Nobody Knows I'm Normal:
An Adolescent Perspective of
Attention-Deficit/Hyperactivity Disorder

by

BIRDIE JANE BEZANSON
B.Com., St. Mary's University, 1990
B.Ed., University of Toronto, 1993

Thesis
submitted in partial fulfillment of the requirements for
the Degree of Master of Education (Counselling)

Acadia University
Fall Convocation, 2000

TABLE OF CONTENTS

ABSTRACT

This study examined the phenomenon of Attention-Deficit/Hyperactivity Disorder (ADHD) as it relates to the lives of two young men. The purpose was to gain an understanding of how the adolescent diagnosed with ADHD perceived their successes and failures in adjusting their behaviours to the expectations of a predominately non-ADHD environment. This study was based on the assumption that by ascertaining the problems faced by the adolescent with ADHD, possible counselling interventions could be developed. Interpretive interactionism provided the framework for this social inquiry. The prevalent question of how the adolescent perceived their success and failures was explored by in-depth interviews guided by the two participants. Positive relationships with adults and a sense of independence were of paramount importance to each of the participant.

ACKNOWLEDGEMENTS

First of all, I give thanks to David and Joe who shared their stories openly and generously. They are living proof that young people with ADHD can transcend the limitations that are normally associated with the disorder.

I offer my sincere gratitude to my supervisor, Dr. James Foster. His belief in me has opened my eyes in many ways. His quiet wisdom has taught me more in a shorter time than I have allowed myself to learn before.

I would also like to acknowledge Dr. David MacKinnon. His joy in the gift of questioning stirred my thirst for understanding.

The people in my life who have challenged and supported me are too numerous to mention by name. It is my hope that I have managed to communicate their importance to me in the moment.

Specific to this task, I would like to thank Lee-Anne Arsenault, Kathy Khayatt and Christy Ann Conlin. Each pushed me forward and added to this project in different ways.

This thesis is dedicated to Farah Sleiman, an intelligent and beautiful young woman just coming of age in Beirut, Lebanon. As a wise man once told me, there are people who may remain in our lives only a short time but still leave footprints on our heart. Farah's footprints have inspired me.

CHAPTER 1: THE BACKGROUND

Introduction

The mere mention of attention-deficit/hyperactivity disorder (ADHD) invokes a number of different reactions. Least often heard is Edward M. Hallowell's (Hallowell & Ratey, 1994) description of an individual with ADHD as high energy, intuitive, creative, and enthusiastic. Hallowell, who was diagnosed with ADD (currently referred to as ADHD, combined type) at the age of 31, aptly named his book *Driven to Distraction*. Perhaps the title is not only meant as a descriptor for the time leading up to his diagnosis and with that, an understanding of the characteristics of ADHD, but perhaps the title can also be used to describe the state of the people involved in his life. Regardless, *Driven to Distraction* offers a much needed, optimistic view for those diagnosed with the disorder.

Although ADHD may appear to be a relatively new phenomenon, evidence can be found which indicates otherwise. Russell Barkley (1998), a prominent ADHD researcher and clinician, identified a hyperactive character in a poem written in the mid-1800s by Heinrich Hoffman. *Fidgety Phil* may well have received the diagnosis of ADHD in a mental health clinic today. A British pediatrician, George Frederic Still, is credited with the first clinical reference to the syndrome (Barkley, 1997; Hallowell & Ratey, 1994). In a series of lectures given to the Royal College of Physicians in 1902, he described children in his medical practice as impulsive, inattentive, overactive, and lacking moral control over their behaviour. More surprisingly, he did not attribute these characteristics to poor parenting, but rather to biological inheritance or an injury at birth. So why then, if this disorder has been

around for more than 100 years, does the adolescent with ADHD still baffle and frustrate parents, teacher, counsellors and friends? More research in the area of adolescents with ADHD is needed to understand why the images of the rebellious troublemaker come to mind and not the intuitive, creative, high-energy person that Hallowell describes.

First, I have supplied a complete explanation of the purpose behind this study. A brief description of the three subtypes of ADHD as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) for ADHD is given. A list of the criteria for diagnoses of ADHD and criteria for other terms used from the DSM-IV are defined in order to give a clearer understanding of the disorders discussed (see Appendix A). As with most researchers, I have not ventured into this area of study without a desire to understand more about the topic. To enable the reader to understand where my interest originates from, I have included my personal agenda. To some extent, bias is inherent in all research. As the researcher, it is my responsibility to recognize biases. My pre-understanding of the topic is outlined in Research Considerations. A review of the literature is provided to support the need for this study.

The methodology section details the theory behind interpretive interactionism as a method of social inquiry. I have chosen to integrate the discussion of the methodology that directed my work with the method I used to complete my study. The justification for the purpose of my work did not become clear to me until I gained an understanding of how the interpretive interactionist envisions social inquiry. By

combining the two sections, I was able to give a better description of the complete process.

What follows is the story of two young men who have been diagnosed with ADHD. Each share a behaviour disorder which is viewed as problematic in the classroom, at home and in any situation where social interaction is required. Both provided me with a reflection of their lives with ADHD.

In conclusion, I have attempted to bring together what I have learned from these young men that will assist me as I continue my work with adolescents.

Purpose

The purpose of this study was to gain an understanding of how adolescents diagnosed with attention-deficit/hyperactivity disorder (ADHD) perceive their successes and failures in adjusting their behaviours to the expectations of a predominately non-ADHD environment. This study was based on the assumption that by ascertaining the problems faced by the adolescent with ADHD, possible counselling interventions can be developed. The term ADHD will be used to describe those who fit the criteria listed in the DSM-IV (American Psychiatric Association, 1994) for ADHD.

The DSM-IV lists three subtypes of ADHD: Combined Type (ADHD-C), Predominately Inattentive Type (ADHD-I) and Predominantly Hyperactive-Impulsive Type (ADHD-HI). Children who are considered ADHD-HI have problems sitting in their seats, playing quietly alone or with other children, fidgeting and/or talking excessively. They are often described as being driven by a motor. These children

often interrupt and have difficulty delaying gratification. Children who are considered ADHD-I may fail to pay attention to detail, have difficulty sustaining attention, do not seem to listen, can be easily distracted, may lose things and are often disorganised. Children who are considered ADHD-C can show a combination of these symptoms. Inattention is common to ADHD-C and ADHD-I but each represents different types of attentional difficulties. The child with ADHD-C has difficulty maintaining their focus on appropriate stimulus while the child with ADHD-I has difficulty "with selective or focused attention or focusing on relevant stimulus in the environment." (Brown, 2000, p. 196)

Many of these symptoms are what we would consider consistent with child behaviours, however, to be diagnosed with ADHD, symptoms must have been evident for at least six months to a degree which is maladaptive and inconsistent with the developmental level of the child. Further to this, symptoms must be identifiable in two or more settings and have been present before age seven. The above overview of symptoms listed in the DSM-IV pertains mostly to preadolescent behaviours.

Aside from the absence of diagnostic criteria for adolescent or adult ADHD (Danckaets, Heptinstall, Chadwick, & Taylor, 1999; Zeigler-Denny, 1995; Faigle, Sznajderman, Tishby, Turel, & Pinus, 1995), much of the literature focuses on the preadolescent child. Researchers traditionally thought ADHD was a child disorder. A strong indicator of this myth is the abundance of literature written focusing on childhood ADHD symptoms and treatments. Most notably are the books written for the teacher and the parent. A plethora of books can be easily obtained describing how to parent or teach a child with ADHD. Comparably speaking, very little has been

written with the adolescent in mind and less has been written for the adolescent diagnosed with ADHD. What is even less evident is research describing how adolescents identify themselves with their diagnoses. The absence of the voice-centred research has caused a lack of an understanding of how the adolescent relates to the non-ADHD population and as a result, creates a gap in possible counselling interventions.

Adolescence is considered by some to be a social invention (Bakan, 1972 & Kett, 1977, as cited in, Stevens-Long & Cobb, 1983). It is often regarded as the time of transition between childhood and adulthood with no distinct beginning or ending. Elder (1975a: 3, as cited in, Schlegel & Barry, 1991, p. 4) highlights the lack of an agreement on a single definition.

> Despite a lack of consensus among social scientists on the social boundaries of contemporary adolescence, the clearest marker for entry into adolescence is the transition from primary to secondary school (from sixth to seventh grade). Entry into one or more adult roles (marriage, parenthood, full-time employment, financial independence) is commonly regarded as the upper boundary.

For the purpose of this study the definition of adolescence given by Stevens-Long and Cobb (1983, p. 27) will be used.

> Adolescence is a period in life that begins with biological maturation, during which people must accomplish certain developmental tasks, and that ends when they achieve the self-sufficient state of adulthood as society defines it.

There are three approaches which may be considered when defining the phase of adolescence: biological, psychological and sociological. No research was found to suggest that a diagnosis of ADHD affects reproductive maturity and as a result, will not be consider relevant to this study. What is of more interest is the developmental tasks to be achieved in this stage of life. Stevens-Long and Cobb (1983) list eight developmental tasks, which relate to the central task of developing an individual identity.

1. Acquiring new social skills.
2. Achieving a masculine or feminine sex role.
3. Accepting changes in one's body.
4. Achieving emotional independence from parents and other adults.
5. Integrating sex into an adult life-style.
6. Occupational commitment.
7. Developing a personal ideology.
8. Membership in the large community.

The developmental tasks presented strongly resemble the skills, knowledge and attitudes outlined by R. J. Havighurst in 1951 as being critical to the development of a healthy personality. Although social scientists do not agree on a single definition, it is apparent that adolescence is a time of rapid change during which attitudes, behaviours and self-concept become the basis for adult beliefs.

The non-ADHD environment may be characterized by the behaviours that are preferred and deemed socially acceptable. Many times in our daily schedule we are required to sustain our attention on low interest tasks. Current pedagogy relies more

and more heavily on the didactic flow of information as one progresses through educational institutions. Cultural norms dictate eye contact is maintained during conversations with intimate friends as well as casual acquaintances. The notion of time is clearly defined by the numerous scheduled appointments we may have during our day. Tardiness is seen as either an insult or a strong indicator of a lack of responsibility. Interruptions in conversations are seen as rude or aggressive and our ability to restrain our desire to interrupt is seen as positive self-control. More often than not, we are expected to notice subtle social cues of displeasure or sadness in order to be thought of as sensitive. The ability to organize and plan ahead is most likely preferred over the opposite forms of these behaviours. Much of what we desire is only offered after a period of waiting. Dessert is to be consumed after we have finished our main course, a test grade is not given for days or even weeks after the test has been written, and even a paycheque may come only twice a month. Hyperactivity is seen as a lack of maturity, only children may be excused from sitting through a church service or a movie at a cinema. Many of the social norms that are adhered to appear to be almost instinctual but in fact are unrecognisable by an adolescent with ADHD (Halverstadt, 1998). Further to this, what seems to be favourably recognised in our society is our ability to conform to the different societal norms which are present across different settings. What may be acceptable in social interaction among family may not hold true in school or our place of employment.

Most of us instinctively follow what Edward T. Hall (1959) refers to as the "hidden rules" (p.144) of our society. The literature review will provide evidence that

an adolescent diagnosed with ADHD is ill equipped to adjust to the age appropriate required societal norm.

Personal Agenda

Qualitative social inquiry requires meaningful interpretation of social experience and as such, it is important for the interpretivist, unlike the positivist researcher, to be a participant in the world which they seek to understand. The following section, which outlines my interest in the phase of adolescence and the behavioural disorder of ADHD, serves two purposes. First, in order to guard against possible biases in my research I have attempted to gain a strong understanding of the preconceived notions I harbour for this topic. Writing what I chose to label as my agenda has allowed me to explore my own adolescences and my work with students who have been diagnosed with ADHD. Second, my personal agenda permits the reader to appreciate my relationship with the topic.

My decision to become a teacher is directly related to my sometime unpleasant journey to this point. Often school was a distasteful job that I was forced to attend but was completely ill-suited for. I do not profess to always have been the best teacher I could have, but I do take pride in many of my efforts as a teacher. The children in our schools today are the adults that will shape our world in the future. I am amazed that this simple fact seems to be forgotten so often.

I don't believe I actually realised I could learn in an academic setting until 1993 at the age of 27. I don't believe I realised what a gift learning was and how exciting learning could be until that point. I often wonder where I would be if this

lesson had come earlier in life. My feelings of inferiority started early when I compared myself to my best friend who obviously had the knack for the school system. I labelled her as smart and myself as not smart in that world. I find it amusing that I am in the midst of my third university degree. Not because I have proven I am smarter, the number of degrees cannot tell me that. What I find amusing is that I am venturing down the path that I thought had been silently chosen for her and silently ruled out for me.

When I, by chance, run into the people who were blessed to have my less then pleasant disposition in their classroom I am amused by the shock on their faces when they learn where my life has taken me. I welcome their excitement and questions with a smile and wonder if they realise the effect they had on my choices. I wonder what their reaction would be if I told them, I chose to be a teacher because my education was less than enjoyable or enlightening. This is a moot point; my intention is not to place blame. I do not have a vendetta to change or show them the error of their ways. People work with the tools they have, they do the best they can. To place blame would be self-indulgent and serves no purpose. It is I who must take the responsibility for my journey. I will take comfort in the children I have touched and I will take comfort in the fact that I have tried to do the best I can to show the children I have known that they decide who they will become.

I am actually thankful for where I have come from. I do have memories of success in the classroom as a student. I distinctly remember being very proud of a fable I wrote in my middle school years. In my eyes, it was nothing short of brilliant. An insightful teacher allowed me to think this and even encouraged me. It is amazing

that this one success sticks out so clearly in my mind and the failures are all rolled into one big cloud. This is the reason I went into teaching. Children are resilient and have a lust for living that can be fed by the smallest victory. Victories can come in so many ways.

Farah, a beautiful girl with a tiny scar over her left eye, will never stray far from my memories. Her scar came from a hurried trip to a bomb shelter in the middle of the night when she was still a toddler. She had survived so much by the time she entered my grade 4 classroom. I called Farah a rat for a full school year due to my mispronunciation of her Arab name. She continually reassured me with a smile that she understood I could just not get my tongue around the breathy H at the end. Farah was a strong young woman who had not been taught how to give up. Even as I handed back yet another grade that did not quite make the passing 70% mark she would wait patiently for whatever advice I could give her. Farah is now successfully moving through her middle school years. Not many students have the strength that Farah has. I would love to have the opportunity to work with the Farahs in the school system but they are few and far between. I am certain Farah does not know the impact she has had on me. I am sure she doesn't know that her acceptance of me has taught me how important acceptance of the individual person is. My first experience of unconditional personal regard came from a child of 9 years old.

