Hyperactivity Disorder Questions:

1) What is your understanding of ADHD?
2) What symptoms did you experience as an ADHD child?
3) Tell me about your history of ADHD. At what age were you diagnosed with ADHD and can you remember who the first person was to refer you for psychological assessment?
4) When you were told you were ADHD, how did it make you feel? Did it provide a sense of relief or did it come as a surprise? What overall effect did the realization of your ADHD diagnosis have upon you?
5) In your experience, do you think teachers truly care about the well-being of ADHD children, or does the ADHD label provide a sense of relief for teachers as they can use it to make the classroom more manageable? For example, by allocating the ADHD children to sit in the front of the classroom.
6) What were your experiences of ADHD in terms of your relationships with your parents and/or siblings? Did these experiences have any effect upon you?
7) Did you find yourself comparing yourself to your siblings, if you have any?
8) Did you find that your parents' were also affected by your ADHD diagnosis?
9) Did the ADHD diagnosis have any effect upon your peer relationships or your relationship with your friends?
10) Did you find yourself abstaining from informing your peers about your own ADHD diagnosis? Or were you open about your diagnosis?
11) Did you know of any other children who were diagnosed? If so, did this provide a sense of relief for you? Or did it not affect you at all?
12) Did you find that the parents' of your non-ADHD friends acted differently towards you in instances that they knew you were ADHD? If so, did this affect you in any way? Or not at all?

Stimulant Medication Questions:

13) After being diagnosed as ADHD, were you referred to a general practitioner? If so, did the general practitioner prescribe you any medication?
14) If so, what kind of stimulant medication did you take? For example, Ritalin, Concerta, Adderall etc.
15) Where were you administered the medication? At school? At home?
16) If you were administered the medication at school, did this have any impact upon you? Did you find yourself hiding it or were you open about it?
17) Can you remember if the usage of stimulant medication had any effect on your personality or behavior? If so, where these effects positive or negative in your own experience?
18) Did you find that it led to any improvements in your academic performance or other areas of your life?
19) Did you experience any side-effects of stimulant usage? If so, what side effects did you experience?
20) Did you use any other therapeutical interventions, apart from stimulant medications? If so, what did you engage in?
21) Do you think that a healthy diet and exercise may be beneficial in alleviating the symptoms associated with ADHD? Did you engage in such practices? If so, did it find that it helped you?
22) Looking back at your experience of stimulant usage overall, do you agree with the way it was handled? Do you think it benefitted you, or were there areas that you felt negatively affected by its usage?

Appendix B: Consent Form Example

Hello, my name is Chelsea Brasher and I am currently conducting research in General Sociology at Master's level. The research to be conducted includes a sociological analysis of Attention-Deficit/Hyperactivity Disorder (ADHD) and the usage of psychostimulant medications amongst previously diagnosed Rhodes University students. As central to this interview, I will be asking you to reflect upon your schooling years as an ADHD pupil in order to ascertain what your overall experience of the diagnosis was. I will furthermore be asking you questions surrounding the usage of psychostimulant medication in terms of how you experienced its usage, or if you used it at all. This interview will take no longer than 45 minutes to an hour of your time, and will only be conducted on one occasion. The reason to why I have decided to carry out research in this field, is because while ADHD and psychostimulant usage has been studied to a great degree in Europe and the United States, there are a very few studies that have been conducted within South Africa. In conducting this research, I hope to add to the sociological body of knowledge surrounding the ADHD topic within a South African context.

It is necessary to inform you that you have the right to withdraw at any stage during the interview or research process, and that no harm will be imposed upon you. In the remote instance that this interview does trigger any form of emotional distress, I have requested that the counselling center be available to provide psychological support. Furthermore, the data gathered will remain confidential and your name or school you went to will not be listed on any report or presentation. Although these interviews will be tape-recorded, these recordings will not be heard by anyone external to the research team. Upon completion of transcribing the recorded piece, these tape-recordings will then be deleted to ensure that you remain anonymous and that the data gathered remains confidential. I have also provided my own contact details on a separate document in case you wish to see the final document upon completion of the study, or your own transcribed piece. Do you consent to participating in this study?

Principal Investigator:

Research Supervisor:

Research Participant: