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UNDERSTANDING THE CONNECTION BETWEEN CLINICALLY DIAGNOSED ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER), AND/OR DEPRESSION, WITH CHILDHOOD ABUSE/MALTREATMENT: A QUALITATIVE INTERPRETIVE META-SYNTHESIS

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by

MIRIAM TEPPER

Presented to the Faculty of the Honors College of

The University of Texas at Arlington in Partial Fulfillment

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November 7, 2018

ABSTRACT

UNDERSTANDING THE CONNECTION BETWEEN CLINICALLY DIAGNOSED ADHD (ATTENTION DEFICIT HYPERACTIVITY DISORDER), AND/OR DEPRESSION, WITH CHILDHOOD ABUSE/MALTREATMENT: A QUALITATIVE INTERPRETIVE META-SYNTHESIS

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The University of Texas at Arlington, 2018

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Attention Deficit Hyperactive Disorder (ADHD) is a chronic, neurological disorder diagnosed in children who show symptoms of inattention, and/or hyperactive/impulsive behaviors. Considering that these symptoms overlap with some symptoms of abuse and neglect, it is necessary to further explore how to differentiate. A Qualitative Interpretive Meta-Synthesis (QIMS) was conducted to synthesize results from existing qualitative studies on students who were abused or neglected. Almost 150 school-aged students and 14 agencies were included in this paper. Six major themes emerged: 1) setting the stage, 2) the unexpected role of school, 3) how it started, 4) how it ended, 5) long term effects of abuse, and 6) intervention/prevention methods. Child victims may exhibit similar symptoms of Attention Deficit Disorder (ADD)/ADHD while trying to cope with abuse;

however, this does not mean they have the neurological disease. Therefore, it is imperative that teachers and relevant school personnel receive additional training in identifying these differences.

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CHAPTER 1

INTRODUCTION

Attention Deficit Hyperactive Disorder (ADHD) is a chronic, neurological disorder diagnosed in children who show symptoms of inattention, hyperactive/impulsive behaviors, and/or a combination of these two symptoms. Symptoms of ADHD can emerge as early as age four and are usually diagnosed in children by age 12 (Attention-deficit/hyperactivity disorder [ADHD] in children, 2017). There is not one specific test that can be given to diagnose ADHD in children. It is a long process that starts by ruling out other factors, such as anxiety or depression that may contribute to inattentive or hyperactive behaviors. Next, professionals interview the child about their problem behaviors to determine if these behaviors are beyond the scope of typical child behavior. Every child has times of inattention and hyperactivity; however, a child with ADHD will have these symptoms to the extreme. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) provides three categories of ADHD: the inattentive type, the hyperactive type, and a combination of the two. Each category has a list of nine symptoms that fall within each category. To be diagnosed with ADHD, individuals must have six of the nine symptoms outlined in the DSM-5 for at least six months (Diagnosis of ADHD using DSM-5TM, n.d.).

1.1 Statement of the Problem

ADHD and Post Traumatic Stress Disorder (PTSD) have some overlapping symptoms. PTSD is an atypical way of processing one’s emotions after a traumatic event

or childhood abuse or neglect. Some of these atypical ways of coping with trauma similar to the symptoms of ADHD are: dissociation or inattention to one's surroundings, hyperactivity or quick response to stimuli, and attention problems (Kaplow, Hall, Koenen, Dodge, & Amaya-Jackson, 2008). Getting the right intervention is a necessary component to the physical, mental and emotional well-being for these victims. Misdiagnosis has short and long-term effects. Getting the wrong treatment can exacerbate behaviors leading to failure and low self-esteem.

1.2 Significance to Social Work

A social worker's role is to be of service to the most vulnerable groups in society (National Association of Social Workers' [NASW] Code of Ethics, 2017). A social worker can be of invaluable service to youth exhibiting symptoms of ADHD, by filtering out what others cannot. By learning about this population and gaining understanding of the underlying reasons for the exhibited symptoms, social workers can assist youth in getting the accurate care that they need. Often, it is simpler in educational settings to diagnose without a proper and thorough background as to why the behaviors are manifesting in a school setting. By understanding the full picture of the biopsychosocial life outside of school, the social worker better serves this population. A social worker can filter out a diagnosis of ADHD, for example, by determining if the behaviors exhibited are a neurological issue or an outcome of abuse and neglect. Thus, the purpose of this study was to conduct a Qualitative Interpretive Meta-synthesis (QIMS) to synthesize results from existing qualitative studies on students who were abused or neglected to further explore similarities among abuse symptoms and symptoms of ADHD.

CHAPTER 2

LITERATURE REVIEW

Symptoms of ADHD will vary based on one's sex, race, ethnicity, and age. Males are more likely to have hyperactive type of ADHD, while females are more likely to have the inattentive type coupled with the depression type of ADHD. This leads to the underdiagnosis of ADHD for females because their symptoms are less disruptive in a classroom setting and can easily go unnoticed by staff members at school (Becker-Blease & Freyd, 2008). Levels of diagnosed ADHD will also vary among different ethnic groups. African Americans and Latinx students are less likely to be diagnosed with ADHD when compared to White Americans exhibiting the same levels of ADHD symptoms (Coker et al., 2016). ADHD symptoms can start as early as age four; however, these symptoms may start earlier and be more severe if that child is being abused. The reason for the early onset of these ADHD symptoms is attributed to environmental stress and genetic predisposition (Sonnby et al., 2011). This means that a child who is genetically more vulnerable to ADHD will show these signs earlier if they are living in an abusive and neglectful environment.

2.1 Prevalence of Sexual Abuse and Other Forms of Abuse

Studies of abused adolescents found that the majority of those who were diagnosed with ADHD or depression experienced sexual abuse (Sonnby et al., 2011). These findings are based on adolescents who were previously referred to Child Protective Services (CPS) for suspected abuse and neglect. Childhood neglect and family stress are the two other (after sexual abuse) most common types of abuse/stress that children experience.

Researchers have found that adolescents (16-18 years old), who were diagnosed with ADHD often came from neglectful, low income, or non-intact families (Hurtig et al., 2007). Here, a connection is observed between family environment and the level of ADHD symptoms in adolescence. However, since the ADHD symptoms were assessed through a self-assessment test that was completed by the parents of these adolescents, the connection is hypothetical. The parents may have been biased about the severity of the symptoms they saw in their children, especially if the parents were chronically stressed.

2.1.1 Sex Differences

ADHD is a common diagnosis given to children who are inattentive, hyperactive, or impulsive and meet the criteria of the DSM-5 diagnostic manual for ADHD. Females and males differ in their symptoms of ADHD, even more so if a child is a victim of abuse. Typically, ADHD symptoms can be seen in children starting as young as age four. Children who continue to show signs of ADHD as they grow older, are usually diagnosed with the disorder before age 11 (Coker et al., 2016). ADHD symptoms and the severity of these symptoms change for children who are being abused or neglected. Becker-Blease and Freyd (2008) studied ADHD in abused children ages 8 to 11. They found that abused girls are more likely to show inattentive-type symptoms, more likely to internalize their problems, and less likely to be referred to treatment as compared to abused boys. The fact that girls are more likely to be inattentive and less disruptive in a classroom setting leads to the underdiagnosis or lack of diagnosis for girls who may be suffering from ADHD symptoms. On the other hand, boys tend to be more hyperactive, externalize their symptoms, and be referred for treatment earlier than girls (Becker-Blease, & Freyd, 2008). This study shows that there is a distinct difference in symptomology of ADHD between

boys and girls. It also demonstrates that girls tend to be underdiagnosed or receive no diagnosis for their symptoms of ADHD. This is a problem because children with ADHD who do not receive treatment are at an even greater risk of dropping out of school, and eventually becoming homeless, than children who are treated for ADHD (Coker et al., 2016).

Another study conducted on 15 to 18-year old Swedish adolescents produced similar results. They found that abused girls who were diagnosed with clinical ADHD were more likely to show signs of poorer health and depressive symptoms when compared with abused boys. The depressive symptoms attribute to girls being underdiagnosed with ADHD and other psychiatric disorders (Sonnby et al., 2011). This is a problem because girls are more likely to experience sexual abuse, which Kaplow et al. (2008) state puts these young girls at a greater risk of developing symptoms of ADHD and depression later on in life. For boys, the risk for ADHD going untreated is less likely because their symptoms lead to early referral to psychiatric evaluation and treatment (Sonnby et al., 2011). With these findings it is important to note the different symptoms of ADHD so that both sexes receive adequate and timely care. The best way to help abused children with ADHD is to identify them as soon as possible and provide the treatment they need.

It is important to note that the previous two studies conducted by Becker and Freyd (2008) and Sonnby et al. (2011) are limited. The difference in symptomology amongst boys and girls were only found if the abuse was sexual or physical. Hurtig et al. (2007) studied the severity of ADHD symptoms as it relates to family environment, did not find any significant sex difference when the contributing factor was neglect.

2.1.1.1 Race, Ethnicity and Age

Research findings support that ADHD varies amongst different ethnic and racial groups in diagnostic and medication statistics. This variation is a result of underdiagnosing particular minority groups. Coker et al. (2016) studied ADHD amongst African Americans, Latinx, and White Americans. They found that African Americans are less likely to be diagnosed with ADHD or take medication for the symptoms, as compared to White Americans. Furthermore, the reason for this phenomenon is that African American and Latinx are underdiagnosed when compared to White Americans having the same symptoms. The reason for the underdiagnosis of these groups is due to their limited access to the healthcare system, language barrier, and fear of being deported if illegally living in the United States (Coker et al., 2016).

ADHD can be diagnosed as early as age four. However, ADHD with depression usually presents itself at a younger age, lasts much longer, and can be more severe. The early onset of these ADHD symptoms can be attributed to environmental stress and genetic predisposition (Sonnby et al., 2011). This means that a child who is genetically more vulnerable to ADHD will show these signs earlier if they are living in an abusive and neglectful environment. Furthermore, abuse and neglect are attributed to longer and/or more severe symptoms of ADHD. It is important to understand that this information was received from a research study that was conducted on children after they had been diagnosed with ADHD. There is no research that shows the symptomology of ADHD present in children who are not predisposed to having ADHD and may be showing these similar symptoms as a way to cope with abuse and neglect. More studies need to be conducted in children who have just started showing signs of ADHD and are experiencing

abuse or neglect at home to ascertain whether abuse and neglect contribute to the early onset of ADHD symptoms.

