

## Attitudes toward Individuals with ADHD

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### Abstract

The purpose of this study was to explore the stigmatization of individuals with Attention Deficit Hyperactivity Disorder in athletes and non athletes. The groups, athletes and non athletes, were chosen because they seem to represent individuals with different lifestyles. People who lead different lifestyles may have opposing viewpoints on individuals with ADHD. Participants were asked to complete a 34-item survey regarding the stigmatization of ADHD. The hypothesis was that McKendree University students who are athletes show a higher stigmatization of ADHD than non-athletes. Analysis of the data found that there was not a statistical difference between athletes and non-athletes. However, results indicated that there was a statistically significant difference in men and women on their attitudes regarding ADHD.

Research has found that out of the 73% of students with disabilities who enrolled in college, only 28% completed their programs, compared to 54% of their peers without disabilities (Stein, 2014). In addition, individuals with psychological disabilities withdraw from their programs at an even faster rate compared to individuals with other disabilities or non-disabled students (Stein, 2014). Failure to pursue or attain educational and vocational goals may lead to unemployment, underemployment, or underachievement (Stein, 2014). Also, some of these challenges may be due to lack of support from colleges and community mental health systems, cognitive skill problems, perceived stigmas, lack of opportunities, and the nature of the illness itself (Stein, 2014). Stigma and the fear of stigma could be considered the most difficult barrier for individuals with psychological disabilities to overcome (Stein, 2014).

### **Attention Deficit/Hyperactivity Disorder**

Understanding ADHD and an individual's willingness to seek help, may give insight on the stigmatization of ADHD. Attention-deficit/hyperactivity disorder (ADHD) is considered a multifactorial neurodevelopmental disorder with strong genetic influences (Waite & Ramsay, 2010). The core symptoms of ADHD, characterized by developmentally inappropriate levels of inattention, hyperactivity, and impulsivity, are the result of poor self-regulation and often cause serious impairments in academic performance and social adaptive and behavioral functioning (Waite & Ramsay, 2010). In addition, ADHD in adults is suspected to be commonly undiagnosed because the symptoms of the disorder change with age (Waite & Ramsay, 2010). Culture, help-seeking behavior, and readiness to engage in care, influence adults' willingness for getting help for their own ADHD (Waite & Ramsay, 2010). Also, parents with ADHD frequently have recurring difficulties with planning and completing tasks as well as managing frustration and other emotions in an effective way (Waite & Ramsay, 2010). It is imperative to examine what

influences a parent's recognition of ADHD symptoms, pursuit of assessment and evaluation for ADHD symptoms and initiation of treatment for ADHD (Waite & Ramsay, 2010).

For instance, cultural issues, such as a stigma against help-seeking, negative expectations, financial barriers, and a lack of perceived need for service, stop some individuals from seeking care (Waite & Ramsay, 2010). Culture plays a role in the appearance of ADHD symptoms, the awareness and perception of the impact of these symptoms, and help-seeking behaviors (Waite & Ramsay, 2010). Recognizing the problem and perceived need are important factors in help-seeking and whether or not to participate in treatment (Waite & Ramsay, 2010). Concealability and the disruptiveness of the disorder, affect the level of stigmatization experienced by those affected (Waite & Ramsay, 2010). In addition, parents affected by ADHD may try to conceal their symptoms in any way possible (Waite & Ramsay, 2010). Those affected may be more willing to accept the ADHD diagnosis if they perceive the treatment duration to be short with a good outcome, be more accepting of having ADHD if the effects of it are non-disruptive, be more tolerant of their ADHD if symptoms are not seen as undesirable or upsetting, be understanding if they are well informed about where the condition originated, and be more concerned about their ADHD depending on the likelihood, contact, or harshness of danger to others (Waite & Ramsay, 2010). Research suggests that the utmost degree of stigma for the individual affected by ADHD would be for those features that are extremely visible, apparent as controllable, and misunderstood by society (Waite & Ramsay, 2010). Degree of impairment may be another critical factor influencing a parent's ability to self-identify ADHD symptoms (Waite & Ramsay, 2010).

In addition, ADHD often causes difficulties for adults in social situations and these challenges can often be detected quickly in social interactions, particularly in the case of

externalizing behaviors, which may result in being an outcast (Waite & Ramsay, 2010). Some individuals have less sympathy and feel more justified in their prejudices when another person's behavior appears to be controllable (Waite & Ramsay, 2010). Also, popular belief suggests that adult ADHD represents an excuse for not fulfilling responsibilities and could be easily controlled with more effort (Waite & Ramsay, 2010). Disorders that are not understood are more likely to be stigmatized by the population (Waite & Ramsay, 2010). Furthermore, strength of will in help-seeking for parents with ADHD is shaped by several factors including: individual knowledge about socio-cultural views and fear relate to adult ADHD, expectations about what will occur if help is sought, and level of influence of social networks' attitudes and beliefs about the validity of diagnosis and treatment for ADHD (Waite & Ramsay, 2010). The greater the parent's confidence in being able to manage a situation, the more likely the parent will take the necessary actions (Waite & Ramsay, 2010).

As adolescents enter the collegiate setting, the level of self-responsibility and independence increases immensely, and those with ADHD are often unprepared for the transition (Meaux, Green & Broussard, 2009). Also, adolescents with ADHD must develop ways in which to ease their own abilities in order to successfully navigate the transition to independence and avoid high-risk behaviors (Meaux et al., 2009). In a qualitative study, college students with ADHD who recently moved away from home were able to provide valuable information and insight about the development of self-management and coping strategies (Meaux et al., 2009). The purpose of the study was to: determine the factors that help college students with ADHD and determine factors that hinder college students with ADHD as they learn to cope with the everyday challenges of life and academics once they leave their parents' home (Meaux et al., 2009). In-depth qualitative interviews were the primary data collection tool during this study. 18

college students were recruited from a small public university in the south central USA (Meaux et al., 2009). In addition, volunteers were considered if they met the following criteria: aged 18-21 years, diagnosis of ADHD prior to high school, scores on the Connor's Adult ADHD Rating Scale indicating persistent symptoms, and no longer living with parents (Meaux et al., 2009). Fifteen of the students who met the requirements were scheduled for an in-depth somewhat structured interview (Meaux et al., 2009).

An in-depth qualitative analysis of the interviews presented the researches with three global themes: gaining insight about ADHD, managing life, and utilizing sources of support (Meaux et al., 2009). The first global theme, gaining insight about ADHD, included descriptions of explicit and/or concealed behaviors that enhanced learning or knowledge about ADHD (Meaux et al., 2009). In addition, reluctance to openly discuss ADHD and its challenges was a common factor that hindered insight and understanding about ADHD (Meaux et al., 2009). Participants described how they and their families tried to keep their ADHD diagnosis a secret (Meaux et al., 2009). Also, several participants related that they always felt different and were often called stupid by other children because of the challenges they faced because of ADHD (Meaux et al., 2009). The factors that helped participants gain insight about ADHD were: learning through experience, seeking information, acknowledging, and opening up (Meaux et al., 2009). All of the participants were diagnosed with ADHD prior to high school, and most described learning about ADHD largely through their own experiences (Meaux et al., 2009). They described how ADHD was simply a part of who they were and that through trial and error they had learned what worked and what did not work effectively (Meaux et al., 2009).

Seeking information was the second factor that helped participants gain insight about ADHD (Meaux et al., 2009). Once they became more independent, about half of the participants

actively began to seek more information (Meaux et al., 2009). The most common source of information was the Internet (Meaux et al., 2009). Friends with ADHD were another common source of information (Meaux et al., 2009). None of the participants had participated in an organized educational program about ADHD (Meaux et al., 2009). The third factor that helped participants gain insight about ADHD was acknowledging (Meaux et al., 2009). Opening up was the fourth factor that helped participants gain insight about ADHD (Meaux et al., 2009).