A more recent experience as a teacher didn't have such a happy ending. Although I did what I thought was best, there is a child that will not have fond memories of me. There is a child that will forever think of me as an evil person whose purpose in life was to remove him from school and take him away from his

friends. Shadi had never successfully fit into the private school system. In his six years in an American school, he had failed to learn enough English to hold even the simplest conversation completely in English. Each year Shadi was pushed forward for lack of a better alternative. After a month of sharing a classroom with him I was completely baffled. His challenges were far beyond my educational training. In October of the school year I told his parents I was concerned for his emotional stability. Shadi was a sensitive young boy and was all too aware that he was not like the other kids. At that point, a colleague of his father's quickly diagnosed Shadi with ADHD. In my opinion, Shadi did not have ADHD. Funnily enough, a friend recently asked me if I ever thought of Shadi. This friend was the same person who consoled me through the year and assured me I would forget Shadi by the first of July.

How does all this relate to what I am doing now? How did my own experience with education shape my desire to deal with the whole student? What is the relationship between the impact Farah and Shadi had on my desire to move into counselling? It is worth noting that as I wrote this, to describe the part of me that is intertwined with my research, I fell into a way of thinking that I have fought against much of my life. I have become overwhelmed with feelings of incompetence. I find myself thinking that I have no control over the relationships around me and that I am driven by rules set for me by some ubiquitous individual. This is precisely the feeling within children that causes the most pain for me as a professional educator. I want to attempt to empower children with the feeling of unconditional positive regard, as Farah did for me. I want to be in a position to facilitate a child's understanding of how they fit into a world that has been given to them without their consent, as I

struggled to do with Shadi. I want to work with the whole child and not only transfer knowledge of facts and figures. I want to be in a position to facilitate progress toward a whole person who understands his or her own self worth.

Motivated by a need to understand why I did not believe Shadi had ADHD, I read all I could on this disorder. What became painfully obvious to me is that children with ADHD are often confused by the troubles that seem to follow them. Most often, these are the children that are asked to leave the class. These are also the children who are lacking social skills to make and keep friends. I found myself thinking about students working through their daily frustrations of invoking such negative emotional reactions from the adults they interacted with. If I think back on my life I am hard pressed to figure out how I learned to cope with my shortcomings and weaknesses. The successful people in life are the ones who learn this early in life. Not only do we have to nurture our strengths but we also must be aware of how our weaknesses shape us. This observation led me back to the two years I taught grade seven. Puberty, for some, is a tough time at best but to add a disorder like ADHD makes it even more difficult. I believe children with behavioural disorders can learn to cope with their weaknesses.

Children with ADHD are often told they could do better if they would only try. Academically and emotionally they can get by in elementary school. Many teachers are now willing to give extra time and more structured activities to children who have been diagnosed with ADHD. Frustration can start to build in the early middle school years as the academic demands increase and they leave the safety of a homeroom. The primary characteristics of ADHD are inattention, hyperactivity and

impulsivity. Many who have been diagnosed with ADHD also suffer from comorbid disorders. To most it would appear that adolescents with ADHD could do better if they tried, but what is often missed is that they are trying. Students are often as confused as teachers at their inability to achieve in the classroom. Much of their world is black and white, they are incapable of dealing with the many grey areas in life. All things considered, it is no wonder they are likely to have conflicts with parents, teachers and other authority figures. There are many resources to help the teacher and the parents cope. It seems strange to me that we haven't addressed the fact that the adolescent must learn to cope also.

In summary, my desire to explore ADHD from the eyes of an adolescent is threefold. First, I believe my own struggles during adolescence have made this age group one with which I am most able to empathise and relate. Second, my eagerness to understand Shadi's problems inspired me to investigate a disorder I knew relatively little about. And finally, perhaps most importantly, Farah's total acceptance taught me that to see the person and not the inabilities which is a more rewarding experience.

Research Considerations

Before proceeding with this study, there where two possible biases which I investigated to ensure the reliability of my data. One of the fundamental intentions of my research was to gain knowledge that would better enable me, as a counsellor, to work with adolescents. This intention, coupled with my own experience of adolescence implies a belief on my part, that adolescence is a time of turmoil and frustration. It was necessary for me to consciously separate my experience from the

experiences of the participants. Awareness of this bias was the first step to not allowing it to dictate the results. Another precaution was to pay special attention to any questions I prepare prior to the interview. I devised neutral, non-leading questions that invited the participants to share the experiences they felt were significant to the study. Finally, each interview was transcribed and reviewed before the next interview. Each participant was invited to review the transcripts to ensure they had not been misrepresented and to give them the opportunity to expand on ideas expressed in the first interview.

The second bias that I attended to was also linked to my intentions. The nature of qualitative research does not allow for generalizations to the population to which the participants belong. Further to this, the information I gathered on ADHD and adolescence, whether through research or experience, could not be directly transferred to the participants as fact for them. Although my desire was to enhance my knowledge and therefore my skills, I invited the participants to voice their experiences to insure my preconceived notions did not direct the patterns that developed. It was important that I remained open to the experiences that were not congruent with the profile of ADHD I have developed through my work and through my research. Again, careful analysis of the transcriptions and the knowledge of this possible bias allowed me, in confidence, to insure the reliability of the data.

CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

Research provides ample evidence to support concern for the future of children and adolescents with ADHD. It is apparent that children with ADHD are more apt to develop significant behavioural problems with more negative long-term outcomes. In order to provide the reader with a basic understanding of ADHD a brief description of prevalence, etiology, and comorbidity is discussed. More pertinent to this study are the characteristics and outward behaviours of ADHD and will be discussed in depth. In summary, current treatment models will be provided.

Prevalence

Researchers and clinicians estimate that 3%-5% of school age children exhibit ADHD symptoms (Barkley, 1998; Hallowell & Ratey, 1994). ADHD is considered the most common form of psychopathology in childhood (Brown, 2000; Coleman & Levine, 1988; Jensen, Mrasek, Knapp, Steinberg, Pferrer, Schowalter & Shapiro, 1997). Although onset of symptoms often occur in the pre-school years, children are not usually diagnosed until the criteria for diagnosis is satisfied in the home environment as well as in the school environment. One third of children diagnosed with ADHD continue to display symptoms into adolescence, another one third experience symptoms, although less severe, into adulthood (Stein, Shafer, Elliot & Levine, 1999). Sam Goldstein (1997) goes further to say that the majority of individuals continue to exhibit symptoms into adulthood.

Etiology

The disorder appears to be more evident in the male population with a ratio of females to males ranging from 1:6 to 1:9 (Guab & Carlson, 1997). One possible theory for the discrepancy is that many females fit the criteria for ADHD-I (predominately inattentive), which often goes unnoticed due to the absence of acting out behaviour (Biederman, 1998; Brown, 2000; Guab et al, 1997). Research in the past has been focused on the male population, which leaves the information available on females with the disorder inconclusive (Biederman, 1998; Guab et al, 1997, McGee & Feehan, 1991). The little research available does not suggest there are significant differences in etiological pathways or symptoms between the sexes (McGee et al., 1991). Many clinicians, including Barkley (1998), believe that ADHD is under-diagnosed in females (McGee et al., 1991).

Traditionally, children diagnosed with ADHD were thought to have come from a disorganised, unstructured home life and were lacking in strong parental guidance (Goldstein, 1997; Teeter, 1998). Nutrition and poor diet were also thought to contribute to ADHD but research has provided lack of significant evidence to substantiate this (Dulcan & Benson, 1997). Environmental factors such as poor parenting or educational practices are not considered to cause ADHD but many clinicians believe the ineffective management of children with ADHD will exacerbate symptoms (Barkley, 1998). Etiology research shows strong support to indicate ADHD is in fact a heritable disorder (Brown, 2000; Goodman & Stevenson, 1989). Most notably, a study revealing prevalence of the disorder between twins as well as a study showing higher incidences among biological relatives than adoptive relatives

(Biederman, 1998). In an earlier study, reported in the same article, Biederman noted that the risk of ADHD in offspring if a parent has ADHD is 57%. Goodman and Stevenson (1989) found that nongenetic factors attributed to less than 10-15% of ADHD symptoms. A number of studies have reported significant differences in activity levels and structure of the frontal lobe of the brain of individuals with ADHD (Brown, 2000; Goldstein, 1997; Teeter, 1998). In summary, strong evidence exists to demonstrate that ADHD is a neurobiological disorder.

Comorbidity

ADHD has been demonstrated to be the most likely disorder to co-occur with Conduct Disorder (Stahl & Clarizio, 1999), which is characterized by extreme behaviour that violates the basic rights of other human beings (DSM-IV, 1994). In addition, 65% of adolescents diagnosed with ADHD are also diagnosed with Oppositional Defiant Disorder and 35% are diagnosed with Conduct Disorder (Zeigler-Dendy, 1995). Tourette's Syndrome is also a concern, 60-80% of children diagnosed are diagnosed with ADHD as well (Zeigler-Denny, 1995). Interestingly enough, ADHD symptoms proceed Tourette's symptoms, on average, by 2.5 years. More recently, research studies have broadened the scope of comorbid disorders to include mood and anxiety disorders (Biederman, Faraone, & Milberger, 1997; Pliszka, Carlson, & Swanson, 1999).

Characteristics

Of more importance to the nature of this study is the outward behaviours exhibited by children with ADHD. As noted previously, inattention, hyperactivity and impulsivity are the dominating characteristics of ADHD. Biederman (1998) notes that children are at risk for developing other psychiatric disorders in adolescence and adulthood. Problems manifested in adolescence and adulthood have been documented to result in increased family disruptions, increased substance abuse, criminality, job failure and divorce (Faigel et al., 1995; Stein et al., 1999). A study, which compared juvenile convictions of participants with ADHD and a control group without ADHD, found that the rate of convictions was 24% and 12.6% respectively (Pliszka et al., 1999).

Studies demonstrate that an adolescent with ADHD is at risk for academic underachievement (Goldstein, 1997; Faigel et al., 1995). In a longitudinal study (Barkley, Fischer, Edelbrock & Smallish, 1990), Barkley noted that the academic performance of adolescents who where hyperactive was significantly lower than a non-hyperactive control group. At least 3 times as many adolescents who where hyperactive failed a grade or were suspended. At a follow-up point in the study, 10% of adolescents who were hyperactive had dropped out of school compared to none in the control group.

Adolescents with ADHD are in a high-risk group for poor peer relations. In fact, one study argues that poor peer relations should serve as a defining characteristic for diagnosis (Landau, Milich & Diener, 1998). Barkley (1998) estimates the social development of adolescents with ADHD is approximately 30% behind their peers.

Despite attempts to engage in social interaction, adolescents with ADHD are often rejected by their peers and as a result spend more time alone than adolescents without ADHD (Landau et al., 1998). Characteristics also limit participation in extracurricular activities (Zeigler-Deny, 1995; Stein et al., 1999; Faigel et al., 1995). Ample research indicates that adolescents with ADHD are lacking the opportunity to develop intimate interpersonal relationships (e.g., Barkley, 1998:Landau et al., 1998; Zeigler-Deny, 1995). The added strain of the disorder on families indicates that the home environment may not provide positive relationships with family members (e.g., Faigel et al., 1995; Stein et al., 1999).

The concept of self becomes of importance in the stage of adolescence. Many adolescents with ADHD receive more negative than positive feedback due to the consequences of inattentiveness, hyperactivity and impulsivity (Barkley, 1998). Lack of positive reinforcement coupled with visits to a psychologist, counsellor or resource teacher can easily become indicators for the adolescent's failures and weakness. Adolescents with ADHD are often labelled as trouble-makers, dumb or lazy and are told they could do better if they tried (Faigel et al., 1995). Judith Stern and Uzi Ben-Ami (ATTENTION!, 1998), noted that children are often not given information regarding the nature of their diagnoses.

Disregarding the positive effects of medication on behaviour and academics, many adolescents will often prematurely discontinue use (Faigel et al., 1995; Stein et al., 1999). Arthur L. Robin (Barkley, 1998) suggests that virtually all adolescents with ADHD resist taking stimulant medications, whether or not they have had positive experiences with it throughout their younger years. This could be attributed

to the characteristics of adolescence in which they desire greater autonomy and a need to assert their independence. Others may discontinue medication because they do not want to be different from their peers or due to recent success they believe that they no longer need the pills (Faigel et al., 1995). Still others may simply refuse any treatment that is imposed by adults (Barkley, 1998).

Conflicting reports have been given on the occurrence of substance abuse. Some research reports that adolescents with ADHD are at a higher risk of becoming substance abusers (Thompson, Riggs, Mikulich & Crowley, 1996). Other studies, however, found that adolescents with ADHD were at no greater risk than their peers for substance abuse when medications are administered appropriately (Barkley et al., 1990; Biederman, 1998: Pliszka et al., 1999). What proves even more confusing is that adolescents with ADHD appear more apt to be cigarette smokers (Barkley et al., 1990) and if they do become substance abusers their abuse is more severe than their peers without ADHD (Pliszka et al., 1999). Despite lack of evidence there is still a belief that medication will stimulate an addiction problem (Faigel et al., 1995).

Current Interventions

Treatment of ADHD is best served by using a multimodal approach (Barkley, 1998; Faigel et al., 1995; Dulcan & Benson, 1997; Landau et al., 1998; Stein et al., 1999; Zeigler-Dendy, 1995). Pharmacological intervention is typically the first step to reduce hyperactivity, distractibility, and inattentiveness (Faigel et al., 1995; Zeigler-Dendy, 1995). Research indicates that stimulant medications are successful in 70 to 96% of individuals with ADHD (Dulcan & Benson, 1997; Faigel et al., 1995;

Frankel, Myatt, Cantwell & Feinberg, 1997). Stimulants most commonly used are methylphenidate (Ritalin), dextroamphetamine (Dexedrine) and pemoline (Cylert). Tricyclic antidepressants provide an alternative medication to stimulants (Faigel et al., 1995; Geller, Reising, Leonard, Riddle, & Walsh, 1999).

Concurrently with medication, both child and parents should be involved in psychoeducational counselling (Banez & Overstreet, 1998). Both behavioural modification and cognitive therapy strategies can be used. Barkley (1998) has developed a comprehensive parenting program, which focuses on positive attending, ignoring negative behaviours, giving effective commands and using a token-based contingency discipline program. Although the first part of the program is recommended for all individuals with ADHD, the token system is not suited for adolescence. Finally, because ADHD symptoms are evident across all settings, school based interventions with the teachers involvement is also necessary (Faigel et al., 1995; Stein et al., 1999; Zeigler-Dendy, 1995).