2.2 ADHD and Depression

Sonnby et al. researched the co-occurring symptoms of ADHD and depression in adolescent boys and girls. They found that adolescents diagnosed with ADHD are five times more likely to suffer from depression as well (2010). Masten et al. studied the facial emotions of maltreated children with high rates of PTSD due to childhood maltreatment. The results of this study concur with the previously stated findings. They conclude that maltreated children are at greater risk for developing major depressive disorder than children who have not been abused (2007).

2.3 ADHD and Post Traumatic Stress Disorder Symptomology

ADHD and PTSD have some overlapping symptoms. PTSD is an atypical way of processing emotions after a traumatic event or childhood abuse or neglect. Some of these atypical ways of coping with trauma that are similar to the symptoms of ADHD are: dissociation or inattention to one's surroundings, hyperactivity or quick to respond to stimuli, and attention problems (Kaplow et al., 2008). Kaplow et al. (2008) concluded from studying dissociation present in sexually abused children that the faster these children received intervention after the abuse occurred, the less likely they were to develop inattentive behaviors later on in life. However, this research included children who were already referred to child protective services and an investigation had been conducted that confirmed the presence of child maltreatment (specifically sexual abuse) in the home. There is a lack of research on whether there is a way to determine if a child is showing signs of inattention/dissociation or impulsivity due to PTSD or ADHD.

Masten et al. (2007) also found that there is a connection between childhood maltreatment and PTSD. However, their study did not specifically compare the symptoms of PTSD to ADHD. They concluded that children who are maltreated are quicker to respond to stimuli, lack the ability to focus, and have atypical ways of processing and expressing emotions (Masten et al., 2007). This shows that childhood maltreatment can lead to children acting out in a way that may present itself similar to the symptoms of ADHD.

2.4 Effects of Sexual Abuse

Sexual abuse is a heinous crime and a traumatic event for the child involved. Sexual abuse effects the development of the child victim in many ways. Sonnby et al. (2011) studied abused adolescent boys and girls and found that a majority of the adolescents who were diagnosed with ADHD or depression experienced sexual abuse. However, they did not find a link between adolescents who reported being sexually abused then later experiencing symptoms of ADHD or depression (Sonnby et al., 2011). Another study conducted by Kaplow et al. (2008), found a link between sexually abused victims and adolescents who later developed symptoms of ADHD in the form of inattentiveness, poor concentration, and hyperactivity. This means that there could be a way to determine if a child is being abused at home, based on a specific set of symptomologies that child is showing in school.

2.5 Effects of Other Types Abuse

Childhood neglect and family stress are the two other (besides sexual abuse) most common types of abuse/stress that children experience. Hurtig et al. (2007) conducted a study on ADHD and co-occurring disorders as they relate to the family environment. They found that adolescents (16 to 18 years old), who were diagnosed with ADHD many times came from non-intact families, low income families, families in which parents were neglectful, or a had a single mother who was not happy with her situation in life. Symptoms of ADHD were worse in those who grew up in an environment that was unsupportive when compared to children with ADHD in a supportive environment (Hurtig et al., 2007). Here, we see a connection between family environment and the level of ADHD symptoms in adolescents. However, this connection is limited because the ADHD symptoms were reported through a self-assessment test that was completed by the parents of these adolescents. The parents may have been biased about the severity of the symptoms they saw in their children, especially if the parents were chronically stressed. More studies need to be conducted to ascertain if there is a connection between an unsupportive/neglectful environment and the severity of the symptoms of ADHD.

Perroud et al. (2015) found different results in their scientific study of the hormone levels of Serotonin 3A. They studied the effects of childhood maltreatment (e.g., physical, sexual, emotional abuse, witnessing violence) on Serotonin Receptor 3A in ADHD and other psychiatric mood disorders. Serotonin 3A is responsible for mood regulation. When this hormone is higher or lower than it should be, one will experience mood swings/disorders. They found that childhood maltreatment did in fact affect the levels of this receptor, putting these children at a greater risk of several psychiatric disorders later in

life. Some of these disorders include: depression, anxiety, mood disorders and others. However, they did not find a direct link between childhood maltreatment and ADHD (Perroud et al., 2015).