Six of the participants were receiving special education services for ADHD at the university (Meaux et al., 2009). Managing life was the second global theme and included descriptions of overt and/or covert behaviors that affected self-management of ADHD (Meaux et al., 2009). This theme contained two factors that were obstructions to managing life for the college student with ADHD: persistent ADHD symptoms and addictive behaviors (Meaux et al., 2009). All of the participants continued to struggle with persistent symptoms of ADHD-inattention, impulsivity and hyperactivity (Meaux et al., 2009). In addition, the symptoms created challenges to academic success because of poor time management and organization skills, difficulty staying focused, failure to complete work on time, poor motivation, poor reading and study skills, and difficulty sleeping and getting up in the morning (Meaux et al., 2009). Many participants received failing grades simply because of repeatedly missing class (Meaux et al., 2009). Outside of academics, persistent ADHD symptoms presented different challenges (Meaux et al., 2009). For instance, female participants in particular reported that impulsivity posed challenges in their social relationships (Meaux et al., 2009). The factor, addictive behaviors, also created problems for study participants (Meaux et al., 2009). Six male participants described problems with video gaming in which they became so wrapped up and focused on the games that they often played into the early morning hours at the cost of

everything else (Meaux et al., 2009). Alcohol abuse was another addictive behavior that affected at least three of the participants (Meaux et al., 2009).

Data analysis yielded seven factors that helped college students cope with ADHD and manage challenges in everyday life: being accountable, learning from consequences, setting alarms and reminders, taking/using central nervous system stimulants, engaging in self-talk, removing distractions, staying busy and scheduling (Meaux et al., 2009). Having someone to be accountable to was an important self-management strategy (Meaux et al., 2009). For instance, participants described how important it was to have someone to report to (Meaux et al., 2009). Participants recognized that experiencing consequences was often the factor that got their attention and helped them to stay on task and make better decisions (Meaux et al., 2009). An interesting factor that seemed to help participants was self-talk (Meaux et al., 2009). For example, they described how they used self-talk to modify their own behavior (Meaux et al., 2009). Removing distractions was another factor that was commonly described by participants (Meaux et al., 2009). Rather than simply turning off the computer or video game, participants actually physically removed them so that they could not use them at all (Meaux et al., 2009). Studying in a sound proof room in the library, closing blinds as not to observe people walking by and even paying extra for a private room were all measures taken specifically to remove environmental distractions (Meaux et al., 2009). Participants indicated that staying busy and careful scheduling was more helpful than having a lot of free time (Meaux et al., 2009).

The third theme, utilizing sources of support, included descriptions of external sources of support such as parents, friends, teachers/tutors/advisors, academic disability services and healthcare providers, as well as descriptions of lack of support or choice to refuse available resources (Meaux et al., 2009). Two factors related to this theme, lack of knowledge and missed

opportunities, hindered participants coping with ADHD and managing challenges in everyday life (Meaux et al., 2009). Some participants had little knowledge of ADHD beyond their own experiences, and most had little knowledge about the services available to them because of their ADHD (Meaux et al., 2009). The second hindering factor relate to the theme utilizing sources of support was missed opportunities (Meaux et al., 2009). Some participants utilized teacher support to help them cope with academic challenges related to their ADHD (Meaux et al., 2009). Participants reported that college professors who knew about their ADHD diagnosis usually went out of their way to provide necessary accommodations as long as they showed they were willing to do the work (Meaux et al., 2009). Academic support or disability services were also an important source of support for six of the participants (Meaux et al., 2009).