Involving the adolescent as an active participant in the treatment process has proven to be a necessity for successful intervention (Faigel et al., 1995; Stein et al., 1999; Stern & Ben-Ami., 1998; Zeigler-Dendy, 1995). Arthur L. Robin (Barkley, 1998) suggests individual counselling sessions to assist the adolescent dealing with issues relating to self-esteem, depression and sexuality. As mentioned previously, many clinicians recommend the need for a reliable and valid assessment procedure for adolescents. Research has shown that self-reports are not effective (Danckaerts et al., 1999).

In summary, research provides strong evidence that when the problems associated with ADHD are added to developmental issues, adolescence can prove to be a challenge for teachers, parents and the individual. The associated features of ADHD hinder the successful mastering of developmental tasks as well as magnify unpleasant conflicts with authority figures. As noted previously, adolescents with ADHD are at risk of developing the more detrimental symptoms of Conduct Disorder. The fact that many adolescents discontinue treatment is even more cause for alarm.

CHAPTER 3: METHODOLOGY & METHOD

Interpretive Interactionism

My inquiry is based on an approach to social research which Norman Denzin (1989) coined interpretive interactionism. While still in the initial stages of attempting to understand what exactly ADHD was, I happened on Denzin's book, *Interpretive Interactionism*. As I read, I realized I was reading the concepts that I was basing my research on but was unable to articulate. I had a *feeling* for what my passion was leading me to. In my mind, I understood why I needed to become more familiar with the phenomenon of ADHD. But I simply could not explain or defend my research to my satisfaction. As I continued with Denzin's work, I was relieved and a little unsettled to find, written in black and white, what I was in the process of unravelling in my mind.

The basic assumptions of interpretive interactionism are consistent with how I understand my role as a counsellor. If I am to be effective working with a specific population, in my case adolescents with ADHD, I must first attempt to gain an understanding of how they perceive their experiences. Interpretive interactionism, in its basic design, investigates the interrelationship between private lives and public responses to personal troubles. ADHD is a personal trouble which instigates a public response. In order to supply a marginalized population, such as adolescents diagnosed as ADHD, with support I must first understand ADHD from the point of view of someone who has experienced ADHD personally.

Interpretive interactionism endeavours to bring to the reader the stories of those being studied by capturing their voices, actions and emotions (Denzin, 1989). Denzin contends that:

> The perspectives and experiences of those persons who are served by applied programs must be grasped, interpreted, and understood if solid, effective, applied programs are to be put into place. (p. 105)

Research and personal experience has brought to light my need to better understand the perspectives and experiences of adolescents with ADHD if I am to be effective working with them.

Interpretive evaluation seeks to provide research that can be used to assess the effectiveness of programs developed to benefit marginalized groups. Pure interpretive work attempts to provide meaningful interpretations of social interactions which can be used to inform interpretive evaluation. The premise of interpretive interactionism is based on the importance of interpretations and understanding in social life. Denzin goes so far as to say, "In social life, there is only interpretation." (1989, p. 11).

Interpretive interactionism is an evaluative research method which aims to ensure that people in positions of decision making do not mistake their experiences for the experiences of those they serve. The tendency to misinterpret and to make judgements based on one's own experiences leads to policies and practices that are not based on the experiences of the persons they are developed to assist. One such example is the practice of permitting students who have been diagnosed with ADHD twice the allotted time to complete standardized tests. As a supervisor for standardized testing, I have observed that extending the time for a student who is

inattentive or hyperactive does not make it easier for them to complete the task. Other allowances must be made along with the extended time period. Students have requested the opportunity to move around or take short breaks during the test. Unfortunately, the policies followed for administering standardized testing do not permit these allowances if the results are to be considered valid. It appears that the policy described above was developed based on judgements that were not grounded in the experiences of students with ADHD.

The interpretive interactionist conducts the inquiry from the point of view of the persons being studied. That is not to say that the point of view of other individuals involved, or rather the public responses, are not considered in the inquiry. My research focused on two adolescent boys who are in a position to graduate from high school and continue with post-secondary education. I have attempted to bring their experiences as adolescents with ADHD to the reader. In true interpretive interactionism style, combining their experiences with the experiences of those involved in the boys' lives, such as family, friends and teachers, would compliment the data I have gathered.

The researcher's main concern is "the life experiences that radically alter and shape the meanings persons give to themselves and their life projects." (Denzin, 1989, p. 14) What Denzin describes as "transformational experiences" or "epiphanies" (p. 15) becomes the focus of the research. In the process of recording the participant's experiences, moments of crisis or epiphanies, are better understood and turning points are discovered.

Denzin cites four types of epiphanies: the major, the cumulation, the minor and the relived. The major epiphanies are situations which forever alter a person's life. An example of this may be a near death experience. A series of events, which result in a change in attitudes or lifestyle, are referred to as cumulation epiphanies. A minor or illuminative epiphany exists when underlying tensions or problems are revealed. A person who experiences a relived epiphany actually relives a crisis moment from his or her past. The researcher works backwards from public to personal in an attempt to locate epiphanies in interactional situations where personal troubles have become public issues.

Denzin breaks the interpretive process down into six steps: framing the research question, deconstruction, capturing, bracketing, construction and contextualizing.

Deconstruction

The initial stages of my research involved what Denzin would consider deconstruction. He refers to "a deconstructive reading' (Denzin, 1989, p.51) of the phenomenon, in this case ADHD. In the beginning, the purpose was to become knowledgeable of the etiology, symptomatology and interventions regarding ADHD. As I progressed, I pieced together definitions, observations and analyses to gain a better understanding of how ADHD is conceptualized by teachers, caregivers, and mental health workers. I was struck by the differences in the literature depending on the author's relationship to the disorder. The research papers written by clinicians, who have not been diagnosed with ADHD, had a definite negative tone as compared

to the books and articles written by individuals with ADHD. The latter, written by individuals who have been diagnosed with ADHD or had children or siblings with ADHD, were optimistic in their prognosis of life with ADHD. An excellent example of this difference in attitudes is Edward Hallowell's (1994) choice of adjectives to describe an individual with ADHD which is included in the introduction of this thesis. Along with expanding my knowledge of ADHD, a thorough deconstruction of the literature revealed that little had been written using the voice of the adolescent.

The Research Question

As I continued my research, I began to question how the adolescent perceived the disorder. I did not want to focus on why 35% of students with ADHD develop Conduct Disorder or why they suffer from poor peer relations. There was ample academic literature that explained etiology, symptomatology and possible interventions. In spite of the availability of stacks of literature, the clinicians I had the opportunity to work with continued to be troubled by the fact that adolescents were not seeking or continuing with assisted interventions. Interpretive interactionism seeks to ask not why but how such experiences or situations occur. A statement such as this in Denzin's book cased an epiphany of sorts for me. My research question, how do adolescents diagnosed with ADHD perceive their successes and failures in adjusting their behaviours to a non-ADHD world, did not seem to fit until I read this statement. Instead of *why*, the interpretist asks, "*how* is social experience, or a sequence of social interaction organized, perceived and constructed by differentially wide-awake, self-reflective, socially constrained, free individuals?" (Denzin, 1989).

Answering the how question in this situation, will allow me to use the experiences of an adolescent with ADHD, rather then my experiences, to best assess their needs.

Capturing

Capturing the phenomenon involved, in this case, collecting personal experiences of two adolescents who had been diagnosed with ADHD. In order to access the student population in the Annapolis Valley Regional School Board I first gained permission from Dr. James Gunn, Superintendent of Schools, to contact the local schools. Three possible participants were located through counsellors in five local schools. Two young men fit the criteria: each had been diagnosed by a child psychologist, each were in grade 12 and each were anticipating graduation. A psychologist had not officially diagnosed the third possible participant, a young woman, with ADHD.

Before they were identified, the two possible participants were given a Student Questionnaire (see Appendix B) by their guidance counsellor. The purpose of the questionnaire was to ensure that a psychologist had diagnosed the participants and to gather information on the process. After their legal guardians had signed the questionnaire, I met with each participant to explain the research process and to give them the opportunity to ask questions or voice concerns. The two participants agreed to continue and were given the final Permission Letter (see Appendix C) to have signed by their guardian.

The method of data collection was semi-structured individual interviews. Although an interview guide (see Appendix D) was used to initiate conversation, each

participant was encouraged to discuss what he deemed instrumental in enabling him to move through his education. The first interviews were held in the guidance counsellor's office. The second interviews were held in a small room off the school's biology lab. Each location provided sufficient privacy to converse freely. Each interview lasted 60 minutes except for the final interview with Joe, which lasted 75 minutes. The first interview was transcribed and analysed immediately and provided the starting point for the second interview. The participants were given the opportunity to review the interview transcript or audiotape and to make changes.

In order to capture the phenomenon, Denzin states that multiple personal and self-stories must be obtained from the participants. By asking open-ended questions and allowing the young men to speak freely, each was given the opportunity to share their experience of growing up with ADHD. The stories they shared offered me the opportunity to identify experiences that shaped their development.

In a meta-analysis of follow up studies of children with ADHD, Hechtman (1991) states that following up with children with a certain disorder can serve two purposes. First, the study can provide a view of the condition's natural history and prognosis. Second, the study can provide information on how the condition manifests itself in adolescence and adulthood. More importantly to my research, a follow up study could provide information that speaks to the factors that may have influenced positive outcomes.

Bracketing

The fourth stage of the interpretive process involves examining the phenomenon through the stories of the participants. Bracketing uses the text to dissect the information away from the world in which it occurs. The preconceptions that were discovered in the deconstruction stage of the research are suspended as much as possible at this stage of the process. The researcher attempts to confront only the subject matter made available by the participants.

Each transcript was analyzed for descriptions and meanings. Twenty-four codes were finalized by identifying the different segments of the text. The second interview was used to allow the participants to offer their interpretations of the topics discussed in the first interview. For instance, David's discussion concerning the supportive people in his life initially focused on his grandparents with only a brief mention of his mother. When David and I discussed his responses from the first interview he elaborated on how his mother's support had been very important to him. By analysing the text I was able to ascertain that David considered the support he received from his mother tremendously important. Through further discussion with regard to support, David added, "Mom was always there and she would...kinda go with my shape more or less", giving the impression that his mother's support had been so constant he almost neglected to mention it.

Construction

The second to the last step uses the codes identified through bracketing to build or construct categories. "If bracketing takes something apart, construction puts

it back together." (Denzin 1989, p. 58) In order to identify the categories which arose from conversations with the young men, I literally used the codes as pieces of a puzzle. Each code was written on a cue card which represented a piece of the puzzle. I looked for commonalities within the codes and grouped them together. Piecing together the codes with other similar codes identified six categories: symptoms, description, medication, academics, strategies, and finally, understanding and support. In this case I use the word *category* instead of the word *theme* as Denzin would use. The categories represented the topics of conversation which arose repeatedly. Subsequently, within each category themes emerged. For example, as David and Joe described their symptoms to me, it became apparent that their symptoms were part of them and not part of ADHD: I am restless, as opposed to, one of my symptoms is restlessness.

In summary, the coding and analysis was broken into three steps. First, the transcriptions were examined for codes. The codes represented the main idea of each segment of text. Second, the codes were pieced together based on similarities to form the main categories that emerged from conversations with Joe and David. Finally, within the categories, themes become apparent. The themes provided a better understanding for how Joe and David perceive their successes and failures in adjusting their behaviours to a non-ADHD world.

Contextualization

As the word implies, contextualization puts the themes, which were revealed in the earlier stages of the study, back in the context of the natural social world.

"[Contextualization] brings [the] phenomenon alive in the world of interacting individuals." (Denzin, 1989, p. 60) To reveal the phenomenon, as the participants perceive it, I have written their words in a style that can be considered a story. Denzin states that the experiences must be presented "in their terms, in their language, and in their emotions." (p. 60).

Although I used an interview guide to stimulate conversation, each young man was given the freedom to discuss what they thought was relevant: an attempt to allow the participants to produce the stories in their terms. Including their words verbatim posed a problem. In parts, the text is hard to read because of the colloquial forms of speech and inconsistency in their thoughts. I chose to include their words in complete segments, as much as possible, rather than providing continuous clarification within parenthesis or dropping the yeahs, ahs, and ums: an attempt to allow the participants to produce the stories in their own words. My intention was to give the reader the opportunity to gain insight to David and Joe's personalities, which in this case, could only be offered through their verbatim speech. During our discussions I remained sensitive to body language and inflections in their speech. A laugh, a sigh, or a rolling movement of their eyes identified a topic which evoked strong feelings with them. Using these indicators as a guide would allow me to further investigate feelings that the two young men did not readily identify or articulate: an attempt to allow the participants to produce the stories in their own emotions.

The initial stage of contextualization offers the stories in the participant's words. As I wrote I remained sensitive to the fact that, although I was providing their words, I was still using my judgement as to what words to offer the reader. To the

best of my ability I have remained an *objective vehicle* in which David and Joe's stories have been delivered. As an interpretive researcher, it was my goal to understand the subject better than they understand themselves. I have used a method to interpret, which the participants would not typically employ. I have gathered information that encompasses many years of their lives, information that the participants would not routinely compile and analysis. Based on this course of action, I have been able to investigate the "transformational experiences" or "epiphanies" (Denzin, 1989, p. 15) which have altered their lives.

"Interpretive interactionism asserts that meaningful interpretations of human experience can only come from those persons who have thoroughly immersed themselves in the phenomenon they wish to interpret and understand." (Denzin, 1989, p. 133) My preoccupations with my own adolescence, my career as a teacher, and my research of the phenomenon of ADHD permits me to attempt to provide meaningful interpretations. My inquiry has provided me with information which I may use to be a more effective counsellor. "The interpretivist rejects generalizations as a goal and never aims to draw randomly selected samples of human experience." (p. 133) And as such, I do not assume this is the end of my journey or that of the readers.

CHAPTER 4: DAVID & JOE

Diagnosis

Both participants were diagnosed with ADHD at the age of nine by a psychologist. David's diagnosis took place over a two-month period with weekly visits to the local mental health clinic. He began taking Ritalin at the time of diagnosis. Follow-up appointments with his family physician consisted of evaluation of weight gain and other related health issues. Neither David nor his mother could remember more details around the events of this time. From conversations with David it appears that the cause for concern arose from his behaviour in school.