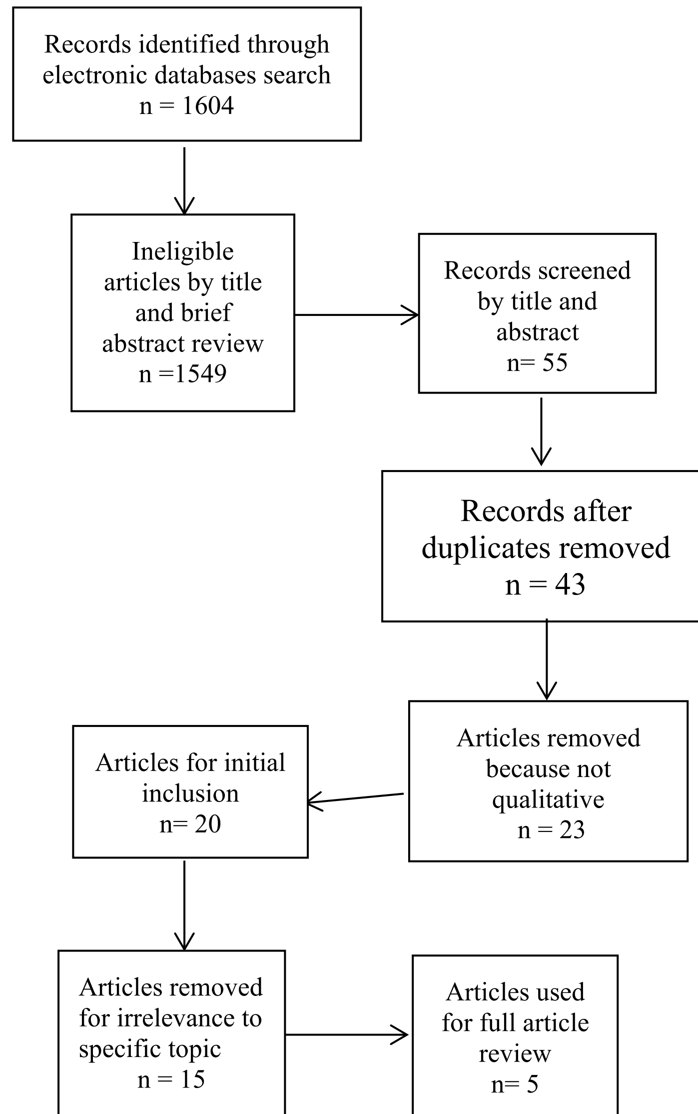
CHAPTER 3

METHODOLOGY

This research used a Qualitative Interpretive Meta-Synthesis (QIMS) design. QIMS is an in-depth, qualitative design that systematically analyzes already published articles on a specific human experience of a particular group of people, synthesizing what is shared from this particular experience and what may be different across studies. The development of this method is relatively new and is used as a qualitative cross-study analysis specifically for the field of social work (Aguirre & Bolton, 2013).

There are several steps identified in a QIMS study. The first is to develop a research question by looking at published qualitative research on a specific topic. The main question is: Does the qualitative literature illuminate how abuse could be misdiagnosed as ADHD? Next, a large sample of qualitative articles, that were relevant to this topic, were selected. The database used was Academic Search Complete. Some of the key words used were ADHD/Attention Deficit Hyperactive Disorder, childhood maltreatment and/or neglect, sexual abuse, and PTSD/Post Traumatic Stress Disorder. Third, the articles were reviewed and eliminated based on their relevance to the topic being studied, their bias, or if there were other fatal flaws as set forth by Aguirre and Bolton (2013). The remaining articles were sent to the faculty advisor overseeing this research, who looked over the remaining articles and eliminated 30 out of the 50 articles. The reason these 30 articles were eliminated was because they were either not qualitative or they were not relevant to the topic at hand (Figure 3.1).

Figure 3.1: Quorum Chart



Next, demographics and themes from each of these articles were recorded in a data table (see tables 1 and 2 below); after reading these articles a few times, new, overarching themes from the cross-study analysis were derived. Finally, triangulation was completed with the faculty advisor to ensure that personal biases did not lead to misinterpretation of the results. (Aguirre & Bolton, 2013). Some of these biases include personal work experience and working with high school teenagers who struggled academically in most of

their classes. Most of these students were diagnosed with ADHD and some were taking medication. They were considered at risk of being kicked out of school because of their behavior issues. These individuals struggled in most of their classes, however, the hour and half they sat one-on-one or in small groups, they were able to sit and focus the entire time. Getting to know them throughout the years, a common theme emerged. These students all came from dysfunctional families. Some were struggling with absent parents while others were struggling with emotionally and sexually abusive situations. After a few months of being in counseling, these students behavioral issues lessoned dramatically in the classroom. Research was conducted on this topic to see if there is a way to help these students more effectively, and at a younger age.

Table 3.1: Demographics of Studies Included in QIMS

Authors and publication year	**Tradition and data collection method**	**(N)**	**Age, sex, race, ethnicity**	**Setting**	**Presenting problem**
Cummings, Addante, Swindell, & Meadan, 2017	Initial contact through survey via phone or email; combined questionnaire and semi structured interviews were conducted either by phone or face-to-face meeting	14 community-based service providers	Male and female professionals who provide services to young children ages 0-5 and their families	Phone, or at a convenient place that was agreed upon by both parties	Counseling and enhancing support for young people. Improving parent-child relationship
Foster, 2017	Narrative intervention and analysis	19	3-17; males; 8 Caucasian, 7 Latino, 2 African American, and 2 Mixed	"The Center"- a large center that specializes in advocating for treating child abuse victims	Counseling for young males who are victims of sexual abuse
Leahy, 2015	Grounded Theory Approach; Individual interviews	8	30-64; 5 men and 3 women; White, non-Hispanic	Not specified	Counseling and enhancing support for young people who are dealing with a mentally ill parent
Oaksford & Frude, 2003	Psychometric testing; face-to-face interviews	11	18-41; females	Qualified counselor and clinical psychologist	Counseling for young people
Tutty, 2014	Focus groups; individual semi structured interviews	116	6-12; 65 girls, 51 boys; 97 Caucasian, 11 East Indian/Middle Eastern, 7 Asian, 1 South American	2 Elementary schools in Calgary	Childhood sexual abuse prevention programs