### **Stigma and Mental Illness**

Stigma may be defined as social judgment that separates individuals from one another based on the idea the some people or groups are have characteristics that label them as less than the people around them(Martin, Lang, &Olafsdottir,2008). Even though psychiatry has claimed remarkable increases in effective treatments and social scientists have documented greater levels of public acceptance of medical theories about underlying biological and genetic causes of mental illness, recent research has shown that individuals fear and avoid people with mental illness (Martin et al., 2008). Consequently, negative attitudes and experiences of rejection and discrimination have continued to affect the quality of life for persons with mental illness and their families (Martin et al., 2008). Classic studies conducted in the 1950's and 1970's documented a lack of understanding of mental illness and negative attitudes surrounding causes, treatments, and outcomes (Martin et al., 2008). In the 90's, research found that Americans and Canadians reported an unwillingness to work with or have intimate relationships with persons



with mental illness and agreed with images of persons with mental illness as unpredictable and dangerous (Martin et al., 2008). Individuals with mental health problems, their families, and their providers reported intense and continuous experiences of stigma and discrimination (Martin et al., 2008). In addition, effects of stigma include a lower quality of life and well-being, persistent stress, low self-esteem, interference with recovery, loss of legal rights, discrimination in medical care, and shortened life-span (Martin et al., 2008). Stigma lies in the ideas of community and individual factors. The FINIS framework focuses on the central theorem that several different levels of social life set the standard expectations that play out in the process of stigmatization (Martin et al., 2008). FINIS stands for Framework Integrating Normative Influences on Stigma (Martin et al., 2008).

In the micro level, the combination of social and illness characteristics shape how easily a person can be identified by a stranger as a person with a mental illness (Martin et al., 2008). In other words, the more that the target person holds devalued attributions, the more likely that the person they come in contact with will label the problem as serious, perceive it as a mental illness, and express stigmatizing responses (Martin et al., 2008). The greater social differentiation between the target and the receiver, the likeliness of negative responses increases (Martin et al., 2008). If the problem is perceived as serious or as causing the person to behave in ways outside the social norms, stigma increases (Martin et al., 2008).

New social and cognitive psychologists have suggested that stigmatizing attitudes are implicit, hidden in motivation, and unrecognized by individuals (Martin et al., 2008). However, there are other social psychologists who believe that conscious motivations and emotions drive stigma (Martin et al., 2008). In addition, individuals who feel social cues associated with others' behavior toward them may experience negative self-stigma (Martin et al., 2008). A persons

awareness of having a devalued social identity can also influence the perception and response to social insults and to the acts of discrimination (Martin et al., 2008). Furthermore, understanding the dismissive stereotypes held by others in society sets up a stereotype threat, which can negatively affect an individual's performance, reinforcing the stereotype and the prejudice and discrimination that follow from it (Martin et al., 2008).

In the macro level, research has suggested that media represents a powerful influence in shaping the image of mental illness (Martin et al., 2008). In addition, research examining newspapers, movies, and television has indicated that individuals with mental illness are seldom portrayed in a positive light (Martin et al., 2008). Images of danger, unpredictability, and incompetence dominate (Martin et al., 2008). Also, people view the world through mental and social constructs and viewers make subconscious judgments about the real world based on information obtained while watching TV (Martin et al., 2008). From a national perspective, cultural and historical forces shape norms. Economic and cultural systems both have implications for stigma (Martin et al., 2008). Furthermore, social organization of a society has revealed who is able to obtain power and has also shaped how citizens view themselves and others within society (Martin et al., 2008).

In the meso level of social networks, the concept of contact with persons with mental illness has long been thought to be a potential source of change and a basic force in human lives (Martin et al., 2008). Early studies in workplaces, neighborhoods, and schools widely supported the notion that increasing interaction between those marked and unmarked increases ideas of liking (Martin et al., 2008). Furthermore, training or other educational efforts have been documented to break down barriers and to decrease perceptions of persons with mental illness as dangerous (Martin et al., 2008). The contact hypothesis has only held if contact is voluntary,

equal, intensive and/or rewarding, prolonged, or where there are a number of people involved (Martin et al., 2008). FINIS has suggested that media exposure to images of MI and real-life exposure to individuals known or appearing to have mental illness will interact to create physiological, cognitive, attitudinal, and emotional responses (Martin et al., 2008). Even a small amount of experience harmonious to the TV messages may considerably increase a message's success (Martin et al., 2008). Having contact with a person with mental illness is likely to dilute the impact of negative media images only if positive experiences occur (Martin et al., 2008).