Joe's behaviour, on the other hand, seemed to be more problematic at home. At the request of Joe's mother, Joe was observed at school by a mental health clinician. The process of diagnosis continued with an undetermined number of visits to the local mental health clinic. Joe's parents did not seek pharmacological treatment at the time of diagnosis, rather Joe's father attended parenting courses on how to best manage Joe's behaviour.

It is unclear which subtype each was diagnosed with possibly due to the newness of the current terminology. David describes behaviour that most resembles an inattentive type. He does not describe clinical hyperactivity but does mention situations when his actions would be considered impulsive. He once described his behaviour as "out of control". Joe, on the other hand, clearly describes behaviour which would today be considered the combined type of ADHD. His symptoms at present still include clinical hyperactivity and impulsivity.

David discontinued medication in grade 7 because both he and his mother felt it was no longer providing any benefits. Joe's mother described junior high school as 'too overwhelming' for Joe and he began taking medication in grade 7 to alleviate his symptoms.

You Just Gotta Cope

A simple *afterthought* is the best way to describe how the two young men who participated in this study identified their diagnosis of ADHD. Each was willing to aid me in my research on ADHD but both were unsure of what exactly they had to offer to my inquiry. Both would agree that ADHD had played a role in their lives and further, they could identify many of the typical symptoms manifested in adolescents. However, the strong impression that both young men gave was that the symptoms were part of their identity and not part of the identity of the disorder. Neither talked of behaviours that may be indicative of their diagnoses both simply related stories of the way things were in their lives. What came up repeatedly is what I soon started to call their *just gotta cope attitude*. David clearly describes this mindset.

> **Birdie:** How did it affect you and your family when you were diagnosed with ADHD?
>
> **David:** Ah, well [it's] about the same as anything. What are you going to do? Really. I think that was her attitude [mother], the same as mine. Like, what do you do? You can't just wait to next week, like a cold that goes away. It's here, don't worry about it. How are you going to get rid of it? ... Well don't worry about it.

Birdie: Do you feel like you are David with ADHD?

David: No, I don't think about that anymore.

Birdie: So it's not even part of you anymore?

David: No. I think I just learned, learned to deal with it and here I am.

David did not find it easy to reflect on how this attitude was fostered in him. Although he had the impression that this was his mother's initial response to his diagnosis, he did not feel this was a typical response for her or other members of his family.

Birdie: Where do you think you got that [this attitude]?

David: Ah, I couldn't tell ya, cause my mom's not like that. She blats about ever little thing.... How are you going to get rid of it? Well you can't, don't worry about it. That's my dad's... he's somewhat like that but I wouldn't say nowhere near me, I wouldn't say.

This attitude in no way suggested a sense of helplessness, rather a strong appreciation of his strength and weaknesses. David showed a keen understanding of his abilities within and outside of the academic realm.

> Like I could sit here and read a science book all day and then shut it and then you ask me questions and I would have no idea what you were talkin' about. But most stuff about entrepreneurship and I could probably tell you without, without even thinking about it. That's just the way it is.... Like driving' a standard car. I could drive a standard before I even got my license just as good as anybody else. And I've never driven before.

For Joe, the more hyperactive of the two participants, controlling his inability to focus was no longer a priority.

> And like, you can't concentrate... you can't make yourself do what you wanna do. So you just have to let yourself go and hope it passes. ...it's just, I don't know. It's weird.... I'm sick and tired of tryin' to hold myself back, so you just, you give up and it's like, whatever.

Again, for Joe, there is a strong sense of this *just gotta cope* attitude.

> Just take it as it comes usually, like. Yeah, just take it as it comes.... I have never really said, well I am really hyper today; I should go do somethin'. I would just wake up and it would be subconsciously just, let's do somethin'.

Symptoms

Although both David and Joe did not seem to be preoccupied with the way in which ADHD was manifested in their behaviour, each easily gave vivid descriptions of their past and present symptomatology.

When David reflects on his behaviour, his most obvious frustration was his inability to focus his attention on one task.

> When I was in school workin' and the bell would ring... I just went, throw my books and I'm gone. [The teachers] wouldn't' know where I was at and what I was doin'.

Although for David, this symptom was more prevalent in childhood, it is perhaps more of an aggravation for him as an adolescent.

David: Just like, to me, the real thing that stuck out in my mind was [being] very unfocused and ah, outspoken is not the right word because you aren't old enough to use you that word, just very unfocused.... One minute you would be very [focused]...you change a lot. Like your mind would just be, your mind would be [pause], you were workin' on something like a bike over here and then leave it and then go somewhere else, right. Just forget it. Forgetful, about stuff like that. You were interested in somethin' one time and a couple of days later you weren't interested in it.

Birdie: That must be frustrating.

David: Oh yeah, very. And that, still goes on to some, some degree now. My mind was [is] in other places when I was supposed to be doin' what was here, right.

It almost appeared impossible for David to describe coherently this lack of ability to focus to his satisfaction. He likens this feeling to boredom, a boredom that he often does not share with others.

I don't take it to the extent that I guess I used to. Like now you get a little bored and you are like, all right, all right, just, you know, just forget about it and it doesn't usually get, like it happens maybe once every two months or something and you think it in your head. You don't say anything. You know, kinda pass it over...

David also seemed frustrated by his inability to remember information if the topic at hand did not interest him. He was very clear that his inability to remember things was

directly related to how involved he was with the information. "I can't remember anything unless I am interested."

He goes on to explain the subjects in school that he was able to do well in and how each had something specific that could maintain his interest. On the other hand, he very easily articulated what lost his interest in his academic studies. He was not willing to attribute this to ADHD.

David: So unless I am interested in it I cannot remember anything. I don't know why.

Birdie: Do you think it is a bigger struggle to stay with something that you are not interested in than for somebody who doesn't have ADHD?

David: I don't know. I don't know for sure.... That's just the way it is.

Throughout our conversations, David used the phrase, "That's just the way it is", repeatedly to explain his situation in life.

Both young men spoke of their strong inclination to speak or act first and think later. Dr. Robert Brooks (Zeigler-Dendy, 1995) cleverly uses the phrase, *Ready, Fire, Aim, Oops!* to describe impulsive behaviour to friends, parents and teachers of individuals with ADHD.

Joe: Oh yeah, all the time. I, I never think before I say any[thing], well now I do but before like, probably a year or two ago I just, I was always saying stuff that I shouldn't of said. Yeah, a year or two ago. Like I still do it. I just, somethin' will pop in my head, like a smart remark or just somethin' stupid and I'll say it. And then I'll think afterwards, I'll be like, why did I say that?

David: Like I usually think, like I do that and I think, oh my God, what did I say that for, I'm in big trouble now.

For David, this tendency seemed to climax in grade 8.

I was kind of, you know, comin' to school and, I don't know, I did a lot, I did a lot of stuff for no reason. That was my biggest thing. I couldn't understand it. I thought about it afterwards and I was like, why did I do that? There was no point. That is the way I am now. I'm a big person on why do people do stuff...[when] there is no point to it.

Joe still finds his impulsivity a concern. Although the severity of impulsive behaviour was greater in childhood, as an adolescent the consequences of this behaviour often pose a greater problem. Joe describes a recent situation where he was instrumental in putting another young man in a situation where he could have been seriously harmed. Egged on by one of his friends, Joe called the young man to ask him to come party knowing that there were people at the party who did not like him.

And I just did it for somethin' to do and he got worked over and he got beat up pretty bad. And like, I don't know, he, he's goin' out with one of my good friends too so that didn't work out...but I patched things up. But I didn't even think about what was gonna happen. I's just like, yeah, this might be kind of cool, so I did it.

Joe does not consider himself a fighter and did not physically take part in the fight with the young man he mentioned. He still feels a sense of responsibility for the result. He attributes the fact that his friend did not harbour anger towards him to luck.

> ...and like I talked to the, the girl and she was like, I'm still mad at you and all this stuff. And I's like, yeah and you should be. And she was like yeah but I think we can still be friends and all this stuff and I's like, yeah cool man.

This situation is what Dr. David Rabiner of Duke University describes as one of the distinguishing characteristics between ADHD and more serious behaviour disorders such as Oppositional Defiant Disorder and Conduct Disorder. The symptoms of ADHD do not involve behaviour that is deliberate and wilful. In this situation, Joe's intention was not to cause harm to anyone but rather to satisfy his need for stimulation. His thoughtlessness or rather his inability to think things through was, in fact, more of a quest for something "kinda cool" to do.

As relationships become more complex the inability to monitor what they say becomes more challenging and the repercussions become more severe. David explains that his girlfriend of four years has learned to adapt to what he refers to as his style.

> Like I think she [girlfriend] has adapted pretty good. Like she knows my style I guess you would say...and [she] knows that I usually,...say stuff without thinkin' about it...I've never, never really had to explain anything [symptoms]. Like she knows my moods and knows that I do that. I don't know, maybe she hasn't even though about it, but I mean that is the way I see it anyway.

Joe uses the term 'zone out' to describe his inattentive behaviour. This scenario below describes a school situation but this type of behaviour was not isolated to the school environment.

Joe: I'd sit there and I'd like, I'd zone out, and like I'd just, for two or three minutes at a time like, every ten, fifteen minutes and I'd just, I'd look at somethin' and I'd just not hear anything around me. And then like, I wouldn't know what was goin' on in class cause the teacher just explained it or somethin' and then I'd just be like, I don't know how to do this stuff so I'd turn around and talk to somebody or I'd be doodlin' on my paper, never payin' attention.

Birdie: Is there any kind of physical feeling to what you are describing? Can you feel it in you body or mind?

Joe: Um, it's just a feeling like, if I'm, like if I'm at home, like really, really bored and I didn't take my pill or whatever I'll just...sit there and I'll be like, I gotta do somethin'. Like it just, it drives me nuts to sit there and not do somethin'. Like it is a gut feelin' like you just have to do somethin'. Anything, anything that gets the energy out. Anything.

Joe identifies with a young boy whom he believes had ADHD.

Joe: Like he'll say, "give me a hug", and you'll give him a hug and he'll just latch on and won't let go and he'll scrape ya and just, he just all out goes...

Birdie: So how are you with this little kid?

Joe: Well I, I'm good, like, I think it is good because I know what he's going through. Like I know how crazy it can be and that you just can't stop.... And I also have the energy to stick to him and like do things he wants to do.

Even with Joe's ability to empathize he still finds the young boy's behaviour frustrating. As he spoke, he immediately became aware of how his mother may have felt at times when she was trying to keep up with him.

> It, it gets annoying...it gets to the point where you just can't stand it after awhile...you just want to wring him.... But I imagine she [Joe's mother] felt like that too a lot of times.

Joe described his behaviour in grade 7, just before he started pharmacological treatment. He again seemed to have an understanding of the impact of his actions on the people around him.

> **Joe:**...she was a good teacher but I was pretty horrible in her class.
>
> **Birdie:** How were you horrible?
>
> **Joe:** Everything. I's just nuts, wouldn't pay attention, never had my homework done, my binders were a complete mess, could never find anything and stuff like that.

Risk-taking is a well known characteristic of young men with ADHD (Faigel et al., 1995; Landau et al., 1998; Ziegler-Dendy, 1995). David does not consider himself a risk taker. He seems to prefer to observe the actions of others and learn through their mistakes. "So I'd rather think in my head for a minute, how I could handle somethin' rather than just do somethin' and fight and argue about it after." Joe, on the other hand, epitomizes risk taking behaviour.

> **Joe:** Like it doesn't take much coaxin' to get me to do somethin'.
>
> **Birdie:** You're a risk taker, hey? You jump off cliffs into ponds and...
>
> **Joe:** Oh yeah, literally.

Birdie: What about driving? Do you have your license?

Joe: Yeah, I'm a good driver but I drive fast and, I don't know, I'm just, I always feel like I am in a rush to go somewhere and I'm not.

Birdie: Even when you are on medication?

Joe: Yeah. It's just, I, I just love driving. My dad loved drivin'. He had an old muscle car that I wish I still had. But I would have killed myself in it. So that is why mom sold it.

Joe continues to describe situations where he can fulfil his love for speed.

> And in, in the winter I go ski-dooing a lot.... I go out to my aunt's cottage quite a bit and they have two four-wheelers out there so. Just anything like that. Anything that I can go fast on I'll get on.... I play[ed] hockey and I was a really fast skater and everything like that. And I got best defenseman and I mean, like that's pretty good cause I'm small right? Ah, I don't know, I'm just, I'm just not scared to hit anybody.

Their Description

Both participants paused when asked how they would describe ADHD to someone who did not have first hand knowledge of the behavioural disorder. David's first response was simply "oh," which implied to me that describing ADHD was a task too big to contemplate. He did go on to use words like "unfocused" and "forgetful." Life with the disorder was "frustrating" and "things chang[ed] a lot". He considered his disorder a "mild case" or "small," " I think I remember them

[psychologists] saying it wasn't, it wasn't that bad, like it was just a small – how can I say it – diagnosis I guess. It wasn't that severe."

Joe also minimized his disorder saying, "it wasn't as bad as it could be." In spite of this, his initial one word response to my request for a description of what it was like to be ADHD was alarming. After a long pause, he simply said, "crazy." Later in our discussion he again uses the word crazy to describe himself, "Like mom has never had anybody this crazy to deal with before." He goes on to describe a sense of being out of control, words similar to David's when he described behaviour warranting continuation of medication. Joe's description immediately brought visions of roller coasters to mind.

> Just really fasted paced. Like, I don't know, your life seems almost more, like a lot more fast paced when you're ADHD. Like, I don't know, it's hard to explain. It's just there. It's one of those things that you can't control and it kind of bugs you that you can't control it on your own. You need somethin' else to help you control it. It's just, I don't know, it kind of makes you feel out of control. You know what I mean?

For Joe, crazy became a reoccurring theme in his descriptions.

> You're just wired, like [makes a sound]. Eyes popping out of your head and just goin' crazy some days and other days, like it fluctuates. If I don't take my pill like. If I don't take my pill two days in a row, I find it gets really bad. But if I like, forget it one day and then like two or three days later I forget it again, it just, it's bad but not that bad. Like I can control myself when I have to.

Joe often mentions control. His environment seems to influence his sense of control. When I asked why he was able to sit calmly during our hour-long interviews he suggested it was the situation that allowed him to remain relatively attentive.

> I don't know. It's just environment type thing. It depends what my environment is. Like if I'm around my friends I'll be, 'yeah, let's go do something.' If I'm just like sittin' here and there's not much to do, like just talkin', I'll be fine.

When asked to speculate if other people he knew had ADHD David used negative behaviour as his benchmark for speculation.