Table 3.2: Themes Extracted from Original Studies

Author and Year	**Original Themes**
Cummings et al., 2017	Theme 1: Realizing the existence and impact of trauma among young children • The existence of trauma: Defining characteristics • The impact of trauma: Adaptive behaviors Theme 2: Recognizing reactions to trauma • Emotional and behavioral signs • Identification challenges • Resilience Theme 3: Responding to trauma: Promotive approaches and strategies • Be attuned • Convey positive regard • Collaborate with parents and other professionals • Support positive social and emotional and communicative responses • Engage in proper reactions Theme 4: Resisting re-traumatization: Environmental considerations • The social environment • The temporal environment • The physical/sensory environment
Foster, 2017	Theme 1: Memories of the abuse • Boys' abuse descriptions • Perpetrators of the abuse • Force • Threats • Pressure • Manipulation • Bribes • Thoughts and feelings Theme 2: The disclosure and subsequent events • The disclosure • The investigation • The justice system
Leahy, 2015	Theme 1: New Themes Theme 2: School as a refugee during the elementary years Theme 3: Quiet students in secondary school Theme 4: Role of relatives Theme 5: Clinical significance
Oaksford & Frude, 2003	Theme 1: Qualitative results: Immediate and long-term coping strategies. • Psychological escapes • Support Seeking • Action Oriented • Cognitive appraisal • Positive reframing (long-term coping only) Theme 2: Changes in coping strategies across time
Tutty, 2014	Theme 1: Prior exposure to sexual abuse prevention concepts Theme 2: Key concepts learned from the program Theme 3: What children like about WDYT Theme 4: Children's comfort with WDYT material Theme 5: Suggested changes to WDYT

CHAPTER 4

RESULTS

4.1 Results from the Voices of the Survivors

The QIMS produced six major themes: a) setting the stage, b) the unexpected role of school, c) how it ended, d) how it started, e) long-term effects of abuse (two subthemes including, fear and mistrust and inner strength and empathy for others), and f) intervention/prevention methods. The first five major themes cover one overarching theme of identifying the ways a child may cope with abuse in a classroom setting, and how they can be similar to the symptoms of ADHD. The sixth theme of intervention/prevention methods depicts appropriate ways a school can create a supportive environment for children who were abused and/or to prevent abuse from occurring. The following table demonstrates these new, overarching themes that emerged from the original articles.

Table 4.1: New Overarching Themes with Original Themes Noted

New, Overarching Theme	Original Themes that Aligned with New Theme
Setting the stage	Memories of the abuse[1] • Boys' abuse descriptions • Thoughts and feelings Qualitative results: Immediate and long-term coping strategies[2] • Psychological escapes • Cognitive Appraisal
How it started	Memories of the abuse[1] • Perpetrators of the abuse • Force • Threats • Pressure • Manipulation • Bribes Role of relatives[3]
The unexpected role of school	New Themes[3] • School as a refugee during the elementary years[3] • Quiet students in secondary school[3] • Thoughts and Feelings[1] Recognizing reactions to trauma[4] • Identification challenges
How it ended	The disclosure and subsequent events[1] • The Disclosure Qualitative results: Immediate and long-term coping strategies[2] • Support seeking
Long-term effect of abuse • Mistrust and fear • Inner strength and empathy for others	Qualitative results: Immediate and long-term coping strategies[2] • Action Oriented • Cognitive appraisal • Positive reframing (long-term coping only) Recognizing reactions to trauma[4] • Identification challenges Realizing the existence and impact of trauma among young children[4] • The impact of trauma: Adaptive behaviors
Intervention/prevention methods	Responding to trauma: Promotive approaches and strategies[4] • Be attuned • Convey positive regard • Collaborate with parents and other professionals • Support positive social and emotional and communicative responses • Engage in proper reactions Resisting re-traumatization: Environmental considerations[4] • The social environment • The temporal environment • The physical/sensory environment What children like about WDYT[5] Children's comfort with WDYT material[5] Suggested changes to WDYT[5] Key concepts learned from the program[5]

Notes: Foster (2017)[1]; Oaksford and Frude (2003)[2]; Leahy (2015)[3]; Cummings et al. (2017)[4]; Tutty (2014)[5]

4.1.1 Setting the Stage

When a child is being abused, especially if it is sexual abuse, many thoughts and feelings consume their mind which can make it difficult for them to stay focused in a classroom setting (Leahy, 2015, p. 104). The following quotations describe some of the ways a child may try to cope with a traumatic event, including feeling sad, finding ways to distract themselves, denying, downplaying the event, and trying to reason with their abuser (Foster, 2017; Oaksford & Frude, 2003): "It hurt, and I felt sad" (Foster, 2017, p. 859); "Now my face is frowning and sad because of what happened" (Participant 7, age 10) (Foster, 2017, p. 862); "I used to pretend I was asleep...and I used to cut off and think of other things. I used to think about really silly irrelevant things just to take my mind off what he was doing" (Oaksford & Frude, 2003, p. 58); "I used to think I was making a fuss about nothing and it wasn't that bad" (Oaksford & Frude, 2003, p. 60); "I tried to reason and think that it was because of his temper and he couldn't help himself" (Oaksford & Frude, 2003, p. 61).