Negative inferences and false assumptions connected with mental illness may be as harmful as the disease itself (Overton and Medina, 2008). Societal stigma significantly limits opportunities that are available for people with serious mental illness (Overton and Medina, 2008). In addition, mental illness may be defined as the spectrum of cognitions, emotions and behaviors that interfere with interpersonal connections as well as day-to-day occupations such as work and school (Overton and Medina, 2008). Stigma is a adaptable construct that involves feelings, attitudes, and behaviors (Overton and Medina, 2008).

Social identity theory considers how people use social constructs to judge someone who is not the same or is disfavored (Overton and Medina, 2008). Stigmatized people form a virtual social identity when they become disfavored or dishonored in the eyes of the people around them, and then they become outcasts (Overton and Medina, 2008). Historically, mental illness has been viewed as a character of moral flaw (Overton and Medina, 2008). Spoiled combined identity describes people who were stigmatized and whose identity as a whole were brought into question; the stigmatized person has been condensed in the minds of others from a whole and normal person to a tainted, discounted one (Overton and Medina, 2008). Stigma occurs when an

actual social identity falls short of an expected socially defined identity (Overton and Medina, 2008).

Self-stigma is an internal assessment where people judge themselves (Overton and Medina, 2008). Self-esteem decreases as a person tells him or herself that he or she does not fit in or is not good enough to live up to the expectations that others inflict on a individual and his or her environment (Overton and Medina, 2008). Self-efficacy has an impact on the belief that one can perform, confidence in one's future is diminished when self-efficacy is meager (Overton and Medina, 2008). When individuals do not live up to the social norms regarding their identity, they have feelings of inferiority and self-hate (Overton and Medina, 2008). Structural stigma is an external evaluation of a person that is based on society's outlook (Overton and Medina, 2008). This theory looks more in depth at the process of stigma throughout culture and how stigma works as a system (Overton and Medina, 2008). Structural stigma denies people with a mental illness their privilege to things that people who are considered normal take for granted (Overton and Medina, 2008). People with mental illness may have difficulty finding their occupation or a sense of place in the world and they might also be challenged in the effort to find considerate and supportive relationships with others, happiness, participatory citizenship, and peace of mind (Overton and Medina, 2008).

Structural stigma may be defined as a process that involves the detection of cues that a person has a mental illness, activation of stereotypes, and prejudice or discrimination against that person (Overton and Medina, 2008). A cue is a social cognitive process of recognizing that something is different about a person and may be something physical or observable (Overton and Medina, 2008). For instance, a cue could be defined by a label or psychiatric diagnosis (Overton and Medina, 2008). After a person has been cued that there is something different about a

person, stereotypes are triggered with that individual's thought process (Overton and Medina, 2008). Stereotypes may be defined as knowledge structures that are learned by the majority of members in a social group (Overton and Medina, 2008). When someone allows a negative stereotype, he or she is creating what is called prejudice (Overton and Medina, 2008). Consequently, prejudice is a result of cognitive and affective responses to stereotypes (Overton and Medina, 2008). Prejudice leads to discrimination: a behavioral response to the emotions and beliefs provoked by prejudice (Overton and Medina, 2008). There is an emotional reaction that comes from attaching stigma to someone or something (Overton and Medina, 2008).