> **David:** And if my Dad had it, it would be a very, very small like mine and ...he grew out of it or adapted to it cause he was very, very, very bad when he was my age.... He hasn't got over a Grade 8 education. That was back then when you didn't need it. He was terrible. Oh, thirteen out drivin' around with cars, no windshields in them. And all his friends, it was wild. My grandmother could tell you a lot of stories.
>
> **Birdie:** Do you think that could have to do with ADHD?
>
> **David:** Oh, it would have to I think. It was unreal.

Joe on the other hand used hyperactivity as his benchmark.

> **Birdie:** Do you think your dad might have had ADHD?
>
> **Joe:** Yeah to some point. Like he was really active too. He loved to do everything. Like he hunted, fished, and I mean his job was hard work and I mean, I don't know, he was always goin' too. Maybe a little bit but not enough to be diagnosed and be put on medication or anything like, so.

Joe described a friend who was also very active, which to him meant the possibility of ADHD. He highlights his attraction to active people.

> T. is another one that I'm guaranteed he has ADHD. He, he doesn't stop. He's worse than I ever thought of bein' I think. And his dad's just like that.... Anyway, he's really, he's always goin' and he always has a smart remark or something; like. He's, ah, he's like me. And I think he might have it too. T is one of my best friends and I think, I, I think I relate to people that are really active more. Like I can't stand bein' around people that just want to lay back and say, I don't wanna do anything cause I'm just wired and I wanna go.

Similar to David's description, Joe describes a state of constant change and frustration. Although he is able to "think things through quite a bit better" as he grows older, there are still times when he is unable to regulate his actions. His description of the constant change of his state of being can almost be likened to temperature and the changes on a thermometer.

> **Joe:** I don't know if that's just life experience or that's Ritalin or what it is. I don't know. I do notice a difference in like how I act and how calm I can be when I wanna be and stuff. Like I can sit down and think things through quite a bit better now.... I don't know. It's a weird thing, just.
>
> **Birdie:** The changes are weird or the medication is weird?
>
> **Joe:** Just how, like it kind of fluctuates. Like it goes from good to bad, good to bad but like not horrible or like, it goes up to really good sometimes and then it goes back down to good and then it goes to bad or it'll go from really good to bad to good. It never really goes horrible.

Birdie: Do you mean your ability to think things through?

Joe: Yeah, just your focus. Capacity or whatever you wanna call it. Being able to like tunnel vision on something. Like I still have problems. Like if I'm really tryin' to concentrate on somethin', like my eyes will just go [make a sound] and I will just wander around. I just won't be able to focus sometimes but other times if I really wanna do somethin' I will sit there and do it.

In the end, both participants felt it was hard for people to understand where they were "comin' from." Joe expresses compassion for his mom by showing an understanding that she is only able to identify so much with who he is.

And I don't know, I just think she's had a hard time tryin' to figure out where I'm coming from. Like she tried her hardest and I understand that but she just, she doesn't know. Like, just like a lot of people don't. They just say, oh he's hyper and that's the end of it.

Medication

The history of pharmacological treatment for one of the men almost appears to be a reverse pattern of the other. David began treatment immediately after he was diagnosed in grade 4 and discontinued medication in grade 7. Joe, on the other hand, did not start Ritalin treatment until he entered junior high school in grade 7 and continues with treatment today. Similarly, the experiences and sensations of being on medication differ for David and Joe. David felt an immediate difference when he commenced Ritalin treatment.

David: It was weird at first but I got used to it and it [Ritalin] did quite a bit. I could pay attention a little more and at home too, I could notice it.

Birdie: What do you mean it was weird?

David: Ah, I don't know. I found myself doin' stuff that I never did before. Like that way I was talkin' and everything. I don't know. It seems like I could think more. I knew more stuff.... It kind of settled me down a little.

David continued to take Ritalin for almost four years until, unintentionally, he discovered the positive effects of the medication was not as great as they originally had been. He and his mother decided that the Ritalin was not providing enough benefits to justify continuing with the treatment.

I don't know, it was just, I don't know if I just said it wasn't working any more or, or maybe just ah, cause I remember one time the medication upset and we lost like a lot of them and I'm not sure if I didn't have them for a certain period of time, like a few days, a week, and it didn't change anything or, but I don't think I just said, well I doesn't work because you can't really do that.

Although he easily *felt* a difference when he initially started taking Ritalin, it was harder for him to *feel* a difference when he discontinued the medication.

We probably lost a few [pills] here and there and like, like there is one time they got upset and went everywhere so we probably lost a few. I mean that's probably the reason. I don't know for sure.... Just like I say, ah I didn't take it and it didn't, didn't seem to bother me and Mom said well you're not taking

medications and there's nothin' serious goin' on and you're still, you know what I mean, I wasn't out of control any more so why do it right?

The decision for David to discontinue his medication was not premeditated. It was based on the lack of evidence of 'out of control' behaviour when he had forgotten to take his medication.

David:...it's just that I found that it wasn't doin' anything, like what was the point. Like the same thing, what's the point of doin' this [taking medication] if it ain't doin' anything, so I just quit.

Birdie: So you didn't notice any difference when you stopped taking Ritalin?

David: No, not to any amount....[laughing] Now, so I was immune to it.

Birdie: You felt immune to it?

David: Yeah, like, I don't know, I was just, I was into the routine of it [Junior High School] and that's about it.

Until grade 7, Joe's symptoms did not affect his performance in school enough to warrant medication. Unlike David, Joe was not conscious of immediate differences in himself when he started pharmacological treatment. The first indicators of the treatment's effectiveness, for Joe, were external.

Joe: Just I noticed, me and my mom noticed a huge difference. Like my marks automatically went up ten, fifteen points. That was good.

Birdie: How did it feel for you, to be on medication?

Joe: Well I thought it was like, it didn't really make a whole lot of difference. I just noticed that I was doin' better in school and stuff.

Joe had difficulty articulating a difference in how he felt when he started Ritalin treatment. It was much easier for him to compare the differences in his current behaviour of being on medication as opposed to being off medication. This was different than David's experience.

> **Joe:** Oh yeah, if I don't take it [pill] one day I just all out won't stop the whole day.
>
> **Birdie:** Does it feel any different for you when you're on medication?
>
> **Joe:** Yeah. Well I notice a big difference. I'll talk to friends but I'll get my work done too, like when I have to get it done I'll do it.

Only in hindsight was Joe able to see the effects of Ritalin treatment.

> It wasn't like, it wasn't a big difference at first. But now that I look back on it I can notice a difference...and I find that I handled some situations better than others. I don't know if that's just life experiences or that's the Ritalin or what it is. I don't know. I do notice a difference in how I act and how calm I can be when I wanna be and stuff. Like I can sit down and think things through quite a bit better.

Joe's peers noticed, without much difficulty, the difference in his behaviour when he has not taken his medication. "Like they'd [friends] make the odd comment, did you take your pill today? And like I still get that. Like when I forget to take it they [friends] notice a huge difference."

Joe's pharmacological treatment is consistent through the week but he often misses his pill on Saturday. He attributes his inability to hold on to his money on the weekends to this fact.

That's somethin', like if I don't take my pill one day I know, I'll have bucks in my wallet and it's gone in like two days. Like I get my check and it's usually around like a 110, 120 bucks and I give Mom 50 bucks every week for smashin' up the car, and its [the rest] gone by Sunday, sometimes Saturday. It's cause a lot of weekends I don't get my pill. Like I'll get it Friday but then I'll spend the night at somebody's house Friday night and won't get it Saturday and then I'll get it Sunday cause I usually work Sunday mornings.

During our conversations regarding the altercation involving the young man at the party, Joe wondered out loud if medication would have caused things to come out differently. He suspects that he would have thought the situation through and not put the young man in a dangerous situation if he had taken his pill. His mother, it appears, agrees with this hypothesis.

Joe: Like mom said, she thinks the reason that I did it is because I didn't have my pill that day, which I didn't, but I don't know.... I think maybe I would have thought it out a little bit better.

Birdie: So that is what medication does? It helps you think things through a bit more?

Joe: Yeah just focus on what is happenin' like right then and there like. I wasn't even thinkin' about what I was doin', I was just, okay, yeh, I'll do it.

He goes further to describe an increased ability to organize his thoughts better. When writing for school, something he enjoys and feels he is good at, he finds medication enables him to be more effective.

Birdie: Do you write any differently when you are on medication than when you don't take your pills?

Joe: Maybe, I, I can focus my thoughts. Like I can put more than like two thoughts together better when I'm on my medication. Like it just connects better.

Possible due to the fact that he is currently taking medication, Joe discussed what he considered the effects of medication more readily than David was able to. Joe describes what happens when his medication wears off.

I think it [ADHD hyperactive symptoms] kind of helps me doin' my job cause I come home from school and all I wanna do is sleep and I gotta go to work at four and I'm just like [makes a sound to indicate he is tired] and then I get there and it's just, I know I gotta kick myself into gear. So I kinda do and then my Ritalin starts wearin' off and I just, I kinda have more energy. So it just makes my job easier.

Joe feels his sleeping patterns are disrupted by his ADHD symptoms and by his medication. Although he is "wired" during the day he does "crash" early in the evening and has difficulty waking in the morning.

...I have a real problem with gettin' up in the mornin'. Like I sleep like a log. Nothin' can wake me up. I missed a complete shift for work two weeks ago on a Sunday because my alarm went off from 6:40 until 1:30 in the afternoon. And that's sleeping really, like just, that's nuts. I couldn't believe I slept that long. I don't know. That kind of scared Mom. She was like, she, like she always noticed that I slept really good but that, that's the first time that's ever

> happened and it's never happened again. But I don't know, I might have just been over-tired or something.

For Joe, there seems to be no in between: he is either awake and going or he is ready for sleep. There are times, however, that his medication can disrupt his sleep and keep him awake if not taken early enough in the day.

> Like it is usually around about 10, 10:30 and I'm just like ready to, ready to hit the sheets but like, by taking my pill like around one or two in the afternoon, like if I forget it and come home from school and like Mom will give it to me. I can't sleep until about three or four in the morning.

Misuse of medications is a concern for many practitioners. While not something he did regularly, Joe admits to selling his pills once.

> I sold some [Ritalin] once. Well like, it was in grade 9, eight or nine. And I guess like if you don't have ADHD or whatever and you take the pills then you can, like, get wired or whatever I guess. I don't know, it doesn't work [like that] for me.

Medication helped David feel like he could "think more". For Joe, on the other hand, medication seemed to give him the ability to control his behaviour. Joe commented on research he had heard about from his sister that stated Ritalin did not improve academic performance.

> And she said she [sister] was readin' a thing somewhere and it said that Ritalin, when taken by ADHD kids, is proven not to help in their education. It doesn't improve their education anymore.... I don't know, that's weird cause I found it helped me out some. Not as much as I woulda liked but.

What Joe was referring to, was that although Ritalin helped him focus more in school he did not feel, unlike David, that it helped him to better understand the academics of his work. Either way, for both participants, pharmacological intervention played a significant role in their development.

Academics

Although not considered a learning disorder, ADHD symptoms have been shown to negatively affect academic performance (Barkley et al., 1990; Goldstein, 1997; Faigel et al., 1995). Neither participant has repeated a grade and both were anticipating graduation, nevertheless, each easily articulated the problems they faced in the academic realm.

David's main hurdle in school seemed to be his lack of faith in his abilities. His frustration with a task would elevate before he would even attempt to complete it.

> I didn't like the idea of work then. Like they [teachers] say, you gotta write a 800 word essay or somethin'. I's like, okay, wouldn't even look at it right. It's just, I don't know, I just don't like writin' and I figured well what if I get to the end and I can't get an ending or I can't get enough words. I said, what's the point. That's that way I thought it seemed.

Only recently has David overcome this "what's the point" attitude.

> I had to write a 3000 word essay last year in Global History. I didn't get quite 3000. I got, I think I got 2500. It took me, I, I worked on it like ah...I don't know, just not into that kind of thing. I just have to get by I guess you could say.... I worked on it, that was the first time I worked on somethin' for, well a

> time every night for four nights and I got it done. The day before it was due [laughs].

When asked what he thought enabled him to complete such a mammoth task he simply replied, "I had to have that credit. Had to have it." Of the two young men, this *just gotta cope* attitude seemed strongest in David.

Both David and Joe maintained that working one-on-one proved a much better way for them to work in school. Joe says he is "real good one-on-one."

> Like it was just me and a teacher and it was just one-on-one so I got a lot more attention. So it was just stuff like that, like one-on-one things are, like I do, I do really good at those. I can focus a lot better if there's no distractions around. Like, yeah like if there is you and another researcher or somethin' I think I'd have a bit of a harder time.

Distractions in a classroom caused Joe to become "pissed off" which inhibited his learning and ability to work.

> Like I don't like big huge crowds a lot. Like it's all right if I don't know the people and they're just kind of around but if I know them and everybody is like tryin' to talk to me or somebody's trying to talk over me to another person. It's just, I find it annoying. Just, I don't know, [I] get pissed off.

Even though David believes he understood the material, he attributes his passing grade in a course required to graduate to the extra help he received from a teacher.

> I know most things. But just one little thing would mess me up.... I got, I had extra help with my tests and, and like the same thing again, like [the] teacher could sit here and say okay we'll read, we'll read, both read the question and

> he would, he would kind of explain it a little bit and then I could usually get the right answer. So that's how I got through.... He [teacher] was just there to maybe explain the question a little better and, and maybe we'll write it down on paper so it looks different, like little charts and graphs and stuff. And then I could realize, I would know what it is.

He explains that being able to discuss the question helped him when he was writing tests.

> And then he'd, like well, break that down a little more and he would write it down and then we'd, you know, I guess you'd call [it verbal testing], because we talked about it a little bit and like usually figured it out.

David received the help he described above in his most recent semester in school. His desire to graduate and to progress towards his goal of full time employment out weighed his need to feel equal. His desire to feel equal is described more fully later in the chapter.

> **David:** It was helpful. Like I say I needed that credit.
>
> **Birdie:** How was that for you, leaving the class and coming in here [for help]?
>
> **David:** Ah wasn't my favourite thing but. The first couple of times it was kind of weird but after that you get used to it. Same as anything else.
>
> **Birdie:** Did it make you feel different?
>
> **David:** Yeah a little. Didn't matter, I needed it to graduate so that's what I kept thinkin'.

For Joe, there was sense of underachievement and that it was not his intellectual aptitude that was inhibiting his academic performance. He seemed to feel the effort he had put into his education was consistent with the grades he received.