4.1.2 How it Started

Foster (2017) interviewed survivors of child sexual abuse to understand how the abuse started. One participant stated that his abuser would tell him, "He would say he was just playing" (Foster, 2017, p. 859). Another participant explained that his abuser would find him whenever he was left alone without adult supervision. "He would abuse me whenever he got the chance to when his parents were not around, which was pretty much like always…. He abused me in his room … in the pool … in his living room" (Participant 4, age 10) (Foster, 2017, p. 860). Another way abusers attacked their victims was through force and threats, "He grabbed onto me and threw me on the bed. I felt bad, and he laughed"

(Participant 15, age 5) (Foster, 2017, p. 861), "He use [sic] threaten me with a BB gun. He used to say that he won't be my friend if I didn't do it" (Participant 4, age 10) (Foster, 2017, p. 861). Finally, the most powerful method that abusers used to start the abuse were different forms of manipulation, "He only made me perform oral sex on him one time. It was super nasty. The only reason I did it was because every day all the time he just kept asking me to do it" (Participant 2, age 14); "He told me that he would only buy me the video game if I let him touch my private part for one month" (Participant 17, age 13), (Foster, 2017, p. 861);

> He told us to follow him and so we followed him…. He told us he needed to practice on us and somehow the conversation was steered into me and [other child victim] pulling our pants down, and so we did just that. Right then and there he anally raped both me and [another child victim]. (Participant 10, age 17), (Foster, 2017, p. 861)

4.1.3 Unexpected Role of School

Many children who were being abused at home found school to be an escape for them, and it provided them stability that they did not receive at home: "It was definitely an escape, and yes I did like school" (Leahy, 2015, p. 104); "I craved normalcy and felt that I received it at school" (Leahy, 2015, p. 104); "School made sense of chaos for me" (Leahy, 2015, p. 104).

Some children could not focus in school because their minds would keep wandering to the abuse or they would obsessively worry about their loved ones: "I guess you could say I was a bit of a daydreamer" (Leahy, 2015, p. 104); "I was preoccupied worrying about my mom, which made it hard to concentrate" (Leahy, 2015, p. 104); "It happens sometimes in school and prevents me from actually paying attention because instead of learning and

listening to what the teacher is saying. I just sit there and think of nothing but the abuse" (Participant 10, age 17) (Foster, 2017, p. 862). It was also noted that a teacher might think that a child is "not listening" or "ignoring" when instead they "check out" because they are overwhelmed (Cummings, 2017, p. 2733). Other survivors would make sure no one noticed them: "I was really quiet in school" (Leahy, 2015, p. 104); "I was quiet, shy, and basically invisible as a kid. I was the good, quiet child" (Leahy, 2015, p. 104); "no one noticed me" (Leahy, 2015, p. 104).

4.1.4 How it Ended

From the moment the abuse starts a child wishes they could tell someone but does not know who nor how. The following is a statement from a child survivor of sexual abuse, "My worst memory with this whole experience was thinking about when, who, and if I should tell. I was worried how I was going to encourage myself to tell and also how the person would react that I told" (Participant 11, age 11) (Foster, 2017, p. 863).

This child chose to tell his mother because he felt that she could really help him. "The person I told was my mom. I told her because I didn't feel too comfortable telling my dad, and I felt like she could help me more" (Participant 19 (age 8), (Foster, 2017, p. 863).

The following two survivors expressed feeling a sense of relief and protection once they told their parents about the abuse: "I felt safe after I told because it wasn't going to happen anymore" (Participant 17, age 13) (Foster, 2017, p. 864); "I could deal with it as soon as I told my parents, because I had my parents 100% support" (Oaksford & Frude, 2003, p. 62).

Contrastingly, one survivor expressed feeling further rejected, ". . . my parents were very angry with me for mucking up their year and mucking up my sister's year...everyone was very angry with me at home" (Oaksford & Frude, 2003, p. 59).

4.1.5 Long-Term Effects

Trauma that is left untreated has long-lasting effects as well. For example, one survivor stated that, "I won't go out late at night on my own. And if a boy asks me out, I just won't go out with him, I'm so overly cautious about them taking advantage of me" (Oakford & Frude, 2003, p. 62). Another survivor stated that she always feels on guard, "It's put me on my guard a lot more, definitely. I'm just much more aware and not so naïve. That's been really useful" (Oaksford & Frude, 2003, p. 63). Small children will exude similar reactions as adults do long-term. They will appear guarded,

> "Linda shared, they will strike out first. So, they are aggressive as well, like, 'I'm going to hurt you before you hurt me, kind of 'I'm going to be on guard all the time.' And so, it's kind of their first reaction to things might be kind of aggressive and push away …to protect themselves from hurt. We've certainly seen that" (Cummings, 2017, p. 2735).

Small children who were abused may also appear fearful at specific times of the day:

> I think it differs depending on age and child, but some of the typical ones are, definitely for younger children, just overly emotional and some…they can be fearful…night terrors are something I've seen or trouble sleeping. The fear of being alone, maybe just constant crying is something that I've seen as well. Inability to be consoled. I've also seen, I guess reclusion would be the word, where a child just wants to be isolated just kind of has a fear of adults or maybe attaches to one adult

> but is afraid of interacting with others. For different types of physical or sexual abuse I would definitely say changing and bathing and things like that. There is a definite fear surrounding that. You can just kind of see the fear in crying, in body language, stiff bodies when they are picked up. (Cummings, 2017, p. 2735)

On the other hand, many survivors take their tough experiences to reach unimaginable strength and courage to not only help themselves but to support others who have had similar experiences. "I think it's made me more self-assertive, and now I put across more what I want. I'm definitely a much more confidant person because of what happened" (Oaksford & Frude, 2003, p. 63); "I think now, when people come to me with their problems, because of what I went through, I can think rationally and empathize better, and help them, and that's got to be a good thing" (Oaksford & Frude, 2003, p. 63); and, "I think it's made me a better listener. I can relate to people in sort of similar circumstances, as I've got a sense of what people might be going through" (Oaksford & Frude, 2003, p. 63).