For instance, the belief systems that society holds about mental illness are so deep-seated that when someone has an interaction with a mentally ill person, their cognitive processes often distort the social relationship, leading to conscious and unconscious behaviors (Overton and Medina, 2008). Behaviors displayed by the majority group result in negative action toward the stigmatized group and positive action for the majority group (Overton and Medina, 2008). The positive action reinforces beliefs and stereotypes that were previously held by the majority group and creates barriers between the groups (Overton and Medina, 2008). Avoidance is a common act that a majority group can take; the stigmatized group becomes the out-group (Overton and Medina, 2008). Avoidance may be described as the act or practice of keeping away from or withdrawing from something not wanted (Overton and Medina, 2008). It has been suggested that avoidance might serve several different uses, including social exchange, maintenance, and contagion (Overton and Medina, 2008). In addition, social exchange is based on the idea that people get something positive out of social interactions (Overton and Medina, 2008). If individuals are cued that someone with a mental illness is not the same or is perceived as less than them in social status, they are less likely to interact with that person (Overton and Medina,

2008). They might be concerned about the social transaction and use avoidance with someone who they perceive will offer them little or no social gain (Overton and Medina, 2008).

Maintaining an ideal identity is also important to maintain group norms and beliefs (Overton and Medina, 2008). Furthermore, distancing allows the group with power to exploit un-favored groups and maintain their ideal identity as a group (Overton and Medina, 2008). People often act as if physical contact with or even being close to the stigmatized person can result in some sort of contamination (Overton and Medina, 2008). Avoidance is useful in dealing with the social consequence that being associated or socializing with a stigmatized person may influence one's social standing (Overton and Medina, 2008). The person socializing with someone with mental illness may be subject to the infection of falling into the social group of the mentally ill (Overton and Medina, 2008).

As a culture, it is considered normal to view people with mental illness as dangerous and violent (Overton and Medina, 2008). Citizens are less likely to hire people who are labeled mentally ill (Overton and Medina, 2008). Also, employers often assume that people with a mental illness may be more likely to be absent, dangerous, or unpredictable (Overton and Medina, 2008). Anticipation of negative responses from employers and fellow employees can also result in people with mental illness withdrawing from or limiting their social or occupational responsibilities (Overton and Medina, 2008). In addition, researchers have found that once people have been labeled mentally ill, they are more likely to be unemployed and to earn less than people with the same psychiatric difficulties but who have not been labeled as having them (Overton and Medina, 2008). Furthermore, this research demonstrates that labeling alone can affect chances of employment without taking into consideration a person's ability, knowledge, education, or qualifications for a particular job (Overton and Medina, 2008). Controllability may

be the key to acts of discrimination toward people with mental illness (Overton and Medina, 2008). Controllability may be defined as the amount of choice one has in a situation (Overton and Medina, 2008). Research has found that stigmatized people who had an attribute that was easily concealed from others could avoid negative attitudes by concealing the attribute and choosing to not seek support services (Overton and Medina, 2008). If a person with mental illness is able to reach out and seek service, the effects of stigma have been shown to influence the efficacy of his or her treatment (Overton and Medina, 2008).

After hearing negative feedback and experiencing a large amount of negative actions, people with mental illness begin to see themselves in a negative way (Overton and Medina, 2008). Those who have been diagnosed with a mental illness often find that their self-image and confidence are sacrificed by living under the pressure and negative expectations created by stigma (Overton and Medina, 2008). In addition, stigmatizing language is the result of a history of oppressing and dehumanizing people with mental illness (Overton and Medina, 2008). These ideas reflect an underlying attitude that contributes to a lack of self-efficacy for people with mental illness (Overton and Medina, 2008). Self-efficacy may be defined as people's beliefs about their ability to achieve social expectations (Overton and Medina, 2008). Furthermore, self-efficacy is influenced by negative thoughts and low self-esteem (Overton and Medina, 2008). When people with a mental illness perceive that they do not have a support system and that they are dehumanized, they have a lower level of self-efficacy (Overton and Medina, 2008). Consequently, stigma imposed by others creates the prospect that people with mental illnesses are incapable of living up to the responsibilities that are a part of everyday life (Overton and Medina, 2008). Self-esteem is also affected by stigma and is defined as a person's appraisal of himself or herself at an emotional level (Overton and Medina, 2008).