> Like I could, I could ah got 80's all through high school and junior high. I just didn't have the work ethic. I still don't. Like studying for tests and stuff, I don't do it as much as I should. Like Math, I hate studying for Math because it feels like you're not even studying. It just feels like you're doin' six hours of homework. And it just, it's crazy, so I just, I don't do it that often like, like I should do it a lot more than I do and I just, I give up because I get bored, I get bored really easy.

Hyperactivity often manifests itself as restlessness in adolescents with ADHD. During our second meeting Joe again brought up the subject of underachievement. He feels that his underachievement in school is due to his inability to maintain his attention on his studies. In discussing his academic history, Joe highlights one of the nuances that both young men seemed to embody: I am restless, as opposed to, one of my symptoms is restlessness.

> I would have liked to have done better in school. Like I know I could but I've always been the type of person to say, okay I have to do this to get by and I just, I've never really had the urge to excel. I just said, okay this is what I need to do to pass or this is what I need to do to get out of here or somethin' like that.

Both Joe and his mother feel he could do much better than he has done, "She [mother] knows I can pretty much always do better than what I do, like mainly in

school cause I just, I give up when I, when things get too hard." The following description of his mother's response to a failing grade emphasizes his frustration at being told something he is aware of.

> She [mother] was always on me to do better in school. And like, I still hate it when she gets on me about school. I had a 23 on a Math exam this term, a 23 and I just couldn't believe that. And she, she was off the wall about it. When I came home I told her I got like a 30 on my Math exam. Like I didn't know the mark then. That was like the day I wrote my Math exam I told her, I said I didn't do good on my Math Exam at all. She said, well what do you think you got? I said around 30. She's like, that's pathetic and I was like, yeah I know. She's like, she gets on me about school because she knows I can do better and she's worried. Like I've always been a person that I do what I have to do to get through and that's it. I don't try to excel. It just doesn't, it's in me but it just doesn't drive me to do it.

Although there seems to be a little regret regarding his academic career so far, he implied that he recently has made attempts to do better in school.

> ...over the past couple of years I've done better in like certain courses but Math is just impossible. Like I am not good with numbers but like English and stuff, it's just, I don't know. Yeah, I would definitely like to do better than I have but I'm satisfied with what I've done.

Part of Joe's motivation to succeed in school came from a completely unplanned and uncontrollable event in his early years.

> Wanting to graduate in the year 2000 I think... like when I was in grade primary we got this medal sayin' graduate of 2000 or somethin' like that and she's [mother] always like, when I'd come home with a bad test mark or somethin' she'd be like, you want to wear that medal to graduation? I'd be like, yeah. She's like, well do better. And she was just always like that...

As well, the fear of being kept behind while his friends moved forward compelled him to maintain passing grades.

> ...that wasn't the whole reason but like I always, I never wanted to feel stupid, like all my friends go on to another grade and I'm stuck back in Grade 9 or somethin'. I always wanted to get that level up. I wanted to get that closer. Like, I did not wanna stay in school an extra year.

More recently, Joe's motivation seems to come from a desire to move on in life.

> Because if I don't, I mean, I don't go anywheres and it's plain and simple. And I wanna get out of here. I wanna go somewhere else. Like I haven't, I went to Toronto when I was in Grade 3, three or four. I went to visit my uncle and aunt for a week and like that was a blast, but I haven't gone anywhere really since.

For David, there was not so much a motivation to succeed in school but rather a desire to be the same, not to be singled out in school. When in "little school", David felt like the "kid with ADHD". When he moved to Junior High School he felt he was starting out the same as everyone else. He used the term "equal" to describe how he wanted to feel in his new school. His desire was not to excel but more importantly, not to stand out in anyway among his peers. "Getting about the same marks and

getting your work done and not the bad one in the class, not the good one in the class. Just another person. Just, I'm the same as everyone else."

His more recent motivation seemed to stem from his aspirations in life. Again, there did not seem to be a need to excel but rather a desire to be able to make his way in the world.

> I would like to have a, just a full time [job], I don't expect to be super but I don't, I like just, I'd like to have a house. I'd like to at least be paying for one anyway. And just have a full time job and I'd be, I'd be happy with that.

As with many other of David's philosophies of life, he has come upon the realization that completing secondary school is necessary to attain his goal by observing the people in his life. "You look at people that don't have a Grade 12 education, they are not working in the winter time and they're always on unemployment. You can gather a lot of stuff from watching [other people.]"

Strategies

Each participant expressed a need to learn to cope with the ways in which ADHD was manifested in their outward behaviours. David's symptoms have changed as he has matured; he believes he has learned to manage his conduct. "Ah, I think I've learned to cope with it [ADHD symptoms] a lot, really myself. I don't think you grow out of anything to tell you the truth. But I think I've just learned to cope with it really well." Coping "with it really well" seemed to be learning not to act or speak on impulse. To quote Brooks again, coping seemed to mean being able to change *Ready, Fire, Aim, Oops* to *Ready, Aim, Fire, Ahh!*. "And like you figure a lot of stuff out

when you're growin' up so.... That goes back to the same thing again, thinkin' things through before you do it."

Moving to Junior High School proved to be a positive transition for both young men. In his new school, David found motivation to learn to think first and then act.

Birdie: You said one of the reasons it was easier in this school [Junior High School] was because there were more people?

David: Yeah, just different people.

Birdie: What does that mean?

David: Like people you didn't know and, just strangers.

Birdie: How did that help?

David: Kept to yourself a little better. You didn't yell things out.

Birdie: So you might have been a little intimidated?

David: No, just equal I guess. Like, cause up the little school you knew everybody and you were just kinda like, you know, on top. But you come here and there is all these different people and just feels like you're all just little people.

David differentiates between being intimidated by strangers in his new school and feeling equal to them possibly because of the newness of the situation for all the students. Regardless, "thinkin' things through before you do it", is a skill both young men have had to learn. For Joe, his ability to think things through is directly linked to when he is taking his medication.

The logistics of Junior High School seemed to provide a more productive environment for David and Joe. Joe found moving from class to class gave him the breaks he needed. "I like it [Junior High School] a lot more 'cause you just, you get a break in between classes. You don't have to sit there for so long in the same classroom." This was a significant change from "little school" for David also.

> Well, it's just like you, you're not in the same classroom doin' the same thing with the same people, with the same teacher all day. It's just, I don't know, there's more people to talk to and there's, I don't know. You get breaks and it's just, it's good.

Joe agrees that more people somehow made the Junior High School a better place to be.

> It was good [moving to Junior High School]. Like my sister had been in the school for a while. She, she has way more friends than I would ever think of havin'. Like she had probably 120 friends in the school, right. So like all her friend's brothers and stuff were in my classes. Like they were all like the same age as me.

Researchers once thought that affected children outgrew maladaptive traits as they moved through adolescence (Coleman & Levine, 1988). David described the strategies he used to ensure that his behaviour did not place him in unpredictable situations, more easily than Joe. David does not believe he outgrew his symptoms, rather he says he "learned to cope." One major lesson for him was learning to communicate. He prefers to be clear when dealing with people "so there's no confusion with me."

I like to [be clear] because, I just like to. Same as if people talk to me. I like people being clear with me too. Like you don't include one little piece of information and that frigs everything up and ah, just mishaps. Like you learn from your mistakes. So like I say I usually like making myself clear so that doesn't happen.

In other situations, David has learned not to insist on continuing with conversations when an agreement is not likely. He describes a situation where he became very frustrated with his father.

David: A lot of it, it don't make sense at all. And, and just another thing, here a year ago I think, ah window got broke. So it wasn't a problem. It was broke, right? Couldn't do nothin' about it. But it started to turn fall. Okay, we're gonna put a door on the tow truck. No, can't do that. Why? Cause it ain't green. All right, we're gonna put a window in it. No, don't put a window in that door. Why? The bottom of the door is rusty. So here it is snowin' with no window in it cause you're not allowed to put a window in it because the bottom of the door is gone. All right. What do you do when it rains? Hmm. Oh, oh, stuff like that makes me mad. Oh yeah, it's just, it's no good to even say anything.

Birdie: What do you do in that situation?

David: Oh I, I just walk away.

Birdie: When did you start walking away?

David: Just like in the last, I would say year.... That's about the time that I realized that he didn't make any sense at all.

Even more important than learning to communicate or learning to walk away, finding ways to be independent proved to be the most helpful strategy for David.

> Yeah. I, I like, I love doin' stuff by myself. Just people usually get on my nerves when I'm trying to do somethin' and I just don't like it. Depending. If you gotta have somebody it's not a problem. But as far as like, like going to the pit, taking a part off or something' for somebody, I don't like havin' somebody watch over my shoulder, and do that and do this, well, try this. I don't like that. I learned to like to, you know, kind of be independent. It's not that I don't like the family or anything but it's just, that's just the way I am....I like doin' stuff with people but it's, I'm an independent person.

Gaining independence with his leisure activities along with the work he described above seemed to provide a sense of empowerment for him.

> I started huntin' that year [Grade8] and I use to go with my Grandfather puttin' apples and stuff out for deer and this and that and I watched how he did things. I, I watched how to build, like a tree nest, to watch the deer and stuff and I watched how he put the apples out because he'd stick 'em on the trees, little bushes and make an apple tree. I learned how to do that. And like I say I just watched and, I can do that. I said, that's no big deal so I went and did it. So that was the biggest thing. I did that by myself. I got apples and I lugged them and I lugged them and I cut and slashed and I did it myself. That's, that's cool. I remember that.... I like goin' fishin' by myself and huntin' by myself.

David often talked of watching people and learning either from their mistakes or from their competencies. He does not feel, however, he has found any role models through his observations.

> I don't have any role models to tell you the real truth. I'm very independent that way I got my own mind and that's about it. Everybody tells ya, right. You know that. A lot of people tell you this and tell you that but I don't pay no attention. I do as I like. I'm not, it's not mean or anything but I just kind of like doin' stuff my way. Unless it's like out to my Dad's, the same thing again, like towin' and stuff and yeah, okay, that's just the way you gotta do it, right, he's gotta tell ya. But as far as people tellin' ya, ah you gotta get to school, you gotta do this, you gotta do that, well I know this and it's my life and I'm gonna do it.

David's academic strategy for success seemed to be to recognizing his limitations.

> Well, I'm not saying that I'm the best student...I'm not great but I, like I say, I do what I can. I get a little side tracked once in a while but I usually try to get out of it at the end but, like [I] try to work a little hard on the last end and get things caught up.

Not only did David require a sense of independence in his work and play, it proved to be conducive to success in school also. He describes a teacher who he found much easier to work with in his graduating year than he had in the previous year.

> Well he came here and I didn't, we didn't really click cause he's a little different and he's a little bossy.... Then I had a class with him last semester, it was a Grade 12 class, and he, for some reason, he is one of these people that if

> you're Grade 11 he tells you everything to do whether it's a coloured pen or whatever, but as soon as you're in Grade 12 you can do whatever you want. And he's really a good teacher I think. Like he explains things really well and he just, he's a good teacher and, and he's my favourite teacher actually. Now. But he's the one's losing his job now.

Understanding and Support

Both young men recognized people in their lives that seem to be able to separate their behaviour from their persona. David seemed to think his girlfriend had "adapted" to his manner which meant he didn't have to explain his behaviour to her. His paternal grandmother also provided a source of unconditional support.

> My Gramma S., she was very, she's always there. That's who I spent most of my time with on the weekends. I spent most of my weekends and my time off with my Grandmother and my Uncle D. I liked it there. But my Grandmother, I use to go and we'd go bowling and stuff together and she was always there.

Joe's *you just gotta cope* attitude may have been originally modelled for him by his paternal grandmother.

> Like my grandmother, she's really cool, I love her.... She's just, she doesn't take things as hard as a lot of my family does. Like when my Dad died it was her, it was his mom and she, she's just one of those people that just figures, oh shit happens, life goes on. She cried for a while and then she was just like, there's no point in me dwelling on this, might as well just move along.

He was also keenly aware of the faith she had in him. Her acceptance of him translated into giving him the responsibility for his achievements. She held him accountable without expressing disappointment in him.

> She just, she's a joker and she just, I don't know. She always had faith in me....she asks me how I'm doin' in school when I go up there and I'm like, not too bad and she's like, you can do better.... Every time I get a report card I take it to her and she's like, well these aren't bad but you can do a lot better.... She's just like, she doesn't get on me about it but she, she knows I can do better.

Feeling understood was important to Joe. He tries to describe a friend's mother who he respects and has felt supported by. Although he searched for the right words, he conveyed the message that she is accepting and patient with him.

> She's, she just, she's a person that you can tell anything and she will not judge you. Like, she just, she's open minded about everything. She just, she doesn't have a mean-spirited part of her at all. She just, and like, I don't know, she just, she takes things in stride, almost like I do.

Joe and David often referred to the continual support of their families. David describes his mother's support over the years.

> Like she would do pretty well anything for me. Like, like if I needed to go somewheres then she'd do it. And if, if ah, very supportive, I guess you could say. She tried to help me out anyway she could. I don't know, like, like goin' to dances and stuff and we didn't have a whole lot of money back, like years ago when, when all this was goin' on and, and she, she always just seemed to

> come through I guess. It was good.... Well she always stays on top of me about my school and what I'm gonna do after school and, and she's always just tryin' to help me out, doin' whatever she can.

Joe says his family was his "main support system." Joe's father initially denied the need for Joe to take medication but later accepted the intervention when he saw positive rewards.

> Yeah, they [mother and father] were great. Well my mom was. And my Dad was like, I don't know, I don't think he, he almost didn't want to admit that I had it [ADHD]. He didn't want me to go on pills cause he thought I could control myself if I wanted to. And but like, after awhile he noticed a big difference too and he, he was, yeah, he was great after that but at first he was sceptical kind of.

He commented often on his mother's support and faith in him. "She always kind of believed in me that no matter what I faced, like I could always do as good as she knew I could or like as good as I knew I could." She also seemed to hold him accountable for his accomplishments.

Joe remembers his Grade 6 teacher fondly. The significance of having someone understand that he wasn't in complete control of his behaviour is made obvious by the clarity of the six year old memories.

> **Joe:** I had a pretty cool teacher in Grade 6. He like, I think he knew what was goin' on, sort of, and he was just, like, he, I don't know, he was just sympathetic I guess.
>
> **Birdie:** What kind of stuff did he do?

> **Joe:** Well instead of like sendin' me to the principal's office he'd talk to me and tell me how to do that or that and just stuff like that. Like he wouldn't get me in trouble cause he knew that it wasn't really my fault, I think....he knew I had a lot of energy and when I'd start getting' like nuts in class and stuff he'd go and tell me to run around the school and I did.