4.2 How to Better Prepare Young Children to Prevent Future Victimizations

Children spend most of their day at school, therefore, it is important that teachers and caregivers at school are aware of the signs of abuse to ensure that the right intervention plan is implemented to help this child. The following quotations are ways in which a teacher can make a significant impact on a child's life: Terry explained that when a child has gone through something potentially traumatic "looking at the bigger picture" is important (Cummings et al., 2017, p. 2736); "I think keeping a respectful relationship with the parents is going to make sure that you're more knowledgeable of what your kids are

going through and what kind of mindset they're bringing into the classroom" (Cummings et al., 2017, p. 2737); "I think music, rhythm, dancing, kind of that, those kinds of activities that kind of bring us into a kind of more relaxed state, I think [those] kind of activities are really important" (Cummings et al., 2017, p. 2737).

In addition to looking out for the signs of abuse, when handling a difficult child, it is important to approach them with unconditional, positive regard. For example, "We'll see you tomorrow and we're going to start again tomorrow" (Cummings et al., 2017, p. 2736).

> It is also important to stay attuned to each child's needs and situations that may be triggering. I think children pick up on an adult's demeanor and I think if an adult is maybe not warm or friendly to an extent and represents a coldness of maybe of someone whom they've experienced trauma with before that could be a characteristic. Social interactions with children with other children as well. A lot of times in homes we'll see large families where abuse has occurred with an older sibling or cousin and that will trickle down to the younger children…That can cause anxiety as well from child to child (Cummings, et al, 2017, p. 2738).
>
> Linda noted,…especially after a weekend…I've heard teachers say, 'It's the worst time, I hate that period of time,' because they're very, like, they've experienced—and they have to come back in to the classroom and reacclimate to a system or a schedule, um, at the end of the day, um, or at the end of the week, that's difficult for some children. I think, um, around meal times, around, uh, certainly around nap times—nap time really starts out-or if they have to use the restroom, if they have to use the bathroom, so all of those basic functions…they'll throw up after they eat, or they just fight going to sleep, they won't even won't even lay down on the pad.

> Those are all, you know they could be indicators of trauma, I don't want to say that it always is. (Cummings et al., 2017, p. 2738)

"Linda explained, 'Fire alarms, slamming of a door, chaotic environments where they see a lot of movement in the room is very disorienting to the child'" (Cummings et al., 2017, p. 2738).

Another significant role a teacher/caregiver can fulfill in a school setting is teaching their students about what to do if they are victimized, such as is done in the program Who Do You Tell (WDYT). This program was created to educate children as young as four years of age about appropriate and inappropriate touching. Children also learn who they should tell if someone is touching them inappropriately. For example, a first grader learned how to be safe from this program. "[Was it a good program?] 'Yeah.' [What did you like about it?] 'It teaches us to be safe'" (Grade 1) (Tutty, 2014, p. 25). Fourth graders learned new things from taking WDYT. "[Did you like WDYT?] 'Yes' (in chorus). 'Yes, it was very informative.' 'I liked it because I learned some things I didn't know before' (Grade 4) (Tutty, 2014, p. 25).

Most students felt comfortable taking this program; however, they made some suggestions that would improve WDYT. "[Did anybody feel uncomfortable?] 'No' (in chorus). [You didn't feel nervous?] 'No' (in chorus). [Not scared that it might happen to you?] 'No' (in chorus)" (Grade 1) (Tutty, 2014, p. 28); "I would separate the girls and the boys and talk to the girls about the boy's private parts and the boys about the girl's private parts"; "[To the boys: Is that true for you?] 'Yeahs' (Grade 4) (Tutty, 2014, p. 29); "I think the teachers should teach us. The teachers know us through the year. They [WDYT

program staff] came in and talked. We didn't ask questions because we didn't know them. They kept asking if we had questions" (Grade 6) (Tutty, 2014, p. 29).

These students learned that they should tell a grown up, and that it is okay to stand up for themselves. "If somebody touches you, you need to tell a grown-up" (Grade 1), (Tutty, 2014, p. 29); "If somebody touches your private, and you say, 'Please don't do that, and they still keep on doing that, tell a parent'" (Kindergarten), (Tutty, 2014, p. 29); "You can even tell your friends. You can tell the principal. You can tell your uncle, your teacher, or your mom and dad" (Grade 2), (Tutty, 2014, p. 29); "It said what to do if you do get sexually abused, how to handle it. You've got to tell someone or it just keeps happening" (Grade 6), (Tutty, 2014, p. 29).

4.3 Discussion

QIMS was used to conduct a thorough search on existing data in order to compare ADHD symptoms to symptoms of abuse and neglect. Theme 1 (Setting the Stage), states that the reason a child may appear to not be listening to instructions in a classroom setting is because that child may be too preoccupied processing a traumatic event. Theme 2 (How it Started), describes different ways in which the abuse may have started. Foster (2017) found that a child left alone without adult supervision is more likely to be abused. This is important information for parents and teachers to note in order to help child victims of abuse, and prevent future abuse of young children. The articles studied for this paper also uncovered the surprising, positive role that school played in a child survivors' life. Many children used school as an escape from the abuse and the chaos that waited for them at home every day. Some children exhibited signs of hyperactivity/impulsivity type ADHD by becoming really loud, seeking any type of attention, and being unable to stay focused.