There are three areas in which stigma researchers have suggested could encourage change to help reduce stigma related to people with mental illness: protest, education, and contact (Overton and Medina, 2008). Protest may be defined as a complaint or objection and through protest an attempt is made to suppress stigmatizing attitudes by directly instructing individuals not to think about or consider negative stereotypes (Overton and Medina, 2008). Protest may be used to negate ingrained beliefs by proposing arguments or facts that disprove the belief system (Overton and Medina, 2008). Research found that the attempt to suppress stereotypes through protest can often result in a rebound effect and generally does not reduce stigma (Overton and Medina, 2008). The attempt to keep unwanted thoughts out of the mind might actually make these thoughts more prevalent (Overton and Medina, 2008). Education is another method that has been used to attempt to end stigma and is the means of conveying factual information to specific populations (Overton and Medina, 2008). Education is helpful for changing attitudes but has little effect on future behaviors (Overton and Medina, 2008). Furthermore, education may help to stop stigma slightly but does not last over time (Overton and Medina, 2008). Contact or direct interaction is an additional way to reduce stigma (Overton and Medina, 2008). There is an extensive amount of research that shows that interpersonal contact with someone with a mental illness is far more effective at extenuating stigma than either protest or education (Overton and Medina, 2008). Contact has the ability to change both attitudes and behaviors (Overton and Medina, 2008). The more personal contact a person has with a stigmatized group, the fewer stigmatizing attitudes he or she will have (Overton and Medina, 2008). Overall, a combination of personal contact, education, and cooperative contact may reduce stigma (Overton and Medina, 2008). When people have contact with someone with a mental illness and this person is



perceived to have equal status, either professionally or personally, then such contact reduces stigma (Overton and Medina, 2008).

## **Research Hypotheses**

It appears as though individuals with ADHD tend to fail to seek help because of the stigmatizing factors in their environment. This study will attempt to explore how athletes view ADHD differently than non-athletes

Undergraduate research participants will be asked to complete a 34-item survey measuring the stigmatization of ADHD. It is predicted that athletes will show a higher level of stigmatization than non-athletes. These predictions will be tested by an independent samples t-test with college students as the independent variable and ADHD stigmatization as the dependent variable. Athletes will be measured by self report and ADHD stigmatization will be measured by the ADHD Stigma Questionnaire (Kellison et al., 2010).

## **Method**

### **Participants**

Eighty-seven undergraduate students from a private midwestern university participated in the study. Forty-eight percent of the sample were men and 52% were women. Twenty-two individuals reported that they were transfer students, 48 students reported that they participated in sports, and 46 people reported that they were athletes. Seven surveys were thrown out due to incompleteness.

### **Materials**

A 34-item survey was used to measure individual's attitudes toward ADHD. Six items in the survey asked demographic questions, 26 items were the ADHD Stigma Questionnaire, one

question asked the participant if they knew anyone who had been diagnosed with ADHD, and the final questions asked if the participant taking the survey had been diagnosed with ADHD.

**ADHD Stigma Questionnaire.** A study was conducted to assess the validity of the ADHD Stigma Questionnaire (ASQ) (Kellison, Bussing, Bell, and Garvan, 2010). It consisted of a sample of 301 adolescents (11-19 years old) who were at high and low risk for ADHD (Kellison et al., 2010). Factor analysis of disclosure concerns, negative self image, concern with public attitudes, and a Schmid-Leiman analysis supported a general stigma factor (Kellison et al., 2010). Test-retest stability was evaluated after two-weeks (Kellison et al., 2010). The study's hypothesis was that assessment tools originally developed to assess relevant stigma constructs in other health conditions might lend themselves to adaptation (Kellison et al., 2010). The use and validity of a tool designed to assess stigma associated with HIV has been implemented and is potentially relevant to ADHD because of disclosure concerns, negative self image, and negative public perceptions towards affected persons (Kellison et al., 2010). Participants were gathered from a longitudinal study designed to produce a representative community sample of students at high and low risk for ADHD (Kellison et al., 2010).