Joe started taking medication after a rocky start in Junior High School. His Grade 7 teacher, Ms G, "didn't have much patience" in the beginning. He explains the difference in his teacher's attitudes once he commenced Ritalin treatment.

> And like once the teachers found out that I was on medication and all that they were like, well okay, we'll try and help you out as much as we can, right. And Ms G was great after that. She was, like she went through all my binders with me and helped me organize everything and stuff like that. And she would call my house or like tell me, at the end of the day she would tell me to come in and she'd write down all the homework and get me to give it to Mom so I'd make sure I did it.

Whether it was the teachers who were more supportive or that Joe was more ready to accept their help, their assistance had a huge impact on him.

> I don't know how it all started. I don't know if she just noticed a difference in me and like almost rewarded me for trying' harder or somethin'. I don't know but it was cool. Like I don't, don't think I would have passed Grade 7 without her doin' all that extra stuff for me.

The extra time Ms G's gave to Joe to help him be more successful in school both increased his grades and alleviated the sense that his situation was overwhelming. "It was a relief to know that I wasn't, didn't have to do it all on my own."

Advice

David hesitated when asked if he had any advice for a child with ADHD. He felt it was "none of my [his] business." Although he did not want to place what he described as judgement, when pressed he did in fact have compelling advice: *you just gotta cope.*

> Ah, it's just like I don't, I don't judge people and I don't unless they ask.... I'd just tell 'em like it is, like you gotta deal with it. Just gotta start thinkin' a little more and you get into that routine. Of course not right off the bat, you know. Start actin' better right, and this and that but you gotta get used to it and you gotta, just, once you get into thinkin' about it, then that's, that's what you are into. And then you just basically learn to deal with it.

Joe felt he had more to offer and gave more concrete advice that may help a hyperactive child learn to cope.

> I think I could help them out some, just tellin' 'em like, from my experiences and how I coped with it in class or somethin' like that, right. Like just techniques or something. Just techniques that worked for me and see if they worked for him or somethin' like that.... Always be doin' something, always. Just, when you have to sit down and actually focus on somethin', really try but if you can't don't do somethin' stupid. Just try, really try and if you're really

> hyper, say if you just got out of a class that you didn't focus at all in, just go and do somethin'. Go get a football and throw it or go get a soccer ball and kick it. Do somethin'. Just run.

Accountability was an important issue. As Joe explained, maintaining acceptable behaviour in the classroom should be, in part, the responsibility of the student. Possibly this could lead to the sense of independence that both young men found empowering. Joe explains how to take steps towards taking control of your limitations.

> Let all your teachers know that you have it [ADHD] and that sometimes you need to get out of the classroom and just say like, just make a contract with your teacher or somethin'. Put your hand up and say, can I go down to the office or something. I forgot somethin', I got to check the lost and found or somethin' like that.

Most of us understand that we must be aware of our weaknesses and adapt to our situation if we are to be successful. The source of this advice is crucial to the probability of acceptance. The necessity of the ability to identify with a young person with ADHD is not lost on Joe. He stresses the fact that advice from a teacher or family member who does not face similar struggles is most likely to go unheard.

> Like it's just the same as anything. You go through the same situation. Like it's a lot easier to talk to somebody like, that lost their Dad or somethin' like that because they know what it's like, even, you don't have somebody that still has their Dad saying, oh I know how it feels. Like they don't really. And you just kind of shrug them off cause you're like, you don't really know.

Joe, however, remains sensitive to the fact that assistance and support can only be given to someone who is ready to receive it.

> ...but like somebody in Grade 9 is only gonna listen to me so much. Like they're only gonna take in like, account what I say so much....like I'm only what, three or four years older than him and they're just gonna say, yeah, whatever. Like, if they're anything like me they won't pay any attention. Or they will pay some attention but it won't make enough difference to help them out.

When asked for advice to give parents, David stressed the importance of not being judgemental. The emerging theme is that there are times when you have to look at behaviour separately from the person.

> You can't be judgemental, I guess you could say. Like I'm not sayin' that most parents judges their kids but like that's, that's, I don't know, I'm not a parent. I don't know. But you just, you gotta keep it cool I guess and just, realize that it's really not all their fault right? It's just, they can't control it and they say they're gonna do this and this and this, but.

Joe was much more comfortable articulating the same type of advice he would offer to parents. He too stressed the importance of understanding the lack of control and not placing blame.

> Take it easy on 'em. Like don't, don't get pissed off a lot cause they don't do what you want them to do. Like, it's completely out of their hands. It's just, you just, you can't stop yourself. It's just, you plan it in your brain that you're

> not gonna do that and you don't do it. It's just, it's not impossible but it's really hard to like stop and say, okay I have to do this.

Joe's advice to teachers was to be patient, not unlike his Grade 6 teacher was. "Just try to understand that they're not wacko, they're just, they just got a lot of energy." Joe didn't feel "wacko" but realized that people without ADHD may see his hyperactive behaviour as such. Joe summed up the difference in the internal and external perceptions of the negative outward behaviour of a child with ADHD.

> I was active. I always did stuff ever since I've been a little kid I'd always be doin' something. So it was no change for me to just notice that I was just going all out, completely all out all the time.

What the people around him might have seen as "wacko" behaviour was "no change" to him, or simply just the way he was.

CHAPTER 5: THE NEXT POINT OF DEPARTURE

Discussion of the Epiphany

By collecting stories, the interpretive interactionist is guided to the transformational experiences or epiphanies which *transform* a person forever. This "existential thrust" (Denzin, 1989, p. 15) provides one of the distinguishing characteristics of this form of research. Other interpretive researchers examine the more commonplace occurrences in life. The interpretive interactionist works backwards by seeking out those whose troubles have become public issues. In my case, as an educator and mental health practitioner, the struggles being faced when attempting to offer support to adolescents with ADHD became the starting point for my research.

The stories David and Joe told me have left what Denzin would call surface level and deep level effects on their lives. Surface level effects are barely noticeable and are taken for granted. Deep level effects "cut to the core of the person's life and leave indelible marks on them." (Denzin, 1989, p.39) These biographical experiences have been encountered with many names attached to them: a boy, a brother, a son, a boyfriend, a student. In their case, the name that must be added is ADHD. Denzin contends that the individual builds biographies around the experiences that are associated with these names. The focus, therefore, has been, what are the deep level effects of being a boy with ADHD, a student with ADHD, a son with ADHD and so on.

Research supplies the statistics that gives us reason to believe that young people with ADHD can be considered a marginalized group and should be regarded as high risk. High risk, in this case means that individuals with ADHD are more apt to be retained in school, experience poor peer relations, develop ODD or even CD. The importance of this research is in the fact that both David and Joe are in the high risk group but have not followed the path that many others in the same situation have.

As mentioned before, Denzin describes four types of epiphanies: the major epiphany, the cumulative epiphany, the illuminative or minor, and the relived or retrospectively meaningful epiphany. These types of epiphanies are not mutually exclusive and may in fact build on each other. The cumulative epiphany may eventually cause a major epiphany, as well, an event may be first a minor or major then later relived. For the young men, as for all of us, many interactional episodes have created turning points which have influenced their lives to bring them to the place they are now. These turning points or epiphanies have shaped the men they have become.

At many points in our conversations, Joe used the experiences of around the time he entered grade 7 as benchmarks to describe how his life was and how it has changed. These experiences became part of turning point moments in his relationships with the people in his life. The combination of commencing Ritalin treatment and the support of Ms G in Grade 7 shaped his ability to accept the understanding and support that was available to him. Ms G's actions provided the opportunity to feel the "relief" of knowing that he "didn't have to do it alone." Although, the events may not have shattered his life and as a result caused an

immediate transformation, as Denzin would define a major epiphany to do, the combination of these two factors in his life did have a major effect on his life and caused an immediate reaction in how he viewed the effects of his disorder. The revelation that he may not have to struggle alone empowered him to attempt what to him was a monumental task.

During this time Joe was not cognizant of the changes taking place in him. Even in hindsight he does not articulate easily the effects of the situation but rather alludes to transformational experiences.

> But not like, the first one or two or three years I was on medication [I didn't notice a difference], it was, cause now I can look back and notice the difference...I'd be able to notice a difference from like the first year, like Grade 7.

Joe is aware, however, of the long-term effects of his experiences at that time. He goes so far as to attribute his progression into Grade 8 to Ms G.

> I don't know how it all started. I don't know if she [Ms G] just started noticin' a difference in me and like almost rewarded me for tryin' harder or somethin'. I don't know but it was cool. Like I don't, I don't think I would have got through Grade 7 without her doin' all that extra stuff for me.

Ms G's ability to see, that although ADHD symptoms were causing difficulties in school, these difficulties did not necessarily preclude his success in Grade 7. "And I said...well I don't think I'm gonna get through Grade 7. She's [Ms G] like, yeah you will, don't worry..." This understanding that the behaviour is not the person was already evident in Joe's home life.

> ...like it wasn't a big thing to screw up in my family. Like a lot of people in my family screw up quite a bit and we're all used to it and we just, we know, we know each other and just like, don't worry about it this time. Learn from what you've done. My family's generally like pretty cool about stuff like that.

Joe describes support as, "Just bein' around a lot. Just sayin' like, you can do it and stuff like that....just bein' there like knowin' that you don't have to go through all that crap by yourself type thing." He felt this type of support from his family. Once he started Ritalin treatment, for whatever reason, he began to experience this type of support in school.

A series of events has altered and shaped the meaning David has given himself and his life projects. Denzin names this type of epiphany as cumulative. David is aware that many events in his life have contributed to his success to this point.

> Oh there was just a lot of little things right. I'd get in trouble and then, why did you do it and I'm like ah, I don't know, so. I was just, I don't know, a lot of little things.... I don't know. I can't really explain it. It's just one more thing to add to it, right. A lot of stuff adds to why [a person changes].... Just every, everything adds up and then just after a while it's like okay, all this makes sense to me now.

He speaks of times in his life when he has experienced realizations that initiated change. The first of these changes took place in Grade 7 and 8. "Grade 7 was [the] worst and like [in] Grade 8 everything started to change. Like I got first with my

girlfriend and just everything changed." Starting to date his girlfriend was "just one more thing to add to it." For David, he continually processed the events as they happened which in turn caused more changes. Even in grade school he was aware of the modifications he was making to his life. "Like you go to school and then you came home and it's just be like, it hits you right, that you did all this stuff all day." Again, in Grade 9, he speaks of a realization that he must do something to redirect his path. "After ah, about Grade 9 I realized like, I gotta get out of this right? So I gotta start workin' and settlin' down." This constant reassessment of his life appears to continue to help him stay on track even in the present.

> Same as happened in Grade 12, I didn't, I failed a bunch of stuff in Grade 10 and 11 cause, you know, what's school right? And then in Grade 12 you finally start to realize what it is.... The last six months, all these little things they all gathered in my head and they all went into this one big thing.

For David, all the little things are rolled into one big thing to help him make sense of his world.

Reflection on his own conduct is not the only way he has come to these realizations. He spoke often of observing the interactions of the people around him. "I learn a lot of things from mistakes. Like people would...give somebody a set of instructions and I'd say well, why did you just say this, right?" Even his actions are dictated to some extent by what he sees around him. "I like seeing what happens without me actually doin' it. I like to see the outcomes first." He attributes the fact that he doesn't drink to the fact that he has seen the effects of alcohol on his grandfathers.

> The same with drinkin', both my Grandfathers use to. My ah, my Grandfather M quit and it's just, that's why I don't drink and I have, never have and that's why. I see like, you know, I just see what goes on and I don't.

Around the time David was in Grade 7, he became more cognizant of his behaviour and the behaviour of others around him. He continues to use this type of information to direct his actions.

> I just seen a lot of people do things that didn't really have to be done and I seen people get mad and, and a lot of arguing, stuff like that and I'm not really into that kind of thing so.

Simply put, David says, "You can gather a lot of stuff from watching people."

Implications for Counselling Practice

The purpose of this study was to understand how adolescents perceive their successes and failures in adjusting their behaviours to the expectations of a predominately non-ADHD environment. By design, qualitative research negates the possibility of finding a single truth. David and Joe have not provided the definitive answer to this question. What they have provided is a richer understanding of what it is like to have ADHD. Their stories are invaluable because they present a point from which to make a new departure. David and Joe have reaffirmed for me that as a counsellor I must never enter into a counselling relationship with the information I know but I must enter listening for information that I need to know. The basic premise of interpretive interactionism dictates that to provide assistance to marginalized groups you must listen to their experiences through their voices. David

and Joe have defined ADHD through their own experiences. As a counsellor, I will use their stories to build a clearer, albeit not complete, picture of life as an adolescent with ADHD.

The young men did not discuss ADHD as a disorder that was separate from them. Their inattentive and hyperactive behaviour along with their impulsivity were not part of a behavioural disorder: all three characteristics were part of their identity. Practitioners have created a template that has been included in the DSM, which defines what ADHD is. The significant people in the young men's lives, for example, David's girlfriend or Ms G, identified with them as individuals, not as part of this template. It is necessary to remain knowledgeable of current research but it is of the utmost importance not to reduce the individual to the template that is created by this research. It is imperative to nurture a sense of identity, which does not focus on the symptoms of ADHD.

As Joe highlighted, it is essential to encourage responsibility but not at the risk of laying blame. The literature attests to the fact that many individuals with ADHD often feel as nothing they do is right or good enough (Gordon, 1993; Parker, 1991) David and Joe discussed people in their lives who treated their behaviour with consequences but did not treat their behaviour as their total identity. Joe speaks very highly of a friend's mother with whom he was free to be without judgement. David's grandmother and his girlfriend offered this type of relationship to him. For both, their mother's support and help was constant and important in allowing them to find their way to be successful.

When asked to give advice to people who work with individuals with ADHD, neither participant hesitated. Both acknowledged the necessity for understanding that many of the behaviours of children with ADHD are often beyond their control. Dr. Michael Gordon's (1993) book, *I Would If I Could*, uses the voice of Sam, a Grade 7 student, to acknowledge this point.