Other children exhibited signs of inattention type of ADD, and did everything they could to shy away from the limelight, achieving the label as the good, quiet student. A caregiver who notices a dramatic shift in a child's behavior should question that behavior and see if there is an underlying issue other than ADHD going on in that child's life (See Figure 4.2 for additional signs to look for in identifying abuse). Furthermore, a school can have an even greater impact in helping a child victim by creating a safe environment for all children. Oftentimes, a child is looking for someone to tell but does not know whom to turn to. Caregivers who create a safe environment will help a child open up and is more likely to: 1) support their needs, 2) put an end to the abuse, and 3) give the child a chance to heal and live a healthy, productive life. Healing from a traumatic event at the time the abuse occurs can prevent some of the long-term negative effects. Long-term negative effects include: hypervigilance, mistrust in almost everyone, and fear. There were also some positive long-term effects that survivors gained from their traumatic experiences as a child. These include a higher level of intuition, being able to help others, being assertive, and developing confidence.

Figure 4.2: Five Ways Abuse Can be Misdiagnosed as ADD/ADHD

- A child who cannot seem to settle down may be suffering from abuse
- ADHD/ADD symptoms that seem to get worse in a child as they get older
- A child who is extremely quiet
- A child who is defiant towards authority/teachers
- A child who doesn't care whether he/she does well in school, and puts in zero effort into school work

Understanding the impact trauma can have on a young child's development brings into question how to better prepare our children to prevent future victimization. The

program WDYT was developed to teach young children, as young as age four, how to protect themselves from sexual abuse. Although it may have caused some students discomfort, they all found the program to be educational and eye opening. The following is a list of some of the ideas these children learnt from WDYT: 1) what is considered inappropriate touching, 2) they can say no if the touching makes them feel uncomfortable, 3) that someone close to them are usually the ones to take advantage of them, and 4) it is okay to tell an adult even if the abusers tells them they should not tell anyone. Lessons these children learn are extremely important in preventing further child victimization.

Table 4.2 compares the symptoms of ADHD to the symptoms of a child coping with abuse. The purpose of the table is to clearly show how similar these symptoms are, which can lead to misdiagnoses in young children. This could prevent many young children from receiving the assistance they need. A child may not be able to focus and appear to be inattentive because that child really cannot focus or because they are trying to process something traumatic, while another child may act hyper and impulsive as a way to cope with trauma and set boundaries.

Table 4.2: Distinguish Between ADHD and Abuse Symptoms in a Classroom Setting

ADHD Symptoms (according to the DSM-5)	**Abuse Symptoms**
Inattention • Has difficulty keeping attention on one task for long periods of time • Appears to not listen when spoken to directly • Fails to complete tasks, such as homework assignments • Easily distracted • Avoids activities that require long periods of mental effort (Diagnosis of ADHD using DSM-5TM). Hyperactive/impulsive • Fidgets, taps hands, squirms in one seat • Acts as if always on the go, talks excessively • Interrupts others, and blurts out answers (Diagnosis of ADHD using DSM-5TM).	Inattention • This child is trying to process a traumatic event and will appear inattentive in class. "It happens sometimes in school and prevents me from actually paying attention because instead of learning and listening to what the teacher is saying. I just sit there and think of nothing but the abuse" (Participant 10, age 17) (Foster, 2017, p. 862). • Linda also noted that a teacher might think that a child is "not listening" or "ignoring" when instead they "check out" because they are overwhelmed. (Cummings, 2017, p. 2733). Hyperactive/impulsive • Other children may fight back as a way to cope with trauma. "…. they just fight going to sleep, they won't even won't even lay down on the pad. Those are all, you know they could be indicators of trauma, I don't want to say that it always is (Cummings et al., 2017, p. 2738). • Linda shared, they will strike out first. So, they are aggressive as well, like, "I'm going to hurt you before you hurt me……" (Cummings, 2017, p. 2735).

4.4 Study Limitations

Using this method has its limitations. First, there is no way to interview the sample participants if there are further questions or more clarification is needed. Second, as with all qualitative research, objectivity is hard to achieve and there may be some level of researcher biases in these articles when reviewing them for themes. The fact that this research was looking for a specific topic may have caused the articles to be incorrectly interpreted. In order to decrease the chances of this happening, triangulation was done with the faculty advisor.

CHAPTER 5

CONCLUSION

This study shows that additional research is required to explore the connection between an unsupportive or abusive environment and the symptoms of ADHD. Before diagnosing and medicating a child, it is necessary to get to the root of the issue in order to provide the proper treatment. Medicating a child for ADHD who does not have the disorder will actually serve as a stimulant and exacerbate the behaviors intended to be treated, defeating the purpose.

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BIOGRAPHICAL INFORMATION

Miriam Tepper grew up in New York City. She took three years of college through Touro College before moving to Dallas, TX in 2012. At first Miriam wanted to be a Physical Therapist, but was offered a job to teach and mentor high school students in Dallas. After her first year, Miriam pursued a degree in Personal Training and Health Management through Ultimate Medical Academy. She was certified in 2014 and worked part-time at 24-hour Fitness as a personal trainer, and part-time as math and science tutor. Miriam fell in love with the helping profession and being able to work with clients one-on-one; however, she wanted to more than help people learn a healthy lifestyle through exercise and eating well. Miriam enrolled in the School of Social Work at the University of Texas at Arlington (UTA) in 2016, and graduated with an Honors Bachelor in Social Work in 2018. She plans to continue in the UTA Social Work graduate program beginning in Spring 2019.