This study was conducted via telephone interviews (Kellison et al., 2010). Additional measures used were the Swanson Nolan and Relham Version IV, Vanderbilt Assessment Scale-Parent Report, and the Behavior Assessment for Children, Self Report of Personality (Kellison et al., 2010). The study suggested that higher stigma perceptions are associated with greater disclosure concerns, more negative self-image, and increased concern with public attitudes (Kellison et al., 2010). Some limitations included not asking about the stigma associated with medication and the lack of gender and cultural background on the perception of stigma surrounding ADHD (Kellison et al., 2010). It seems as though this study provides a survey that

can support a general assessment of the stigmatization of ADHD (Kellison et al., 2010). Their participant group was useful in that it included individuals with and without ADHD (Kellison et al., 2010). The study could have focused more on the cultural implications surrounding ADHD and should have included more information specifically pertaining to ADHD. It seems as though the survey should have consisted of some questions pertaining to the stigmatization of medication taken by individuals to reduce their symptoms.

## **Procedures**

Each survey was handed out to students at the beginning of their class period. The researcher handed out the surveys and requested that participants initial and date the informed consent form. After surveys were completed, the researcher collected the surveys and put them into a manila envelope.

## **Results**

In order to test whether is a difference in athletes and non-athletes in their perception of ADHD, an independent samples t-test was performed between athletes and non-athletes on the ASQ. This analysis indicated that there was not a significant difference in the scores for Athletes (M= 56.93 SD= 11.44) and Non-Athletes (M= 61.59 SD= 10.48) conditions;  $t(85) = -1.97$ ,  $p = .052$ . Even though it was not hypothesized an independent samples t-test was performed between men and women. This analysis indicated that there was a significant difference in the scores for Men (M= 56.45 SD= 11.79) and Women (M= 61.62 SD= 10.08) conditions;  $t(85) = -2.20$ ,  $p = .0$ .

## **Discussion**

The Hypothesis that there is a difference in the stigmatization of ADHD in athletes and non-athletes was disproved by the results presented by the independent samples t-test. However, the results did show that there is a difference in the stigmatization of ADHD in men and women. This information may suggest that women show a higher stigmatization of ADHD than men. For future studies, it would be ideal to have more diverse participants and a much larger population to get a better view of how people view individuals with ADHD. In addition, it may be beneficial to test the data against a different stigma scale.

## References

- Kellison, I. Bussing, R., Bell, L., & Garvan, C. (2010). Assessment of Stigma Associated with Attention-Deficit Hyperactivity Disorder: Psychometric Evaluation of the ADHD Stigma Questionnaire. *Psychiatry Research*, 178(2), 363-369.
- Martin, J.K., Lang, A., & Olafsdottir, S. (2008) Rethinking Theoretical Approaches to Stigma: A Framework Integrating Normative Influences on Stigma (FINIS). *Social Science & Medicine* (1982), 67(3), 431-440.
- Meaux, J., Green, A., & Broussard, L. (2009). ADHD in the College Student: A Block in the Road. *Journal of Psychiatric & Mental Health Nursing*, 16(3), 248-256. 9p.
- Overton, S.L., & Medina, S.L. (2008). The Stigma of Mental Illness. *Journaling of Counseling & Development*, 86(2), 143-151.
- Stein, K.F. (2014). Experience of College Students with Psychological Disabilities: The Impact of Perceptions of Faculty Characteristics on Academic Achievement. *International Journal of Teaching & Learning in Higher Education*, 26(1), 55-65.
- Waite, R. & Ramsay, J. (2010). A Model for Parental ADHD: Help-Seeking and Readiness to Change. *Issues in Mental Health Nursing*, 31(12), 793-803 11 p.