Initially my research asked what type of interventions would best benefit the adolescent with ADHD. By gaining more knowledge of ADHD and of the research methodology of interpretive interactionism I realized that before I could answer this question I must first understand the adolescent perspective. As I moved through the stages of my research I became aware that this form of qualitative research would not allow me to make concrete recommendations that could be carried out by other practitioners. Although I believe that a therapy group could provide a suitable forum where out of control behaviour can be acknowledged and supported by peers and counsellors I cannot assume this intervention would be suitable for all practitioners. Group therapy provides situations and experiences that help correct behaviour, overcome faulty impressions of self and others and remove faulty distortions (Johnson, Riester, Corbett, Buehler, Huffaker, Levich & Pena, 1998). What was of paramount importance to David and Joe was positive relationships with authority figures and a sense of independence. Therapeutic groups for adolescents have been shown to provide warm accepting relationships with adults and an environment with which to enhance their self-image as autonomous individuals (Leaman, 1983). Although Joe's family was supportive and he had friends he could trust he felt he

"...didn't have anybody else. Like nobody to sit down like we're doin' now. Like nobody to talk to and just tell them what it was like."

No research or literature was found around the use of group therapy specifically for adolescents with ADHD. Russell Barkley's parenting course for defiant children employs the group process to assist parents. Many group models are available for adolescents with food addictions, depression, and a host of other disorders. The success of the group process with adolescents has been well documented (Berube & Berube, 1997; Dennison, 1998; Smead, 1995). David and Joe have helped me decide how I would be most effective as I continue to work as a counsellor. My next point of departure, after having had this experience, is to explore the feasibility using the group process to assist adolescents with ADHD to 1) generate warm accepting relationships with adults and 2) to enhance their sense of independence.

REFERENCES

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Banez, G. A., & Overstreet, S. (1998). Parental strategies for promoting self-esteem in children and adolescents with ADHD. The ADHD Report, 6(15), 8-9

Barkley, R. A. (1998). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment. New York: The Guildford Press.

Barkley, R.A. (1997). ADHD and the nature of self-control. New York: The Guildford Press.

Barkley, R. A., Fischer, M., Edelbrock, C. & Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria: I. An 8-year prospective follow-up study. Journal of the American Academy of Child and Adolescent Psychiatry, 29(2), 546-557.

Berube, E. & Berube, L. (1997). Things that work: Creating small groups using school and community resources to meet student's needs. The School Councelor, 44, 294-302.

Biederman, J. (1998). ADHD: A life-span perspective. Journal of Clinical Psychiatry, 58(7), 4-16.

Biederman, J., Faraone, S. & Milberger, S. (1997). Predictors of persistence and remission of ADHD into adolescence: Results from a four-year prospective follow-up study. Journal of the American Academy of Child and Adolescent Psychiatry, 35(3), 343-351.

Brown, M. (2000). Diagnosis and treatment of children and adolescents with attention-deficit/hyperactivity disorder. Journal of Counselling & Development, 78, 195-203.

Coleman, W. L. & Levine, M. D. (1988). Attention deficit in adolescence: Description, evaluation, and management. Pediatrics in Review, 9(9), 287-298.

Danckaerts, M., Heptinstall, E., Chadwick, O. & Taylor, E. (1999). Self-report of attention deficit and hyperactivity disorder in adolescents. Psychopathology, 32(2), 81-92.

Dennison, S. T. (1998). Activities for adolescents in therapy: A handbook of facilitating guidelines and planning ideas for group therapy with troubled adolescents (2nd ed.). Springfield, Illinois: Charles C Thomas Publisher, Ltd.

Denzin, N. K. (1989). Interpretive interactionism. Newbury Park, CA: Sage.

Dulcan, M., & Benson, S. (1997). Summary and the practice parameters for assessment and treatment of children, adolescents and adults with ADHD. Journal of the American Academy of Child and Adolescent Psychiatry, 36(9), 1311-1317.

Faigel, H. C., Sznajderman, S., Tishby, O., Turel, M., and Pinus, O. (1995). Attention deficit disorder during adolescence: A review. Journal of Adolescent Health, 16, 174-184.

Frankel, F., Myatt, R., Cantwell, D. P., & Feinberg, M. D. (1997). Parent-assisted transfer of children's social skill training: Effects on children with and without attention-deficit hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry 36(8), 1056-1064.

Guab, M. & Carlson, C. L. (1997). Gender differences in ADHD: A meta-analysis and critical review. Journal of the American Academy of Child and Adolescent Psychiatry 36(8), 1036-1045.

Geller, B., Reising, D. Leonard, H. L. Riddle, M. A., & Walsh, B.T. (1999). Critical review of tricyclic antidepressant used in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry 36(5), 513-516.

Goldstein, S. (1997). Managing attention and learning disorder in late adolescence and adulthood: A guide for practitioners. New York: Wiley Interscience Press.

Goodman, R., & Stevenson, J. (1989). A twin study of hyperactivity: II. The aetiological role of genes, family relationships, and perinatal adversity. Journal of Child Psychology and Psychiatry, 30, 151-159.

Gordon, M. (1993). I would if I could: A teenager's guide to ADHD/Hyperactivity. New York: GSI Publications.

Hall, E. T. (1959). The silent language. Garden City, NY: Doubleday.

Hallowell, E. M. & Ratey, J. J. (1994). Driven to distraction. New York: Pantheon Books.

Halverstadt, J. S. (1998). ADD & romance. Dallas, TX: Taylor Publishing Company.

Hechtman, L. (1991). Resilience and vulnerability in the long-term outcome of attention deficit hyperactive disorder. Canadian Journal of Psychiatry, 36, 415-421.

Jensen, P. S., Mrasek, D., Knapp, P. K., Steinberg, L., Pferrer, C., Schowalter, J. & Shapiro, T. (1997). Evolution and revolution in child psychiatry: ADHD as a disorder of adaptation. Journal of the American Academy of Child and Adolescent Psychiatry, 36 (12), 1672-1681.

Johnson, C., Riester, A., Corbett, C., Buehler, A., Huffaker, L., Levich, K. & Pena, E. (1998). Group activities for children and adolescents. Journal of Child and Adolescent Group Therapy, 8(2), 71-88.

Landau, S., Milich, R., & Diener, M. B. (1998). Peer relations of children with attention-deficit hyperactivity disorder. Reading & Writing Quarterly: Overcoming Learning Disorders, 14(1), 83-105.

Leaman, D. R., (1983). Group counseling to improve communications skills of adolescents. Journal of Specialists in Group Work, 8, 144-150.

McGee, R. & Feehan, M. (1991). Are girls with problems of attention under recognized? Journal of Psychopathology and Behavioral Assessment, 13(3), 187-198.

Parker, H. C. (1991). Making the Grade: An Adolescent's Struggle with Attention Deficit Disorder. Plantation, FL: Specialty Press, Inc.

Pliszka, S. R., Carlson, C.L., & Swanson, J. M. (1999). ADHD with comorbid disorders: Clinical assessment and management. New York: The Guildford Press.

Robin, A. L. (1998). Training families with ADHD adolescents. In R. A. Barkley (Ed), Attention deficit hyperactivity disorder a handbook for diagnosis and Treatment (pp. 413-457). New York: The Guilford Press.

Schelgel, A., & Barry III, H., (1991). Adolescence: An anthropological inquiry. New York: The Free Press.

Smead, R. (1995). Skills and techniques for group work with children and adolescents. Champaign, IL: Research Press.

Stahl, N. C. & Clarizio, H. F. (1999). Conduct disorder and comorbidity. Psychology in the Schools, 36(1), 41-50.

Stern, J. & Ben-Ami, U. (Fall 1998). Talking to children about ADD. ATTENTION! Washington, DC: CH.A.D.D.

Stevens-Long, J., & Cobb, N. (1983). Adolescence and early childhood. Palo Alto, CA: Mayfield Publishing Company.

Stein, M. T., Shafer, M., Elliot, G., & Levine, S. (1999). An adolescent who abruptly stops his medication for attention-deficit hyperactivity disorder. Journal of Development and Behavioral Pediatrics, 20(2), 106-110.

Teeter, P. A. (1998). Interventions for ADHD: Treatment in developmental context. New York. The Guilford Press.

Thompson, L.L., Riggs, P. D., Mikulich, S. K. & Crowley, T. J. (1996) Contributions of ADHD symptoms to substance problems and delinquency in conduct-disorded adolescents. Journal of Abnormal Child Psychology, 24(3), 325-347.

Zeigler-Dendy, C. A. (1995). Teenagers with ADD: A parent's guide. Bethesda, MD: Woodbine House, Inc.

Appendix A

Definitions

For the purposes of this thesis the following terms drawn from the Diagnostic and Statistical Manual of Mental Disorders, (1994), will be used.

Attention Deficit/Hyperactivity Disorder (ADHD), Combined Type - as defined by the DSM-IV, six (or more) of the following symptoms of inattention and hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

Attention Deficit/Hyperactivity Disorder (ADHD), Predominately Inattentive Type - as defined by the DSM-IV, six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

Attention Deficit/Hyperactivity Disorder (ADHD), Predominately Hyperactive-Impulsive Type - six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level

Inattention

a. often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.

b. often has difficulty sustaining attention on tasks or play activities

c. often does not seem to listen when spoken to directly

d. often does not follow through on instructions and fails to finish

schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand)

e. often has difficulty organizing tasks and activities

f. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

h. is often easily distracted by extraneous stimuli

i. is often forgetful in daily activities

Hyperactivity

a. often fidgets with hands or feet or squirms in seat

b. often leaves seat in classroom or in other situations in which remaining seated is expected

c. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

d. often has difficulty playing or engaging in leisure activities quietly

e. is often on the go or often acts as driven by a motor

f. often talks excessively

Impulsivity

g. often blurts out answers before questions have been completed

h. often has difficulty awaiting turn

i. often interrupts or intrudes on others (e.g. butts into conversation or games)

Note: some hyperactive-impulsive or inattentive symptoms have been present before age 7; some impairment from symptoms must be present in two or more settings (e.g., school, work, home)

Oppositional Defiant Disorder (ODD) - as defined by the DSM-IV, a pattern of negativistic, hostile and defiant behaviour lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehaviour
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful or vindictive

Note: the disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning; the behaviours do not occur exclusively during the course of a Psychotic or Mood Disorder; criteria are not met for Conduct Disorder or if over 18, Antisocial Personality Disorder

Conduct Disorder (CD) - as defined by the DSM-IV, a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 6 months.

Aggression to people or animals

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, a knife, a gun)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity

Destruction of property

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed other's property (other than by fire setting)

Deceitfulness or theft

10. has broken into someone else's house, building, or car
11. often lies to obtain goods or favours or to avoid obligations

(i.e., cons others)

12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

13. often stays out at night despite parental prohibitions, beginning before age 13 years

14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

15. often truant from school, beginning before age 13 years

Note: the disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning; if the individual is age 18 year or older, criteria are not met for Antisocial Personality Disorder.

Appendix B

Student Questionnaire

Dear Student,

I want to thank you for your interest in my research. By now you know I am a student at Acadia studying counselling. Through my past teaching experiences, I have become interested in working with students who have been diagnosed with ADHD. I would like to talk to two students in grade twelve about their experiences over the past 5 or 6 years.

Please answer the following questions. Completing this questionnaire does not obligate you to participate nor give consent to participate in this study. I am in the process of looking for participants and if you fit the criteria for my research, we can discuss the procedure in more detail. You will have the opportunity to ask me any questions you might have.

In order for us to meet, I will need your guardian's signature.

Thank you,
Birdie Jane Bezanson
Master of Education, Candidate

Name: _____ Date of Birth: _____
School: _____

At what age were you first diagnosed with ADHD? _____

Who was involved with your diagnosis? Circle one or more
Family Doctor Psychologist Psychiatrist Other _____

Briefly explain the procedure that was followed for a diagnosis.
(If you were diagnosed as a child, your guardians may be able to supply this information)

_____

_____

_____

_____

Have you ever been prescribed medication for your symptoms of ADHD?

Yes No

Have you been diagnosed with other behaviour or learning disorders?

Yes No

_____ _____
Student's Signature Date

_____ _____
Guardian's Signature Date

Appendix C

Permission Letter

Informed Consent Permission Letter
An Adolescent Perspective of Attention-Deficit/Hyperactivity Disorder
Thesis Research in Partial Fulfillment of the Master of Education (Counselling)
April, 2000

Researcher: **Birdie Jane Bezanson**, Master of Education, Candidate
Acadia University

Ms Bezanson is requesting that consent be given for _____ to participate in a research study concerning adolescence and ADHD.
The purpose of this study is to gain an understanding of how adolescents diagnosed with attention-deficit/hyperactivity disorder (ADHD) perceive their successes and failures in adjusting their behaviours to the expectations of a predominately non-ADHD environment. This study is based on the assumption that by discussing the problems faced by the adolescent with ADHD possible counselling interventions can be developed. In short, this study hopes to gain a better understanding of how _____ has moved through their adolescent years.
As stated, the purpose of this study is to examine ADHD during adolescence through the adolescent's own reflections of themselves and themselves in relation to others. It is anticipated that no more than three, one-hour interviews will be needed. Each interview will take approximately 60 minutes. During the interviews, participants will be encouraged to draw from their own memories of what they deem as instrumental in enabling or hindering their movement through adolescence.
Each interview will be audio taped and may be professionally transcribed. The transcriptions will be made available for the participants to read to ensure they are represented accurately. The participant will have the opportunity to remove any part of the interview from the transcriptions. The participant will have the opportunity to clarify any part of the transcript. The participant will have the opportunity to read the final copy of the thesis before it is submitted for defense. At that time, the participant may chose to request that text be omitted from the document. The participant may also chose to clarify anything written in the document. Confidentiality will be respected. No information that discloses the participant's identity will be released or included in the final document. In the event that any form of abuse is disclosed or that there is a possibility that the participant is in danger of hurting him or herself or someone else, the researcher is required by law to inform the proper authorities. Participation is completely voluntary. The participant has the right to refuse to participate and to choose to withdraw from the study at any time without negative consequences. There are no known or anticipated negative effects involved with this research study.

My signature indicates that I have read and understood the above.
I give permission for _____ to participate in this research.

_____ _____
Guardian's Signature Date

My signature indicates that I have read and understood the above.
I agree to participate in this research.

_____ _____
Participant's Signature Date

Appendix D

Interview Guide

1. What is it like to have ADHD?

2. When did you know you had ADHD?

3. If you had to explain what ADHD is to a group of people who had never heard of it, what would you say?

4. In what situation are you most comfortable? Can you explain why? (Home, school, friends house, grandparents house...)

5. What has been your biggest frustration so far?

6. Was there any one person or situation, that you can remember, that made your life easier? Can you explain how they made things easier for you?

7. Was there any one person or situation, that you can remember, that made your life harder? Can you explain how they made things harder for you?

8. If you were to meet a young girl/boy who just found out they had ADHD what would you tell them? What would you tell their parents/friends/teachers?